Health Care Reform Toolkit

Small Employers

ELT INSURANCE SERVICES
Excellence in Employee Benefits & Insurance

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This Toolkit is not intended to be exhaustive nor should any discussion or opinions be construed as legal advice. Readers should contact legal counsel for legal advice. The contents of this document may be affected by future regulations and sub-regulatory guidance.

Introduction

The health care reform law, the Affordable Care Act (ACA), has many complex requirements for employers and health plans. Many employers are starting to focus more attention on the ACA's rules and, as a result, have more questions than ever.

This Health Care Reform Toolkit is your one-stop guide for upcoming health care reform concerns. The Toolkit is designed to help you address health care reform issues, topic by topic, step by step. Each section of the Toolkit focuses on a single subject and includes:

- An executive summary;
- An action checklist to help you take the appropriate actions to achieve compliance; and
- A list of supporting documents that ELT Insurance Services can provide upon request.

The Health Care Reform Toolkit will continue to expand and be updated as new regulations are released. As these changes are announced, please contact ELT Insurance Services to request an updated copy.

What is a small employer?

The health care reform law doesn't have a consistent answer for that. An employer might be considered small for one rule but not another. For this Toolkit, a small employer is one that has **fewer than 50 employees**.

Most of the sections in this guide apply to these small employers. However, your clients may have questions about whether certain provisions apply to them. They should also be aware of the rules that apply to larger employers as their businesses grow. Certain sections of this Toolkit briefly describe some of the rules for large employers to help you answer these types of questions.

Notice of Exchange

Who is Covered?	When?
Employers subject to the FLSA	Oct. 1, 2013

Employers must provide all new hires and current employees with a written notice about ACA's health insurance exchanges (Exchanges). ACA required employers to provide the Exchange notice by March 1, 2013, but the DOL delayed this deadline. On May 8, 2013, the DOL set a compliance deadline for providing the Exchange notices that matches up with the start of the first open enrollment period under the Exchanges, as follows:

- New Hires – Employers must provide the notice to each new employee at the time of hiring beginning **Oct. 1, 2013**. For 2014, the DOL will consider a notice to be provided at the time of hiring if the notice is provided within **14 days** of an employee's start date.
- Current Employees – With respect to employees who are current employees before Oct. 1, 2013, employers are required to provide the notice no later than **Oct. 1, 2013**.

In general, the notice must:

- Inform employees about the existence of the Exchange and give a description of the services provided by the Exchange;
- Explain how employees may be eligible for a premium tax credit or a cost-sharing reduction if the employer's plan does not meet certain requirements; and
- Inform employees that if they purchase coverage through the Exchange, they may lose any employer contribution toward the cost of employer-provided coverage, and that all or a portion of this employer contribution may be excludable for federal income tax purposes.

The DOL also provided **model Exchange notices** for employers to use, which will require some customization. The notice may be provided by first-class mail, or may be provided electronically if the requirements of the DOL's electronic disclosure safe harbor are met. Federal agencies plan to issue more specific guidance on this notice requirement.

Action Items:

- ☐ Customize the appropriate model Exchange notice.
- ☐ Prepare to provide the customized notice to all new and current employees by the deadline.
- ☐ Monitor health care reform developments for upcoming guidance on the notice requirement.

Documents Available from ELT Insurance Services:

- Health Care Reform: 2013 Compliance Checklist
- Health Care Reform Timeline
- Health Care Reform: Exchange Notice Requirements for Employers
- Health Care Reform: Model Exchange Notice for Employers that Offer Health Plans
- Health Care Reform: Model Exchange Notice for Employers that Do Not Offer Health Plans

Summary of Benefits and Coverage

Who is Covered?	When?
Health insurance issuers	Sept. 23, 2012
Health plans (insured and self-funded)	First open enrollment period beginning on or after Sept. 23, 2012 First plan year beginning on or after Sept. 23, 2012

Health plans (both insured and self-funded) must provide a Summary of Benefits and Coverage (SBC) to participants and beneficiaries. The SBC is a succinct document that provides simple and consistent information about health plan benefits and coverage in plain language. For insured plans, issuers must provide an SBC to the plan sponsor and may also send the SBC to participants and beneficiaries on behalf of an insured health plan.

