

# 2016 Healthcare Reform Guide

## *The Home Stretch*



## Introduction

This document is being provided as an informational tool for self-funded plan sponsors to provide an overview of requirements under the Affordable Care Act (ACA). **Self-funded plan sponsors should pay particular attention to the following chapters as provisions within them will require action of the plan sponsor during 2016:**

- **Chapter 3- Grandfathering.** This chapter includes information on benefits that must be covered by non-grandfathered plans. Pay special attention to the new rules that impact the out-of-pocket maximum for non-grandfathered plans beginning on or after January 1, 2016.
- **Chapter 5- Employer Shared Responsibility Provision.** This chapter talks about the requirements employers with 50-99 full time or full time equivalent employees need to be aware of and gives a refresher for those already complying with the employer mandate.
- **Chapter 7- Taxes, Fees and Other Reporting Obligations.** New to this chapter is information regarding the employer and individual mandate reporting.

It is recommended that plans consult with their own experts or legal counsel to review all applicable federal and state legal requirements that may apply to their group health plan. By providing this publication and any attachments, Meritain Health is not exercising discretionary authority over the plan and is not assuming a plan fiduciary role, nor is Meritain Health providing legal advice.

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# Chapter 1 - Which Plans Must Comply With ACA

Over the last six years, there may have been moments when you felt you were in a race to comply with the many benefit reforms, new reporting requirements, and new taxes brought on by the Affordable Care Act (ACA). In 2016, employers and plan sponsors will enter the home stretch.

Meritain Health remains committed to helping you understand and navigate through the various ACA requirements that are still needed. We will continue to keep you informed as the last pieces of regulatory guidance remain outstanding or are in a proposed rule or draft form today. Keep in mind that even though the changes brought about by ACA apply to the majority of employer-sponsored health plans, there are a few exceptions to this rule.

Below is a snapshot of which plans must comply and which plans are generally not subject to the regulatory requirements (unless otherwise noted). The distinction between whether a plan is ERISA or Non-ERISA is not significant here, as ACA applies to both ERISA and non-ERISA plans.

## Plans That Must Comply

- Self-Funded Medical Plans
- Insured Medical Plans
- Church Medical Plans
- Governmental Medical Plans
- Employer Plans that are deemed a single employer under the common-ownership rules
- Multiple Employer Welfare Arrangements (MEWAs) that provide medical benefits
- Plans governed by a Collectively Bargained Agreement (CBA) that provide medical benefits
- Mini-Med Plans
- Dental and Vision Plans that are bundled with Medical
- Stand-Alone Prescription Drug Plans
- Employee Assistance Programs or EAPs (whether insured or self-funded) if part of the group health plan (or subject to Knox-Keene requirements)
- Executive Medical Plans

## Plans That Do Not Need to Comply

- Stand-Alone Excepted Benefit Plans such as stand-alone dental and vision benefits. Excepted Benefits can generally be explained as benefits that are separate from medical coverage (or are not an integral part of your medical coverage).
- Most health Flexible Spending Accounts (unless otherwise noted later in Chapter Four)
- Medigap policies
- Accidental death and dismemberment coverage
- Specified disease (e.g., cancer) and limited hospital indemnity (e.g., \$100 per day in hospital) coverage
- Stand-Alone Retiree Plans that operate separate from a medical plan (offered through a separate plan document) and treated as separate for applicable reporting requirements (Form 5500). One exception here is that stand-alone retiree plans must comply with the PCORI fee that is discussed later.
- Health Savings Accounts (HSAs); however, the underlying medical plan associated with the HSA must comply.

## Chapter 2 – Benefit Reforms in Place Today

### Benefit Reforms

The ACA imposes a number of requirements on group health plans regardless of whether or not a plan is deemed a grandfathered or non-grandfathered health plan. However, some reform requirements do not apply to grandfathered plans as long as that status is maintained. For more information on Grandfathering, please refer to Chapter Three.

Provided below is a quick reference to those benefits or provisions that **should already be included in plan(s)**, regardless of grandfathered status, and those that will need to be added (in the future if not already included today), upon loss of grandfathered status. This is a summary only.

Applicable to <b>both</b> grandfathered and non-grandfathered plans	<ul style="list-style-type: none"><li>Prohibition of Annual and Lifetime dollar limits on essential health benefits</li><li>Eligibility of dependent children up to age 26, including coverage of married children</li><li>Pre-existing condition limitations/exclusions, regardless of age</li><li>Rescissions of coverage, except in cases of intentional misrepresentation or fraud, are prohibited</li><li>Waiting periods limited to 90 days or less</li><li>Coverage of over-the-counter medications no longer covered without a doctor's prescription for Flexible Spending Accounts (FSA), Health Reimbursement Arrangement (HRA), Health Savings Account (HSA) and Archer Medical Savings Account (Archer MSA) plans</li><li>Health FSA salary reductions limited to \$2,550 per year</li><li>Employers who maintain prescription drug plans for their Medicare Part D eligible retirees are no longer able to deduct these expenses</li></ul>
Applicable to <b>non-</b> grandfathered plans only	<p><b>These are in addition to the reforms listed above (or upon loss of Grandfathered Status):</b></p> <ul style="list-style-type: none"><li>Coverage of certain immunizations and preventive care services (including women's preventive care services and coverage for contraceptive services) without cost share when they are provided in network</li><li>Patient Protections</li><li>Expanded requirements associated with claims and internal and external review processes</li><li>Out-of-pocket maximum requirements</li><li>Clinical Trial Requirement</li></ul>

## 60-Days Advance Notice Required on Material Modifications

If, at any time, a plan sponsor makes any material modification to the terms of the plan or coverage involved (whether it is an enhancement or reduction in benefits) that is not reflected in the most recently provided Summary of Benefits and Coverage (SBC), the plan must provide notice of the modification to enrollees at least 60 days in advance. The requirement for the Notice of Material Modification is not triggered upon renewal. The Notice of Material Modification may be satisfied by providing an updated SBC or a separate notice.

## Wellness Awards/Penalties

- The maximum permissible reward under a health-contingent wellness program offered in connection with a group health plan is 30% of the cost of coverage.
- The reward may be increased to 50% for wellness programs designed to prevent or reduce tobacco use.
- Health-Contingent Wellness Programs are classified as either:
  - Activity based (individual is required to complete an activity related to a health factor to obtain the reward but not required to attain a specific outcome) or
  - Outcome Based (reward for not smoking or reward for meeting a certain result on biometric screening)
- Participant must be given an opportunity to qualify at least once per year for the reward.
- The program must be reasonably designed to promote good health (i.e. reasonable to improve health or prevent disease, not overly burdensome, not highly suspected for discrimination).

For those individuals for whom it is unreasonable due to a medical condition or is inadvisable to participate in the program, they must be offered a reasonable alternative.

- Plans must disclose availability of reasonable alternative in the plan materials describing the wellness program.
- Examples of this language can be found in the final regulations and state as follows:

*Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact us at [insert contact information] and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.*

## Chapter 3 - Grandfathering

### Qualifications to retain Grandfathered Status

Health plans in existence on March 23, 2010 had the option to “grandfather” their health plan if certain criteria were met. As previously discussed, some reform requirements do not apply to grandfathered plans as long as that status is maintained.

*If a plan meets all of the grandfathering requirements discussed below and is interested in maintaining grandfathered status, they **MUST** certify with Meritain Health at the time of their renewal each of the plans that qualify for grandfathered status. **If certification is not received at renewal for each of the plans that qualify for grandfathered status, Meritain Health will assume that a plan does NOT intend to maintain grandfathered status.***

Plans should review all of the information in this chapter and consider their options carefully. The information that has been provided is a summary only. Remaining grandfathered subjects the plan to severe on-going restrictions on future benefit changes.

