The Affordable Care Act: Let’s Get Ready for the 2013/2014 Health Care Reform Mandates

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PLEASE NOTE: In order to lighten this presentation, we’ve included some health care reform cartoons throughout, presenting both sides of the political debate on this issue. ThinkHR is committed to providing our clients with the facts and tools to comply with the laws and have no political opinion – either way – on the Affordable Care Act. Our only goal is to educate you and give you the tools you need to manage your health care compliance.
“Ashley wanted to play doctor, but I’m trying to stay out of the health care debate.”
What We’ll Cover Today

• The Affordable Care Act (ACA) Timeline:  Where We Have Been and What Lies Ahead
• Employer Shared Responsibility Provisions (“Play or Pay”)  
• “Minimum Value” and “Affordability” Rules
• Insurance Exchanges and What That Might Mean To Your Business
• Key Dates and Next Steps: Preparing for ACA
"Yes, we have 'All You Need To Know About The Health Care Legislation' but it is part of a twelve volume set."
ACA Timeline: Where We’ve Been

2010

• **March 3, 2010:** Affordable Care Act (ACA) signed into law
• **Extended Coverage for Young Adults:** Group health plans and health insurance issuers make coverage available for adult children up to **age 26.** Some states provide for additional coverage past that age
• **Grandfathered Plans** (health plans in existence on or before March 23, 2010) exempt from many ACA reforms
• **Reinsurance for Covering Early Retirees:** Temporary reinsurance program established to reimburse participating employment-based plans for providing health insurance coverage to early retirees, spouses, surviving spouses and dependents – program designed to end on January 1, 2014, or earlier, if the $5 billion in funding was exhausted -- closed to new applications effective May 5, 2011, no longer accepting reimbursement requests for claims incurred after December 31, 2011
ACA Timeline: Where We’ve Been

2010 – continued

• **Pre-existing Condition Exclusions for Children under age 19**: This provision applies to all employer plans and new plans in the individual market. This provision will also apply to adults in 2014.

• **Coverage of Preventive Care Services**: Group health plans/health insurance issuers must provide coverage for certain preventive care services without cost-sharing (deductibles, copayments or coinsurance). Grandfathered plans exempt

• **Prohibiting Rescissions** (retroactive cancellations of coverage): Plans and issuers must provide at least 30 days’ advance notice before coverage may be rescinded and applies to all grandfathered and non-grandfathered plans

• **Lifetime and Annual Limits**: No lifetime limits or unreasonable annual limits on essential health benefits; applies to all plans, with the exception of plans that applied and received a waiver of the annual limit requirement (closed to applications in September 2011); all annual limits will be prohibited beginning in 2014
ACA Timeline: Where We’ve Been

2010 – continued

- **Nondiscrimination Rules for Fully Insured Plans (provision delayed indefinitely):** Fully insured group health plans will have to satisfy nondiscrimination rules prohibiting eligibility to participate in the plan and eligibility for benefits in favor of highly compensated individuals – grandfathered plans exempt from this rule.

- **Rebates for the Medicare Part D:** Once the Medicare Part D plan and participant have paid $2,930 in total drug costs ($2,970 for 2013), the participant is in the coverage gap (often called the “donut hole”). The coverage gap ends when the participant has spent $4,700 ($4,750 for 2013) out of pocket for drug costs in a calendar year.
  - 2010: ACA provided a $250 rebate check for all Medicare Part D enrollees who entered the donut hole.
  - 2011: ACA provided discounts on brand-name drugs and generic drug coverage in the donut hole.
  - Lawmakers expect that the donut hole gap will be filled by 2020.
ACA Timeline: Where We’ve Been

