What You Need to Know About the Affordable Care Act

Prepared by:
Rebecca L. Sczepanski
Hunter, Maclean, Exley & Dunn, P.C.

LORMAN® EDUCATION SERVICES
November 2015

INTRODUCING

Lorman's New Approach to Continuing Education

ALL-ACCESS PASS

The All-Access Pass grants you UNLIMITED access to Lorman's ever-growing library of training resources:

- ☑ **Unlimited Live Webinars** - 60-90 live webinars added every month
- ☑ **Unlimited OnDemand and MP3 Downloads** - Over 1,000 courses available
- ☑ **Videos -** Just released
- ☑ **Slide Decks -** More than 700 available
- ☑ White Papers
- ☑ Reports
- ☑ Articles
- ☑ ... and much more!

Join the thousands of other pass-holders that have already trusted us for their professional development by choosing the All-Access Pass.

Get Your All-Access Pass Today!

SAVE 20%

Learn more: **www.lorman.com/pass/?s=special20**

Use Discount Code Q7014393 and Priority Code 18536 to receive the 20% AAP discount.

*Discount cannot be combined with any other discounts.

What You Need to Know Now About:
The Affordable Care Act

Rebecca L. Sczepanski, C.P.A., J.D.
Hunter, Maclean, Exley & Dunn, P.C.

I. What is the Affordable Care Act?

A. Intended to expand health insurance coverage

B. Insurance reform

1. Ended retroactive rescissions of coverage
2. Guaranteed issue insurance, and for all except large employer group coverage, no additional premium charges for health conditions
3. No pre-existing condition coverage exclusions
4. Limit the maximum waiting period for employer coverage
5. Limit insurance company profit margins

C. Expanded Medicaid coverage - later court action made this optional for states

D. It is not aimed at reducing the cost of health coverage; other than limiting insurer profit margins, relying on competition through the Marketplaces to drive costs down

E. For employers, the overall requirements break down into determining:

1. Whether the employer is an "applicable large employer" required to offer coverage;
2. If coverage is offered, who must be covered and when; and
3. If coverage is provided, does the coverage comply with all of the health reform requirements

II. Shared Employer Responsibility Mandate (Pay or Play) - Applicable Large Employers

A. Final Regulations Issued February 12, 2014

B. General framework is unchanged

C. Employers must first determine if they are "applicable large employers."

1. Generally, beginning in 2015, employers with 50+ full-time equivalent (FTE) employees on average over the prior year must offer affordable, minimum value health coverage to all full-time employees (those working 30+ hours per week *on average)* or be assessed penalties
2. For new employers, if they are in existence for even one day of the prior year, coverage during the current year is based on the reasonably expected number of employees; if an employer did not offer coverage during a prior calendar year because it was not an "applicable large employer," can offer coverage by April 1 to avoid first quarter

penalties. This is a one-time-only transition period. If an employer drops below 50 employees one year, then returns to more than 50 in a subsequent year, must cover by January 1 of following year to avoid penalties

3. Further guidance is expected in areas such as counting hours and determining FTEs after business mergers and acquisitions
4. Controlled groups must count all employees of every member of the controlled group to determine if they are large employer
5. The common law definition of "employee" still applies when determining the identity of full-time employees who must be covered. Decades of litigation over classification of independent contractors shows this definition is difficult to determine and apply.
6. General rule - seasonal workers are taken into account for determining large employer status. However, seasonal employees may or may not need to be covered, depending on how the plan is written and how long they work during the year

D. Final Rules Provide Limited Additional Transition Relief

1. Transition rule: employers of between 50-99 FTEs have until 2016 to comply, if they satisfy certain conditions. These are:
    a. Can't reduce aggregate hours or workforce size to take advantage of this delay between 2/9/2014 and 12/31/2014
    b. Can't eliminate or materially reduce the health care coverage offered from 2/9/2014 through 12/31/2015 (calendar year plans) and from 2/9/2014 to last day of plan year beginning in 2015 (for fiscal year plans)
        i. This means the employer contribution toward the cost of employee-only coverage continues to be at least 95% of the dollar amount of the contribution toward the coverage offered on 2/9/2014, or
        ii. the employer contribution is the same (or higher) percentage of the coverage cost paid by the employer on 2/9/2014
    c. Workforce reductions or aggregate hours reduced for bona fide business reasons, e.g. sale of a division, terminations for poor performance, or changes in the economic marketplace, are permitted
    d. Will need to certify that these conditions are satisfied to obtain the relief on the Section 6056 transmittal form
2. Transition rule: for 2015 only, large employer status may be determined over a consecutive period of at least 6 months rather than entire 2014 calendar year, beginning no later than July 1, 2014. Can begin the counting period earlier in 2014 if employer wishes to have a time period to analyze and make any necessary plan design adjustments before January 1, 2015
3. Transition rule: for 2015 only, employers may start coverage at the later of the first of the month of the stability period or the first day of the first payroll period to start during the month; for following years, must cover for the entire month to avoid penalties
4. Transition rule: for 2015, if you did not cover dependents at any time during the plan year beginning in 2013 and calendar year 2014, and employer is "taking steps" to cover them in 2015, may not have to pay penalty for those not covered; if coverage was offered to some, but not all, dependents, transition relief applies only to dependents

not offered coverage during the 2013-2014 periods. No guidance as to what constitutes "taking steps."

5. Transition rule: for 2015, employers who did not previously provide coverage can avoid penalties by providing coverage to at least 70% of their FT employees and dependents; however, if this coverage is not affordable or provide minimum value, would still be subject to $3,000 pay and play penalty for employees who obtain subsidized coverage on the Marketplace
6. Transition rule: for 2015, calculation of pay or play penalty - first 80 full-time employees (rather than first 30 employees) is subtracted from total full-time employees before multiplying by $2,000 to calculate penalty for not providing coverage
7. For January 2015 – can begin coverage the first day of the first payroll period beginning in the month and avoid penalties. For subsequent months/years, must cover on every day of a month.
8. Penalties will be adjusted for inflation beginning in 2015; those numbers have not been released yet
9. Non-calendar year plan years – some transition relief is available, but generally the plan year must have been a non-calendar year plan as of December 27, 2012 and the plan year must not have been subsequently changed
10. Transition relief will generally be unavailable beginning on or after January 1, 2016, as they are available only for 2015 or the 2015 plan year, as applicable

E. Applicable Large Employers must offer coverage to full-time employees and their dependents (but not necessarily spouses) that constitutes "minimum essential coverage" to avoid the "Pay or Play" $2,000/employee penalty, and the coverage provided must be both "minimum value" and "affordable" to avoid the $3,000/person penalty for employees who instead purchase individual coverage on the Marketplace and receive a subsidy.

