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Chapter 1 - Which Plans Must Comply With ACA

On March 23, 2010, President Obama signed the Affordable Care Act (ACA) into law. ACA represents the most comprehensive change to the health care industry in the last 50 years and applies to the majority of employer-sponsored health plans. However, there are few exceptions to this rule, such as retiree only coverage and certain stand alone “Exception Benefit” plans (described further below). Below is a snapshot of which plans must comply, and which plans are generally not subject to the regulatory requirements (exempt) (unless otherwise noted).

**ASBAIT is a self funded Trust and will follow guidelines for self-funded medical plans. The ASBAIT dental and vision plans are considered "stand alone".**

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\(^1\) Plans such as:
  - Stand-alone dental and vision benefits
  - Most health Flexible Spending Accounts (unless otherwise noted later in Chapter Six)
  - Medigap policies
  - Accidental death and dismemberment coverage
  - Specified disease (e.g., cancer) and limited hospital indemnity (i.e., $100 per day in hospital) coverage

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\(^1\) Excepted Benefits can generally be explained as benefits that are separate from medical coverage (or are not an integral part of your medical coverage) and require an additional premium to be paid to obtain such 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)

Chapter 2 - Reforms In Place Today

ASBAIT plans are compliant with Benefit Reforms mandated through the current plan year of 2013-2014. There are mandates that will bring changes to the 2014-2015 benefit plans. These mandates will be discussed in this document. Where grandfathered vs. non-grandfathered plans are discussed, ASBAIT is a non-grandfathered plan.

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 work 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.

Benefit Reforms

Provided below is quick reference to those benefits or provisions that are already included in plan(s).

- Prohibition of Annual and Lifetime dollar limits on essential health benefits
- Eligibility of dependent children up to age 26, including coverage of married children
- Pre-existing condition limitations/exclusions for children under age 19 prohibited (for all ages beginning in 2014)
- Rescissions of coverage, except in cases of intentional misrepresentation or fraud prohibited
- Waiting periods limited to 90 days or less (beginning in 2014)
- 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
- Health FSA salary reductions limited to $2,500 per year.

Applicable to non-grandfathered health plans only

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2 The underlying medical plan associated with the HSA must comply.

Produced October 2013
Coverage of certain immunizations and preventive care services without cost share when they are provided in network. Beginning with the first plan year starting 8/1/2012 plans must cover certain women’s preventive care services without cost share when they are provided in network.

- Patient Protections included (Discussed further in Chapter Three)
- Expanded requirements associated with claims and internal and external review processes
- Out of pocket maximum requirements (beginning in 2014)
- Clinical Trial Requirements (beginning in 2014)

W-2 Informational Reporting Requirement

In January 2013, Meritain Health the ASBAIT claims administrator made available a report for each participating school to assist with the accurate reporting on W-2 forms. This report includes the member name, last 4 digits of SSN, coverage(s), number of months covered, coverage months, aggregate cost of employer sponsored health coverage (COBRA premium - 2%), COBRA premium. Questions regarding this report should be directed to your assigned Meritain Client Relationship Manager (CRM).

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. Meritain Health does have a report available to assist you with 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

There are certain costs and types of coverage that are not reportable on the Form W-2. The IRS has developed a very user friendly chart identifying employers that are exempt from compliance, along with certain coverage types that are also exempt. This list may be changed in future guidance. 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.

Provided below are a few examples of where information is not required to be reported on the W-2 today:

- Employers who file less than 250 W-2s in the preceding calendar year
- Employers who offer self-insured coverage that is not subject to COBRA (ie. Church plans)
- Federally recognized Indian tribal government plans and plans of tribally charted 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
Summary of Benefits and Coverage (SBC)

During the 2013-2014 renewal/open enrollment period, each ASBAIT school was provided by Meritain Health an accurate SBC for each of the medical plan options offered by ASBAIT along with distribution requirements.

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, 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.

Timing of Distribution

- Upon application
- By first day of coverage (if there are changes)
- Upon renewal
- For enrollment periods
- During special enrollments
- Upon request
- Upon material modification (during plan year, as defined under ERISA)

The delivery triggers each have particular timing implications that must be met.

Distribution Method

Group health plans have the option of either providing the document as a stand-alone document or in combination with other summary materials, such as their Summary Plan Description (SPD).

SBC Standard

The standards are designed to guide the construction of the SBC in the following areas: appearance, language, form, and contents.

