

HEALTH CARE REFORM

LOOKING FORWARD TO 2012 AND BEYOND

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PPACA Overview

- ❑ Patient Protection And Affordable Care Act
 - Signed March 23, 2010 and amended by the Health Care and Education Affordability Reconciliation Act on March 30, 2010
- ❑ Once fully implemented, PPACA is intended to provide all Americans with access to affordable health care coverage.
 - Individual Mandate
 - Health Care Exchanges
 - Expansion of Medicare and Medicaid
 - Expansion of Employer Coverage

It's Still Here

- ❑ Court challenges
- ❑ Repeal efforts
- ❑ Resistance from States



PREPARING FOR 2012

Grandfathered Group Health Plans

- ❑ Group health plans that were in existence on March 23, 2010 are grandfathered plans.
- ❑ Grandfathered status determined separately for each benefit option.
- ❑ While, in the long run, maintaining grandfathered status will be difficult, it may be good for some employers:
 - Avoidance of new claims and appeals requirements
 - Allowing administration of preventive care benefits to be worked out

Keeping Grandfathered Status

- ❑ Don't eliminate benefits.
- ❑ Don't increase percentage cost-sharing requirements.
- ❑ Don't significantly decrease contribution rate by employers and/or employee organizations.
 - The decrease in contribution rate cannot be more than 5 percent below the contribution rate in effect on March 23, 2010.
 - A decrease in contribution rate that is more than 5 percent with respect to one tier of coverage (e.g., self-only coverage) will cause the plan to lose grandfathered status even if another tier of coverage (e.g., family coverage) remains unchanged.

Keeping Grandfathered Status (Cont'd)

- ❑ Don't significantly increase fixed-amount cost-sharing requirements.
 - The limit with respect to fixed-amount requirements other than co-payments is medical inflation plus 15 percent (the "maximum percentage increase").
 - The limit with respect to fixed-amount co-payments is the greater of the maximum percentage increase or five dollars increased by medical inflation.
 - Medical inflation is measured by the increase since March 2010 in the overall medical care component of the Consumer Price Index for All Urban Consumers (CPI-U) (unadjusted) published by the Department of Labor using the 1982-1984 base of 100.

Keeping Grandfathered Status (Cont'd)

- Don't implement or reduce an annual limit.

Was there an overall <i>annual</i> limit in place on March 23, 2010?	Was there an overall <i>lifetime</i> limit in place on March 23, 2010?	Result
No	No	GHP loses grandfathered status if it implements an annual limit.
No	Yes	GHP loses grandfathered status if it implements an annual limit that is lower than the lifetime limit.
Yes	Yes or No	GHP loses grandfathered status if it decreases the overall annual limit.

Keeping Grandfathered Status (Cont'd)

- ❑ CAN increase benefits.
- ❑ CAN change third-party administrators.
- ❑ CAN increase premiums.
- ❑ CAN amend plan to conform to required legal changes and to voluntarily comply with mandates under the PPACA.
- ❑ CAN change insurance issuers for coverage effective after November 15, 2010.
- ❑ CAN make any other plan changes that would not fall under the "CANNOT" descriptions above.

Remember to Disclose Grandfathered Status

- ❑ Disclosure requirement: Grandfathered plans must include a statement in any plan materials provided to a participant describing the benefits under the plan that:
 - States that the plan believes it is a grandfathered plan, and
 - Provides contact information for questions and complaints.
- ❑ Recordkeeping requirement: Grandfathered plans must maintain documentation of the terms of coverage in effect on March 23, 2010 and make such records available upon request.

PPACA Coverage Mandates

First group of new coverage mandates, effective for plan years beginning on or after September 23, 2010

New Coverage Mandate	Applicable to Grandfathered Plans?
No pre-existing conditions	Yes
No lifetime or annual dollar limits	Yes
Adult child coverage	Yes
No rescissions	Yes
First dollar preventive health care coverage	No
Internal and external appeals process	No
Mandated patient protections	No
Non-discrimination rules extended to insured plans	No



WHAT APPLIES IN 2012
FOR ALL GROUP HEALTH PLANS

No Pre-Existing Conditions - 2012

- ❑ GHP cannot impose any pre-existing conditions on enrollees younger than age 19.
- ❑ GHP cannot impose any pre-existing conditions on **any** enrollees for plan years beginning on or after January 1, 2014.