F. What does it mean to "offer coverage" under the rules?

1. Minimum essential coverage is defined in Section 5000A(f), includes most coverage under eligible employer-sponsored plans except coverage that consists solely of "excepted benefits," such as stand-alone dental, vision, or specific health condition coverage; preventive health treatments must be covered without cost to the employee
2. Minimum value coverage is designed to cover 60% of total expected medical expenses on an actuarial basis; this does not mean that the employee can be required to pay 40% of the premium
3. Affordable coverage can cost the employee no more than 9.5% of his or her household income.
    a. Since employers have no way of knowing what an employee's total household income, 3 safe harbors were issued: the employee's W-2 (Box 1, gross pay), the employee's rate of pay, or the federal poverty line (for 2014, in most states, this was $11,670). If the cost to the employee is less than 9.5% of the chosen safe harbor, the coverage is deemed "affordable."
    b. To satisfy the W-2 safe harbor, the employee contribution must remain constant throughout the entire year, as an amount or percentage of compensation

c. Special rules take into account partial years of coverage, for example, if you are using the W-2 safe harbor

4. Can employers offer a salary deduction only flexible spending account or a health reimbursement account that reimburses employees on a pre-tax basis for purchasing individual insurance, without offering other insurance coverage?

   a. Guidance issued fall 2013 generally said health reimbursement accounts and FSA-only plans would not be permitted unless coupled with a comprehensive health plan; reasoning based on failure to satisfy the reform requirements, e.g. the requirement that there can be no maximum cap on benefits.

   b. Some argued that salary reduction only FSAs were still permitted under this guidance, based on a very close and technical reading of the original guidance

   c. Penalty for failing to comply with the ACA coverage reform requirements is $100/day/affected participant, makes the stakes very high for taking this risk - up to $36,500 per year per participant

   d. IRS issued a FAQ in May 2014 that clarified its position on this, saying every such plan is an "employer payment plan" and falls within its prohibition, reiterating the magnitude of the penalty which could apply

   e. Taxable reimbursements are unlimited and unregulated

5. Can employers offer a "skinny" plan - e.g., one covering only preventative care and a minimal amount of additional coverage, for a very low cost, either alone or in conjunction with a more expensive qualifying and affordable plan?

   a. Several brokers and others are promoting this as a way to keep employer costs for providing coverage very low, particularly in industries with many lower-paid employees, e.g. hospitality, restaurants, retail industries

   b. The promotional materials say this is permissible, and perhaps that actuaries have certified that the plan provides sufficient benefits to avoid treatment as an "excepted benefit" plan and therefore satisfies the requirements of "minimum essential coverage" so employers won't "pay the penalty"

   c. Promoters assume that cash-strapped employees will take the cheaper plan, reducing the cost to the employer by a large number

   d. It is important to understand that these plans may, if carefully structured, avoid the $2,000 per employee penalty for not providing coverage at all, but employees who go to the Marketplace to get better coverage and receive a subsidy will still subject a large employer to a $3,000 penalty

   e. If even one employee receives a subsidy, you **will** hear from the IRS, but not until after the individual tax filing deadline for the year. It doesn't even matter if they aren't, in the end, entitled to the subsidy and had to repay all or part of it. **It is critical that employers keep extremely good records to defend against the imposition of a penalty.**

   f. Presumption is that the cost savings for this design will be greater than the total penalty the employer will have to pay

   g. Be very careful here – other coverage mandates that apply to group health plans may result in additional penalties if not satisfied, e.g. mental health parity or Women's Health and Cancer Rights Act coverage

h. Violations of these other health reform rules, e.g. discrimination against individual participants based on health status by specifically excluding AIDS coverage when you have only one employee with that health condition, could cost you $100 per day per affected participant, or $36,500. This could far exceed the penalties the employer is trying to avoid.

   i. *If you are subject to this excise tax, must self-report and pay on Form 8928 by the due date for the employer's tax return*

   ii. *Limited time to correct without paying the penalty – if failure is corrected within the 30-day window after the employer knows or, exercising reasonable diligence would have known, that the failure existed*

   iii. *Failure to file the excise tax form when due means the statute of limitations never begins to run; there is no time limit within which the IRS must catch you in order to assess the tax, and if they ever do, they can assess it retroactive for all the years since the failure first occurred*

G. Who is a full-time employee entitled to coverage?

1. Employees who are reasonably expected to work 30+ hours a week on average when hired must be treated as full-time employees and offered coverage

   a. Facts and circumstances test

   b. Factors which show employers "reasonably expect" include: whether the new employee is replacing someone who was or was not full-time, the extent to which same or comparable positions are full-time, whether the job was advertised or described in the job description or offer letter as requiring an average of 30 or more hours of service per week

2. For variable-hour, part-time, or certain seasonal employees, the issue becomes much more difficult to determine.

   a. When such an employee is hired, you first determine if they work 30+ hours per week <u>on average</u> over an "initial measurement period."

   b. If the answer is yes, then during the subsequent "stability period," the employee continues to be treated as full-time and entitled to coverage, even if their hours drop below full-time status.

   c. If the answer is no, then during the subsequent "stability period" the employee continues to be treated as part-time and not entitled to coverage, even if their hours increase, <u>unless</u> they are transferred to a job category that is reasonably expected to work 30+ hours on average

   d. After the initial measurement period, the employee's status is determined during successive standard measurement periods for the subsequent stability period