2010 – continued

• Medicaid Flexibility for States: State option under to cover additional individuals under Medicaid -- parents and childless adults up to 133 percent of the Federal Poverty Level
• Small Business Tax Credit: Phase 1 of the small business tax credit for qualified small employers began in 2010 where eligible employers could receive a credit for contributions to purchase health insurance for employees.
  – Tax credit: Up to 35 percent of the employer’s contribution to provide health insurance for employees.
  – Up to a 25 percent credit for small tax-exempt organizations
  – When health insurance exchanges are operational (2014): Tax credits increase up to 50 percent of premiums
ACA Timeline: Where We’ve Been

2011

- **Medical Loss Ratios:** Health insurance issuers annually report on the share of premium dollars spent on health care and provide consumer rebates for excessive medical loss ratios – employers then must distribute the MLR rebates to eligible plan enrollees in 2012

- **Qualified Medical Expenses:** ACA changed the so that expenses for over-the-counter medicines and drugs may not be reimbursed by these tax-favored reimbursement plans (FSAs, HRAs, HSAs) unless they are accompanied by a prescription, except for insulin and some medical supplies and devices

- **Cafeteria Plans:** Simple cafeteria plan created for small businesses to provide tax free benefits to employees and exempts employers from some nondiscrimination requirements that apply to highly compensated and key employees
ACA Timeline: Where We’ve Been

2011 – continued

- **Medicare Part D:** 50 percent discount on brand-name drugs in the “donut hole”
- **Additional Preventive Care Services:** Free, annual wellness visit and personalized prevention plan services for Medicare beneficiaries, eliminated cost-sharing for preventive care services
- **Increased Tax on Withdrawals from HSAs and Archer MSAs:** HSA withdrawals prior to age 65 for non-qualified medical expenses tax up from 10 to 20 percent; Archer MSA withdrawals for non-qualified medical expenses increased from 15 to 20 percent
ACA Timeline: Where We’ve Been

2012

- **Preventive Care Services for Women** (effective for plan years beginning on or after August 1, 2012): Includes specific services for women, including contraceptives and contraceptive counseling (with exceptions to the contraceptive coverage requirement for religious employers)

- **Uniform Summary of Benefits and Coverage**: All health plans must provide a uniform summary of the plan’s benefits and coverage to participants, written in easily understood language and limited to four double-sided pages. Any mid-year changes to the summary must be provided to participants 60 days in advance.
ACA Timeline: Where We’ve Been

2012 – continued

• **Uniform Summary of Benefits and Coverage:** Plans and issuers must start providing the summary by the following deadlines:
  - Health plans effective September 23, 2012
  - To participants and beneficiaries who enroll or re-enroll during an open enrollment period starting with the first day of the first open enrollment period that begins on or after September 23, 2012
  - To participants who enroll for coverage other than through an open enrollment period (for example, newly eligible individuals and special enrollees) starting with the first day of the first plan year that begins on or after September 23, 2012

• **Reporting Health Coverage Costs on Form W-2:** Requirement is optional for small employers (those filing fewer than 250 Form W-2s) at least for the 2012 tax year and will remain optional until further guidance is issued; mandatory for employers that file at least 250 Forms W-2 for 2012
2012 – continued

• **Medical Loss Ratio Rebates:** Sponsors of fully insured plans receive rebates by August 1, 2012 if they qualify for a rebate; any portion of a rebate that is a plan asset must be used for the exclusive benefit of the plan’s participants and beneficiaries.

• **Comparative Effectiveness Research (CER or PCORI) Fees – plan years on or after October 1, 2012:** Plan issuers and sponsors of self-insured health plans must pay fees to fund health care research. For calendar year plans, the fees will be effective for the 2012 through 2018 plan years.
  
  • 2012 calendar year plans: Research fee is $1 multiplied by the average number of lives covered under the plan, with the first due date for paying fees on July 31, 2013
  
  • Plan years ending on or after October 1, 2013 and before October 1, 2014 (indexed for future years): Fee raises to $2 per covered lives annually until plan years ending on or after October 1, 2019 payable by July 31 of each year
ACA Timeline: Today

2013

• **Health Flexible Savings Account Contribution Limits** (effective for plan years beginning after December 31, 2012): Health FSAs limited to salary reduction contributions of $2,500 per year, indexed by CPI for subsequent years.