Plans and issuers must provide the SBC to participants and beneficiaries who enroll or re-enroll during an open enrollment period beginning with the first open enrollment period that begins on or after Sept. 23, 2012. The SBC also must be provided to participants and beneficiaries who enroll other than through an open enrollment period (including individuals who are newly eligible for coverage and special enrollees) effective for plan years beginning on or after Sept. 23, 2012.

Action Items:

☐ Determine the type of coverage offers for which an SBC must be provided.

☐ Identify the plan year(s) and compliance date(s) for providing the SBC.

☐ For self-funded plans, prepare an SBC according to the instructions for each affected plan and provide the SBC to participants and beneficiaries at specified times according to the distribution rules.

☐ For insured plans:

- Confirm that the carrier will prepare an SBC and coordinate whether the carrier will provide the SBC to participants and beneficiaries.

- If not provided by the carrier, provide the SBC to participants and beneficiaries at specified times according to the distribution rules.

Documents Available from ELT Insurance Services:

- Health Care Reform: Summary of Benefits and Coverage
- Health Care Reform: FAQs on Summary of Benefits and Coverage
- Health Care Reform: Additional FAQs Released on Summary of Benefits and Coverage
- Health Care Reform: Year One Template for Summary of Benefits and Coverage
- Health Care Reform: Year Two Template for Summary of Benefits and Coverage
- Health Care Reform: Instructions for Summary of Benefits and Coverage

60-Day Notice of Plan Changes

Who is Covered?	When?
Health insurance issuers Health plans (insured and self-funded)	After SBC effective date

A health plan or issuer must provide 60 days' advance notice of any material modifications to the plan that are not related to renewals of coverage. Specifically, the advance notice must be provided when a material modification is made that would affect the content of the SBC and the change is not already included in the most recently provided SBC.

A "material modification" is any change to a plan's coverage that would be considered by the average plan participant to be an important change in covered benefits or other terms of coverage.

A material modification may include an enhancement in covered benefits or services or other more generous plan or policy terms, a material reduction in covered services or benefits, or more strict requirements for receiving benefits.

Notice can be provided in an updated SBC or a separate summary of material modifications. This 60-day notice requirement becomes effective when the SBC requirement goes into effect for a health plan.

Action Items:

☐ Determine if the SBC requirement is already effective for the plan.

☐ If yes, analyze proposed plan changes that are not related to renewal to determine if they are material modifications to the plan.

☐ If the mid-year changes are material modifications, provide notice of the change using a new SBC or a summary of material modifications at least 60 days before the change is scheduled to be effective.

☐ For insured plans, determine whether the carrier will provide this notice.

Document Available from ELT Insurance Services:

- Health Care Reform: 60-Day Advance Notice of Plan Changes

Statement of Grandfathered Status (GF plans only)

Who is Covered?	When?
Grandfathered plan administrators and issuers	Currently effective Provide periodically with participant materials

Grandfathered (GF) plans are those that existed on March 23, 2010, and have not made certain prohibited changes. In order to retain GF status, these plans must provide a statement of GF status to participants. The first statement was required to be provided before the first plan year beginning on or after Sept. 23, 2010. The statement must continue to be provided on a periodic basis with participant materials describing plan benefits.

Action Items:

☐ Confirm whether the plan is grandfathered or non-grandfathered.

☐ If grandfathered, include the model statement in participant plan materials.

Documents Available from ELT Insurance Services:

- Health Care Reform: Overview of Grandfathered Plans
- Health Care Reform: Grandfathered Plans – Permitted and Prohibited Changes
- Health Care Reform: Model Notice for Grandfathered Plans

Notice of Rescission

Who is Covered?	When?
Group health plans	Currently effective
Health insurance issuers	Provide 30 days before any rescission

Group health plans and health insurance issuers may not rescind coverage for covered individuals, except in the case of fraud or intentional misrepresentation of a material fact. A "rescission" is a cancellation or discontinuance of coverage that has a retroactive effect. A termination of coverage that has a retroactive effect is permissible if it is due to the participant's failure to pay required premiums or contributions for the coverage.

This prohibition applies to grandfathered and non-grandfathered health plans, whether in the group or individual market, and whether coverage is insured or self-funded.