### Notices to Participants and Beneficiaries

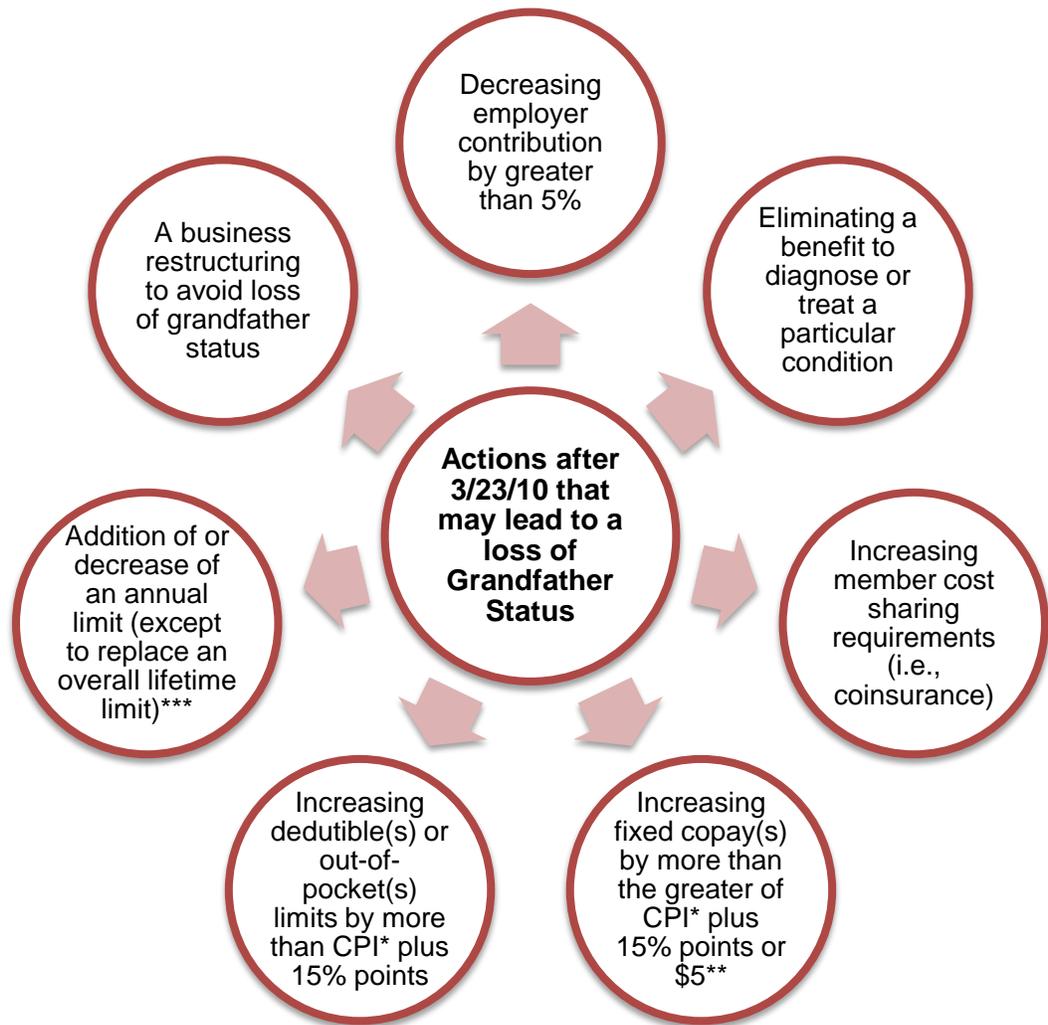
A grandfathered plan must (1) include a statement, in any plan materials provided to participants and beneficiaries, describing the benefits provided under the plan or health insurance coverage that the plan or health insurance coverage believes that it is a grandfathered health plan and (2) must provide contact information for questions and complaints. (A model notice has been issued by The U.S. Department of Labor).

### Recordkeeping

A grandfathered plan must also maintain records documenting the terms of the plan or health insurance coverage that were in effect on March 23, 2010, and any other documents necessary to verify, explain or clarify its status as a grandfathered health plan. The plan or insurer must make such records available for examination for as long as the plan or insurer takes the position that the plan or health insurance coverage is a grandfathered health plan. The records must be made available for examination by participants, beneficiaries, individual policy subscribers or a state or Federal agency official.

### Restricted Benefit Changes

Changes in benefits or other plan terms may result in the loss of grandfathered status. To make a determination about whether grandfathered status has in fact been or soon will be lost, the Plan must look closely at any changes that have been made since March 23, 2010. Any action falling into the following triggers could cause a loss of grandfathered status.



\*Based on the overall medical care component of the Consumer Price Index for All Urban Consumers, unadjusted (CPI), published by the Department of Labor using the 1982 - 1. using the 1982 – 1984 base of 100.

\*\* Adjusted for inflation.

\*\*\* Permitted only if the plan did not already have an annual limit on March 23, 2010, and the new annual limit must not be lower than the prior lifetime limit and is subject to regulatory minimums.

## Benefits that must be added upon relinquishing grandfathered status

If a plan decides to relinquish its grandfathered status or makes changes that defeat its grandfathered plan status, a plan will also be required to add the following benefits to their plan as of the date grandfathered status is lost:

### Patient Protections

- The Patient Protections provided three new requirements that plans must follow. They are: (1) allowing participants the choice of in-network Primary Care Providers (PCPs); (2) allowing direct access for female participants to seek coverage for in-network obstetrical (OB) or gynecological (GYN) care; and (3) providing coverage for emergency services, whether provided by in-network or out-of-network providers.
- Plans must allow designation of any in-network PCP that is accepting new patients, including the designation of any in-network pediatrician in the case of any child that is required to designate a PCP.
- Plans may not require prior-authorization or referrals of female patients seeking services from an in-network provider that specializes in OB or GYN care.
- Referrals or prior-authorization on out-of-network OB/GYN care is still permissible.
- The OB/GYN provider must still follow plan procedures regarding the services they rendered including referrals, obtaining prior-authorization and, when applicable, adherence to a treatment plan approved by the plan and nothing prohibits a plan from requiring the OB/GYN provider to communicate with the participants' PCP or the health plan regarding treatment decisions
- If the plan requires the designation of a PCP or previously required prior authorization or referrals for OB/GYN care, then **written** notice must be provided whenever the SPD, or other similar materials describing benefits under the plan, is issued informing each participant of the terms of the plan regarding designation of a PCP and their right to designate any in-network PCP, including designation of an in-network pediatrician in the case of a child. The notice must also state that the plan is prohibited from requiring prior authorization or referrals for OB/GYN care.
- Prior authorization may not be required for emergency services (including out-of-network emergency care) and plans may not impose any other administrative requirement or other limitation on out-of-network coverage that is more restrictive than the requirement or limitation for in-network coverage.
  - Out-of-network copays and coinsurance amounts may not be greater than the in-network emergency room copay and/or coinsurance amounts.
  - Out-of-network deductibles and out-of-pocket maximums may only be imposed if generally imposed on other out-of-network services.
  - If a plan covers non-emergency services in the emergency room, nothing prohibits a plan from continuing to impose higher copays, deductibles or coinsurance amounts and a plan does not have to reimburse out-of-network services at the in-network level for treatment of non-emergency medical conditions.
- Usual and Customary may still be imposed and balance billing of the participant is allowed if the emergency services billed exceed a “reasonable” amount.

- A reasonable amount means the **greatest** of (excluding any in-network cost sharing): (1) the median negotiated rate for in-network; (2) the same method the plan uses for determining other out-of-network amounts (i.e., usual and customary; reasonable amount); or (3) the amount Medicare would pay.
- When determining if a medical emergency exists, plans must apply a prudent layperson standard.
  - An emergency medical condition is defined as being a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a **prudent layperson** possessing an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention could result in (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (ii) serious impairment to bodily functions; or (iii) serious dysfunction of any bodily organ or part.

## Coverage of Preventive Services

- Plans must provide coverage at no cost (no copays, deductibles or coinsurance can be imposed) for certain in-network “recommended preventive services”, including preventive immunizations.
- If a service is identified as being a recommended preventive service, the plan **must** provide coverage of that service.
- A plan may impose cost-sharing requirements on coverage of recommended preventive services delivered by an out-of-network provider.
  - A complete list of the recommended preventive services that are required to be covered without cost sharing can be found at <http://www.hhs.gov/healthcare/facts/factsheets/2010/07/preventive-services-list.html><sup>1</sup> but generally are broken into the following categories:
    - Evidence-based items or services with an “A” or “B” rating from the U.S. Preventive Services Task Force (USPSTF)
    - Immunizations for routine use in children, adolescents and adults with a recommendation in effect from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention
    - Evidence-informed preventive care screenings for infants, children and adolescents provided in guidelines supported by the Health Resources and Services Administration (HRSA)
    - Evidence-informed preventive care and screening for women provided in guidelines supported by HRSA and not otherwise addressed by the USPSTF.

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<sup>1</sup>Plans will need to review this website at least once annually to ensure full compliance as the list of recommended preventive services is updated periodically. Any recommendation that is added or changed throughout the year is not required to be complied with until the first plan year beginning on or after the date that is one year after the new recommendation is added.