3. Measurement period rules –a summary only

   a. Generally, this period can be from 3-12 months long

   b. Final regulations added a monthly measurement period option. Any employee credited with at least 130 hours during a calendar month is a full-time employee for that month; in this option, instead of using calendar months, employers can use a period of successive 7-day "weeks" that fits with a payroll period to count

c. "Initial" measurement period for new hires can be different than the "standard" measurement period; can use payroll periods; must start no later than first of month after hire, or first day of payroll period that starts after date of hire
    i. *After the initial measurement period, move to standard measurement period*
    ii. *New rule: if there is a gap between the end of the initial measurement period and beginning of the standard measurement period, extend the initial measurement period to the beginning of the first standard measurement period*
d. Employees on unpaid leave, including FMLA or USERRA, or other employment breaks are simply treated as having no hours of service during that period. If paid leave, must count hours for which paid or entitled to payment.
e. **Rehired employees:** proposed guidance said anyone rehired within 26 weeks had to be treated as if they had never terminated, so they can't be treated as new employees with new measurement and waiting periods. Final guidance says this can be reduced to 13 week breaks or, if less, the longer of 4 weeks or the period the employee worked before the break. However, **these rules are optional, so must be included in the plan document to be enforceable.** Otherwise, rehired employees are not treated as new hires no matter how long they're gone, they go right into standard measurement periods with "0" hours counted for the time they're not working.
f. Same hour-counting rules apply to variable, seasonal, and part-time employees
    i. *Non-hourly equivalency methods can be used: 8 hrs/day or 40 hrs/week worked*
    ii. *Can use different methods for different employee categories, but must be applied on a reasonable and consistent basis within categories*
    iii. *For hourly employees, must count hours - the equivalency methods aren't permitted*
    iv. *Special rules for education organizations prevent taking expected breaks into account in determining expected full-time status*
    v. *Some guidance provided in areas with difficult tracking situations, such as adjunct faculty, airline layovers, and on-call hours. In the interim, use a reasonable method; e.g., a method which does not take into account travel time for commissioned salespeople is not reasonable. Further guidance will be forthcoming*
g. There is an anti-abuse rule included; even if employers follow these rules, if they push interpretation a little too far, could still be ruled non-compliant if the purpose behind the choices made is to avoid offering coverage
h. Every one of these choices made must be properly documented, ideally in a plan document or summary plan description (if subject to ERISA)

4. Stability period rules – a summary only
    a. In general, the longer the look-back period the longer the stability/coverage period
    b. Minimum stability period is 6 months
    c. Employers who choose the one-month measurement period option have no minimum stability period requirement; this can mean employees will be flipping in and out of eligibility for coverage, so need to address paperwork and administration

issues and, if insured, need to coordinate with the carrier how to get cards, coverage confirmations, handle deductibles, fulfill out of pocket requirements

d. Can have different measurement and stability periods for different categories of employees: hourly vs. salaried, different geographic locations, union and non-union, different bargaining units, and different employers within the controlled group

e. Can have up to 90 days after the end of the measurement period to determine who must be covered, though need to watch this for employees' first measurement period so employers don't run afoul of the 90-day maximum waiting period rules (see below)

f. Employers' choices have a big impact on plan administration. For example, if you choose a 6-month measurement and stability period, you might need two open enrollment periods each year, and there is a cost associated with this

5. Who is a dependent who must be offered coverage?

   a. Generally, most of an employee's children, but not their spouse

   b. Final rules removed stepchildren and foster children; they can, but need not be, covered

   c. Child is a dependent through the end of the month in which they turn age 26

   d. Non-US citizens and non-US residents are not dependents unless they are residents of Canada or Mexico

   e. Employers can rely on employees' representations regarding children and their ages; no need to investigate, though employers who want to ensure that ineligible dependents are not being covered may wish to do so

6. **Staffing Agency Employees** – who is responsible for providing coverage?

   a. The "common law employee" rules are difficult to determine and apply, and may be different in different parts of the country based on independent contractor versus employee lawsuits

   b. In the preamble to the final regulations, there seems to be a distinction between "temporary staffing firms" and "staffing firms." The IRS suggests that temporary staffing firms are the common law employers of their employees, while for general staffing firms, PEOs, leasing companies, etc. the IRS assumes the service recipient is the common law employer

   c. If employers use workers from a staffing firm for anything other than a short-term, temporary assignment, employers risk an IRS determination that the worker is their common law employee. This means they must be counted to determine if you are an applicable large employer and if the employer owes any penalties

   d. Safe harbor: a staffing firm's offer of qualifying coverage through a MEWA (multiple employer welfare plan) is deemed to be an offer of qualifying coverage by the service recipient

   e. Safe harbor: a staffing firm's offer of qualifying coverage through a plan other than a MEWA is deemed to be an offer of qualifying coverage by the service recipient <u>if the fee the staffing firm charges the service recipient is higher for an employee enrolled in the staffing firm's health plan is higher than it is for the employee not enrolled in the health plan.</u>

f. Conservative approach – ensure your contract with the staffing company incorporates one of these safe harbors.

III. 90-Day Waiting Period Rules

A. General rule: employers cannot impose a waiting period of more than 90 days after employees have satisfied the requirements to be covered under the plan and is otherwise eligible to enroll

1. Group health plans that violate this requirement are generally subject to an excise tax of $100 per day per failure, which must be self-reported on IRS Form 8928
2. These rules are in the Public Health Service Act and are incorporated by reference into ERISA and the Code; as a result, they apply to health insurance issuers as well as group health plans (regardless of grandfather status), whether fully-insured or self-funded, and also apply to church and government plans

B. Employers can still impose eligibility periods on employees, such as:

1. Eligibility conditions based solely on the lapse of time of no more than 90 days;
2. Cumulative hours-of-service requirements of up to 1,200 hours;
3. Other conditions, so long as those conditions are not designed to avoid compliance with the 90-day waiting period limitation
4. Plans which impose eligibility periods will not run afoul of this requirement if coverage is made effective no later than 13 months from the employee's start date plus, if the employee's start date is not the first day of a calendar month, the time remaining until the first day of the next calendar month