Lifetime Dollar Limits - 2012

- ❑ GHPs may not place a lifetime dollar limit on "Essential Health Benefits."
- ❑ GHPs may continue to place a lifetime dollar limit on "non-Essential Health Benefits."

Restricted Annual Dollar Limits - 2012

- For plan years that begin prior to January 1, 2014, GHPs may place the following restricted annual dollar limits on "Essential Health Benefits."
 - \$750,000 for plan years beginning on or after 9/23/10 but before 9/23/11
 - **\$1.25 million for plan years beginning on or after 9/23/11 but before 9/23/12**
 - \$2 million for plan years beginning on or after 9/23/12 but before 1/1/14
- For plan years that begin on or after January 1, 2014, GHPs may not place an annual dollar limit on "Essential Health Benefits."
- GHPs may continue to apply an annual dollar limit on "non-Essential Health Benefits."

Restricted Annual Dollar Limits - 2012

- ❑ Prohibition of annual limits does not apply to FSAs, HSAs, or integrated HRAs.
- ❑ August 19, 2011 guidance that prohibition of annual limits does not apply to stand alone HRAs through January 1, 2014, if certain notice and retention requirements met.
- ❑ Plan sponsors/administrators could apply before 9/22/11 to Secretary of HHS for a waiver of annual limits through 2014.
 - o June 17, 2011 guidance extended waivers through 2013 if certain notice requirements met and annual information submitted to CMS.

Restricted Annual Dollar Limits - 2012

"Essential Health Benefits" are to be defined by the Secretary of HHS, but include services and supplies in the following general categories (*good faith interpretation allowed until regs issued*):

- *Ambulatory patient services*
- *Emergency services*
- *Hospitalization*
- *Maternity and newborn care*
- *Mental health and substance abuse*
- *Prescription drugs*
- *Rehabilitative, habilitative, devices*
- *Lab services*
- *Preventive and wellness services*
- *Pediatric services, including oral and vision care*

Typical debated areas: TMJ, transplants, infertility, hearing aids, integrated dental and vision benefits

Adult Child Coverage - 2012

- PPACA requires coverage of children up to age 26 regardless of residence status, parental support, marital status of the child, student status, or similar restrictions.
 - Restrictions are still allowed on other adult children covered under the plan such as grandchildren or other relatives, as well as children of domestic partners.
- For plan years beginning before January 1, 2014, the adult child mandate applies to Grandfathered Plans only if the adult child is not eligible to enroll in any other employer health plan.
 - This includes any employer-sponsored plan other than a plan of the adult child's parent (e.g. adult child's spouse's plan would count as "other" employer health plan).

Adult Child Coverage - 2012

- ❑ Coverage provided to adult children who as of the end of the year have not turned age 27 will not result in imputed income to the employee.
- ❑ Still must impute income for coverage for non-tax dependents such as domestic partner children.
- ❑ Allows for FSA and HRA reimbursement for adult child medical claims.
 - This apparently does not allow reimbursement of adult child expenses through an HSA (which can only be used for true tax dependents).
- ❑ State tax law may be different, so employers must review the tax laws of all of the states in which they have employees because adult child coverage may be taxable for state income tax purposes.

Rescissions - 2012

- ❑ GHPs may not rescind coverage.
- ❑ Includes any retroactive cancellation of coverage.
 - Exception for fraud or intentional misrepresentation of material fact (but 30-day notice must be provided).
 - Exception if participant fails to timely pay premiums.
- ❑ This would include retroactively canceling coverage when employer finds it failed to drop coverage when an employee changes eligibility categories.
- ❑ May impact dependent audits and spousal carve-out policies if employer wants to retroactively cancel coverage of improperly enrolled individuals.
- ❑ Consider protective language in plans for when employees fail to notify of dependent changes.
- ❑ IRS theory for failure to pay premiums.