- A plan may impose cost-sharing for a treatment not included in the specified recommendations, even if the treatment is deemed a preventive service.
- A plan may use reasonable medical management techniques to determine the frequency, method, treatment or setting for a required preventive care item or service to the extent not specified in the recommendation or guidelines.
- A few special rules apply to preventive services delivered in connection with office visits:
  - Cost-sharing **may not** be imposed for the cost of the office visit if the primary purpose of the office visit is the recommended preventive service and the recommended preventive service is NOT billed or itemized separately.
  - Cost-sharing **may** be imposed for the cost of the office visit but not for the preventive services if the recommended preventive service is billed or itemized separately from the office visit.
  - Cost-sharing may be imposed for the cost of the office visit if the preventive service is not billed or itemized separately but the primary purpose of the office visit is not the delivery of such an item or service.

## Internal Claims and Appeals and External Review Processes

All plans must adhere to internal claims and appeals and external review processes.

- All group health plans (including Non-ERISA plans) must initially incorporate the current DOL guidance on internal claims and appeals. Non-ERISA plans should review their procedures closely as compliance was previously not required with DOL guidance.
- An Adverse Benefit Determination now includes “rescissions of coverage.”
- A claimant must be provided, free of charge, **before** an adverse benefit determination is issued, with any new or additional evidence considered, relied upon or generated by the plan in connection with the claim.
- Steps must be taken to avoid conflicts of interest and ensure the independence and impartiality of the persons involved in making the adverse benefit determination.
- A “culturally and linguistically appropriate” standard must be met if the Plan has a certain number of non-English speaking participants residing in a county where the predominant language is something other than English. If a plan has a participant that resides in an county identified by the United States Census Bureau as being impacted by this requirement, the plan must:
  - Include a statement in the English versions of all notices, prominently displayed in the non-English language, advising of the availability of language assistance.
  - Provide a customer assistance process with oral language services in the non-English language and provide written notices in the non-English language, upon request.
- Adverse benefit determination to participants must include certain required content.

- Self-funded ERISA Plans must comply with a federal external review process to ensure that, in certain qualifying situations, independent medical peer review is conducted in order to determine whether coverage is required pursuant to the terms of the plan in question.
- Non-ERISA plans and insured plans must comply with external review processes in states that have implemented such processes (if applicable) and meet other requirements to be deemed compliant with the state external review process, that are designed to mirror the NAIC Model Act.

## Coverage for participation in approved clinical trial

- Qualified individuals” participating in an approved clinical trial:
  - Cannot be denied coverage in the plan;
  - Cannot be discriminated against on the basis of their participation in the approved clinical trial.
- Routine patient costs associated with items or services furnished in connection with participation in an approved clinical trial may not be denied, limited or have any other additional conditions imposed.
- May require a qualified individual to use in-network providers, if available and if the provider accepts the individual as a participant.
- If a member is participating in an approved clinical trial conducted outside of the state in which the member lives coverage cannot be denied if the plan provides out-of-network coverage for routine patient care services.
- Note: “Qualified Individual”, “Approved Clinical Trial”, “Life Threatening Condition” are defined within this provision, shaping this requirement
- The provisions do not preempt state laws that require insurance plans to have a clinical trial policy in addition to what is required by Section 2709.
- Guidance through a joint Department FAQ stated that plans are expected to implement these requirements using a good-faith, reasonable interpretation of the law.

## Out-of-pocket maximums

- One single **in-network** out-of-pocket (OOP) maximum must apply to cost-sharing of services under the plan (e.g., medical, prescription drug and mental health and substance use disorder benefits).
- OOP maximum for 2016 cannot exceed \$6,850 single/\$13,700 family.



# Chapter 4 - The Individual Mandate and Other Noteworthy Aspects of ACA

## Individual Responsibility (“Individual Mandate”)

All taxpaying individuals are required to maintain a minimum level of healthcare coverage or pay a penalty. Participation in employer-sponsored coverage satisfies the individual mandate.

If individuals don't have health insurance, they may be required to pay a penalty or tax which will increase over time. They are generally as follows:

### 2015

- \$325 per adult and \$162.50 per child (up to a maximum of \$975 for a family) or
- 2% of family income, whichever is greater

### 2016 and Beyond

- \$695 per adult and \$347.50 per child (up to a maximum of \$2,085 for a family) or
- 2.5% of family income, whichever is greater

## Simplified Cafeteria Test for Small Employers with 100 or Fewer Employees

Employers with less than 100 employees enrolled in a cafeteria plan (during either of the two preceding years) are now eligible for safe harbor protection from the nondiscrimination rules applied to cafeteria plans provided that employers allow all employees who worked at least 1,000 hours in the preceding year to participate and every eligible employee has the ability to elect any benefit available under the plan. Employees under age 21 who have not yet completed one year of service, and/or who are covered under a collective bargaining agreement, do not have to be offered participation.

Plans must make contributions toward qualified benefits on each qualified employee's behalf in the amounts of a standard percentage of the employee's compensation (which cannot be less than 2%), or an amount not less than one of 6% of the employee's compensation for the plan year, or double the employee's contribution.

## Automatic Enrollment

The automatic enrollment mandate was repealed on October 28, 2015. The mandate would have required employers with 200 or more full-time employees to automatically enroll all new employees and to continue the enrollment of current employees in group health coverage. Due to its repeal, plans will not need to comply with this provision.

## Employee Exchange Notification

Under ACA, employers across all segments are required to provide their new employees, at the time of hire, with a written notice:

- (1) informing the employee of the existence of the marketplace, including information on how they can contact the marketplace for assistance;

(2) providing certain relevant information to assist the employee with determining if they are eligible for premium tax credits or cost sharing (if applicable); and

(3) informing the employee that if they purchase a plan through the marketplace, the employee may lose his or her employer contribution (if any) for their employer health plan and that any contribution required by the employee in the marketplace is taken on an after-tax basis.

This applies to **all employers** (regardless of group size or whether the employer offers plan coverage) that are subject to the Fair Labor Standards Act (FLSA). The majority of employers must comply with FLSA, but there are a few employers who do not. The DOL has developed a tool to assist employers with determining whether or not they must comply with FLSA. Meritain Health is unable to assist with making this determination on your behalf.

Model notices are available on the DOL website. These model notices satisfy the content requirements under ACA. There is [one model notice](#) for employers who do not offer a health plan and [another model notice](#) for employers who offer a health plan to some or all of their employees. Notices are required to be sent whether the exchange is operated by the state or federal government, and whether or not the employer offers health coverage. Either model notice must be provided free of charge and can be delivered by first-class mail or electronically, provided the DOL's electronic disclosure "safe harbor" is met.

## COBRA Election Notice

COBRA election notices that are used by groups subject to the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), must include additional information regarding health coverage alternatives offered through the Health Insurance Marketplace, or simply the "marketplace", (also known as state exchanges). Since qualified beneficiaries (those individuals who are eligible for COBRA coverage under their plan after their active coverage terminates) may wish to consider and compare coverage available in the marketplace to their COBRA coverage, the DOL model notice was revised to inform qualified beneficiaries of other coverage options in the marketplace, and of the fact that the qualified beneficiary may be eligible for a premium tax credit. The [model election notice](#) is available on the DOL website- <http://www.dol.gov/ebsa/cobra.html>.

## Chapter 5 - Employer Shared Responsibility Provision

For employers with 50 to 99 full-time or full-time equivalent employees (FTEs), the 2016 plan year brings with it some important changes to the employer shared responsibility requirements.

### Changes in the employer shared responsibility requirements

Employer Size*	2016
Large employers <b>with 100 or more FTEs</b>	<p>The percentage of full-time employees and their dependents that must be offered coverage has increased to 95 percent starting with the first plan year beginning on or after January 1, 2016. Please note, 4980H(b) penalties related to affordable/minimum value coverage may still apply.</p> <p>In 2015, Employers in this category were required to offer coverage to 70 percent of full-time employees and their dependents to avoid potential tax penalties under 4980H(a).</p>
Medium-sized employers <b>with 50-99 FTEs</b>	Employers in this category are required to offer coverage to 95 percent of full-time employees and their dependents starting with their first plan year on or after January 1, 2016 to avoid potential tax penalties under 4980H(a).
Small employers <b>with less than 50 FTEs</b>	Not applicable

\* All employees, including seasonal and part-time employees, must have their hours counted for the purpose of determining employer size. Any employer or combination of employers who are members of the same controlled group must look at the aggregate number of employees employed within the control group to determine employer size.

