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The Benefit of Balance

LEGAL UPDATE

As we venture into 2013, EBMS wants you to have all of the tools available to manage your group health plan. The Affordable Care Act (ACA) brings some changes for 2013 and a large number of changes for 2014. In order to make the best decisions for your group health plan in the years ahead with regard to the ACA requirements, you must be well prepared. As your partner, EBMS has committed to providing you with the knowledge and tools to move ahead. This communication, along with our companion timeline, should provide you with a good overview of the issues facing your group health plan over the next few years.

2013

PREVENTIVE HEALTH BENEFITS FOR WOMEN - If your plan is a non-grandfathered plan that has not already made this change, you will need to make this change as of the first day of the first plan year after August 1, 2012. The ACA requires that the preventive benefits for women listed at www.hrsa.gov/womensguidelines/ are paid with no cost-sharing to the member if a network provider is utilized.

RESTRICTED ANNUAL LIMITS – For plan years beginning September 23, 2012 to January 1, 2014, the plan can have an annual dollar limit on essential benefits of no less than $2 million. After January 1, 2014, the plan cannot have any annual or lifetime dollar limit on essential benefits. However, a plan can have annual or lifetime dollar limits on non-essential benefits.

SUMMARY EXPLANATION OF BENEFITS AND COVERAGE (SBC) - If your plan has not already met the new SBC requirement, you will need to provide an SBC for each benefit option to your plan members. The SBC must be provided at all enrollment opportunities and upon request by the member. If you make any material modification to the Plan that will affect the terms listed in the SBC, you must provide 60 days advance notice to plan members of the change.

HEALTH FLEXIBLE SPENDING ACCOUNT – The salary reduction limit for any health flexible spending plan has been limited to $2,500 per calendar year beginning January 1, 2013.

W-2 REPORTING – The value of all health benefits provided to your employees must be reported to them on their 2012 W-2 form in Box 12 DD. The value includes the employer and the employee paid portion of the premium and includes any employer contributions to a health flexible spending account, on-site clinic, or health reimbursement arrangement. Employers that filed less than 250 W-2s for the 2011 taxable year are exempt from this requirement in 2012.

NOTICE OF AVAILABILITY OF STATE EXCHANGES – ACA requires that employers notify their employees of the availability of the State Exchanges at the time of hiring or for current employees, no later than March 1, 2013. However, the DOL delayed the timing for distribution of this notice until late summer or fall of 2013 to coincide with open enrollment for the State Exchanges. Model notice language is expected. EBMS will assist you with the distribution of the notice upon request.

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PATIENT CENTERED OUTCOME RESEARCH (PCOR) FEE - For Plan years ending on or after October 1, 2012, the Plan Sponsor is required to report the average number of covered lives for the prior plan year on IRS Form 720. The Form 720 along with the payment is due by July 31 of the immediately following calendar year. For example, for a plan year ending June 31, 2013, the Form 720 must be filed by July 31, 2014. The fee may not be paid from plan assets. For the plan year ending before October 1, 2013, the fee is $1 multiplied by the average number of covered lives. Beginning for plan years ending before October 1, 2014, the fee is $2 multiplied by the average number of covered lives. Subsequent amounts will be determined based on health care cost increases. This fee will no longer apply for plan years ending after October 1, 2019.

PLAN EDI CERTIFICATION – the Plan is required to certify with HHS its, or its designee's, compliance with Electronic Data Interchange (EDI) standards and operating rules as required by the HIPAA rules no later than December 31, 2013.

2014

PLAN CHANGES – For the first plan year beginning on or after January 1, 2014, the plan must be amended to comply with additional ACA requirements. No annual or lifetime dollar limits will be allowed on essential health benefits of all plans (including grandfathered plans). No pre-existing condition exclusions will be allowed for any plan member on all plans. No plan may have a waiting period of more than 90 days for full-time employees. Non-grandfathered plans must allow for payment of the routine medical costs for plan members participating in a clinical trial.

INDIVIDUAL COVERAGE MANDATE – All individuals who file a tax return for the tax year 2014 are required to maintain minimum essential health coverage. If the individual cannot prove coverage, he/she will incur a penalty. For tax year 2014, the penalty for an individual is the greater of 1% of income or $95. The penalty amount increases for subsequent tax years and applies to all individuals in a household who cannot prove coverage.

DEPENDENT COVERAGE TO AGE 26 – All plans will be required to provide coverage for all dependents up to age 26 without regard to the availability of other employer-sponsored coverage for the dependent.

PCOR FEE – Beginning for the plan year ending on or after October 1, 2013, the fee imposed on Plan Sponsors increases to $2 multiplied by the number of lives covered during the prior plan year.

WELLNESS PENALTY/REWARD EXPANSION – Beginning January 1, 2014, a Plan may impose a penalty/reward for reaching the goals of a health-contingent wellness plan of 30% of the total cost of coverage (an increase from the prior limit of 20%). A reward/penalty of an additional 20% is allowed for incentives to prevent tobacco use.