C. The shared responsibility rules and the 90-day waiting period rules are generally aligned, so employers that follow the former will generally be deemed to comply with the latter

D. Other types of eligibility conditions, such as eligible job classifications, achieving job-related licensure requirements, or satisfying a reasonable and bona fide employment-based orientation period, may be included without violating the 90-day rule

1. Other group health plan requirements should be considered, e.g. discrimination and coverage mandates
2. Regulations do not specify when or how an orientation period would be either "reasonable" or "bona fide." Proposed regulations issued at the same time suggested one month as the maximum length of any orientation period.
3. For special enrollees – e.g., for new spouses and children – the period before enrollment is not a "waiting period" for purposes of these rules

IV. Other Issues

A. DOL Announcement Regarding Personnel Changes to Avoid Coverage Mandates

1. ERISA §510 Actions - Employment actions taken "for the purpose of interfering with any [benefit] right to which [the employee] may become entitled." This prohibits companies from discharging, fining, suspending, expelling, disciplining or discriminating against employees for this purpose

2. Historically, these have been difficult to prove, as most termination decisions are the result of multiple causes; wholesale terminations of part-time employees, or reductions to less than 30 hours per week on average for all part-time employees, would be easier to prove
3. An ERISA 510 suit requires a finding of specific intent to interfere with health-care rights
4. Communication Strategies:
    a. Monitor external communications
    b. Avoid public statements about employment policy
    c. If unavoidable, focus on business reasons for taking these actions
    d. Ensure internal communications convey same message and set forth the business needs for changing workforce policy
    e. If possible, ensure sensitive internal communications are covered by attorney-client privilege
    f. Avoid sweeping changes to workforce hours alterations, as these are most likely to garner attention; consider capping hours only for new hires
5. Not yet tested in the courts

B. Other Requirements of Health Reform Law Have Taken Effect

1. Employers who do provide health insurance coverage must comply with these requirements, or face additional penalties
2. Specific coverage provisions that generally apply:
    a. Women's preventive health care coverage required (was effective in 2013)
    b. No pre-existing condition exclusions permitted
    c. Coverage of clinical trials required
    d. New incentive standards for wellness plans will apply (see below)
    e. Rules prohibiting discrimination against health care providers and based on health status have taken effect
    f. No annual benefit limits allowed (lifetime benefit limits were previously prohibited)
    g. Essential health benefits requirements apply
3. HIPAA coverage certification requirements will end December 31, 2014
4. October 1 deadline for annual distribution of Marketplace notices to employees
    a. Counties with more than 10% of individuals who are literate only in the same foreign language will require distribution of all relevant notices in that foreign language as well
    b. Counties affected by this requirement will be announced each year; for 2014, only 5 counties in Georgia are affected, which are Atkinson, Echols, Gwinnett, Hall, and Whitfield counties, all will require distribution in Spanish
    c. Distribution is required, but no penalty for failure to distribute
5. Filing and paying of PCORI and reinsurance fees

6. Maximum annual and lifetime benefit limits no longer permitted

C. Coordination of COBRA with individual Marketplace coverage

1. Individual health coverage, whether on the Marketplace or purchased directly from an insurance company, can only be purchased during the annual enrollment period (Nov. 15 - Feb. 15 each year) or during a special enrollment period, triggered by specific events
2. Loss of group health coverage, such as due to loss of a job, is an event which triggers a 60-day special enrollment period; early termination of COBRA coverage, such as for failure to pay the COBRA premium is not
3. As a result, individuals otherwise entitled to COBRA coverage can choose Marketplace coverage instead when they first loss their group health coverage, when the COBRA eligibility period ends, and during any annual open enrollment period, but cannot drop COBRA mid-year any time they like to change to individual coverage, whether on the Marketplace or purchased directly
4. Employers who might be considering paying for all or part of the first month or more of COBRA coverage for former employees may incentivize these individuals to choose COBRA; if they cannot continue making the COBRA payments after the employer subsidies end, they may be without any access to insurance coverage for a period of months, and subject to an ACA penalty for not having coverage as well
5. HHS and DOL, concerned that individuals didn't fully understand this, issued updated model COBRA notices in May, 2014, which refer to alternate individual coverage options available; COBRA is not going away
6. Reimbursements for COBRA coverage, if structured correctly, can be tax-free, which reimbursements for Marketplace coverage are taxable for income and Social Security/Medicare tax purposes

D. SBC (Summary of Benefits and Coverage) Templates

1. No changes for 2015 notices, to be distributed in 2014
2. No additional guidance provided, to date, on all the knotty questions preparers have been struggling with, and the many provisions which don't fit into the mandatory template
3. Many, perhaps most, of those being provided by insurers and TPAs do not entirely comply with the requirements; to date, no evidence that DOL has been auditing these forms for compliance, but could occur in future

E. Recommendations

1. Continue with implementation plans
2. For employers who have more than 50 FTE employees, determine which of your employees are "variable hour employees" for whom service will need to be counted; determine the various counting and stability periods to be used for new variable hour employees
3. Ensure that plan documents correctly reflect all decisions, processes, and procedures, and that all required provisions have been incorporated
4. Follow new regulatory developments closely

F. New opportunities for designing coverage

1. Groups over 50 employees are now protected by guaranteed issue - insurance companies doing business on the Marketplace cannot refuse to insure your group as they previously could - but are not eligible to purchase insurance on the Marketplace and therefore not protected by the rate regulations
2. If an employer has a certain group of employees who are driving up the cost for the entire group, it may be economically advantageous to offer these employees minimum coverage but not at an affordable rate.
    a. This would allow these employees to obtain coverage on the Marketplace and, if their income is less than the maximum required, possibly subsidized coverage
    b. The plan sponsor would have to pay $3,000 for each employee who obtains coverage on the Marketplace and who is eligible for a subsidy or cost sharing.
    c. This could, overall, be less expensive for the company because not all of these employees may be eligible for subsidized coverage, and in 2014, no penalty will be payable at all
    d. For self-insured plans, this should only be done if the various groups are non-discriminatory and can be described objectively, not by name; non-discrimination rules for insured plans will not be effective until regulations are issued, which has not yet happened, but risky to design a plan assuming they will not be issued
    e. Use this approach with caution; ensure you have the relevant testing in hand and the plan document reflects the design correctly