### Potential penalties

If an employer that is subject to the employer mandate, referred to as an *Applicable Large Employer (ALE)*, fails to provide both affordable and comprehensive coverage and a full-time employee (i.e., an employee who works an average of at least 30 hours per week, or if using a monthly measurement, a 130 hours of service per month) receives subsidized coverage through an exchange, the employer may be subject to penalties under Internal Revenue Code Section 4980H. The penalties differ depending on the circumstances—an employer who does not provide minimum essential coverage to its full-time employees and dependents, versus an employer who does not provide affordable coverage or coverage that meets minimum value.

#### “No Offer” Penalty—4980H(a)

Section 4980H(a) penalties may apply if an ALE does not offer minimum essential coverage to "substantially all" of its full-time employees (and their dependent children), and one or more full-time employees receives subsidized coverage on the exchange. An ALE will be treated as offering coverage to its full-time employees if:

- Employees have an effective opportunity to enroll no less than one (1) time per plan year.
- The Substantially All Test for a month is satisfied. **For 2016 and beyond**, this test is satisfied for any month that the employer offers coverage to at least 95 percent of its full-time employees (or, for smaller employers, all but five of its full-time employees, if greater). 4980H(b) penalties related to

affordable/minimum value coverage may still apply to the percentage of full-time employees not offered coverage under this test (for 2015 only, the threshold was reduced to 70 percent).

- Coverage must be offered to dependents; however, foster children, stepchildren and certain children that are not U.S. citizens do not have to be offered coverage. The definition of “dependent” also **does not include** an employee's spouse.

If coverage is not offered and one or more of the employer's full-time employees enroll in subsidized coverage on a public exchange, the employer may be subject to a penalty on all full-time employees, not just the employee who went to the exchange. This **monthly penalty** is equal to the total number of full-time employees employed for the preceding year minus 30 (for 2016 and beyond) multiplied by \$2,160. It is known as the 4980H(a) penalty. The penalty amount may be indexed in future years.

The requirement for a self-funded plan to offer minimum essential coverage is satisfied merely by offering an employer-sponsored major medical plan. Application of this penalty is not based on the cost of coverage to the employee. Avoiding this penalty is as simple as providing access to a plan that can be 100% employee paid.

The final rule clarifies that an offer of coverage includes an offer of coverage made on behalf of an employer, including an offer made by a MEWA or Taft-Hartley plan on behalf of a contributing employer. This would also apply for coverage offered to employees performing services for an employer that is a client of a Professional Employer Organization (PEO) or staffing firm, except in the case that it's only treated as an offer of coverage if the fee paid by the client employer to the PEO is higher for an employee enrolled in health coverage than if the same employee did not enroll in coverage.

### **An important note about dependent coverage**

The final employer shared responsibility rules clarify that a child is a dependent for the entire month in which he or she attains the age of 26. To avoid potential penalties, coverage for dependent children should not be terminated on their 26<sup>th</sup> birthday, unless that day is the last day of the month.

### **“Unaffordability” Penalty—4980H(b)**

Section 4980H(b) penalties may apply to ALEs if:

- The employer offers minimum essential coverage to “substantially all” of its full-time employees (and their dependents) but that coverage is either unaffordable to the employee based on contributions to employee-only coverage, or if the coverage does not meet minimum value.
- One or more of the full-time employees that is not covered receives subsidized coverage on the Exchange (i.e., 5% in 2016 and beyond or for smaller employers, all but five of its full-time employees, if greater).

The **monthly penalty** is equal to \$3,240 divided by 12 for each full-time employee receiving subsidized coverage through an exchange for the month. However, the penalty will not be greater than the monthly penalty that would apply if the employer offered no coverage at all. Employers may have plans above and below 60 percent, as long as at least one plan is a minimum of 60 percent and is affordable to eligible full-time employees. The penalty amount may be indexed in future years.

## Determining if coverage is affordable for employees

Coverage is considered affordable if an employee's required contribution toward the cost of **self-only** coverage does not exceed 9.5 percent of the employee's modified, adjusted gross household income. Since employers typically do not know an employee's household income, there are three "safe harbors" that may be used for purposes of determining whether an employer's coverage satisfies the affordability test as outlined below:

Form W-2 safe harbor	Rate of pay safe harbor	Federal poverty line safe harbor
<ul style="list-style-type: none"><li>•Employers may rely on the W-2 wages for determining affordability for the period coverage was offered. Coverage will be deemed affordable if the lowest option for self-only coverage that meets the minimum value does not exceed 9.56 percent of the employee's adjusted W-2 wages for the period when the employee was offered such coverage.</li></ul>	<ul style="list-style-type: none"><li>•For each eligible hourly employee, employers may take the hourly rate of pay, multiply it by 130, and determine affordability based on the monthly wage. Affordable coverage requires a contribution of no more than 9.56 percent of that amount. For salaried employees, the monthly salary will be used instead of the hourly salary. If the employer reduces wages during the year, this "safe harbor" does not apply.</li></ul>	<ul style="list-style-type: none"><li>•Coverage is considered affordable when the self-only cost of coverage does not exceed 9.5 percent of the most recently published federal poverty level for a single individual.</li></ul>

## Determining if coverage is comprehensive for employees

Coverage is considered comprehensive if the affordable plan covers a minimum value of 60 percent of the expected healthcare costs. According to the [latest HHS guidance](#), a plan may use one of the following methods to determine if the plan meets minimum value:

- Use the design-based "safe harbor" checklists (to be released by HHS in the future) to determine if the plan(s) provide minimum value without calculations or actuarial assistance
- Use the [minimum value calculator](#) developed by HHS or obtain actuarial certification for plans with non-standard features that preclude the use of the minimum value calculator or "safe harbors," without adjustments
- Offer a plan that is comparable to any plan in the small-group market that meets any of the levels of coverage (assumed to satisfy both actuarial value and minimum value)

## Employees who will never receive a Premium Subsidy

When assessing whether a potential penalty may apply or not, it is important to understand that the following employees will never receive a premium subsidy under any of the following circumstances:

- The employee does not enroll in the Marketplace;
- The Full-time employee has household income in excess of 400% of the poverty level;

- The Employee is eligible for coverage that is both affordable and provides minimum value;
- The employee *voluntarily* enrolls in an employer sponsored plan, even if that coverage is unaffordable or doesn't provide minimum value;
- The employee is eligible for Medicare Part A, Medicaid, CHIP or TRICARE; or
- The employee is not a citizen or legal resident.

## Identifying Full-Time Employees

For purposes of the employer responsibility provision, a “full-time employee”, is one who works an average of at least 30 hours per week, or 130 hours of service per month. Please make note of the following when looking at certain classes of employees and trying to determine if the employee should be counted as **full time or not**:

- *Seasonal employees*: Defined in the final rule as those employees in positions for which the customary annual employment is six months or less or a retail worker hired during the holiday season. They are generally treated the same as variable-hour employees.
- *Educational employees*: Teachers and other educational employees will not be treated as part time for the year simply because their school is closed or operating on a limited schedule during the summer.
- *Volunteers*: Hours contributed by bona fide volunteers for a government or tax-exempt entity, such as volunteer firefighters and emergency responders, will not cause them to be considered full-time employees.
- *Staffing firm employees*: Sets forth additional factors relevant for determining whether a new employee of a temporary staffing firm is a variable-hour employee.

## Safe Harbor Approach for Variable Hour Employees

Under an optional safe harbor approach, employers who are unsure whether an employee meets the required hours to be considered full-time due to varying hours may choose (but are not required) to use the safe harbor method in making such a determination. The safe harbor method varies slightly depending on whether an employee is an “ongoing employee” or “new employee.” Employers who choose to use the safe harbor must establish **measurement, administrative, and stability periods** as discussed below:

	Overview	Duration
<b>Measurement Period</b>	<p>The period of time an employer “looks back” to identify whether variable hour employee/seasonal employee average enough hours to be considered a full-time employee. An employee’s aggregate hours of services are collected during this time.</p> <p>Employers may vary the <i>standard measurement period</i> for (1) Employees subject to a collectively bargained agreement and employees not subject to a collectively bargained agreement, (2)</p>	<p>May be no less than three months and generally no more than 12 months.</p> <p>The <i>monthly measurement method</i> is offered as an alternative to the <i>look-back measurement method</i>. Under the monthly measurement method, employers identify full-time employees based on the hours of service each month, rather than over a longer period of time.</p> <p><i>Impact on New Employees</i>: The measurement period may begin on the date of hire or first day</p>

Each group of collectively bargained employees covered by a different collectively bargained agreement, (3) Salaried and hourly employees or (4) Employees located in different states

of the month following the date of hire; however, any delay in the initial measurement period must be factored into the duration of the administrative period.