- **Appearance** – an SBC must be presented in a “uniform format”, may not exceed four pages in length, and may not include print smaller than 12-point font. The final rule allows four double-sided pages.

- **Language** – an SBC must be presented in a culturally and linguistically appropriate manner and must utilize terminology understandable by the average plan enrollee. The final rule follows the same standards for language assistance that was adopted in the internal claims and appeals rule that applies to non-grandfathered plans. Under this standard, plans are required to disclose the availability of language assistance in certain non-English languages where at least 10% of the population is literate in the same non-English language, and support any language assistance requests in such languages, based on county level census data.

Currently, the languages that the SBC may need to be translated include (1) Spanish, (2) Chinese, (3) Tagalog and (4) Navajo. HHS has agreed to provide written translations of the SBC template to comply with this requirement and have posted the samples on their website.

3 Very small plans (groups with less than 2 participants that are current employees), stand-alone retiree only health plans and excepted benefits do not have to comply with this requirement. Excepted benefits generally include dental-only and/or vision-only plans, most health FSAs, Medigap policies and accidental death and dismemberment coverage.

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Form — an SBC can always be provided in paper form, and can be provided in electronic form if additional requirements are met. The final rule varies the requirements for electronic delivery depending on the market involved, and in the group market depending on whether the participant is currently enrolled in coverage or not.

Content — at a minimum, ACA requires an SBC to include: uniform definitions of standard insurance and medical terms; 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. With respect to coverage beginning on or after January 1, 2014, a statement of whether the plan or coverage provides minimum essential coverage and a minimum value statement; a statement that the outline is a summary and that the coverage document itself should be consulted to determine the controlling contractual provisions; and a contact number for questions and obtaining a copy of the plan document or policy. The final rule also includes, 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.

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.

Uniform Glossary Requirement

A uniform glossary must be made available upon request. The uniform glossary is a standard document which must be provided in the form issued by the Departments.

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.

For the first two years of applicability, the Departments have issued a safe harbor period for non-enforcement to the extent the plan is working diligently and in good faith to comply with the SBC requirements.

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 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.
Chapter 4 - Taxes and Fees

A number of taxes and fees were included with healthcare reform. Provided below is a quick snapshot of those taxes and fees.

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

Based on the average number of covered lives per month in the current plan year 7/1/2012-6/30/2013 the fee is $1 per covered life. **ASBAIT will pay this fee** on behalf of all pooled participating school districts during the 2013-2014 plan year. The fee of $1 per covered life is payable by July 31, 2014.

The Affordable Care Act (ACA) established the PCORI fee, formerly the Comparative Effective Research Fee (CERF). The fees collected will be used to fund clinical outcomes effectiveness research.

The fee is a temporary fee and applies to plans ending on or after October 1, 2012 but before September 30, 2019. The amount of the fee that will be collected will be based on plan year:

- **For policy years ending between October 1, 2012 – September 31, 2013**, the fee is $1 per covered life.
- **For policy years ending between October 1, 2013 – September 31, 2014**, the fee is $2 per covered life.
- **For policy years ending on or after October 1, 2014**, 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. 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.

Payment is due to the IRS no later than July 31 of the year following the last day of the plan year. This means for plans ending between October 1, 2012 – December 31, 2012, payment is due by July 31, 2013. For plans ending between January 1, 2013 – December 31, 2013, payment is not due until July 31, 2014.

**How to calculate enrollment**

Enrollment can be calculated using either a daily, monthly or quarterly average for the plan year that just ended. The following counting methods 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. For plans maintaining two or more group health plans that collectively provide major medical coverage for the same covered lives, the plans may be regarded as one group health plan for purposes of determining the PCORI fee.
Excluded Plans
Plans that do not have to comply with this requirement are: 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.)**

Available Report to access covered lives
A report is available now to support our self-funded clients requesting PCORI calculations. The report is available at no charge and enables clients as well as authorized consultants and brokers to access plan membership information.

Reinsurance Contribution

**For schools who renew their pooled ASBAIT participation for the 2014-2015 plan year, ASBAIT will pay the mandated Reinsurance Fee utilizing the following method. The average number of covered lives (employees and dependents) per month 1/1/2014-9/30/2014 multiplied by $63. This fee is due by December 31, 2014.**

On March 1, 2013 the U.S. Department of Health and Human Services (HHS) released a final rule that provided, in part, additional guidance on the transitional reinsurance program or also known as the reinsurance contribution (RC) requirements. The following summarizes the final rule's guidance.

