Health Care Reform – 2013 & 2014 Planning

Employers should review the fast-approaching 2013 and 2014 health care reform requirements. State Exchanges will be opening enrollment as soon as October 1, 2013 with benefits effective January 1, 2014. Along with many questions from employees, employers face a multitude of reform provisions. For answers and guidance, they will look to attorneys, brokers, consultants and third party administrators to help sort out the rules and reporting requirements. Below is a recap of the issues that employers face for 2013 and 2014 and what action they should take in response. In the following table, "PPACA" is an abbreviation for Patient Protection and Affordable Care Act of 2010, better known as the health care reform law. Please note that the following information may change due to future published guidance.

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Summary of benefits & coverage (SBC) is a document that provides health plan information in a consistent format so that employees can easily compare the different health benefits offered by the employer.	Applies to insurers and group health plans subject to PPACA (fully-insured and self-insured). Grandfather plans must comply.	Existing employees – the SBC must be provided during the open enrollment (OE) period that begins on or after 9/23/12. New enrollees – first day of plan year that begins on or after 9/23/12.	Insurance carriers should be providing the SBC's to employers. Employers who have not already provided SBC's to employees should be coordinating these forms with their insurance carriers (or claims administrators for self-insured plans). The DOL has modified the model SBC for plan years beginning in 2014 to include information about minimum essential coverage and minimum value information. The SBC should be distributed to your new employees as of the first day of your plan year that begins on or after 9/23/12 and no later than the first date the employee is eligible to enroll in benefits. You should also be distributing these forms during your next open enrollment period. For special enrollees during the plan year, the SBC should be provided within 90 days after a special enrollment right. When a participant requests an SBC, employers must provide it no later than 7 days following the request.
Health flexible spending account (HFSA) maximum salary reduction of $2,500 – employees cannot elect an annual HFSA salary reduction greater than $2,500 during the plan year.	Applies to Cafeteria Plans – Health Flexible Spending Accounts only. Grandfather status not applicable. All HFSA plans must comply.	Effective for plan years beginning on or after 1/1/13.	All calendar year cafeteria plans should have reduced the salary reduction limit effective 1/1/13. For plans that are off-calendar year plans, employers should be coordinating the reduced limit for plan years starting in 2013 with their FSA administrator and communicate this to employees during the 2013 open enrollment period. Payroll departments should limit total HFSA salary reductions to $2,500 per plan year. Cafeteria plan documents must be amended no later than 12/31/14.
Patient Centered Outcome Research (PCOR) Fee funds a non-profit entity (Patient Centered Outcome Research Institute) to support clinical effectiveness research. The fee is $1 for plan years ending before 10/1/13 and $2 for the second plan year. The fee will be increased after year two and published by the Treasury.	Applies to insurers, group health plans subject to PPACA, retiree-only health plans, active and retiree-only HRA plans and non-exempt governmental health plans. May apply to EAP, wellness or disease management plans. Grandfathered plans must comply.	Effective for plan years ending after 9/30/12 until 9/30/19. Reports and payments are due no later than July 31 of the year following the last day of the policy or plan year.	**Fully-insured plans** – the carriers are responsible to pay the PCOR fee. Employers should be contacting their carriers now to ensure that they will calculate and pay the PCOR fee. **Self-insured plans** – plan sponsors are responsible to pay the PCOR fee. Employers should determine who will calculate the head count for the IRS Form 720. We suggest employers contact their third party claims administrator and determine if they will provide the employer the employee head count. Plan sponsors of self-insured plans should be prepared to complete and file Form 720 on or before 7/31/13 for plan/policy years ending 10/1/12 – 12/31/12. Plan/policy years ending 1/1/13 – 12/31/13 should be filing the Form 720 and paying the PCOR fee by 7/31/14, and so on and so forth.