If a rescission is permitted, the plan administrator or issuer must provide a notice of rescission to affected participants at least 30 days before the rescission occurs.

Action Items:

- ☐ Before terminating coverage for a participant, review whether the termination will have a retroactive effect.
- ☐ If yes, confirm that the retroactive termination is due to fraud, intentional misrepresentation or non-payment for coverage. Rescissions are not permitted based on an inadvertent misstatement or to correct a plan error (such as mistakenly covering an ineligible employee).
- ☐ Before terminating coverage retroactively, provide 30 days' advance notice to the affected participant.

Document Available from ELT Insurance Services:

- Health Care Reform: Prohibition on Rescissions

Notice of Patient Protections and Selection of Providers (Non-GF plans only)

Who is Covered?	When?
Non-GF group health plans Health insurance issuers of non-GF plans	Currently effective Provide with SPD or similar description of benefits

Non-GF group health plans and health insurance issuers that require designation of a participating primary care provider must permit each participant, beneficiary and enrollee to designate any available participating primary care provider (including a pediatrician for children). Non-GF group health plans and issuers that provide obstetrical/gynecological care and require a designation of a participating primary care provider may not require preauthorization or referral for obstetrical/gynecological care.

Plan administrators or issuers of these plans must provide a notice of patient protections/selection of providers whenever the summary plan description (SPD) or similar description of benefits is provided to a participant. The first notice should have been provided no later than the first day of the plan year beginning on or after Sept. 23, 2010.

Action Items:

☐ Determine whether plan is GF or non-GF.

☐ If non-GF, incorporate Notice on Patient Protections into SPD or benefits description.

Documents Available from ELT Insurance Services:

- Health Care Reform: Patient Protections
- Health Care Reform: Model Notice on Patient Protections

Preventive Care Services for Women (Non-GF plans only)

Who is Covered?	When?
Non-grandfathered health plans	Plan years beginning on or after Aug. 1, 2012

Effective for **plan years beginning on or after Aug. 1, 2012**, non-grandfathered health plans must cover specific preventive care services for women without cost-sharing requirements. The covered preventive care services include:

- Well-woman visits
- Gestational diabetes screening
- Human papillomavirus (HPV) testing
- Sexually transmitted infection (STI) counseling
- Human immunodeficiency virus (HIV) screening and counseling
- FDA-approved contraception methods and contraceptive counseling (exceptions apply to certain religious employers and various legal challenges to this provision are in process)
- Breastfeeding support, supplies and counseling
- Domestic violence screening and counseling

The preventive care guidelines for women are available at: www.hrsa.gov/womensguidelines/.

Action Items:

☐ Insured plans: confirm with carrier that plan will cover recommended preventive care services for women on plan's effective date.

☐ Self-funded plans: amend plan to cover recommended preventive care services for women with no cost-sharing on plan's effective date.

Documents Available from ELT Insurance Services:

- Health Care Reform: Preventive Care Coverage Guidelines
- Health Care Reform: Preventive Care Guidelines for Women
- Health Care Reform: Contraceptive Exemption for Religious Employers
- Health Care Reform: Federal Courts Divided on Contraceptive Coverage Mandate

$2,500 Contribution Limit for Health FSAs

Who is Covered?	When?
Health FSAs	Plan years beginning on or after Jan. 1, 2013

Effective for plan years beginning on or after Jan. 1, 2013, an employee's annual pre-tax salary reduction contributions to a health flexible spending account (FSA) through a cafeteria plan must be limited to $2,500. (The $2,500 limit will be indexed for cost-of-living adjustments for 2014 and later years.)

Health FSA plan sponsors are free to impose an annual limit that is lower than the ACA limit for employees' health FSA contributions. Also, the $2,500 limit does not apply to employer contributions to the health FSA and it does not impact contributions under other employer-provided coverage. For example, employee salary reduction contributions to an FSA for dependent care assistance or adoption care assistance are not affected by the $2,500 health FSA limit.

Action Items:

- ☐ Determine whether the health FSA limits the amount of money an employee can set aside into the FSA on a pre-tax basis per plan year.
- ☐ If yes, confirm that the limit is $2,500 or lower.
- ☐ If there is no limit or a limit above $2,500, establish a limit that does not exceed $2,500 for the first plan year beginning on or after Jan. 1, 2013.