### **Administrative Period**

The employer will determine the employee's average hours over the measurement period during a subsequent *administrative period*. The administrative period is the period during which employees are identified as full-time or not based on their hours of service during the preceding measurement period. The administrative period allows a plan time to perform plan administrative functions such as distributing enrollment material to employees determined to be newly eligible based on the measurement period.

The *total* administrative period (i.e., the combined period before and after the initial measurement period) cannot exceed 90 days in length.

The administrative period and the initial measurement period combined cannot extend beyond the last day of the first calendar month beginning on or after the employee's first anniversary of their start date.

### **Stability Period**

The stability period is the period of time that a variable hour/seasonal employee must be treated as full-time employee and therefore eligible for plan benefits. Each employee who averages the requisite hours during a measurement period must be treated as full-time during a subsequent *stability period*.

Must be at least six months in duration, but no shorter than the standard measurement period and must begin immediately following the standard measurement period and any applicable administrative period. Must be the same duration for new employees and ongoing employees.

The employer must treat the employee as full-time during the entire associated stability period (or until the employee's employment is terminated, whichever is earlier), even if the employee changes employment status during the stability period.

If an employee who had been deemed to be full-time during a stability period terminates employment during the stability period and then resumes employment as a continuous employee during the same stability period, then the employee must be treated as a full-time employee as of the first day the employee is credited with an hour of service or as soon as reasonably possible thereafter.

## **Measurement Period Examples**

Below are three examples to help illustrate how the look back measurement period works. The following general assumptions apply to the examples below.

- ABC becomes subject to the 4980H rules on January 1, 2015. ABC maintains the plan on a calendar year basis.
- The plan is offered through a Code Section 125 cafeteria plan. ABC has adopted the Look Back Measurement Period Method for identifying Full-Time Employees.

	Initial Period for New Variable Hour or Part-Time Employees	Standard Period for Ongoing Employees
<b>Measurement Period</b>	11 months	12 months
NOTE: Cannot be shorter in duration than three (3) months and no longer than 12 months)	Begins on the first day of the month following the month in which the employee is hired	Begins on October 4th each year and ends the following October 3 <sup>rd</sup>
<b>Administrative Period</b>	60 days	Begins October 4th each year and ends the following December 31
NOTE: Cannot exceed 90 days		
<b>Stability Period</b>	<b>12 months</b>	12 months (January 1 – December 31)
NOTE: Cannot be shorter than six (6) months, must equal at least the measurement period and should not exceed 12-months. In addition, the initial stability period must be equal to the ongoing stability period.		

**Note:** An employee who has a period during which the employee is credited with no Hours of Service for 13 full weeks or longer is treated as having a “break in service”. Thus, an employee who resumes service After 13 full weeks is considered a new employee whereas an employee with a period during which the employee is not credited with any Hours of Service for less than 13 weeks is considered a Continuous Employee. There are special averaging rules for employees who experience a period during which the employee is credited with no Hours of Service due to a Special Unpaid Leave or to Employment Breaks (if the employer is an educational organization).

**Example #1: Bob is a non-variable employee:**

- Bob is hired on June 15, 2015. Bob is a non-variable employee because his employer was able to make a determination on his start date that he was reasonably expected to be employed 30 or more Hours of Service per week, on average, during his employment.
- Under the terms of the Plan, Bob is subject to a 60 day waiting period. Bob is offered coverage that becomes effective on August 15, 2015.
- Bob’s first Standard Measurement Period begins October 4, 2015 and ends October 3, 2016. Even though Bob was “non-variable” during the Initial Measurement Period and corresponding Stability Period, Bob is employed through the first standard measurement and, as a result, he is an “ongoing employee” subject to the first Standard Measurement Period.
- Bob was credited with 1750 Hours of Service during the first Standard Measurement Period ending October 3, 2016; therefore, Bob qualifies as a Full-Time Employee to whom qualified coverage must be offered in order to avoid excise taxes during each month of the Stability Period beginning January 1, 2016 and ending December 31, 2016 (to the extent he remains employed).

**Example #2: Marty is a Variable Hour employee and has full-time Hours of Service during Initial**

**Measurement Period and Standard Measurement Period (impact of cafeteria plan rules):**

- Marty is hired by ABC Company on June 14, 2015. ABC is unable to make a determination on Marty’s date of hire that Marty is reasonably expected to have 30 or more Hours of Service per week during the time that he is employed during the Initial Measurement Period; therefore, Marty is a Variable Hour employee.
- Marty’s Initial Measurement Period begins July 1, 2015 and ends May 30, 2016. Marty’s administrative period ends July 31, 2016. Marty’s 12-month Stability Period begins August 1, 2016.
- Marty averages 30 or more Hours of Service per week during the Initial Measurement Period ending May 30, 2016; therefore, Marty qualifies as a Full-Time Employee to whom coverage must be offered during the Stability Period beginning August 1, 2016 and ending July 31, 2017. ABC will permit Marty to make an initial election that begins August 1, 2016 and ending December 31, 2016. During the annual enrollment period for 2017 plan year, Marty makes an election for the 2017 plan year. Whether Marty remains eligible for all of the 2017 plan year depends on whether Marty averages full-time Hours of Service during the Standard Measurement Period ending October 3, 2016.
- Marty averages full-time Hours of Service during the Standard Measurement Period ending October 3, 2016; therefore, Marty qualifies as a Full-Time Employee to whom qualifying coverage must be offered during the Stability Period January 1, 2017 through December 31, 2017. Since Marty’s election during the annual enrollment period for the 2017 plan year was effective for the entire 2017 plan year, no additional action is required.

**See Summary of Dates Below:**

Hire Date	Initial Measurement Period	Initial Administrative Period	Initial Stability Period	Standard Measurement Period	2016 Open Enrollment (Administrative Period)	2016 Coverage Period (Ongoing Stability Period)
June 14, 2015	July 1, 2015 – May 30, 2016	June 1, 2016 – July 31, 2016	Aug. 1, 2016 – July 31, 2017	October 4, 2015 – October 3, 2016	October 4, 2015 – Dec. 31, 2015	Jan. 1, 2017 – Dec. 31, 2017

Marty’s Initial Stability Period and the Standard Measurement Period overlapped, however; Marty was able to retain his eligibility beyond July 31, 2017 (when his initial stability period would have ended) based on information that was gathered during the Standard Measurement Period.

**Example #3: Marty is a Variable Hour employee and averages full-time Hours of Service during Initial Measurement Period but not the Standard Measurement Period.**

- Marty is hired by ABC Company on June 14, 2015. ABC is unable to make a determination on Marty’s date of hire that Marty is reasonably expected to have 30 or more Hours of Service per week during the time that he is employed during the Initial Measurement Period; therefore, Marty is a Variable Hour employee.
- Marty’s Initial Measurement Period begins July 1, 2015 and ends May 30, 2016. Marty’s administrative period ends July 31, 2016. Marty’s 12-month Stability Period begins August 1, 2016.
- Marty averages 30 or more Hours of Service per week during the Initial Measurement Period ending May 30, 2016; therefore, Marty qualifies as a Full-Time Employee to whom coverage must be offered during the Stability Period beginning August 1, 2016 and ending July 31, 2017. ABC will permit Marty to make an initial election that begins August 1, 2016 and ending December 31, 2016. During the annual enrollment period for 2017 plan year, Marty makes an election for the 2017 plan year. Whether Marty remains eligible for all of the 2017 plan year depends on whether Marty averages full-time Hours of Service during the Standard Measurement Period ending October 3, 2016.
- Marty did not average full-time Hours of Service during the Standard Measurement Period ending October 3, 2016, and does not qualify as a Full-Time Employee to whom Qualifying coverage must be offered during the Stability Period beginning January 1, 2017, Marty did average full-time hours during the Initial Measurement Period and, as a result, he qualifies as a Full-Time Employee to whom coverage must be offered during the first Stability Period ending July 31, 2017.
- Even though Marty made an election for the entire 2017 plan year, Marty ceases to be eligible on July 31, 2017. ABC may terminate his coverage and offer him COBRA.