WHAT APPLIES IN 2012
FOR NON-GRANDFATHERED
GROUP HEALTH PLANS ONLY

Preventive Services - 2012

- GHPs must provide first dollar coverage, without any cost sharing requirements (e.g., deductibles, co-pays, co-insurance, etc.) for:
 - preventive care services recommended by the U.S. Preventive Services Task Force;
 - immunizations recommended by the Centers for Disease Control and Prevention;
 - with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration; and
 - with respect to women, to the extent not already required above, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).
 - August 3, 2011 amendment to interim final regulations gave HRSA discretion to exempt certain religious employers from guidelines with respect to contraceptive services.

Preventive Services – 2012 (Cont'd)

- ❑ Recommendations/guidelines must be covered:
 - If issued before September 23, 2009, must be included in GHPs with no cost sharing as of the first plan year beginning on or after September 23, 2010 (Jan. 1, 2011 for calendar year plans).
 - If issued on or after September 23, 2009, are not required to be provided on a first-dollar basis until the first plan year that begins on or after the date that is one year after the date the recommendation or guideline is issued (so recommendations issued up to Dec. 31, 2010 must be included in January 1, 2012 plan years).
- ❑ An up-to-date listing of required recommendations and guidelines, including the dates on which they were issued is available at <http://www.healthcare.gov/center/regulations/prevention/recommendations.html>.

Preventive Services – 2012 (Cont'd)

- The Interim Final Rule provides guidance with respect to when a GHP may impose cost-sharing requirements for office visits during which required preventive services are provided.

<i>If...</i>	<i>Then</i>
Preventive service billed separately from office visit	Cost sharing permitted on office visit
Preventive service not billed separately and primary purpose of visit was to deliver preventive service	Cost sharing not permitted on office visit
Preventive service not billed separately and primary purpose of visit was not to deliver preventive service	Cost sharing permitted on office visit

Preventive Services – 2012 (Cont'd)

- ❑ Cost-sharing for required preventive services may still be imposed out-of-network.
- ❑ GHPs can use reasonable medical management techniques to determine the frequency, method, treatment, or setting for a recommended preventive service if the recommendation does not provide specific guidance.
- ❑ GHPs may continue to provide "extra" preventive services with cost-sharing requirements.

Claims and Appeals Procedures - 2012

- ❑ Internal Claims and Appeals
 - GHPs are required to have an internal claims and appeals process that follows the ERISA claims and appeals procedures, except as modified by DOL.
 - Additional standards set forth in interim final regulations issued July 23, 2010
 - Technical Release 2010-02 delayed enforcement until July 1, 2011 with respect to certain standards
 - Technical Release 2011-01 delayed enforcement until plan years beginning on or after January 1, 2012 with respect to certain standards
 - Amendment to the interim final regulations issued June 24, 2011 effective at the end of enforcement grace periods

Claims and Appeals Procedures – 2012 (Cont'd)

- Additional standards set forth in July 2010 regulation, as modified by June 24, 2011 amendment:
 - A "rescission" decision can be appealed.
 - **NO CHANGE**
 - Effective first plan year beginning on or after September 23, 2010
 - Notify claimants of an urgent care claim benefit decision within 24 hours (ERISA standard is 72 hours).
 - **REPEALED**, so long as plan defers to attending provider with respect to the decision as to whether a claim is urgent care
 - Effective first plan year beginning on or after January 1, 2012
 - Satisfy additional criteria to meet "full and fair review" – must provide evidence/rationale relied upon for decision prior to issuing decision to give claimant chance to respond.
 - **NO CHANGE**
 - Effective first plan year beginning on or after September 23, 2010

Claims and Appeals Procedures – 2012 (Cont'd)

- Additional standards set forth in July 2010 regulation, as modified by June 24, 2011 amendment (*cont'd*):
 - Ensure new rules are followed to avoid a conflict of interest.
 - **NO CHANGE**
 - effective first plan year beginning on or after September 23, 2010
 - Provide notices of adverse benefit determination in culturally and linguistically appropriate manner.
 - **CHANGED**, establishes a single threshold at 10% or more of the population residing in the claimant's county, as determined based on American Community Survey data. If threshold is met in a county, the plan must provide (i) oral language services in the relevant non-English language, (ii) notices, upon request, in the non-English language, and (iii) in all notices a one sentence statement in the non-English language about the availability of language services
 - effective first plan year beginning on or after January 1, 2012