Documents Available from ELT Insurance Services:

- Health Care Reform: Changes to Health Accounts
- Health Care Reform: IRS Provides Guidance on $2,500 Health FSA Limit

The provisions in this section are set to become effective in 2014. Some of these issues have been addressed in agency guidance; others are still awaiting more information. As developments related to these topics occur, additional content will be provided.

Annual Limits

Who is Covered?	When?
Health plans	Restricted annual limits currently effective Annual limits eliminated for plan years beginning on or after Jan. 1, 2014

Effective for plan years beginning on or after Jan. 1, 2014, health plans will be prohibited from placing annual limits on essential health benefits. Until then, however, restricted annual limits are permitted. Unless a health plan received an annual limit waiver, its annual limit on essential health benefits for the 2013 plan year must be at least $2 million. (This limit applies to plan years beginning on or after Sept. 23, 2012, but before Jan. 1, 2014.)

Action Items:

- ☐ Determine whether the health plan imposes an annual limit on essential health benefits.
- ☐ If yes, confirm that the annual limit is at least $2 million for the 2013 plan year.
- ☐ If the annual limit for the 2013 plan year is less than $2 million, determine whether the plan has a valid waiver of the annual limit requirement.
- ☐ If the plan has a valid waiver of the annual limit requirement, confirm that the required notice has been provided to plan participants.
- ☐ If the annual limit is less than $2 million for the 2013 plan year and the plan does not have a valid waiver, the annual limit must be revised.
- ☐ Ensure that no annual limit will be imposed on essential health benefits for the 2014 plan year and beyond.

Documents Available from ELT Insurance Services:

- Health Care Reform: Lifetime and Annual Limits
- Health Care Reform: Temporary Waiver Program for Annual Limits
- Health Care Reform: Application of Annual Limit Restrictions to HRAs
- Health Care Reform: Model Notice of Annual Limit Waiver

Excessive Waiting Periods

Who is Covered?	When?
Group health plans—insured and self-funded Health insurance issuers	Plan years beginning on or after Jan. 1, 2014

A group health plan or issuer may not impose a waiting period that exceeds 90 days. A waiting period is the period of time that must pass before coverage for an employee or dependent who is otherwise eligible to enroll in the plan becomes effective.

Eligibility conditions that are based solely on the lapse of time are permissible for no more than 90 days. Other conditions for eligibility are permissible, as long as they are not designed to avoid compliance with the 90-day waiting period limit.

A special rule applies if a group health plan conditions eligibility on an employee regularly working a specified number of hours per pay period (or working full time), and it cannot be determined that a newly hired employee is reasonably expected to regularly work that number of hours per period (or work full time). In this type of situation, the plan may take a reasonable period of time to determine whether the employee meets the plan's eligibility condition. This may include a measurement period that is consistent with the shared employer responsibility provisions (even if the employer is not a large employer).

The time period for determining whether a variable hour employee meets the plan's eligibility condition will comply with ACA's 90-day waiting period limit if coverage is made effective no later than 13 months from the employee's start date, except where a waiting period that exceeds 90 days is imposed after the measurement period. If an employee's start date is not the first of the month, the time period can also include the time remaining until the first day of the next calendar month.

Action Items:

- ☐ Review whether your plans contain a waiting period for participation.
- ☐ If the waiting period exceeds 90 days, amend the waiting period to 90 days or less for plan years beginning on or after Jan. 1, 2014.
- ☐ If it is unclear that a newly hired employee will work the required number of hours, set a measurement period to determine whether the hours requirement will be met in the future.

Document Available from ELT Insurance Services:

- Health Care Reform: Proposed Guidance Issued on 90-day Waiting Period Limit

Pre-existing Condition Exclusions

Who is Covered?	When?
Group health plans – insured and self-funded Health insurance issuers	Plan years beginning on or after Jan. 1, 2014

Effective for plan years beginning on or after Jan. 1, 2014, group health plans and health insurance issuers may not impose pre-existing condition exclusions on any covered individual, regardless of the individual's age. Pre-existing condition exclusions are already prohibited for individual's under age 19.

A pre-existing condition exclusion is a limitation or exclusion of benefits related to a condition based on the fact that the condition was present before the individual's date of enrollment in the employer's plan.