• **Employee Notice of Exchanges (October 1, 2013):** Employers must provide a notice to employees regarding the availability of the health care reform insurance exchanges. The purpose is to provide employees with: (1) information about the Marketplaces; (2) how to request assistance in accessing the Marketplaces; (3) describing the availability of a premium tax credit (if applicable) and (4) explaining the implications for the employee if they decide to purchase a qualified health plan through a Marketplace.
ACA Timeline: Today

2013 -- continued

• HIPAA Certification (by September, 2013): Employers with group health plans must certify that their plans comply with certain HIPAA rules on electronic transactions. HHS intends to issue more guidance on this requirement in the future.

• Medicare Part D Subsidy: Tax deduction for employers that receive the Medicare Part D retiree drug subsidy eliminated in 2013

• Additional Medicare Tax: Medicare hospital insurance tax rate increased 0.9 per cent on wages over $200,000 for an individual ($250,000 for married couples filing jointly). The tax is expanded to include a 3.8 percent tax on net investment income in the case of taxpayers earning over $200,000 ($250,000 for joint returns).

• Medical Device Excise Tax: 2.3 percent excise tax on the first sale for use of a medical device, excluding eye glasses, contact lenses, hearing aids, etc.
ACA Timeline: What Lies Ahead

2014

- **Individual Coverage Mandates:** Most individuals will be required to obtain acceptable health insurance coverage or pay a penalty, beginning in 2014.
  - 2014: $95 per person and increases each year
  - Penalty increases to $325 in 2015 and to $695 (or up to 2.5 percent of income) in 2016, up to a cap of the national average bronze plan premium.
  - After 2016, dollar amounts are indexed. Families will pay half the penalty amount for children, up to a cap of $2,250 per family.
  - Individuals may be eligible for an exemption from the penalty if they cannot obtain affordable coverage.
ACA Timeline: What Lies Ahead

2014 -- continued

• Employer Coverage Requirements: Employers with 50 or more employees (or full-time equivalents) that do not offer coverage to their employees will be subject to penalties if any employee receives a government subsidy for health coverage.
  • Penalty amount: Up to $2,000 annually for each full-time employee, excluding the first 30 employees.
  • Employers who offer coverage, but whose employees receive tax credits because the coverage is unaffordable or does not provide minimum value, will be subject to a fine of $3,000 for each worker receiving a tax credit, up to an aggregate cap of $2,000 per full-time employee (excluding the first 30 employees).
  • Employers will be required to report to the federal government on health coverage they provide.

• We’ll spend more time on this requirement and what you need to do next.
2014 – continued

- **Health Insurance Exchanges:** Small employers with no more than 100 employees may be able to shop for insurance through the state or federal exchange.
  - States may limit employers’ participation in the exchanges to businesses with up to 50 employees until 2016
  - Large employers with over 100 employees are to be allowed into the exchanges in 2017
  - States have three options with respect to their exchanges:
    - Establish and run a state-based exchange
    - Have HHS establish a federally facilitated exchange (FFE) for their residents or
    - Partner with HHS so that some FFE functions can be performed by the state

- **Guaranteed Issue and Renewability:** Individual/group market issuers in a state must accept every employer/individual in the state applying for coverage and must renew or continue to enforce the coverage at the option of the plan sponsor/individual.
ACA Timeline: What Lies Ahead

2014 – continued

• **Pre-existing Condition Exclusions:** Group health plans/health insurance issuers may not impose pre-existing condition exclusions on any covered individual, regardless of the individual’s age.