**See Summary of Dates Below:**

Hire Date	Initial Measurement Period	Initial Administrative Period	Initial Stability Period	Standard Measurement Period	2016 Open Enrollment (Administrative Period)	2016 Coverage Period (Ongoing Stability Period)
June 14, 2015	July 1, 2015 – May 30, 2016	June 1, 2016 – July 31, 2016	Aug. 1, 2016 – July 31, 2017	October 4, 2015 – October 3, 2016	October 4, 2015 – Dec. 31, 2016	N/A

Marty is not eligible to continue his benefits beyond July 31, 2017 (his initial stability period) based on information gathered during the Standard Measurement Period. Marty will have to wait until the 2017 open enrollment period (or 2017 administrative period) before he is eligible for benefits again.

## **Special rules for employment breaks and other certain types of leave**

There are special averaging rules for employees who are deemed to have taken an “employment break” or “special unpaid leave.” Employment breaks are defined as a period of at least four consecutive weeks (disregarding unpaid special leave) during which an employee at an educational organization (as defined in 26 C.F.R. 1.170A-9(c) (1), without regard to whether they are a Code Section 501(c) (3) organization) is not credited with hours of service. No more than a period of 501 hours of services are required to be excluded or credited (depending on the particular averaging method that is used by the employer)—excluding any periods of special unpaid leave.

The final regulations shorten the 26-week break in service rule generally to 13 weeks, allowing Employers to treat an employee that has a break in service of 13 weeks or more as a new employee, rather than an ongoing employee. An employer is generally not subject to penalties under the employer mandate with respect to the first three months an employee is eligible for coverage; however, this rule can only apply once per period of the employment of an employee.

## **Measurement periods for employees who transfer positions with different measurement periods**

Employers who have had employees transfer positions within the year, or who have changed their measurement periods for the next calendar year, should use the following guidance to determine their employees' full-time status:

- If an employee is in a stability period and they were employed for a full measurement period at the time of their transfer, the employee retains his or her full-time status through the end of the stability period.
- In the case of a new employee who, as of the date of their transfer, is in an administrative period (the period immediately following the initial measurement period), the employee's status as a full-time employee will apply through the end of that administrative period and subsequent stability period. The employee's full-time status in this case is based on hours of service in the initial measurement period under the first position.
- If the employee is not in a stability period at the time of transfer, the employee's status would be determined by using the measurement period applicable to the second position, but would include hours of service for the first position when applying the measurement period.

As a reminder, employers must treat all similarly situated employees consistently.

# Chapter 6 – Summary of Benefits and Coverage

## Summary of Benefits and Coverage (SBC)

Group health plans are required to distribute an accurate summary of benefits and explanation of coverage document to plan participants and beneficiaries. Regulations govern who is required to provide the SBC, the appearance and format the SBC must be in, to whom it should be sent, when it must be sent and what information must be contained within the SBC upon distribution. There are also standards regarding the use of terminology commonly used across the industry to describe benefits. A high-level summary is provided below:

Timing of Distribution
<ul style="list-style-type: none"><li>• Upon application</li><li>• By the first day of coverage (if there are coverage changes)</li><li>• Upon renewal</li><li>• For enrollment periods or during a special enrollment</li><li>• Upon request</li><li>• Upon material modification (during plan year, as defined under ERISA)</li></ul>
Appearance
<ul style="list-style-type: none"><li>• Must be presented in a “uniform format”</li><li>• May not exceed four double-sided pages in length</li><li>• May not include print smaller than 12-point font</li></ul>
Delivery/Format
<ul style="list-style-type: none"><li>• Paper or electronic (if certain conditions are met)</li><li>• Provided as a stand-alone document or in combination with other summary materials, such as the Summary Plan Description (SPD) provided the SBC is a part of the SPD and prominently displayed at the beginning of the document (i.e., immediately after the Table of Contents)</li><li>• Must use terminology understandable by the average plan enrollee</li><li>• Must be presented in a culturally and linguistically appropriate manner</li><li>• Must disclose availability of language assistance in certain non-English languages where at least 10% of the population (based on county level census data) is literate in the same non-English language and support language assistance requests in such languages, (translated SBCs are available on HHS website)</li></ul>
Content
<p><b>At a minimum, ACA requires the following to be included;</b></p> <ul style="list-style-type: none"><li>• Uniform definitions of standard insurance and medical terms</li><li>• A description of the coverage, including cost sharing; exceptions, reductions, and limitations on coverage; the cost sharing provisions; renewability and continuation of coverage provisions and coverage examples.</li><li>• A statement of whether the plan provides minimum essential coverage and minimum value</li><li>• A statement that the outline is a summary and that the coverage document itself should be consulted to determine the controlling contractual provisions</li><li>• A contact number for questions and obtaining a copy of the plan document or policy</li><li>• As applicable, contact information for obtaining a list of network providers and information on prescription drug coverage as well as an internet address and contact number for obtaining the uniform glossary and a disclosure that paper copies are available</li><li>• Under a special rule, to the extent a plan’s terms that are required to be included in the SBC cannot be reasonably described consistent with the template and the instructions, the plan is required to accurately describe the plan’s terms while using its best efforts in a manner that is still consistent with the instructions and template</li></ul>
Uniform Glossary Requirement
<ul style="list-style-type: none"><li>• A uniform glossary must be made available upon request and provided in the form issued by the Departments</li></ul>

## **Impact on Expatriate plans**

Expatriate plans are not specifically exempted from the SBC requirements; however, the final rule does include a special rule for coverage provided outside of the United States. The final rule states that in lieu of summarizing the coverage provided outside of the U.S, a plan or issuer may provide an Internet address (or similar contact information) for obtaining information about coverage or benefits provided outside of the United States. To the extent coverage or benefits are available within the United States, the plan or issuer is still required to provide an SBC in accordance with the standards in the final rule.

Expatriate plans had been provided with broader temporary relief from having to comply with the SBC provision and other insurance market reform provisions through guidance issued by the Departments for plans starting before January 1, 2016.

## **Penalty for noncompliance**

In addition to existing penalties related to insurance market reform requirements, Section 2715 of the Public Health Services Act (PHSA) allows for the imposition of a \$1,000 fine for each willful failure to comply with the section. Each enrollee is considered an independent failure.

## Chapter 7- Taxes, Fees and Other Reporting Obligations

A number of taxes and fees were included with healthcare reform. Provided below is a snapshot of those taxes and fees. More details on how we can help you further with these requirements can be found in Chapter 9.

### Tax on Higher Income Individuals

As of January 1, 2013, an additional payroll tax of 0.9% for individual wages over \$200,000 and \$250,000 for couples for both employers and employees is required.

### W-2 Informational Reporting Requirement

All W-2 forms issued to employees must contain information on the aggregate cost of employer-sponsored health coverage. The purpose of the W-2 reporting requirement is to provide employees with useful and comparable consumer information on the cost of their health coverage. It is not intended to cause the cost of the coverage to become taxable income. See below for details around this requirement:

#### How to calculate aggregate reportable cost

There are four methods that may be used to calculate the aggregate reportable cost.

The easiest approach for a self-funded health plan is to use the applicable COBRA premium (less the 2 percent administrative fee).

Employers will need to multiply the number of months an employee had coverage times the monthly premium.

Employers may choose to count only active months, or active months plus COBRA months. Whichever of the four methods an employer utilizes, they must be consistent from year to year.

#### Excluded Plans

Employers who file less than 250 W-2s in the proceeding calendar year

Employers who offer self-insured coverage that is not subject to COBRA (i.e., church plans)

Federally recognized Indian tribal government plans and plans of tribally chartered corporations wholly owned by a federally recognized Indian tribal government

Multi-employer plans

Health Flexible Spending Accounts (FSA) funded solely by salary-reduction amounts

Health Reimbursement Account (HRA) contributions

Dental or vision plans not integrated into another medical or health plan; or if integrated, participants were given the choice of declining or electing and paying an additional premium for such coverage

The IRS has indicated that any changes that are made to the list will not go into effect until the tax year beginning six months after the new guidance is issued.

## Patient-Centered Outcomes Research Institute (PCORI) fee

The PCORI fee is a temporary fee and applies to plans **ending** on or after October 1, 2012 but before September 30, 2019. The fee will be used to fund clinical outcomes effectiveness research. Plans maintaining two or more group health plans that collectively provide major medical coverage for the same covered lives may be regarded as one group health plan. See below for important details regarding this fee:

### Amount of Fee per policy year

For policy years that ended between October 1, 2012 – September 30, 2013 the fee was \$1 per covered life.