**Timing and frequency of payments**
Each self-funded group health plan is responsible for reporting their covered life count to HHS by November 15th of each year for the first 9 calendar months of that year.

- The RC is due in one annual payment, instead of quarterly payments, as previous guidance had suggested. 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.
- Third Party Administrators (TPAs, such as Meritain Health) are not responsible for paying the RC on behalf of self-funded group health plans.
- 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.
- Each self-funded group health plan is responsible for collecting and remitting the RC to HHS.

**How to calculate enrollment**
The Affordable Care Act (ACA) expressed the amount of the overall industry contribution in aggregate under the Transitional Reinsurance Program. According to the most recent guidance, the total 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. The final contribution will be expressed as a per capita rate.

- The RC will be $5.25 monthly per covered life, or $63 annually per covered life for 2014.
- 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 of 2014. The fourth quarter of each year will not be factored into the enrollment calculation. HHS has proposed the following counting methods:
  - **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.)

- **Form 5500 method (using the number of covered lives filed with the U.S. Department of Labor for the last applicable plan year).** 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.

  - The regulations state that aggregate enrollee data is needed; state-by-state enrollee breakdown is not required.
  - For customers maintaining two or more group health plans that collectively provide major medical coverage for the same covered lives, the plans may be regarded as one group health plan for determining the RC amount.

**Further clarification on excluded plans**

- Expatriate coverage will be excluded from the RC, but we need to wait for HHS to issue further guidance as to the definition of “expatriate health coverage.”

- RC only applies to a commercial “book of business” and does not apply to Medicare Part C and Part D products, employer-provided health coverage that pays secondary to Medicare, and Medicaid plans.

- Additional excluded plans include coverage that consists solely of benefits for prescription drugs; integrated HRAs, HSAs and FSAs; Employee Assistance Plans; and disease management and wellness programs.

**Reports available to access covered lives**

Meritain Health will be able to provide a report to support ASBAIT’s self-funded member districts requesting RC calculations. This report will be available at no charge and enables member districts, as well as authorized consultants and brokers, to access plan membership information. The report will be based on the snapshot count method. (The counting methods are very similar to those utilized with the Patient-Centered Outcomes Research Institute (PCORI) Fee, where customers pay the IRS directly.)

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

Beginning in 2018, a non-deductible 40% excise tax will be imposed on the monthly value of plan coverage over certain thresholds and will be applicable to both grandfathered and non-grandfathered plans.
Chapter 5 - The Individual Mandate and Other Noteworthy Aspects of ACA

The 2013-2014 Employee Benefit Guide for ASBAIT included informative information with regards to the “individual mandate”.

In September 2013, ASBAIT schools were provided with guidance and model notices to meet the Employee Exchange Notification requirement.

Individual Responsibility ("Individual Mandate")
Beginning in 2014, all taxpaying individuals will be required to maintain a minimum level of healthcare coverage or pay a penalty. Participation in employer-sponsored coverage satisfies the individual mandate.

Automatic Enrollment
Employers with 200 or more full-time employees will be required to automatically enroll all new employees and to continue the enrollment of current employees in group health coverage. Adequate notice must be provided about the auto enrollment provision, and the opportunity given, for an employee to opt-out of any coverage he/she was automatically enrolled in. Until further regulatory guidance is issued, plans do not have to comply with this requirement.

Employee Exchange Notification
As of January 1, 2014, individuals and employees of small businesses will be able to access coverage through the marketplace. Open enrollment for individuals looking to purchase coverage through the marketplace is slated to begin October 1, 2013.

Under ACA, employers across all segments are required to provide their employees with a written notice stating the following:

(1) informing the employee of the existence of the marketplace, and with 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.

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. Notices were originally required to be sent by March 1, 2013; however, the DOL delayed this deadline until they could issue further guidance and generic model language.

Under temporary guidance applicable employers must provide each newly hired employee (and for the first year of compliance existing employees) with written information about available exchange options and whether the employer’s coverage is affordable and meets minimum value.
The new notice requirement 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 and ASBAIT will not assist with making this determination on their behalf.

Model Notices

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.

Timing and delivery

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.

For new employees hired on or after October 1, 2013, notice must be given at the time of hire. For 2014, the DOL has stated that as long as employers provide the notice within 14 days of the employee’s start date, they will be deemed to have satisfied this required.