• **Insurance Premium Restrictions:** Health insurance issuers in the individual and small group markets will not be permitted to charge higher rates due to health status, gender or other factors.
  - Premiums will be able to vary based only on age (no more than 3:1), geography, family size and tobacco use.
  - The rating limitations will not apply to health insurance issuers that offer coverage in the large group market unless the state elects to offer large group coverage through the state exchange (beginning on or after 2017).
  - Does not apply to grandfathered coverage

• **Nondiscrimination:** Group health plans/health insurance issuers offering group or individual health insurance coverage (except grandfathered plans) may not establish rules for eligibility or continued eligibility based on health status-related factors.
ACA Timeline: What Lies Ahead

2014 – continued

• **Nondiscrimination (continued):** Group health plans/health insurance issuers offering group or individual insurance coverage may not discriminate against any provider operating within their scope of practice. This does not require a plan to contract with any willing provider or prevent tiered networks and does not apply to grandfathered plans.

• **Annual Limits:** Plans and issuers may not impose annual limits on the coverage of essential health benefits.

• **Excessive Waiting Periods:** Group health plans/health insurance issuers offering group or individual health insurance coverage will not be able to require a waiting period of more than 90 days.

• **Coverage for Clinical Trial Participants:** Non-grandfathered group health plans/insurance policies cannot terminate coverage because an individual chooses to participate in a clinical trial for cancer or other life-threatening diseases or deny coverage for routine care that they would otherwise provide just because an individual is enrolled in such a clinical trial.
ACA Timeline: What Lies Ahead

2014 – continued

• **Benefits Coverage:** Health insurance issuers that offer health insurance coverage in the individual/small group market must provide the essential benefits package required of plans sold in the health insurance exchanges. This requirement does not apply to grandfathered plans.

• **Limits on Cost-Sharing:** Non-grandfathered group health plans will be subject to limits on cost-sharing. Out-of-pocket expenses may not exceed the amount applicable to coverage related to HSAs and deductibles may not exceed $2,000 (single) or $4,000 (family), with amounts indexed for future years. Proposed guidance provides that the limits will apply to plans and issuers in the small group market only and not self-funded plans or plans in the large group market.
ACA Timeline: What Lies Ahead

2014 – continued

• **Employer Wellness Programs:** The potential incentive for employers offering wellness programs increases to 30 percent of the premium in 2014 for employee participation in the program or meeting certain health standards. Employers must offer an alternative standard for those employees whom it is unreasonably difficult or inadvisable to meet the standard. This incentive may be increased up to 50 percent.

• **Individual Health Care Tax Credits:** Premium tax credits will be available through the exchanges to ensure people can obtain affordable coverage (apply to premiums and cost-sharing). Credits are available for people with incomes above Medicaid eligibility and below 400 percent of poverty level who are not eligible for or offered other acceptable coverage.

• **Small Business Tax Credit:** Qualified small employers can receive a credit for contributions to purchase health insurance for employees, up to 50 percent of premiums.
Believe it or not, we actually get questions about this provision of the ACA that is so far into the future!

• "Cadillac Plan" Excise Tax: 40 percent excise tax will be imposed on the excess benefit of high cost employer-sponsored health insurance, often called a “Cadillac Plan”.
  • Annual limit for purposes of calculating the excess benefits is $10,200 for individuals and $27,500 for other than individual coverage
  • Responsibility for the tax is on the “coverage provider” which can be the insurer, the employer or a third-party administrator.
  • There will be further guidance regarding the exceptions and special rules for high coverage cost states and different job classifications.
Employer Shared Responsibility Provisions

Time to get ready – only months away! Does this apply to you? If so, then will you “play” or “pay”?

Let’s take a look at some of the key features of this part of the ACA – the “large” employer mandate to provide “minimum value” and “affordable” coverage beginning January 1, 2014.
Is Your Company Subject to “Play or Pay”? 

IF YOU:

• Employed at least 50 full-time employees (including full-time equivalents) in the preceding calendar year

• Offer employees the opportunity to enroll in health care coverage to at least 95% of your full-time employees and dependents

THEN:

• You are subject to this provision of the ACA.

• You would not be subject to the penalty. If you did not offer coverage, you would be subject to the ACA penalty if at least one full-time employee is certified to receive a premium tax credit or cost sharing reduction to purchase coverage on an Exchange.
Is Your Company Subject to “Play or Pay”?