For policy years that ended between October 1, 2013 – September 30, 2014 the fee is \$2 per covered life.

For policy years ending between October 1, 2014 – September 30, 2015 the fee will be \$2.08 per covered life.

For policy years ending between October 1, 2015 – September 30, 2016 the fee will be \$2.17 per covered life.

For policy years ending on or after October 1, 2016, the fee will increase by the projected per capita of national health expenditures.

### Reporting and Payment Deadlines

The fees are paid to the IRS using Form 720. Payment is due to the IRS no later than July 31 of the **year following** the last day of the plan year.

Third-party administrators are not permitted to file the return nor pay the fee on behalf of plan sponsors.

Self-funded plan sponsors are responsible for calculating, reporting, and submitting the PCORI fee payment.

### How to calculate enrollment

Enrollment can be calculated using either a daily, monthly or quarterly average for the plan year that just ended. The counting methods described to the right are permissible for purposes of calculating the fee:

- **Actual Count Method.** Total number of lives covered each day of the plan year divided by total number of days in the plan year.
- **Snapshot Count Method.** Calculate the total number of lives covered on a particular date in each quarter of the policy year (or within five days of the previous quarter date), add the total together and divide that total by the number of dates on which a count was made.
- **Form 5500 Method (using the number of covered lives filed with the U.S. Department of Labor for the last applicable plan year).** Add the total number of participants at the beginning of the policy year with the total number of participants at the end of the year and divide by 2.

### Excluded Plans

Stop-loss policies, stand-alone dental and/or vision plans, **integrated** HRAs; HSAs; FSAs; Employee Assistance Plans, disease management and wellness programs, Medicare Part C and Part D products, employer-provided health coverage that pays secondary to Medicare, and Medicaid plans.

Retiree only plans *are not* considered an excluded plan and must comply with the PCORI fee.

## Reinsurance Contribution

The ACA expressed the amount of the overall industry contribution in aggregate under the Transitional Reinsurance Program. The total reinsurance contribution (RC) to be collected **over the three-year period** is in the amount of \$12 billion in 2014, \$8 billion in 2015 and \$5 billion in 2016. Plans maintaining two or more group health plans that collectively provide major medical coverage for the same covered lives may be regarded as one group health plan. See below for important details regarding this program:

### Timing and frequency of payments

Each self-funded group health plan is responsible for collecting and remitting the RC to HHS by November 15th of each year for the first 9 calendar months of the year.

HHS will determine the amount of the fee, based on the report filed, and provide an invoice to the entity by December 15th. Payment of the fee is due within thirty (30) days of receipt of the bill. Payment may be remitted in one annual payment or may be submitted in two payments as directed by HHS.

Customers can request TPAs to report annual enrollment counts, as well as collect and remit the RC on behalf of the plan. Such a request does not shift the obligation, which remains with the self-funded group health plan. TPAs, such as Meritain Health are not responsible for paying the RC on behalf of self-funded group health plans.

### How to calculate enrollment

Enrollment can be calculated using either a daily, monthly or quarterly average of the first nine months of the year instead of the full 12 months. The fourth quarter of each year will not be factored into the enrollment calculation.

Aggregate enrollee data is needed; state-by-state enrollee breakdown is not required. You may use one of the following methods to calculate your enrollment:

- **Actual count method.** Add the total number of covered lives for each day of the first nine months of the benefit year and divide by the total number of days in the first nine months.
- **Snapshot count method.** Add the number of covered lives on any date or dates during the same corresponding month in each of the first three quarters of the benefit year. Then divide the total by the number of dates on which a count was determined. (The date used for each quarter must be consistent.)
- **Snapshot factor method.** Number of lives covered on a date is equal to the sum of the number of participants with self-only coverage on that date; plus the number of participants with coverage other than self-only coverage on that date multiplied by 2.35.
- **Form 5500 method.** (Using the number of covered lives filed with the U.S. Department of Labor for the last applicable plan year for a plan offering only self-only coverage). As reported on the Form 5500, add the total number of participants at the beginning of the policy year with the total number of participants at the end of the year, and divide by two.

### Excluded Plans

Self-insured plans that self-administer claims (do not hire a TPA) will be exempt from the reinsurance fee in 2016 as they were in 2015

Expatriate coverage

Medicare Part C and Part D products

Employer-provided health coverage that pays secondary to Medicare, and Medicaid plans

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Coverage consisting solely of benefits for prescription drugs; integrated HRAs, HSAs, FSAs; Employee Assistance Plans; and disease management and wellness programs.

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## Minimum Essential Coverage (MEC) and Applicable Large Employer (ALE) Reporting Requirement

Employers and carriers must adhere to applicable MEC and ALE reporting requirements under Internal Revenue Code (IRC) Section 6055 and 6056 as added under the ACA. Reporting is based on the previous calendar year. Employers who must submit 250 or more of a single IRS form to satisfy their reporting requirements must submit their filing electronically.

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### General Overview of 6055 and 6056

**6055:** Required of all employers (not just applicable large employers) and health insurance issuers that provide minimum essential coverage. They must report information about the type and period of health coverage to IRS and to the covered individuals. **Employers who sponsor a self-funded medical plan must still report under Section 6055 regardless of the number of employees they employ.** This reporting is required to enforce the individual mandate.

**6056:** Applicable large employers or "ALEs" (i.e. those employers who employ an average of 50 or more full-time or full-time equivalent employees during the previous calendar year), must file a return with the IRS and issue a statement to their full-time employees about the health care coverage the employer offered to the employee (or, that the employer did not offer). This reporting is required to enforce the employer shared responsibility provision (i.e. the employer mandate).

### Social Security Numbers (SSNs) Required

Self-funded employers are required to provide Taxpayer Identification Numbers (i.e., SSNs) for all covered individuals under Sections 6055 and 6056. This would include subscribers and their covered dependents. If you do not have this information for a subscriber or their covered dependent, you are required to make "reasonable efforts" to obtain it from the subscriber, making three separate attempts within a specified timeframe. If you do not have a SSN, you must provide the individual's date of birth. You can rely solely on date of birth for reporting only after reasonable efforts have been made to obtain the SSN. For self-funded plans, the distribution of an enrollment form which requests a member's SSN at open enrollment each year will satisfy these required attempts.

Below is the timeline you need to be aware of when attempting to obtain the SSNs:

- Initial attempt. For self-funded plans, the initial attempt is made when the relationship with the member begins, or in other words, the initial collection attempt may be made at the time of an individual's hire. For fully insured plans, this would be when the member is first enrolled for coverage. If the SSN has been provided to you for other purposes, you may use that SSN to satisfy this requirement.
- First annual attempt. The first annual collection attempt is required by December 31 of the year in which the relationship with the member began. If the relationship begins in December, the first annual collection attempt will be required by January 31 of the following year. This first attempt is satisfied with the open enrollment period and accompanying forms that ask for the

individual's SSN.

- Second annual attempt. If the SSN is not received, the last collection attempt must be made by December 31 (or January 31) of the following year. This is satisfied by the open enrollment period and accompanying forms that ask for the individual's SSN.

Assuming the second annual request is also unsuccessful, the reporting entity would not be penalized if it reported a date of birth in place of a SSN for the individual in question.

## Reporting Deadlines\*

**6055 and 6056 Reporting to IRS:** If filing on paper, this can be no later than February 28 of the year following coverage. If filing electronically (more than 250 of any form), this can be no later than March 31 of the year following coverage. The IRS has extended these deadlines for the 2015 calendar year reporting, making these deadlines March 31, 2016 (paper filing) and June 30, 2016 (electronic filing).

**Statements to Individuals:** Statements must be sent by first class mail, or when given appropriate consent, electronically by January 31 of the year following the calendar year to which the return relates. For 2015 calendar year reporting only, the IRS has extended this deadline to March 31, 2016. Truncated SSNs are permitted to be used on statements sent to individuals (for example, give only the last four digits of the SSN), but the full SSN must appear on the IRS form. The statement can be a copy of the completed IRS form.

Detailed requirements can be found in Internal Revenue Code (IRC) Section 6055 and 6056

## Section 6055 and 6056- Forms

Self funded ALEs will use the 1094/1095-C series of forms, unless they are reporting on a dependent for which they do not have a SSN. The B series forms will need to be used for those individuals.