Claims and Appeals Procedures – 2012 (Cont'd)

- Additional standards set forth in July 2010 regulation, as modified by June 24, 2011 amendment (*cont'd*):
 - Provide additional information in notice of benefit determination (e.g., identifying claim information)
 - **CHANGED**, eliminates the requirement to automatically provide the diagnosis and treatment codes in notice of adverse benefit determination
 - Amended portion of standard is effective first plan year beginning on or after January 1, 2012
 - All other portions of standard effective first plan year beginning on or after July 1, 2011
 - Deemed exhaustion if plan fails to strictly adhere to claims and appeals procedures
 - **RELAXED**, to add an exception to the deemed exhaustion rule if the violation is de minimis, non-prejudicial, and attributable to good cause or matters beyond the plan's control
 - Effective first plan year beginning on or after January 1, 2012

Claims and Appeals Procedures – 2012 (Cont'd)

□ External Claims and Appeals

- GHPs must comply with either a State or Federal external review process and must comply with decision of independent review organization (IRO).
 - State review process applies if state process is binding on insurer issuing fully insured GHP and the state process includes minimum consumer protections in NAIC Uniform External Review Model Act
 - If there is no state external review process or it does not apply, Federal external review process applies (e.g. self-insured GHPs subject to ERISA or Code).

Claims and Appeals Procedures – 2012 (Cont'd)

- ❑ June 24, 2011 amendment to final interim regulations changed State review process
 - Delayed enforcement to 12/31/11
 - Temporary enforcement relief
- ❑ June 24, 2011 amendment to final interim regulations changed Federal review process
 - Narrowed scope of claims eligible for review
 - Relaxed requirement under enforcement safe harbor, so now required to contract with at least two IROs by 1/1/12 and three IROs by 7/1/12
- ❑ Revised model notices issued

Emergency Services - 2012

- ❑ If plan covers hospital emergency department services, it must do so without requiring prior authorization regardless of whether the provider is a participating provider and with same requirements and costs imposed on in-network participating providers (although balance billing allowed within limits).
- ❑ GHPs must also provide other patient protections:
 - Participants may designate a participating primary care provider of choice for themselves and children from physicians available in the network (if plan requires a choice).
 - If GHP covers OB/GYN care, participants are required to have access to such care without referral or authorization.

Nondiscrimination Rules - 2012

- ❑ Nondiscrimination rules under Code Section 105(h) already apply to self-insured GHPs (governmental and non-governmental).
- ❑ Extension of similar rules relating to eligibility and benefits to fully-insured GHPs (governmental and non-governmental).
- ❑ Could impact fully-insured plans for executives as well as fully-insured plans where employer pays greater percentage of premiums for higher paid employees.
- ❑ Could affect severance agreements.
 - Consider just grossing up severance payment equal to COBRA premium.
 - Tax executive on the amount of the employer-provided premium.
 - Not clear that these methods will work until guidance is released.
- ❑ Treasury expected to issue new regulations under Code Section 105(h), but Secretary of HHS is responsible for regulations under PHSA - expect new emphasis on compliance.
- ❑ **Notice 2011-01 suspended rules until regulations issued.**



WHAT ELSE IS ON TAP FOR 2012 AND BEYOND?

Form W-2 Reporting

- ❑ Employers are required to report (not tax) the aggregate cost of employer sponsored health coverage on employees' Form W-2, Box 12, Code DD.
 - The "aggregate cost" is:
 - For fully-insured plans, the premiums paid.
 - For self-insured plans, the cost is determined under rules similar to those that apply for purposes of determining COBRA premiums.
 - Includes both employee and employer contributions and coverage for single and family coverage.
 - Aggregate cost does not include:
 - Employer or employee contributions to Archer MSAs or health savings accounts.
 - Contributions to health reimbursement arrangements.
 - Fully insured dental and vision and self-insured dental and vision that is separately electable and subject to separate employee contribution.
 - Employee contributions to a medical flexible spending account if the amount of the employee's cafeteria plan election equals or exceeds the amount contributed to the medical FSA.