TEMPORARY REINSURANCE FEE – This fee is estimated at $5.25 per month per covered life ($63.00 per year) but may be adjusted. States may impose an additional amount on non-ERISA plans. The number of covered lives will be determined using the first nine months of the year and annualizing that number. Plans must report the number of covered lives to the Department of Health and Human Services (HHS) annually, by November 15th, beginning November 15, 2014. HHS will notify the plan of the reinsurance contribution amount due. Payment is due within 30 days of the notification and no later than January 15 of the following year. The Plan Sponsor is liable for payment and may use plan assets. A Third Party Administrator may be used to transfer contributions on behalf of self-insured plans. This fee applies to major medical plans including retiree plans for retirees under age 65.

EMPLOYER SHARED RESPONSIBILITY ("PAY OR PLAY") RULE – A new IRC §6056 Information Return must be filed by employers subject to the Pay or Play rules ("applicable employers"). Applicable employers employ an average of 50 or more full-time (FT) and "full time equivalent" (FTE) employees in the prior calendar year (see below for a discussion on how to determine the number of FTE employees). The Information Return requires detailed information about the employer's group health plan, the number of employees, monthly premium and the employer's share of total allowed costs of benefits under the plan. A written statement must also be provided to full time employees identified in the Information Return by January 31st of the following year.

The Pay or Play penalty will be imposed on employers that do not offer an eligible, minimum value health plan or, if they offer an eligible plan, the plan is unaffordable to all full time employees (one or more employees qualifies for a subsidy to purchase coverage on the State Exchange). This penalty is not tax deductible. The basic penalty structure for employers is as follows:

PLAN OFFERED BY EMPLOYER	ANNUAL PENALTY
No eligible plan and at least one FT employee enrolls for the exchange subsidy	$2,000 x all FT employees-30
Eligible plan and at least one FT employee enrolls for the exchange subsidy	Lesser of $2,000 x all FT employees - 30 or $3,000 x FT employees enrolled for subsidized exchange coverage
Eligible Plan providing "minimum value" and "affordable" to all FT employees	No penalty

If all full-time employees (those working an average of 30 or more hours per week) and their dependents (as defined by IRC Section 152(f)(1), not including spouses) are offered coverage in a minimum value health plan and the cost of coverage to the employee is not more than 9.5% of the employee's household income for the year, no penalty will apply. The IRS provides a special safe harbor to allow the employer to use the employee's W-2 earnings or the employee's rate of pay to assess the affordability of the coverage, since the employee's total household income is not usually known by the employer.

The "minimum value" requirement is satisfied if the plan's share of total allowed costs of benefits provided under the plan is more than 60 percent of the costs. HHS and the IRS plan to release a "minimum value calculator" and several design-based safe harbors in the form of checklists that may be used to make the "minimum value" determination. The plan may also use an actuary to make the determination. Health Reimbursement Account (HRA) and Health Savings Account (HSA) contributions by the employer may be taken into account in establishing the value of the health plan.

DETERMINING A FULL-TIME EMPLOYEE – Regulations have been released on methods to determine the employer's number of full-time employees. In general, a full-time employee is considered to be one who works an average of 30 hours per week. Several categories of employees are contemplated; ongoing employees (those who have been employed for at least one complete standard measurement period), new employees expected to work full-time hours, new variable hour employees and new seasonal employees. Special rules apply for educational institutions, special unpaid leave, transportation employees, commission employees, and breaks in service.

Three defined time periods have been defined in the safe harbor rules for determining full-time status:

- *Measurement period* means a period of 3-12 months in which hours are calculated. There is a "standard" measurement period for ongoing employees and an "initial" measurement period for new variable hour employees. The agencies provided a transitional rule for the first "standard" measurement period for ongoing employees. The transitional rule permits employers to use a period of at least 6 months beginning no later than July 1, 2013, to determine coverage for the first stability period which may be longer than this first measurement period.

- *Stability period* means a period in which the employee's status of full-time or part-time is locked in. For example, if the employee is determined to be a full-time employee during the measurement period, the employee must be offered coverage during the subsequent stability period, even if the employee's hours decrease. The permissible length varies but it must be the same length for new variable hour and ongoing employees.

- *Administrative period* means a period after the measurement period and before the stability period for employers to determine full-time status and offer enrollment to eligible full-time employees. The maximum length is 90 days but, for new variable hour employees, the initial measurement period and the administrative period cannot extend beyond the last day of the first calendar month on or after the one year anniversary of the new variable employee's hire date.

The plan might consider amending plan language to change the definition of a full-time employee to include those that work 30 or more hours per week. The eligibility requirements for dependents should also be reviewed to ensure all required dependents are offered coverage.

Now is the time to prepare for the upcoming changes in 2014. With careful planning and consideration, the group health plan can avoid altogether or significantly limit the application of the Pay or Play penalties and continue to provide valuable benefits to its members. The plan will need to take necessary steps to comply with the plan changes, new notice and reporting requirements, the new fees and penalties imposed on health plans and the identification of full-time employees. EBMS is prepared to assist the plan to ensure its compliance with all necessary adjustments. We believe self-funding will continue to thrive as employers want to attract valuable employees and have control over the benefit options they offer. More information and learning opportunities will be forthcoming. Please contact your Account Manager if you have any questions or need any assistance working through your upcoming ACA compliance issues.

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