**IF YOU:**
- Offer coverage that provides “minimum value” and is “affordable” to each full-time employee

**THEN:**
- You would not be subject to the penalty. But if the coverage is unaffordable or does not meet required levels of coverage and at least one full-time employee is certified to receive a premium tax credit or cost sharing reduction to purchase coverage on an Exchange, there could be a penalty.
Determining Employer Size Under “Play or Pay”

Follow these steps:

- **Step One:** Calculate the number of full-time employees (including seasonal employees) for each calendar month in the preceding calendar year. *NOTE:* A full-time employee for any month is an employee who is employed, on average, at least 30 hours per week (or 130 hours per month). Hours of service include hours for which an employee is paid or entitled to payment even when no work is performed (such as vacation or sick leave).

- **Step Two:** Calculate the number of full-time equivalents (FTEs), including seasonal employees, for each calendar month in the preceding calendar year. To determine the number of FTEs monthly, calculate the total hours of service for all employees who were not full time for that month, and divide the total hours of service by 120 and record that number (including fractions) as the number of FTEs for the calendar month.

- **Step Three:** Add the number of full-time employees and FTEs from Step One and Step Two for each of the 12 calendar months in the previous year and record the total.

- **Step Four:** Divide the total sum from Step Three by 12. This will give you the average number of full-time employees for the preceding calendar year.

- *If the number you calculate is less than 50, you are not subject to the “Play or Pay” rules.*
Determining Employer Size Under “Play or Pay”

- The calculation we just did was the simple version – there are other considerations, such as special rules for counting seasonal employees, combining companies with common ownership, determining each employee’s full-time status for purposes of offering insurance when they work seasonally or do not have a fixed schedule, and other considerations.

- We will cover those considerations in more depth in future webinars. If you need help now with those rules, give us a call.
Calculating the “Play or Pay” Penalty

• For employers not offering coverage to at least 95% of full-time employees (and their dependents after 2014) where at least one full-time employee is certified to receive a premium tax credit or cost sharing reduction, here is the calculation:

\[
\text{# of Full-Time Employees} \times 30 \times 2000 = \text{PENALTY AMOUNT}
\]

* Do not count full-time equivalents in this number
“Play or Pay” Penalty Example

- Scenario: ABC Company has 130 full-time employees in each calendar month in 2014 and does not offer health coverage. At least one of the employees was certified to receive a premium tax credit or cost-sharing reduction. Here is the calculation of the penalty:

\[
\text{# of Full-Time Employees} = 130 \\
\text{MINUS } 30 = 100 \\
\text{MULTIPLIED by } $2000 \\
= $200,000
\]
Calculating the “Play or Pay” Penalty

• For employers offering coverage that is not affordable or does not provide minimum value and has one or more full-time employees certified to receive a premium tax credit or cost sharing reduction, here is the calculation:

\[
\text{# of Full-Time Employees Receiving the Premium Tax Credit or Cost-Sharing Reduction} \\
\times \frac{1}{12} \times 3000 \times \text{# of eligible months} = \text{PENALTY AMOUNT (which is the lesser of the amount calculated or the amount that would be owed if the employer did not offer coverage)}
\]
“Play or Pay” Penalty Example

• Scenario: ABC Company has 130 full-time employees in each calendar month in 2014 and offers health coverage. 10 full-time employees are certified to receive a premium tax credit or cost-sharing reduction for the full 12 months. Here is the calculation of the penalty:

# of Full-Time Employees Receiving the Premium Tax Credit or Cost-Sharing Reduction = 10
MULTIPLIED 1/12 of $3000 MULTIPLIED by # of eligible months =
(10 x 1/12 x $3000 x 12 months = $30,000)
= $30,000 (which is the lesser of the amount calculated or the amount that would be owed if the employer did not offer coverage - $200,000 in first example)
Minimum Value Definition

• Coverage will not meet ACA’s requirements if the Plan’s share of the total allowed benefit costs is less than 60 percent of the total Plan costs.