Form W-2 Reporting (Cont'd)

- ❑ Employer can choose whether to report post-termination coverage (*e.g.*, cost of COBRA coverage).
- ❑ Employers do not have to report on mid-year Form W-2s.
- ❑ This reporting requirement is applicable for taxable years beginning after Dec. 31, 2011 (generally Jan. 1, 2012), which means it will be required for Forms W-2 issued in January 2013.
- ❑ Small employer exception: For 2012 Forms W-2, employers are not subject to the reporting requirement if they filed fewer than 250 Forms W-2 for a preceding year (applicable until further guidance).
- ❑ Multiemployer plans are exempt.
- ❑ Self-funded church plans are exempt (under exception for self-insured plans that are not subject to federal continuation of coverage [COBRA] requirements).
- ❑ Note that ERISA plans must comply unless otherwise excepted.
- ❑ No requirement to report for people who would not otherwise receive a Form W-2, such as retirees on the health plan.

Summary of Benefits and Coverage (SBC)

- ❑ Summary of benefits and coverage explanation that accurately describes the benefits and coverage under the GHP.
- ❑ Standards for the summary were issued by HHS in proposed form on August 22, 2011, and include standards for appearance, language and content.
 - 4 page (front and back) document
 - Uniform glossary
- ❑ Obligation to distribute SBC becomes effective March 23, 2012. Unclear whether this will be extended because HHS did not meet its timing goal (regulations were due March 23, 2011).
 - For fully-insured plan, insurer has obligation to distribute
 - For self-insured plan, plan administrator and insurer have obligation to distribute

Summary of Benefits and Coverage (SBC) (Cont'd)

- ❑ SBC must be standalone document (comments requested).
- ❑ Can be provided electronically.
- ❑ Provided in a culturally and linguistically appropriate manner.
- ❑ The GHP must provide an SBC:
 - ❑ For all benefit options for which an employee is eligible to enroll (i) with application materials distributed by the plan or (ii) if no application written materials, no later than the first day the employee is eligible to enroll
 - ❑ Within 7 days of request for special enrollment
 - ❑ For the benefit option in which an employee is enrolled with written application materials required for renewal or if automatically renewed, at least 30 days prior to the first day of the new plan year
 - ❑ Within 7 days after request
- ❑ If a plan is materially modified after the SBC is distributed, notice of the modification must be provided 60 days before the date modification is effective. Does not apply to modifications at renewal.

Automatic Enrollment

- ❑ Employers subject to the Fair Labor Standards Act must automatically enroll new full-time employees in the employer's health plan if:
 - Employer has more than 200 full-time employees; and
 - Employer offers employees enrollment in one or more health benefits plans
- ❑ Comments solicited on definition of "Full-time employee" for purposes of this and employer penalty provisions.
- ❑ Employers may still enforce waiting period if the plan imposes them.
- ❑ The automatic enrollment program must include adequate notice and the opportunity for an employee to opt out of any coverage in which the individual was enrolled.

Automatic Enrollment (Cont'd)

- ❑ Pre-empts state wage payment laws if prevents automatic enrollment.
- ❑ Will be effective according to regulations to be issued by Department of Labor.
- ❑ Not yet clear into which of an employer's plan options an individual will be automatically enrolled.

Fees for Patient Centered Outcomes Research

- ❑ New Patient-Centered Outcomes Research Institute funded by fees paid by insurers and plan sponsors of self-insured health plans.
- ❑ Effective each policy or plan year ending after September 30, 2012, and before October 1, 2019.
 - For calendar year plans, effective 2012-2018
- ❑ \$1 for policy/plan years ending before October 1, 2013 times average number of lives covered under policy; \$2 for policy/plan years ending before October 1, 2014; indexed thereafter.