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Exchange Notice must be distributed to employees explaining the State Exchanges, tax consequences of purchasing Exchange benefits (post-tax), eligibility for premium assistance and if employer's plan is affordable and provides minimum value (60% of costs are covered).	N/A	Employers must provide the notice to current employees no later than 10/1/13. Part-time and full-time employees, regardless of health coverage status, should receive the notice.	Generally, employers subject to the Fair Labor Standards Act (FLSA) are required to provide this notice to employees. The Department of Labor (DOL) has published a model notice which employers can create and provide to employees. Employers should check with service providers to determine if they can assist with the Notice(s). Model Notices can be located on the following sites: Employers that do provide health coverage: http://www.dol.gov/ebsa/pdf/FLSAwithplans.pdf Employers that do not provide health coverage: http://www.dol.gov/ebsa/pdf/FLSAwithoutplans.pdf
Individual mandate – most individuals are required to maintain health coverage or they will pay a federal penalty/tax.	N/A – the penalty only applies to individuals who are not exempt. Individuals who are exempt from the penalty are: 1) Individuals who are not U.S. citizens, nationals, or aliens lawfully present in the U.S. 2) Religious conscience objectors 3) Members of a health care-sharing ministry 4) Individuals in jail 5) Individuals who can not afford coverage (coverage cost would exceed 8% of household income) 6) Individuals who are not required to file a federal income tax return due to income level 7) Members of certain Indian tribes 8) Other exemptions	Effective 1/1/14.	The Exchanges will start their enrollment periods on 10/1/13, so employees will have a lot of questions about their eligibility for the Exchanges and the premium tax credit or cost-sharing (government premium assistance). Employers should prepare to answer basic questions and refer them to the appropriate Exchanges. The Exchange Notice should assist employers. Employers who sponsor off-calendar year health plans may allow employees to drop employer sponsored coverage during the 2013 – 2014 plan year to enroll in Exchange benefits or to allow them to enroll in the employer-sponsored coverage to avoid the individual mandate penalties. Employers should speak with their advisors about allowing mid-year election changes for purposes of the individual mandate. Plan documents allowing these election changes need to be amended no later than 12/31/14 and retroactive to 2013.

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State Exchanges – the Federal and State governments are developing health care exchanges that will provide benefits that meet the minimum essential coverage requirements of PPACA. States will either: 1) create their own Exchanges; 2) partner with the Federal government to establish Exchanges; or 3) rely on the Federal government to provide Exchanges to their residents.	Individuals eligible for enrollment in the Exchanges are individuals who are: 1) Citizens, nationals or aliens lawfully present 2) Not incarcerated 3) Residing in the State that established the Exchange. Generally, premium tax credit and cost sharing reductions apply to those whose household income is 100%-400% of the federal poverty level and affordable benefits are not available.	The effective date of the Exchanges is 1/1/14. The initial open enrollment periods for the State Exchanges are 10/1/13 – 3/31/14. Annual enrollments thereafter will be 10/15 – 12/7. Special enrollment rights for certain events will apply.	Employees will have several questions about the difference between Exchange benefits and employer sponsored coverage. Employers need to prepare for answering basic questions and referring employees to the appropriate Exchanges for more information. The Exchange Notice should provide answers to some questions and will direct employees to the Exchanges where they can obtain additional information. Employees may refer to the Summary of Benefits & Coverage for the employer's health plans to compare benefits and costs to the Exchange benefits. Employers should speak with their service providers to determine if the provider can assist with employee questions. COBRA members will question their options of electing COBRA or purchasing Exchange benefits and the availability of the premium tax credit or cost-sharing (government premium assistance). Employers should speak with their COBRA administrators to determine if they will assist COBRA participants with basic information about their options and refer them to the appropriate Exchanges. COBRA notices may need to change to provide PPACA information and options under COBRA. Additional guidance is needed.
Employer shared responsibility ("play or pay" tax) – applicable large employers will pay a nondeductible penalty tax if they fail to offer health coverage to substantially all full-time employees and their dependents (the definition does not include spouses) and the coverage does not provide minimum value or is not affordable. An applicable larger employer is one who employed, on average, at least 50 "full-time" employees (including full-time equivalents) on business days during the preceding calendar year.	Applies to employer-sponsored plans that are group health plans subject to PPACA that are fully-insured or self-insured (including retiree coverage), governmental plans, or any other plan offered in a state's small or large group market. Grandfather plans must comply with the coverage, affordability and minimum value requirements.	Effective 1/1/14. Payments of penalties will be due in 2015 and annually thereafter. For off-calendar year plans, a transition period applies up to the first day of the plan year beginning in 2014 if certain requirements are met.	Beginning 1/1/14, large employers who do not provide minimum essential coverage to all full-time employees and dependents or employers who do not offer affordable health coverage that meets the minimum value requirement must pay a nondeductible penalty to the IRS if an employee receives a premium tax credit (premium assistance). The IRS has provided guidance on determining large employer status, if coverage is provided to substantially all full-time employees, is affordable, and provides minimum value. Employers should begin assessing all requirements now in order to avoid penalty surprises for 2014. For employers who fail to offer coverage to dependents, there is transition relief for 2014 and steps should be taken in 2014 to provide dependent coverage no later than 2015. Off-calendar plan year sponsors should check with advisors that the transition period applies so that "play or pay" tax can be avoided until the first day of the plan year beginning in 2014. However, these employers will be subject to reporting requirements for calendar year 2014. After employees file their federal tax returns and the insurers and employers file required information returns (see "Reporting of health insurance coverage"), affected employers will be contacted by the IRS informing them of their potential liability and provide employers an opportunity to respond before any liability is assessed or demand for payment is made.