V. Reporting requirements, final rules issued

A. Significant changes to the two employer reporting requirements

1. Code Section 6055 requires annual information reporting by organizations that offer Minimum Essential Coverage – e.g., health insurance issuers, self-insured employers, government agencies, and other providers of health coverage
    a. 6055 reports will be used to monitor compliance with individual mandate
    b. Two parts – an aggregate report to the IRS and an individual statement to the responsible person, usually the policyholder, primary insured, or employee
    c. Self-funded employers will include the information they would have been required to report under 6055 with the 6056 filing to avoid double reporting burden
    d. For Minimum Essential Coverage only, not for supplemental coverage (like cancer coverage, HRAs integrated with a medical plan, onsite clinics, wellness plans, or other ancillary medical benefits)
2. Internal Revenue Code Section 6056 requires annual information reporting by applicable large employers relating to the health insurance that the employer offers (or does not offer) to its full-time employees
    a. 6056 reports will be used to determine pay-or-play penalties and to audit premium credits and subsidies provided to individuals in the Marketplace
    b. Applies to applicable large employers only, based on entire controlled group and defined as 50+ FTEs

c. Each member of the controlled group must submit return

d. Employers can use a third party to file the report

e. General reporting method and a number of alternatives, available in limited situations

f. General method will use Form 1094-C for aggregate IRS reporting and Form 1095-C for individual statements; self-funded employers complete both sections of Form 1094-C, while insured medical plans complete only the information needed for 6056 reporting.

g. Alternative methods are "safe harbors" – e.g.:

   i. *A simplified method is available for employees receiving a qualifying coverage offer for all months during an applicable year in which he worked 30+ hours a week (not available to employers not offering dependent coverage in 2015)*

   ii. *A simplified statement may be sent to all employees if employers offered coverage to at least 95% of full-time employees and their spouses and dependents*

   iii. *A simplified method may be used that doesn't separately identify full-time employees if MEC offered to at least 98% of employees reported*

h. ONLY ONE FORM SHOULD BE FILED FOR EACH EMPLOYEE. Since alternatives and "safe harbors" may not cover all employees who must be reported, a combination of reporting methods may be required. It may be simpler to just use the standard method for all

i. Can include the individual reporting on the Form 1095-C in same mailing as the W-2, on or before January 31 each year; can only send statements to individuals electronically if you obtain consent for this specific form – consent obtained for W-2 does not carry over; aggregate reporting to government will be due February 28 (if sent in paper) and March 31 (if filed electronically)

j. PENALTIES:

   i. *For incorrect returns, $100 for each incorrect return up to $1,500,000 maximum per year*

   ii. *For complete failure to file, same penalty but also applies for not providing the individual statements*

   iii. *IRS will recognize "good faith" efforts are reporting for the 2015 year and not assess penalties if incorrect or incomplete information is provided; relief won't apply for late filers or no good faith effort to comply is made*

k. Information required will include:

   i. *Whether full-time employees and dependents could enroll in minimum essential coverage;*

   ii. *Number of full-time employees each month;*

   iii. *For each employee the months MEC was available;*

   iv. *The employee's share of the lowers cost monthly premium for self-only coverage providing minimum value available to that employee (by month);*

   v. *The name, address, and Social Security number for each employee and the months, if any, when the employee was covered under an eligible employer-sponsored health plan;*

vi. *Whether the coverage provides minimum value and whether spouse could be enrolled;*

vii. *Whether effective date of coverage was affected by a permissible waiting period, by month;*

viii. *Whether the employer is part of a controlled group and, if so, the name and EIN of each member that is part of the applicable large employer group on any day of the year;*

ix. *Whether the employer contributed to a multiemployer plan (e.g., a union plan);*

x. *Whether MEC was offered to the employee only, employee and dependents, employee and spouse, or employee and family;*

xi. *If no coverage was offered, whether penalty exemption applies because not full-time, not employed during the month, or another exception exists*

xii. *Whether the employer met an affordability safe harbor; and*

xiii. *The number of months the plan covered any dependents.*

l. If the employer contributes to a union plan, the union should help collect the necessary data so employer can report

m. IRS recommends that the instructions be sent to employees with the form, to help them understand

B. Compliance Timeline: reports will apply for the 2015 calendar year and reports will be due in early 2016

C. Employers still have the separate requirement for reporting the value of health coverage provided to employees on W-2s each year

1. The coverage reporting requirements detailed above are in addition to the W-2 reporting requirement, not in place of it

2. Employers with 250 Forms W-2 had to report the cost of this coverage for the 2012 calendar year; IRS Notice 2012-9 made such reporting optional for smaller employers for 2013 (prepared in early 2014) and for certain types of coverage, e.g. multi-employer plans, HRAs, excepted benefits such as standalone dental and vision plans, employee assistance plans, on-site medical clinics, wellness programs, and terminating employees who request and receive W-2s before year-end. This relief applies until at least six months after further guidance is published. This has not occurred.