Action Items:

☐ Review each plan to determine whether it imposes a pre-existing condition exclusion on any individual.

☐ If yes, amend the plan to delete the pre-existing condition exclusion for plan years beginning on or after Jan. 1, 2014.

Document Available from ELT Insurance Services:

- Health Care Reform: Pre-existing Condition Exclusions

Coverage for Clinical Trial Participants (Non-GF plans only

Who is Covered?	When?
Group Health plans – insured and self-funded Health insurance issuers	Plan years beginning on or after Jan. 1, 2014

Effective in 2014, non-grandfathered group health plans and insurance policies will not be able to 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.

Action Item:

☐ Ensure that plan terms and operations do not discriminate against participants who participate in clinical trials.

Document Available from ELT Insurance Services:

- Health Care Reform: Coverage for Participants in Clinical Trials

Comprehensive Benefits Coverage (non-GF Plans Only)

Who is Covered?	When?
Non-GF insured group health plans Health insurance issuers	Plan years beginning on or after Jan. 1, 2014

Health insurance issuers that offer health insurance coverage in the individual or small group market will be required to provide the essential benefits package required of plans sold in the health insurance exchanges, beginning in 2014. This requirement does not apply to grandfathered plans.

Action Item:

☐ Be aware that insured plans will have to offer the essential health benefits package, even if they are purchased outside of an Exchange.

Documents Available from ELT Insurance Services:

- Health Care Reform: Approach for Defining Essential Health Benefits
- Health Care Reform: FAQs on Essential Health Benefits

Limits on Cost-sharing (Non-GF Plans Only)

Who is Covered?	When?
Deductible limit – non-GF plans and issuers in the small group market Out-of-pocket maximum – all non-GF health plans and issuers	Plan years beginning on or after Jan. 1, 2014 Transition relief may apply

Effective for plan years beginning on or after Jan. 1, 2014, non-grandfathered group health plans will be subject to limits on cost-sharing or out-of-pocket costs. Out-of-pocket expenses may not exceed the amount applicable to coverage related to HSA. Deductibles may not exceed $2,000 (single coverage) or $4,000 (family coverage). These amounts are indexed for subsequent years.

Final guidance on this requirement provides that the deductible requirement will apply only to plans in the insured small group market, while the out-of-pocket cost limit will apply to all non-grandfathered health plans (including self-insured plans and plans and issuers in the large group market).

In addition, special transition relief for the out-of-pocket maximum has been provided for plans that use more than one service provider to administer benefits. Under this transition relief, only for the first plan year beginning on or after Jan. 1, 2014, where a group health plan or group health insurance issuer utilizes more than one service provider to administer benefits that are subject to the ACA's out-of-pocket maximum, the annual limit will be satisfied if both of the following conditions are met:

- The plan complies with the out-of-pocket maximum with respect to its major medical coverage (excluding, for example, prescription drug coverage and pediatric dental coverage); and
- To the extent there is an out-of-pocket maximum on coverage that does not consist solely of major medical coverage (for example, if a separate out-of-pocket maximum applies with respect to prescription drug coverage), this maximum does not exceed the ACA's out-of-pocket maximum.

Action Item:

☐ Be aware that small plans will have limitations on out-of-pocket expenses and deductibles.

Documents Available from ELT Insurance Services:

- Health Care Reform: Cost-Sharing Limits for Health Plans
- Health Care Reform: Cost-Sharing Limitations and Preventive Care Coverage Clarified

Nondiscrimination for Fully-insured Plans (Non-GF plans only)

Who is Covered?	When?
Non-GF insured group health plans	When regulations are issued and applicable

Non-grandfathered fully insured group health plans will have to comply with federal nondiscrimination rules related to compensation. These rules prohibit discrimination in favor of highly compensated employees.

Under the ACA, these plans will have to follow rules similar to the nondiscrimination rules applicable to self-funded plans. These rules are found in Internal Revenue Code section 105(h) and require plans to pass both an eligibility test and a nondiscrimination test.

In December 2010, the IRS acknowledged that plans needed additional clarification to be able to comply with the new law. Compliance with the new nondiscrimination rules will not be required until after guidance is issued.

Because these restrictions will apply to non-grandfathered plans only, grandfathered plans that discriminate in favor of highly compensated employees may wish to retain their grandfathered status.