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Reporting of health insurance coverage – in order to determine penalty taxes, insurers and sponsors of self-insured plans that provide health coverage must report coverage information to the IRS and provide a written statement to covered individuals. There may be multiple reports to file, but the IRS is seeking input on combining the reporting requirements for large employers.	Applies to insurers and self-insured health plans subject to PPACA. Grandfather plans must comply.	Effective for coverage provided on or after January 1, 2014. The first information returns will be filed in 2015.	Both insurers and employers will be required to provide reports to the IRS. The reports will be due in 2015. Large employers will be required to report to the IRS information about their health plans along with specific employee information. The employer must also provide a written statement to their full-time employees. Insurers and employers who sponsor self-insured plans must also provide a similar report. The information that will need to be reported is specific information on the insured, coverage dates and other information. Once additional IRS guidance is provided, employers will need to check with their carriers and third-party claims administrators to determine who will be reporting to the IRS and providing written statements to the individuals that were included on the report. IRS is seeking input on combining the reporting requirements for large employers.
Essential health benefits package – health insurance issuers offering coverage in the individual or small group market must ensure that such coverage includes the "essential health benefits package," limit cost-sharing and provide bronze, silver, gold or platinum coverage.	Applies to insurers offering health plans in the small group market or individual market. Grandfathered plans do not need to comply.	Effective for plan years beginning on or after 1/1/14.	Insurers are tasked with this provision. Employers should discuss this provision with their advisors to inquire whether their health plans must offer the minimum essential coverage. Essential health benefits include the following: • Ambulatory patient services • Emergency services • Hospitalization • Maternity and newborn care • Mental health and substance abuse disorder services, including behavioral health treatment • Prescription drugs • Rehabilitative and habilitative services and devices • Laboratory services • Preventive and wellness services and chronic disease management • Pediatric services, including oral and vision care
Excessive waiting period to enroll in the plan – group health plans and insurers are prohibited from applying a waiting period that exceeds 90 days.	Applies to insurers and all group health plans subject to PPACA, regardless of the size of the employer Grandfather plans must comply.	Effective for plan years beginning on or after 1/1/14.	Employers will need to discuss this provision with their advisors to ensure their eligibility waiting period does not exceed 90 days for their affected group plans. Cafeteria plan documents may need to be amended.

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Prohibition of preexisting condition exclusions – certain health plans can no longer apply a preexisting condition	Applies to insurers and group health plans subject to PPACA. Grandfathered plans must comply.	Effective for plan years beginning on or after 1/1/14. For individuals enrolled in the plan who are under 19 years of age, the effective date was plan years beginning on or after 9/23/10.	Employers should discuss this provision with their advisors to ensure they eliminate any preexisting condition exclusions in their affected health plans.
Annual dollar limits are prohibited – annual dollar limits are prohibited on essential health benefits.	Insurers and group health plans subject to PPACA Grandfathered "group" health plans must comply.	Effective for plan years beginning on or after 1/1/14. Effective prior to 1/1/14, the annual dollar limit maximum was phased in over a 3-year period.	Self-insured plans, large group market and grandfathered health plans are not required to offer "essential benefits." The HHS has clarified that these plans are prohibited from imposing annual dollar limits on the essential health benefits they offer. Employers should discuss these provisions with their advisors to ensure their plans comply with this provision.
Annual deductible maximum – the annual deductible can not exceed $2,000 for individual coverage and $4,000 for any other coverage (may increase with COLA for 2014).	Applies to plans and insurers in the small group market. This may change based on future guidance. Grandfathered plans do not need to comply.	Effective for plan years beginning on or after 1/1/14.	Employers should discuss these provisions with their advisors to ensure their plans comply with this provision.
Out-of-pocket maximum – for high deductible health plans compatible with HSA's, the out-of-pocket maximum cannot exceed $6,250 for self-only coverage and $12,500 for family coverage (may increase with COLA for 2014).	Applies to group health plans subject to PPACA. Grandfathered plans do not need to comply.	Effective for plan years beginning on or after 1/1/14.	Employers should discuss these provisions with their advisors to ensure their plans comply with this provision.