For existing employees who are currently employed with the employer before October 1, 2013, notices must be issued no later than October 1, 2013. This means notices must be provided to all employees, regardless if they are enrolled in the health plan or if they are a part-time or full-time employee. (A separate notice is not needed for existing dependents or any other individuals who may become eligible for coverage under the plan.)

Updated 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 has been revised informing 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.

Most group health plans must comply with COBRA. Small employers (any employer who employed fewer than 20 employees on a typical business day during the previous calendar year), certain church plans and federal government plans are not subject to COBRA. A group health plan subject to COBRA must provide a qualified beneficiary with an election notice within 14 days after the plan administrator receives notice of a qualifying event.

The revised model election notice is available on the DOL website. This model notice may be modified as needed. To assist users with identifying the changes made to the revised notice, the DOL has posted both a clean copy, and a redline version to identify the changes. For those member districts of ASBAIT who Meritain administers COBRA, the election notice utilized will be updated appropriately.
Chapter 6 - 2014 Benefit Mandates

Where ASBAIT plans will be required to make plan changes to comply with the changes listed below, the date that changes must appear on all plans offered is July 1, 2014.

The mandates listed below are applicable as of the first day of the first plan year on or after January 1, 2014 and apply to both insured and self-funded health plans regardless if the plan is a grandfathered or non-grandfathered plan and regardless of group size.

Preexisting exclusion limitations prohibited, regardless of age
- Preexisting exclusions are no longer permitted regardless of age.
- Certificates of Creditable Coverage are required to be issued through December 31, 2014 as individuals may need to offset a pre-existing condition exclusion under a plan that operates with a plan year beginning later than January 1.

Annual dollar limits prohibited on essential benefits
- Annual dollar limits are no longer allowed on essential health benefits.
- Day/visit limits are still permitted.
- Dollar limits are permitted on any non-essential health benefit.
- There are ten broad categories of essential health benefits (1) ambulatory patient services, (2) emergency services, (3) hospitalization, (4) maternity and newborn care, (5) mental health and substance abuse services, (6) prescription drugs, (7) rehabilitative and habilitative services, (8) laboratory services, (9) preventive and wellness services and chronic disease management, and (10) pediatric services (including oral and vision care).
  - Essential health benefits are defined by benchmark plans that are chosen or defaulted to at a state level. For purposes of complying with the annual and lifetime dollar limit requirements, large group plans, grandfathered, and self-funded plans are permitted to choose any available benchmark plan (supplemented as needed to reflect the 10 categories of essential health benefits).
  - South Carolina’s benchmark plan appears to offer the greatest flexibility. Plans may want to consider using the South Carolina (SC) benchmark plan, when determining what is an essential benefit. When following the SC benchmark, the following benefits are not considered essential health benefits: bariatric surgery, adult vision hardware, hearing aids, nutritional support, infertility services including AI/ART, TMJ and voluntary abortions. The SC benchmark plans considers DME, chiropractic services and pediatric vision hardware as essential health benefits.
  - A self-funded health plan is not required to offer essential health benefits, however; this decision may impact whether the plan meets minimum value under the employer shared responsibility provision when it becomes effective. To the extent that an essential health benefit is covered, annual and lifetime dollar limits are prohibited.
  - Plans may continue to impose precertification requirements to manage cost.
**Limitation on waiting period may not exceed 90 days**

- Waiting period is defined to mean the period that must pass before coverage for an employee or dependent who is otherwise eligible to enroll under the terms of a group health plan can become effective.

- Waiting Periods may not extend beyond 90-days.
  - All calendar days must be counted beginning on the enrollment date, including weekends and holidays.
  - Coverage may not start later than the 91st day.
    - First of the month following 90 days is prohibited.
    - If the 91st day is a weekend or holiday, plans may choose to permit coverage earlier.

- Employers may take a reasonable period of time to determine whether a variable-hour employee has satisfied the requirements to be eligible.
  - Measurement period cannot exceed 12 months and may begin on any date between the employee’s start date and the first calendar month following the employee’s start date to make this determination.
  - Cumulative Service Requirement cannot exceed 1,200 hours to remain in compliance.

- Any individuals who are in a waiting period beginning on the first day these rules apply to the plan, such waiting period cannot exceed 90 days.

**Increased Wellness Awards/Penalties**

- Increases the maximum permissible reward under a health-contingent wellness program offered in connection with a group health plan from 20% to 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 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 award.
- 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 who 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.