Account Plans

- Health FSAs/HRAs/HSAs/Archer MSAs
 - Over-the-counter drugs are no longer qualified for purposes of distributions/reimbursements under HSAs, Archer MSAs, health FSAs, and HRAs, except for prescription medicines and insulin. This provision was effective Jan. 1, 2011 (grace period not applicable).
 - Restrictions on reimbursable medications do not appear to impact other medical expense items available for reimbursement, such as contact solution, band-aids, etc. that are not medication.
 - The tax on distributions from HSAs for nonqualified medical expenses is increased from 10 percent to 20 percent (Archer MSA penalty increased from 15 percent to 20 percent). This provision was effective Jan. 1, 2011.
 - Contributions to a health FSA under a cafeteria plan are limited to \$2,500 per year, indexed for inflation after 2013. This provision is effective Jan. 1, 2013.

Looking Ahead: 2014 Coverage Mandates

Second group of new coverage and reporting mandates, effective for plan years beginning on or after January 1, 2014

New Coverage Mandate	Applicable to Grandfathered Plans?
No waiting period in excess of 90 days	Yes
Limits on cost-sharing and deductibles	No
Mandated coverage of clinical trials	No
No discrimination based on health status	No

Waiting Period – ALL PLANS

□ **Waiting Periods**

- GHPs may not impose any waiting period in excess of 90 days.
- This could significantly impact plans in the retail and food service sectors, as well as collectively bargained plans.
- Could increase costs and administrative burden because of short-term employees.

Cost Sharing – Grandfathered Plans Exempt

❑ Cost-Sharing Requirements

- GHPs must limit the out-of-pocket expenses (e.g., deductibles, co-pays, co-insurance, etc.) incurred by participants to the limits on HDHPs.
 - Current HDHP limit is:
 - for single coverage = \$5,950
 - for family coverage = \$11,900
 - Limits indexed after 2014.
- GHPs cannot have deductibles that exceed \$2,000 for single coverage and \$4,000 for any other coverage.
 - Increased by employee and employer contributions to a flexible spending account.
 - Limits indexed after 2014.

Mandated Coverage of Clinical Trials - Grandfathered Plans Exempt

- Mandated Coverage of Clinical Trials
 - GHPs cannot deny participation of a qualified individual in a clinical trial, deny coverage of routine costs in connection with a clinical trial, or discriminate on the basis of a clinical trial.
 - "Qualified individual" is a participant in a GHP who is:
 - Eligible to participate in an approved clinical trial with respect to treatment of cancer or other life-threatening disease or condition, and
 - Referred by a provider or provides information establishing that participation would be appropriate.

Nondiscrimination Based on Health Status – Grandfathered Plans Exempt

- ❑ GHPs may not establish rules for eligibility (including continued eligibility) to enroll based on health status related factors such as health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability and disability.
- ❑ Codification of ERISA, IRC and PHS A regulations that already prevent discrimination in eligibility on the basis of health status since 1996 passage of HIPAA.



THE HEALTH INSURANCE EXCHANGES

Exchanges - 2014

- ❑ PPACA creates state-based health benefit Exchanges through which individuals and small employers (up to 100 employees) can purchase coverage.
- ❑ Premium and cost-sharing credits available to individuals with household income between 133-400% of federal poverty level (FPL).
- ❑ If state does not establish, federal government will do so, either directly or under an agreement with a non-profit entity.
- ❑ Health plans on Exchange must be issued by licensed health insurance issuer and provide an "essential health benefits package."
 - Must satisfy certain cost sharing limits.
 - Must have four benefit categories (bronze, silver, gold and platinum) plus "young invincible" category.

Federal Poverty Level

The 2011 Poverty Guidelines for the 48 Contiguous States and the District of Columbia

Persons in family	Poverty Guideline	133%	400%
1	10,890	14,484	43,560
2	14,710	19,564	58,840
3	18,530	24,645	74,120
4	22,350	29,726	89,400
5	26,170	34,806	104,680
6	29,990	39,887	119,960
7	33,810	44,967	135,240
8	37,630	49,689	150,520



INDIVIDUAL PENALTIES

Individual Penalties - 2014

- ❑ General rule that individuals must either secure "qualifying health coverage" or pay tax penalty.
- ❑ Tax penalty
 - Taxpayer pays for him/herself and for tax dependents.
 - Amount of tax penalty is the greater of \$695 or 2.5% of modified gross income for the household, up to a maximum of three x \$695 (\$2,085) per family or 2.5% of household income. Phase in prior to 2016.
 - Dollar penalty is one-half for dependent under 18 and capped at 300% of annual flat dollar amount.
 - No penalty if gap in coverage is less than 3 months.