Action Items:

☐ Identify whether your plans are grandfathered or non-grandfathered.

☐ Continue to monitor IRS guidance for further rules on nondiscrimination requirements.

☐ For grandfathered plans, consider maintaining grandfathered status if current plan design is potentially discriminatory.

Document Available from ELT Insurance Services:

- Health Care Reform: Nondiscrimination Rules for Fully-Insured Group Health Plans

Wellness Programs

Who is Covered?	When?
Health-contingent wellness programs	2014

Under current law, the reward under a health-contingent wellness program is limited to 20 percent of the cost coverage. Health-contingent wellness programs require individuals to satisfy a standard related to a health factor in order to obtain a reward. There are two types of health-contingent wellness programs:

- **Activity-only wellness programs** require an individual to perform or complete an activity related to a health factor in order to obtain a reward (for example, walking, diet or exercise programs).
- **Outcome-based wellness programs** require an individual to attain or maintain a certain health outcome in order to obtain a reward (for example, not smoking, attaining certain results on biometric screenings or meeting exercise targets).

In 2014, the maximum permissible reward will increase to 30 percent of the cost of coverage. In addition, final regulations increase the maximum permissible reward to 50 percent of the cost of health coverage for programs designed to prevent or reduce tobacco use.

The other common type of wellness programs, participatory wellness programs, does not require an individual to meet a standard related to a health factor in order to obtain a reward or does not offer a reward at all (for example, a fitness center reimbursement program or a program that reimburses employees for the costs of smoking cessation programs, regardless of whether the employee quits smoking). There is no limit on financial incentives for participatory wellness programs.

Action Items:

☐ Review your current wellness program offerings to determine whether they are health-contingent or participatory wellness programs.

☐ If the wellness program is health-contingent, confirm the program complies with current law and consider whether to raise the reward in 2014.

Documents Available from ELT Insurance Services:

- Health Care Reform: Implications on Workplace Wellness Programs
- Health Care Reform: Final Rules on Workplace Wellness Programs

Research Fees

Who is Covered?	When?
Health insurance issuers Self-funded health plans	Plan years ending on or after Oct. 1, 2012 and before Oct. 1, 2019

Health insurance issuers and self-funded group health plans must pay fees to finance comparative effectiveness research. These research fees are called Patient-Centered Outcomes Research Institute fees (PCORI fees), although they may also be called PCOR fees or comparative effectiveness research (CER) fees. The fees apply for plan years ending on or after Oct. 1, 2012. The PCORI fees do not apply for plan years ending on or after Oct. 1, 2019. For calendar year plans, the research fees are effective for the 2012 through 2018 plan years.

For plan years ending before Oct. 1, 2013 (that is, 2012 for calendar year plans), the research fee is $1 multiplied by the average number of lives covered under the plan. For plan years ending on or after Oct. 1, 2013, and before Oct. 1, 2014, the fee is $2 multiplied by the average number of lives covered under the plan. For plan years ending on or after Oct. 1, 2014, the PCORI fee amount will grow based on increases in the projected per capita amount of National Health Expenditures.

A health reimbursement arrangement (HRA) is not subject to a separate research fee if it is integrated with another self-insured plan providing major medical coverage, as long as the HRA and the plan are established and maintained by the same plan sponsor and have the same plan year. If an HRA is integrated with an insured group health plan, the plan sponsor of the HRA and the issuer of the insured plan will both be subject to the research fees, even though the HRA and insured group health plan are maintained by the same plan sponsor.

The same analysis applies to health flexible spending accounts (FSAs) that do not qualify as excepted benefits.

The PCORI fees are due by July 31 of each year. The first possible deadline for filing Form 720 is July 31, 2013.

Action Items:

- ☐ Review your organization's health coverage to determine the plan(s) subject to the research fees.
- ☐ If a plan is insured, the carrier is responsible for paying the fee, although the carrier may shift the fee to the company through a premium increase.
- ☐ If there is an HRA, determine whether it qualifies for the exception for multiple self-funded plans, or whether it is subject to the research fee.
- ☐ If your organization is required to pay the fee for any self-funded plans, select a method for counting covered lives.