D. HIPAA/ACA requirement: employers must obtain a unique health plan identifier number (or HPID) by November 5, 2014 (2015 for plans with < $5,000,000 annual receipts)

1. The HPID must be used for all HIPAA standard transactions, so employers may never use this number

2. TPAs and business associates will be using this number a lot, so employers must share number with them when it is received or ask TPA to obtain it for you – however, it remains the employer's responsibility, so coordinate to ensure SOMEBODY is applying for it and sharing it with other providers

3. Obtain by completing an application on the Health Insurance Oversight System (HIOS)

VI. Small Business Implications

A. Small Business Health Option Program - companies with less than 50 employees were eligible to purchase coverage on the Marketplaces beginning in 2014

1. States had the option to extend this to employers with up to 100 employees, but all or nearly all have chosen to limit to 50 employee size for 2014
2. SHOP regulations were issued on May 31, 2013, effective on July 1, 2013
    a. These final rules were amending those which previously stated that small businesses could have several plan choices for their employees
    b. Announced that federal Marketplaces would only have one choice offered for eligible small businesses in 2014; states with state-run Marketplaces still had the option to offer more than one choice, but didn't have to
    c. Employees of these employers may have more options on the individual Marketplaces
    d. SHOP plans will have special enrollment periods for events similar to those of the HIPAA special enrollment rules; *e.g.*, for new spouses, children, etc.
3. Only on the SHOP Marketplace will small employers have coverage with community rating, maximum price differentials, etc. that are available to individuals on the Marketplaces
    a. For 2014 only, after the implementation problems on the Marketplaces, eligible coverage could be sold directly by the insurance companies
    b. As of now, this relief is not expected to be continued through 2015

B. Small businesses, like large businesses and individuals, may still obtain coverage outside the Marketplaces, if they can find insurers from which to purchase; for young, healthy individuals this may make sense, if they can obtain less expensive coverage than that which would be available to them on the Marketplaces

C. Small business health insurance tax credit

1. Available, but difficult to qualify for
    a. Employer must pay at least 50% of the cost of the coverage and, beginning in 2014, must obtain their coverage on the SHOP to qualify
    b. Credit is up to 50% of employer contributions toward coverage in 2014
    c. Businesses with up to 25 employees, average wages not exceeding $50,000
2. Non-profits eligible for a credit against payroll taxes (35% of employer contribution in 2014)
3. Claimed on Form 8941, with two-year limit on period to claim credit

VII. ACA Fees, Taxes, and Expenses

A. Filing and paying of PCORI (Patient Centered Outcomes Research Institute) fees

1. Second PCORI fee is due July 31, 2014 for plan years ending on or after October 1, 2013; will continue through 2019
2. $2 per covered life in 2014, indexed for inflation for years following until 2019

3. Filed and paid with IRS Form 720; revised form was released in June 2013.
4. Determination of number of plans and how to count participants for payment of fees is critical - and difficult
    a. HRAs are subject to the fee, but if integrated with a self-insured health plan they can be combined to count the number of lives subject to the fee; BUT, if integrated with an insured plan, must determine and pay the fee as if a stand-alone HRA (*e.g.* double-counting of lives). For stand-alone HRAs, you count only employees (no spouses, partners or dependents)
    b. Retiree-only plans (regardless of Medicare coverage) are covered, including HRAs
    c. Can count the average number of covered lives using:
        i. The actual count method;
        ii. The snapshot general method (counting all covered lives and using at least one date each quarter);
        iii. The snapshot factor method (using only the number of participants with self-only coverage x 2.35); or
        iv. Form 5500 number.
5. IRS Chief Counsel's memo, AM2013-002, PCORI fees are deductible for taxable entities

B. Filing and paying of transitional reinsurance fees

1. For transitional reinsurance fee, first filing will be due November 15, 2014 for the first 9 months of the year. Fee will apply to calendar years 2014, 2015, and 2016.
2. First year cost for 2014 is expected to be $63 per covered life, second year (2015) is set at $44 per covered life
3. For 2015 and 2016, but not 2014, plans which are both self-insured and self-administered are not subject to this fee
    a. Plans which use TPAs are not exempt
    b. Exception – can use TPA for pharmacy benefits management if you self-administer other claims
    c. Exception – can obtain the provider network and claims pricing services from a third party
    d. Exception – can use a COBRA enrollment administrator if it does not exceed 5% of the enrollments processed
4. Determination of number of plans and how to count participants for payment of fees is critical - and difficult
    a. Integrated HRAs are not subject to double-counting, regardless of whether self-insured or insured
    b. For stand-alone HRAs, you count all covered lives (employees, spouses, partners, and dependents)
    c. Retiree-only plans are not subject unless they are primary to Medicare coverage (*e.g.*, participants are under age 65 and not disabled)

d. Can count the average number of covered lives using any of the methods used to count for the PCORI fee purpose or can count for the first 9 months of the year and annualize

5. Timing of payments: split into two payments each year, majority of which is due in January and the remainder in the 4th quarter.

   a. 2014 payments are $52.50 per life (which will be due in January 2015) and $10.50 per life (due in 4th quarter 2015)

   b. 2015 payments are $33.00 per life (which will be due in January 2016) and $11.00 per life (due in 4th quarter 2016)

   c. 2016 fees, payable in 2017, are not yet determined but are expected to have the same payment structure and timing

VIII. Individual Coverage Mandate

A. This requirement was effective on 1/1/2014, but transition relief and extended enrollment periods were permitted for the difficult implementation of the healthcare.gov enrollment site.

B. Short gaps in coverage, such as those which occur when changing jobs, will not be subject to penalty for failure to have coverage

C. IRS Notice 2013-42

1. Provided transition relief from the individual mandate for employees of employers with fiscal year plans

2. Issued just prior to the transition relief delaying the employer shared responsibility requirements; although employers do not have to satisfy the minimum essential coverage requirements for fiscal plan years beginning in 2014, the exemptive relief for individuals should end when those plan years begin

D. Individuals who do not have minimum essential coverage will pay a penalty in 2014, the greater of $95 or 1% of income; will increase rapidly in future years

E. Minimum essential coverage could include employer-based coverage, Tricare, SCHIP coverage, Medicare/Medicaid, etc.

F. Individuals receiving subsidies on the Marketplace will have to verify income on tax returns, and may have to repay all or a part of any subsidy they received if their income ended up being higher than they represented at enrollment.

IX. Wellness Plan Developments

A. EEOC released an information letter in January 2013 providing that a disease management program administered under a group health plan is in fact a wellness program and is subject to the Americans with Disabilities Act (ADA)

1. Addressed a group health plan that waived its deductible for participation in a disease management program or adherence to a doctor-prescribed exercise and medication program, and included a requirement that the participants undergo blood tests to determine that they were taking medications as prescribed as part of the physician-prescribed disease treatment program

2. Failure to comply resulted in the employee's disenrollment from the disease-management program and automatic enrollment in the employer's "standard" plan, a high-deductible group health plan.