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Clinical trials – group health plans may not deny an individual participation in an approved clinical trial, deny (or limit or impose additional conditions on) coverage of routine patient costs for items and services furnished in connection with the trial, and discriminate against the individual on the basis of trial participation.	Applies to insurers and group health plans subject to PPACA. Grandfathered plans do not need to comply.	Effective for plan years beginning on or after 1/1/14.	Employers should discuss these provisions with their advisors to ensure their plans comply with this provision.
Health status nondiscrimination and wellness programs – group health plans and insurance issuers cannot discriminate against and charge higher premiums to an individual due to health status-related factors. A group health plan can provide premium discounts or reduced copayments or deductibles for purposes of wellness.	Nondiscrimination on health status is now applicable to insurers offering individual coverage. This provision already applies to fully-insured and self-insured plans. Wellness programs are impacted. Grandfathered plans must comply.	Effective for plan years beginning on or after 1/1/14.	Employers should discuss these provisions with their advisors to ensure their plans comply with this provision.
Guaranteed Availability – each insurance issuer that offers coverage in the individual or group markets is required to accept every employer or individual in the state where coverage is requested. **Guaranteed Renewability** – each insurance issuer that offers coverage in the individual or group markets is required to renew coverage at the request of the plan sponsor.	Effective 1/1/14, both provisions now apply to health insurance issuers in the individual, small and large group markets. Grandfathered plans do not need to comply.	Effective for plan years beginning on or after 1/1/14.	Employers should discuss these provisions with their advisors when applying for new provider's health coverage or renewing their existing coverage.

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Reinsurance payments – a fee to stabilize premiums in the individual health insurance market to protect insurers against adverse selection as reforms are implemented. Fee only applies for 2014 – 2016. The annual per capita 2014 contribution rate published by HHS is $63 per covered life. The reinsurance contribution is calculated by multiplying the contribution rate by the average number of covered lives during the applicable benefit year.	Applies to major medical plans.	Beginning in 2014 through 2016.	**Fully insured plans –** the insurance carrier will pay the fees. Employers may want to confirm that their carriers are paying this fee. **Self-insured plan** – the plan itself is responsible to pay the fee, but a third party claims administrator (the TPA who pays claims) may remit the payment to HHS on behalf of the plan. If there is no TPA, the plan sponsor must remit the payment. Employers of self-insured plans should speak with their TPA to determine if they will be paying the reinsurance fee and providing the count to HHS. Benefit year means a calendar year for which a health plan provides coverage for health benefits. No later than November 15 of benefit years 2014, 2015 and 2016, the responsible party must provide an annual enrollment count to HHS (generally determined on January – September data even for off-calendar year plans). HHS will notify the insurer or employer of the required fees no later than 30 days of submission of the count or by December 15, whichever is later. The fee must be paid within 30 days after the date of the HHS fee notification.
Fair health insurance premiums – in the individual and small group markets only, insurers may only vary premium rates based on certain factors: coverage category, rating area, age and tobacco use.	Applies to insurers in the individual and small group markets. Grandfathered plans do not need to comply.	Effective for plan years beginning on or after 1/1/14.	Small employers should discuss these provisions with their advisors to ensure their plans comply with this provision.
Annual fee on health insurers – any covered entity that provides health insurance in the U.S. (insurance companies) must pay.	Insurers must comply. Employer plans (fully-insured and self-insured) are not impacted.	Beginning after 2013, the annual fee is due no later than September 30.	Employers do not need to do anything with this particular provision. Insurance companies will pay these fees.
Automatic enrollment – employers subject to Fair Labor Standards Act (FLSA), have more than 200 full-time employees and have one or more health plans must automatically enroll new full-time employees in one of the employer's health plans.	Applies to health benefit plans.	Not effective until final regulations are published. It is unclear when this requirement will be effective. More guidance is expected.	Once final regulations are published, affected employers will need to implement this provision so that new full-time employees are automatically enrolled in one of the health benefit plans. Cafeteria plan documents may need to be amended.
Fully-insured plans nondiscrimination – non-discrimination testing will need to be performed (similar to self-insured plans).	Applies to group health plans subject to PPACA. Grandfather plans do not need to comply.	Not effective until final regulations are published.	Once final regulations are published, affected employers will need to speak with their advisors to ensure their plans comply with this provision.