Documents Available from ELT Insurance Services:

- Health Care Reform: Patient-Centered Outcomes Research Institute Fees (PCORI Fees)
- Health Care Reform: Final Guidance Released on Research Fees

Reinsurance Fees

Who is Covered?	When?
Health insurance issuers Self-funded health plans	Three-year period from 2014 through 2016

Health insurance issuers and self-funded group health plans must pay fees to a transitional reinsurance program for the first three years of health insurance exchange operation (2014-2016). The fees will be used to help stabilize premiums for coverage in the individual market. Fully insured plan sponsors do not have to pay the fee directly.

Certain types of coverage are excluded from the reinsurance fees, including HRAs that are integrated with major medical coverage, HSAs, health FSAs and coverage that consists solely of excepted benefits under HIPAA (such as stand-alone vision and dental coverage).

The reinsurance program's fees will be based on a national contribution rate, which HHS will announce annually. For 2014, HHS has proposed a national contribution rate of $5.25 per month ($63 per year). The reinsurance fee is calculated by multiplying the average number of covered lives by the national contribution rate.

Additional guidance is expected to be issued on this fee requirement.

Action Items:

- ☐ Review your organization's health coverage to determine the plan(s) subject to the reinsurance fees.
- ☐ If a plan is insured, the carrier is responsible for paying the fee, although the carrier may shift the fee to the company through a premium increase.
- ☐ If your organization is required to pay the fee for any self-funded plans, select a method for counting covered lives.
- ☐ Monitor health care reform developments for additional guidance on the reinsurance fee.

Document Available from ELT Insurance Services:

- Health Care Reform: Reinsurance Fees will Cost Group Health Plans

Health Insurance Providers Fee

Who is Covered?	When?
Any entity that provides health insurance for any U.S. health risk	Sept. 30 of each calendar year, beginning in 2014

Beginning in 2014, ACA imposes an annual, non-deductible fee on the health insurance sector, allocated across the industry according to market share. The fee, which is treated as an excise tax, is required to be paid by Sept. 30 of each calendar year.

The health insurance providers fee applies to all "covered entities," defined as entities that provide health insurance for any United States health risk. The fee will be assessed on health insurers' premium revenue with respect to health insurance above $25 million. The fee program specifically excludes self-insured employers.

The term "health insurance" does not include coverage for specific diseases, accident or disability only, hospital indemnity, long-term care or Medicare supplemental health insurance. However, limited dental and vision coverage are included for purposes of this fee.

The aggregate annual fee for all covered entities will be apportioned among the covered entities according to their respective market shares, as measured by net premiums written for health insurance. The aggregate annual fee for all covered entities is expected to be $8 billion for 2014, $11.3 billion for 2015 and 2016, $13.9 billion for 2017 and $14.3 billion for 2018. Beginning in 2019, the cost of the fee will increase based on the rate of premium growth.

Action Item:

☐ Watch for communications from the insurance carrier as to how this fee might impact costs for the plan.

Document Available from ELT Insurance Services:

- Health Care Reform: Health Insurance Providers Fee

Additional Medicare Tax

Who is Covered?	When?
All employers	Jan. 1, 2013 (for the 2013 tax year)

Effective Jan. 1, 2013, the Medicare Part A (hospital insurance) tax rate increases by 0.9 percent (from 1.45 percent to 2.35 percent) on wages over $200,000 for an individual taxpayers and $250,000 for married couples filing jointly.

An employer must withhold the additional Medicare tax on wages or compensation it pays to an employee in excess of $200,000 in a calendar year. An employer has this withholding obligation even though an employee may not be liable for the additional Medicare tax because, for example, the employee's wages or other compensation together with that of his or her spouse (when filing a joint return) does not exceed the $250,000 liability threshold. Any withheld additional Medicare tax will be credited against the total tax liability shown on the individual's income tax return (Form 1040).

Action Items:

☐ Monitor employee wages to be aware of the date an employee reaches $200,000 in wages in a single year.

☐ Once an employee has earned $200,000, change the Medicare hospital insurance tax-withholding rate to 2.35 percent.