3. The EEOC took the position that the disease management program was a wellness program because – though the program did not require participants to complete a health risk assessment – the EEOC "assumed" a participant would be required to disclose to the program the existence of the chronic disease in order to be eligible for the disease-management program.

4. Without discussion or analysis, the EEOC letter summarily pronounces these procedures "disability-related inquiries" under the ADA; EEOC stated that a condition of participation was that employees disclose that they have qualifying health conditions, and other disability-related inquiries or medical examinations would be required to determine continued eligibility for any incentive offered

5. The EEOC would not comment on whether the program was "voluntary" for purposes of whether the "disability-related inquiries" in the program were exempt from the ADA's prohibition on such inquiries

6. The EEOC determined that the program would not be deemed involuntary because a non-compliant participant was dis-enrolled from the program and enrolled instead in the high-deductible plan available to all other participants; the EEOC effectively acknowledged that ineligibility as a sanction for noncompliance with a wellness program would not violate the ADA as long as the individual was automatically enrolled in the employer's "standard" plan

7. This means that an employer may in some circumstances be required to provide participants in such a disease management program with a "reasonable accommodation" in order to take full advantage of the benefits offered under the plan

B. Final wellness regulations issued under the ACA place new burdens on employer-provided wellness plans

1. Issued June 3, 2013, and effective with the first plan or policy year beginning on or after January 1, 2014

2. Compliance with the ACA wellness provision and the Final ACA Regulations constitutes an affirmative defense to a claim that the plan or issuer violated the ACA's prohibition against discrimination on the basis of a health factor

3. Require wellness programs that base a wellness reward on meeting a condition related to a health factor based on a measurement, test, or screening (an "outcome-based" wellness program) to offer a participant who does not meet the standard a "reasonable alternative standard."

4. This requirement applies whether or not the participant can show that it would be unreasonably difficult or medically inadvisable, due to a medical condition, to satisfy the standard. The requirements for "participation based" and "activity-only" wellness programs, as defined in the final regulations, remain mostly unchanged from the proposed regulations

C. The ACA generally codified the HIPAA wellness rules and made additional changes

1. Amended ERISA, the Code and the PHSA to prohibit group health plans and insurers offering health coverage in the group and individual markets from discriminating in

eligibility, premium determinations or benefits on the basis of a health status-related factor

a. This added one factor to the list of prohibited categories currently existing under the HIPAA nondiscrimination rule, namely, "any other health status-related factor determined appropriate by the Secretary of HHS"

b. Another difference between the ACA's statutory wellness provision and the 2006 regulations is the addition of the proviso "if reasonable under the circumstances" in determining when a plan may seek verification from the participant's physician that the health factor-based requirement would be unreasonably difficult due to a medical condition, or medically inadvisable, to attain

2. ACA increased the maximum "reward" permissible for satisfying wellness program conditions

a. In general, the reward for all outcome-based wellness programs may not exceed 30% of the cost of coverage, taking into account both employer and employee contributions, applied to the coverage tier of the group of individuals (employee, employee plus spouse, or employee plus family) eligible to participate, and participating in, the wellness program

b. This maximum increased to 50% for health-contingent wellness program targeting tobacco use and cessation

i. Where a health-contingent wellness program includes a requirement relating to cessation or reduction of tobacco use, and a separate requirement not relating to tobacco use, the health-contingent program that is unrelated to tobacco use is tested separately regarding the 30% limit;

ii. However, the reward for the wellness requirement aimed at limiting tobacco use is not tested separately. Rather, the combined reward for meeting any non-tobacco related requirements under the program, together with those relating to tobacco use, may not exceed the 50% limit.

3. The "reward" may be a discount, rebate, credit toward a deductible, or the avoidance of a penalty, such as a surcharge

4. No statutory requirement that a wellness program be part of a group health plan, but the rules only apply in the context of a group health plan that would otherwise discriminate on the basis of a health status factor

D. The final rules divide wellness programs into two categories: "Participatory" programs, which do not condition any reward on satisfying a standard related to a health factor, and "Health-Contingent" programs, which condition receipt of the wellness reward on attaining or maintain a specified health outcome

E. Participatory Programs

1. Examples include:

a. A requirement that the participant undergo a health screen (a "diagnostic testing program") or complete a health risk assessment (HRA), where no part of the reward is based on any outcome of the screening or answers to the HRA questionnaire;

b. Reimbursement of the cost of fitness club membership;

c. Reimbursement of the cost of a smoking cessation program (where there is no requirement that the individual actually stop smoking); and

d. Attending a monthly no-cost health education seminar

2. The sole requirement under the statute for a participation-based wellness program is that it be made available to all "similarly situated employees"

3. Existing regulations define “similarly situated” as a grouping of employees based on a bona fide employment-based classification consistent with the employer's usual business practice

   a. Based on all the relevant facts and circumstances

   b. Examples that may be bona fide include full-time versus part-time status, geographic location, membership in a collective bargaining unit, date of hire, length of service, current employee versus former employee status, and occupation

F. Health-contingent Programs

1. Further subdivided into "activity-only wellness programs" and "outcome-based wellness programs"

2. An activity-only wellness program is a type of health-contingent wellness program in which the individual is required to undertake some form of physical activity, such as a diet or exercise program, in order to obtain the wellness reward

   a. If reasonable in the circumstances, an activity-only program may seek verification from the participant's personal physician that the participant is eligible for the reasonable alternative standard, but only "if it is reasonable to determine that medical judgment is required to evaluate the validity of the request"

   b. an activity-only program must also meet the Reasonable Design and Uniform Availability requirements

   c. A program meets the "reasonable design" standard if, based on all the facts and circumstances, it (i) has a reasonable chance of improving the health of, or preventing disease in, participants, (ii) is not overly burdensome, (iii) is not a subterfuge for discriminating based on a health factor, and (iv) is not highly suspect in the method chosen to promote health or prevent disease.