Fully insured issuers and self funded employers with less than 50 FTEs (those who are not an ALE) will use the 1094/1095-B series of forms.

Form Name	Form Number	Purpose	Initiator	Recipient	Learn More
Health Coverage	1095-B	Reports information on health coverage, including period of coverage, and for whom coverage was provided– including each dependent	Health insurer for insured plans	IRS (and copy of information sent to Individual)	<a href="http://www.irs.gov/Affordable-Care-Act,1095B,Instructions">www.irs.gov/Affordable-Care-Act, 1095B, Instructions</a>
Transmittal of Health Coverage Information Returns	1094-B	Transmittal form filed with Form 1095-B from the insurer to the IRS	Health insurer for insured plans	IRS	<a href="http://www.irs.gov/Affordable-Care-Act,1094B,Instructions">www.irs.gov/Affordable-Care-Act, 1094B, Instructions</a>
Employer-Provided Health Insurance Offer and Coverage	1095-C	Reports information on health coverage offered and information on employees and dependents enrollment in that coverage	Employer for self-funded plans	IRS (and copy of information sent to Individual)	<a href="http://www.irs.gov/Affordable-Care-Act,1095C,Instructions">www.irs.gov/Affordable-Care-Act, 1095C, Instructions</a>

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Transmittal of  
Employer-Provided  
Health Insurance  
Offer and Coverage  
Information Returns

1094-C

Transmittal form filed with  
Form 1095-C from the  
insurer to the IRS

Employer for  
self-funded  
plans

IRS

[www.irs.gov/Affordable-Care-Act,1094C,Instructions](http://www.irs.gov/Affordable-Care-Act,1094C,Instructions)

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## Tax on High Cost Coverage (“The Cadillac Tax”)

Under Section 9001 of the ACA, health insurance issuers and sponsors of self-funded group health plans will be assessed an excise tax on any benefits provided to employees that exceed a pre-determined threshold. The excise tax is imposed beginning in 2020. This is the same tax that the general media has labeled as the “Cadillac” tax. We refer to it here using the actual language in the law.

The amount of the excise tax is 40 percent of an amount considered to be an excess benefit. “Excess benefit” is determined on a monthly basis, and means the amount, if any, by which the “aggregate cost” of an employee’s applicable employer-sponsored coverage for the month exceeds 1/12 of the “annual limitation” for the calendar year including that month. The annual limitation is a dollar threshold adjusted for inflation and other factors, as discussed below.

The “COBRA equivalent” will be used to determine the cost of coverage for self-funded plans -- in other words, what would the employer charge individuals on COBRA. The exact rules for determining the COBRA rate and how the tax will be paid are still to be determined.

The dollar thresholds will vary from year to year depending on a number of factors. For 2018, the base dollar threshold is \$10,200 for self-only coverage, and \$27,500 for coverage other than self-only coverage, but these base limits will be subject to adjustment based upon a variety of factors.

The excise tax applies to “applicable employer-sponsored coverage,” which generally means coverage under any group health plan made available to the employee by an employer that is tax-exempt, or that would be tax-exempt if it were employer-provided coverage. This means that both the employer-paid and employee-paid costs of coverage will be taken into account in determining whether the excise tax applies. The term encompasses insured and self-funded plans. It also applies to governmental plans and coverage providing health insurance to a self-employed individual. Several types of coverage will not be subject to the excise tax. These include, but are not limited to, accident only insurance, disability income insurance, liability insurance, workers compensation insurance, automobile medical payment insurance, credit-only insurance, hospital indemnity insurance, fixed indemnity insurance and long-term care insurance.

The health insurance issuer is liable for paying the share of the excise tax attributable to health insurance coverage that it underwrites. The employer is liable for paying the share of the excise tax attributable to HSA and MSA contributions that are applicable employer-sponsored coverage. The “person that administers the plan benefits” is liable for paying the share of the excise tax attributable to any other applicable employer-sponsored coverage. (How this will be applied in practice is yet to be determined.)

The sponsoring employer is generally responsible for determining the amount of the excise tax. Once it has calculated the amount of the excise tax, the sponsoring employer must allocate the amount among those entities responsible for paying the tax.

*NOTE: Details on a number of issues relating to implementation of the excise tax are yet to be released. As of September 2015, the IRS had requested comment on possible approaches being considered on several key issues. The IRS is expected to issue proposed regulations in 2016.*

# Chapter 8 – Reports and Services Available to Assist You

## Reports Available at No Charge

Reports are available for each platform to support our self-funded clients in complying with the reporting requirements discussed in Chapter 4. The reports are available at no charge and enable clients as well as authorized consultants and brokers to access plan membership information. Reports only apply for membership administered by Meritain.

### W2 Report

Many employers are relying on their payroll vendors to assist them with this reporting requirement; however, we realize that not all payroll vendors are equipped to help. For this reason, Meritain Health can provide a customized eligibility report. This report will reflect enrollment information on behalf of a group health plan for the applicable tax year. The report will provide details such as employee enrollment in two different plans at one time, or a change from single to family coverage throughout the year. Due to state confidentiality laws, the report will contain both the employee's first and last name, but will only contain the last four digits of the employee's Social Security number.

### PCORI Report

This Report is based on the Snapshot Count Method (discussed previously). The report will include the quarter, date of count, number of lives, average for the quarters, applicable fee for the period requested, and the total fee to be paid.

You will be provided with an instructional/explanatory page. Please remember, a separate report is needed for **each** plan year. You cannot combine plan years into one. If for some reason there is a period in which the system does not have the information available to accurately provide the number of lives count, the report will show a zero and the average will not be calculated.

### Reinsurance Contribution Report

If you request this report, we offer two methods for calculating enrollment. The report can be based on either the snapshot count method or the snapshot factor method (discussed previously). You may select whichever reporting method is more favorable to you.

You will be provided with an instructional/explanatory page. If for some reason there is a period in which the system does not have the information available to accurately provide the number of lives count, the report will show a zero.

### 6055 Report for MEC Reporting

Many employers are relying on vendors to assist them with this reporting requirement. Meritain Health can provide an eligibility report that includes information that is required for the filing. This report will reflect enrollment information on behalf of a group health plan for the applicable tax year and will include employee name, dependent names, social security numbers and dates of birth if we have that information in our systems, months of coverage, and a change from single to family coverage (or vice versa) throughout the year. This report also contains the information from our W2 report so that you may use this report for both requirements.

## Services Available (Additional Charge May Apply)

### Summary of Benefits and Coverage (SBC)

Meritain Health will assist with the preparation of the SBC and uniform glossary for an additional fee. Our materials are updated and in compliance with the ACA changes to date. If you choose this service, it will be important for you to work closely with your Meritain Health CRM to finalize your company's benefits early in the new business or renewal cycle to foster compliance with the SBC generation deadlines.

### Submission of Reinsurance Contribution

We are offering two enhanced options to our clients for a small fee, to help assist with their RC reporting requirement:

1. **Periodically.** Meritain Health will calculate based on a snapshot of the first three quarters of the calendar year and bill in three periodic installments no later than the 1st day of April, July and October of the same calendar year. Payment to Meritain is due by the first of the month for the billing invoice date with no exceptions. Meritain Health will then remit the total fee at the end of the year on the client's behalf. This option will appeal to those clients who anticipate a large liability that they want to spread out over the course of the year
2. **Yearly.** Meritain Health will calculate based on a snapshot of the first three quarters of the calendar year and bill in October. Payment to Meritain is due by the first of the month for the billing invoice date with no exceptions. Meritain Health will remit the fee on behalf of the client to HHS at the end of the year.

## Chapter 9 - Publicly Available Sites for Reference

To learn more about the requirements under ACA, access the following links:

- The U.S. Department of Labor website at <http://www.dol.gov/ebsa/healthreform/>
- The [minimum value calculator](http://www.cms.gov/ccio/resources/regulations-and-guidance/downloads/mv-calculator-final-4-11-2013.xlsm) developed by HHS can be found at the following link:  
<http://www.cms.gov/ccio/resources/regulations-and-guidance/downloads/mv-calculator-final-4-11-2013.xlsm>

Information is believed to be accurate as of the production date; however, information is subject to change.

**This document is being provided as an informational tool. It is recommended that plans consult with their own experts or counsel to review all applicable federal and state legal requirements that may apply to their group health plan. By providing this publication and any attachments, Meritain Health is not exercising discretionary authority over the plan and is not assuming a plan fiduciary role, nor is Meritain Health providing legal advice.**