Individual Penalties – 2014 (Cont'd)

- ❑ Exemptions from individual penalties:
 - Financial Hardship (determined by Secretary of HHS)
 - Religious Objections
 - American Indians
 - Undocumented immigrants
 - Incarcerated individuals
 - Those for whom the lowest cost plan option exceeds 8% of an individual's household income
 - Those with incomes below the tax filing threshold (in 2009 the threshold for taxpayers under age 65 was \$9,350 for singles and \$18,700 for couples)



EMPLOYER “FREE RIDER” PENALTIES

Employer Responsibilities - 2014

- ❑ Employers are not required to provide coverage, but tax penalty beginning January 1, 2014, based on whether "minimum essential coverage" is offered.
- ❑ Applies to employers with 50 or more full-time employees (including FTEs).

Employer Responsibilities – 2014 (Cont'd)

- ❑ Calculating Size of Employer's Workforce
 - Determined based on monthly average in previous calendar year.
 - If not in existence during previous year, reasonable expectations
 - Full-time employee = works 30 hours per week.
 - Part-time employee monthly hours totaled and divided by 120 – add to number of full-time employees to determine FTEs.
 - Common ownership rules ("control group" and affiliated company rules) apply both to determination of size and penalty owed.

Employer Responsibilities – 2014 (Cont'd)

□ Two Potential Penalties

- First penalty can apply if employer does not offer minimum essential coverage and even one FTE is eligible for a subsidy on the Exchange.
 - Penalty will apply for ALL FTEs
- Second penalty can apply if employer does offer minimum essential coverage, but an FTE is eligible for a subsidy on the Exchange because the coverage is "too expensive" or "not rich enough."
 - Penalty will only apply to subsidy-eligible FTEs

Employer Responsibilities - 2014 (Cont'd)

□ First Potential Penalty

- If coverage is not offered to all full-time employees (and their dependents) AND
- One or more full-time employees purchase coverage from an Exchange AND
- Any such employee qualifies for taxpayer subsidized coverage, then . . .
 - Penalty of \$166.67 per month (or \$2,000 per year) for each full-time employee (subject to inflation).
 - First 30 full-time employees exempted.

Employer Responsibilities - 2014 (Cont'd)

- ❑ Second Potential Penalty
 - If coverage is offered to all full-time employees (and their dependents) AND
 - One or more full-time employees opt-out of employer coverage and purchase coverage from an Exchange AND
 - Any such employee qualifies for taxpayer subsidized coverage, then . . .
 - Penalty of \$250 per month (or \$3,000 per year) for each opting-out employee receiving a subsidy (subject to inflation).
 - Penalty capped at \$2,000 per year times total number of full-time employees (subject to inflation), with first 30 full-time employees exempted.

Employer Responsibilities - 2014 (Cont'd)

- A FTE employee within employer minimum essential coverage qualifies for a subsidy on the Exchange if:
 - the employee has household income between 133-400% of the FPL, and
 - The employee's contribution under the employer plan exceeds 9.5% of household income OR
 - The employer plan pays less than 60% of the total cost of benefits provided under the plan.
 - Currently, 400% of FPL is \$89,400/year for a family of four and \$43,560/year for individuals.

Resources

- ❑ <http://www.healthcare.gov/>
 - A participant-focused website from the Department of Health & Human Services.
- ❑ <http://cciio.cms.gov/>
 - Many technical materials are available from this site.
- ❑ http://www.icemiller.com/service_detail/mainindustryid/4/id/517/index.aspx
 - Ice Miller LLP health care reform resources.

Questions and Answers



This presentation is intended for general information and does not, and is not intended to, constitute legal advice.