• The federal government has issued a notice proposing that employers can use one of the following methods to determine minimum value:
  – Minimum value calculator (available at http://cciio.cms.gov/resources/regulations/index.html#pm)
  – Safe harbor checklist
  – Actuarial certification
  – Meeting Metal Levels (small group plans only) -- if a plan meets any metal level with respect to coverage offered, the plan satisfies minimum value.
Affordability Definition

- Coverage is defined as unaffordable for an employee if the required contribution for self-only coverage exceeds 9.5% of household income* for the taxable year.
- *The IRS issued safe harbors applicable at least through the end of 2014 that employers may rely on to determine affordability, including using 9.5% of Form W-2 wages instead of household income
- Please note that an employer that offers affordable coverage that provides minimum value to at least 95% but less than 100% of full-time employees may still owe a penalty if an employee who is not offered coverage receives a premium tax credit or cost-sharing reduction.
Health Insurance Exchanges: 2014

• For individuals: Exchanges are expected to begin operating in 2014 as an option for individuals to buy private health insurance

• For businesses: Small Business Health Options Program (SHOP) will be operational to provide an option for qualified employers to purchase employee health coverage
  – May be eligible for a tax credit of up to 50% of the premium payments if they have 25 or fewer employees, pay employees an average annual wage of less than $50,000, and pay at least 50% of the premium
  – Eligibility rules: Small employer of no more than 100 employees
  – Offers all full-time employees coverage in the SHOP health plan
  – Either has its principal business address in the Exchange service area and offers coverage to all full-time employees through the SHOP or offers coverage to each eligible employee through the SHOP serving that employee’s primary worksite

• Final rules for employer participation in a SHOP can be found at: http://www.gpo.gov/fdsys/pkg/FR-2012-03-27/pdf/2012-6125.pdf
HEALTH CARE REFORM

TAXES → MANDATES
TAXES → PENALTIES
TAXES → FEES
TAXES → TAXES
TAXES → TAXES
TAXES → TAXES
TAXES → AMNESTY
TAXES → WASTE
TAXES → FRAUD
TAXES → ABUSE

WHERE DOES IT SAY I PAY LESS FOR HEALTH CARE?

Public Option
Key Dates and Next Steps

• Much of 2013 is already underway – employee notice of the Exchange availability is to be determined based on notification from HHS

• Now:
  – Review your health plan provisions with your insurance broker to ensure compliance with the mandates
  – Determine if you will need to comply with the Employer Shared Responsibility provisions; if so, do the preliminary calculations to determine whether you will “play” or “pay”
  – Ensure that your Plan documents are up to date
  – Work with your Finance team to ensure that your financial and reporting systems are ready for the new IRS and employee reporting requirements
  – Be ready for additional communications/questions from employees about health care issues
Key Dates and Next Steps

- Mandates taking effect in 2014 to watch and prepare for:
  - 90-day limit on eligibility waiting periods
  - Prohibition on annual dollar limits for “essential health benefits”
  - Increase in allowed wellness incentives from 20% to 30%
  - Guaranteed availability and renewability of insured group health plans
  - Medicare Part D “donut hole” fixes begin
  - Out of pocket expenses limited to the level set for non-grandfathered HSA-compatible high deductible health plans ($6,250 single, $12,500 family in 2013)
  - Limits on cost sharing deductibles for non-grandfathered plans to $2,000 for single; $4000 family
  - Employer shared responsibility (“play or pay”) begins
  - Availability of premium tax credits to reduce the cost of coverage purchased through the Exchanges begin
Thanks for attending!

• Issues relating to Health Care Reform seem overwhelming
• Rely on us as one of your trusted advisors as you think through your compliance with the new health reform requirements
• Rely on your insurance broker for specific help relating to your plans and benefits strategy
• Need more information? Give us a call at 1-877-225-1101 or log in to our HR Live website.
• Questions??