Documents Available from ELT Insurance Services:

- Health Care Reform: Proposed Rules on the Additional Medicare Tax
- Health Care Reform: Questions and Answers on Additional Medicare Tax

Employer Penalties for Not Offering Required Coverage (Large Employers Only)

Who is Covered?	When?
Employers with 50 or more employees (including full-time and full-time equivalent employees)	**Delayed until 2015**

Employers with 50 or more employees (including full-time and full-time equivalent employees) that do not offer coverage to their full-time employees (and dependents) that is affordable and provides minimum value will be subject to penalties if any full-time employee receives a government subsidy for health coverage through an Exchange.

The employer mandate provisions were set to take effect on Jan. 1, 2014. However, on July 2, 2013, the Treasury announced that the employer mandate penalties and related reporting requirements will be **delayed for one year, until**

2015. Therefore, these payments will not apply for 2014. The Treasury plans to issue more formal guidance on the delay shortly and additional regulations on the reporting requirements over the summer. Future guidance may also impact the rules described in this document. No other provisions of the ACA are affected by the delay.

The size of the employer for this rule is based on the average size for the prior calendar year. Employers with fewer than 50 employees total should easily be exempt from penalties. However, employers that are close to this number should be aware of the potential penalties if they add employees. Also, keep in mind that companies with common ownership may have to be combined for purposes of this rule.

The penalty amount is 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 full-time employee 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. This reporting requirement has also been delayed for one year, until 2015.

Action Items:

- ☐ Monitor legislative developments for additional guidance on the employer shared responsibility provisions.
- ☐ Confirm that employer has fewer than 50 full-time/full-time equivalent employees. (See the recommended documents below for information on how to calculate full-time and full-time equivalent employees).
- ☐ Continue to monitor employer size if employees are added to payroll.

Documents Available from ELT Insurance Services:

- Health Care Reform: Potential Penalties for Employers under the Pay or Play Rules
- Health Care Reform: Large Employers Subject to Pay or Play Penalty
- Health Care Reform: Employer Mandate Penalties Delayed Until 2015

Form W-2 Reporting (Large Employers Only)

Who is Covered?	When?
Employers that had to file 250 or more Forms W-2 in the prior calendar year	2012 tax year

Large employers are required to report the aggregate cost of employer-sponsored group health plan coverage on their employees' Forms W-2. Smaller employers may be subject to this reporting in the future. The IRS has delayed the reporting requirement for small employers by making it optional for these employers until further guidance is issued.

An employer is considered a small employer if it had to file fewer than 250 Forms W-2 for the prior calendar year. Thus, if an employer was required to file fewer than 250 Forms W-2 for 2011, the employer would not be subject to the reporting requirement for 2012. The IRS has indicated that the Internal Revenue Code's aggregation rules do not apply for purposes of determining whether an employer filed fewer than 250 Forms W-2 for the prior year. However, if an employer files fewer than 250 Forms W-2 only because it uses an agent to file them, the employer does not qualify for the small employer exemption.

The purpose of the reporting requirement is to provide information to employees regarding how much their health coverage costs. The reporting does not mean that the cost of the coverage is taxable to employees.

Action Item:

☐ Confirm that your organization is a small employer by reviewing the number of W-2 Forms filed for the 2011 tax year.

Document Available from ELT Insurance Services:

- Health Care Reform: Form W-2 Reporting Requirements

Automatic Enrollment (Large Employers Only)

Who is Covered?	When?
Employers subject to the FLSA with more than 200 full-time employees	Unknown (after regulations issued and effective)

Large employers that are subject to the Fair Labor Standards Act (FLSA) will be required to automatically enroll new full-time employees in one of the employer's health benefits plans (subject to any waiting period authorized by law), and to continue the enrollment of current employees in a health benefits plan offered through the employer. For purposes of this rule, a large employer is one that has more than 200 full-time employees. Employees must be notified of the enrollment and given the opportunity to opt out of any coverage in which the employee was automatically enrolled.

Before this requirement can take effect, the Department of Labor (DOL) must issue implementing regulations. The DOL has stated that, while it intends to complete this rulemaking by 2014, the automatic enrollment guidance will not be ready to take effect by 2014 and employers are not required to comply with the rule until final regulations are issued and become applicable.

Action Item:

☐ Once regulations are issued clarifying how employees should be counted, confirm that your organization is a small employer under this rule.

Document Available from ELT Insurance Services:

- Health Care Reform: Automatic Enrollment Requirements