   d. A program is available to all similarly situated individuals only during such time as a reasonable alternative to the otherwise applicable activity-based standard is made available to any participant for whom it would be (i) unreasonable difficult due to a medical condition, or (ii) medically inadvisable, to attempt to satisfy the activity-based standard set out in the program

   e. The reasonable alternative standard does not have to be determined in advance, but must be provided to any person described in the preceding sentence, and whether the reasonable alternative standard has been offered is based on a facts and circumstances determination

   f. Must disclose in all plan materials the availability a reasonable alternative standard, including a statement that the recommendations of the participant's personal physician will be accommodated

   g. Model notice provided in regulations

   h. Additional requirements:

i. *the plan may not require the participant to locate and pay the costs associated with the proposed alternative*

ii. *the alternative standard may not impose unreasonable time commitments, such as a requirement to attend a daily one hour health class*

iii. *at the participant's request, the plan must accommodate the recommendations of the participant's personal physician as to the medical appropriateness of the proposed alternative standard, and any subsequent changes to the alternative that the physician may recommend later*

iv. *to the extent a reasonable alternative standard is itself an activity-only wellness program (for example, a walking program substituted for a running program), the alternative program is subject to the requirements for activity-based programs as if it were the initial wellness standard*

3. An outcome-based program is a type of health-contingent wellness program in which the individual is satisfy an objective standard to obtain the wellness reward

    a. Can include maintaining a healthy weight or blood cholesterol level as determined by a biometric screening, or abstaining from tobacco use

    b. Outcome-based programs which initially determine whether the participant is in compliance with the wellness standard on a "measurement, test or screening," such as a biometric screen or HRA questionnaire, must automatically offer the participant a reasonable alternative standard or waive the requirement

    c. The automatically-offered reasonable alternative standard may be either a participatory program or an activity only program, or it may be an outcome-based standard set at a more attainable level than the original standard, with additional time afforded to attain the incremental standard

    d. If a further outcome-based program, the second standard may not offer a different level of the same standard without providing additional time to meet it; rules offer an example of one year

    e. Cannot require participant to verify the need for alternative, unless the alternative is itself an activity-based program

    f. Both activity-only programs and outcome-based programs must allow participants the opportunity to qualify for the wellness reward at least once each year

4. A participatory wellness program made available to all "similarly situated" employees will not violate Section 2705 of the PHSA

5. An issuer covered by the "fair health insurance premiums" provisions of the ACA, generally insurers on the individual and small group markets, may not rescind coverage of a participant who misrepresents his or her tobacco use status on a form required by the wellness program in order to receive the wellness program reward

G. Certain wellness programs are not subject to the wellness requirements

1. Reimbursement for fitness center membership;

2. A "diagnostic testing program" that does not base any part of the reward on the outcome of the test;

3. A smoking cessation program where the wellness reward is provided whether or not the individual quits smoking; and

4. A wellness reward for attendance at a periodic health education seminar

H. DOL may enforce the requirements of the ACA through ERISA, in addition to potential civil actions by participants and beneficiaries

I. Nonfederal governmental plans are subject to HHS penalties that are similar to the excise tax imposed by Code Section 4980D

X. Litigation

A. Individual coverage mandate was, of course, upheld in 2012

B. Employer mandate challenges are still working their way through the court system

1. Additional cases were filed challenging the administration's delay of the employer mandate last fall; these have had little impact on the legal landscape overall
2. In some sense, these are related to the cases challenging subsidies on the federally-facilitated Marketplaces (see below). Since the $3,000/employee pay and play penalty only applies if an employee receives subsidized individual coverage on the Marketplace, a successful challenge to the subsidy would also strip the teeth from part of the employer mandate

C. Contraception Mandate cases

1. Two primary lines of cases: non-profit, religiously affiliated organizations, which under the rules must either offer the contraception coverage or have a 3rd party insurer offer it without their involvement; and secular businesses owned and operated by families who claim providing this coverage violates their anti-abortion and/or religious beliefs
2. Three of the five appeals courts have struck down the contraception coverage rule for secular companies; two have upheld it. Appealed to U.S. Supreme Court, which accepted certiorari in fall 2013
3. Hobby Lobby & Conestoga cases under the secular business line were appealed to the U.S. Supreme Court. Contentious oral argument was heard in March; a ruling is expected by late June
4. Key issue: the 1993 Religious Freedom Restoration Act, which requires the government to seek the least burdensome and narrowly tailored means for any law that interferes with religious convictions. Question is whether that law is limited to individuals or whether corporations also are covered and/or have First Amendment rights.
5. If ruling invalidates mandate, the other religious affiliated organizations will also not be required to offer

D. Cases challenging subsidies provided on federally-facilitated Marketplaces: *e.g.*, Pruitt v. Sebelius, Halbig v. Sebelius, King v. Sebelius, Indiana et. al. v. IRS

1. These cases are still working through the system; *e.g.*, Halbig was dismissed by the District Court in January, appealed, and oral arguments were made before the D.C. Circuit Court of Appeals in March
2. This issue may well end up at SCOTUS as well

XI. Other Individual Impacts

A. 0.9% Medicare tax on each employee's wages in excess income over specified levels

1. Wages in excess of:
    a. Married taxpayers filing jointly - $250,000
    b. Married taxpayers filing separately - $125,000
    c. Single taxpayers - $200,000
2. Employers must withhold the tax on all employers with wages in excess of $200,000, regardless of filing or marital status; individuals will receive a refund, if applicable, when individuals file their individual tax returns
3. Applies only to the *employee's* wages; the employer does not owe a matching tax on this amount as it does on regular wages
4. Same exemptions would apply with respect to calculating wages for this purpose as for "regular" Medicare taxes; *e.g.*, medical insurance premiums are excluded, so existing payroll systems should suffice

B. 3.9% Medicare tax will be payable on investment income

1. Will be reported and paid on Form 8960
2. This is an individual filing and payment obligation; there is no requirement on the employer to withhold taxes on such income