**Coverage for participation in approved clinical trial**
- Qualified individuals" participating in an approved clinical trial:
  - Cannot be denied coverage in the plan;
  - 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.

- Recent 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 limited to HSA amounts**
- 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 cannot exceed $6,350/single and $12,700/family in 2014.

- Plans currently utilizing more than one service provider to administer benefits that are subject to the annual OOP limit ((e.g., medical TPA and separate pharmacy benefit manager [PBM]), will have until 2015 plan year to coordinate with vendors to design a single OOP maximum under a special transition rule provided the following two conditions are met:
- The plan’s OOP maximum for its major medical coverage does not exceed the OOP maximums identified above and.

- Any separate OOP maximums that apply to nonmedical benefits (such as prescription drug coverage), do not exceed the OOP maximums identified above. If a plan’s pharmacy plan does not have an OOP maximum today, the plan can choose to not include an OOP maximum on pharmacy benefits in 2014.

  - A plan’s out-of-network maximum may be higher.

  - Copays, coinsurance, deductibles and other similar charges (i.e., certain “member penalties”) must all count towards the combined OOP maximum.

Note: The in-network deductible limits that apply to certain insured plans; do not apply to self-funded plans at this time.
Chapter 7 - Employer Shared Responsibility Provision

On January 2, 2013, the U.S. Department of the Treasury and the Internal Revenue Service (IRS) published proposed regulations and new Q&As providing guidance on the employer “shared responsibility” excise tax under section 4980H of the Internal Revenue Code. This new tax added by the ACA was slated to go into effect as of the first plan year in 2014, with certain transitional relief being provided for fiscal year (non-calendar year) plans that meet certain criteria, however; the Treasury Department announced on July 3, 2013 that they are delaying implementation of the employer mandate penalties and reporting requirements until 2015. They also have said that they intend to simplify the reporting requirements that were initially required.

Based on IRS Notice 2013-45, employers that had not yet finalized their plans for 2014 now have a choice without facing potential penalties. They may offer coverage that does not meet the minimum value and affordability requirements of the law, with no penalty. **The government’s announcement does not change or delay other plan and benefit requirements that go into effect for 2014.** While employers will not face penalties for failing to provide coverage that is affordable and meets minimum value, employers will still need to assess their plans to determine this information for purposes of the employer reporting requirement that must be satisfied by October 1, 2013, as well as the SBC requirements for plans beginning on/after January 1, 2014 (These requirements are discussed previously in Chapters 5 and 2, respectively.)

The January 2013 proposed regulations are broad in scope and contain several new rules and clarifications based on comments the IRS received in response to earlier notices. This regulation, also commonly known as the “Pay or Play” Mandate, is an employer-shared responsibility that requires **large employers** to offer all their full-time employees (and their dependents) affordable coverage that meets or exceeds a defined minimum value. Employers may face potential penalties for not offering coverage within the parameters of the “Pay or Play” Mandate if any of their full-time employees receive subsidized coverage through a public exchange. If this happens, full-time employees will receive government premium tax credits (tax or cost sharing subsidies) to buy their own insurance through a state exchange.

The proposed [Employer Shared Responsibility Regulations](#) and IRS Q&A’s are positive steps in assisting employers in understanding and complying with the Employer-Shared Responsibility Mandate.

**Definition of “large employer”**

For purposes of this provision, a “large employer” is defined as an employer with 50 or more full-time employees/full-time equivalent (FTE) employees during the preceding calendar year. All employees, including seasonal and part-time employees, **must** have their hours counted for the purpose of determining whether an employer is a “large employer” under the mandate. Only large employers will be subject to potential penalties if their plans do not satisfy certain parameters.

**Definition of “full-time employee”**

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. The proposed rule defined seasonal worker as “a worker who performs labor or services on a seasonal basis as defined by the Secretary of Labor...” The rule also allows employers to apply a reasonable, good faith interpretation of the term.
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 or not 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.”

Measurement Period

Employers who choose to use the safe harbor must establish a measurement period during which an employee’s aggregate hours of service are collected. The measurement period is 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.

Duration of standard measurement period.
The standard measurement period must no less than three months and generally no more than 12 months.

Differing measurement periods.
Employers may vary the standard measurement period for the following classes of employees:

- Employees subject to a collectively bargained agreement and employees not subject to a collectively bargained agreement
- Each group of collectively bargained employees covered by a different collectively bargained agreement
- Salaried and hourly employees
- Employees located in different states

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 described above that is used by the employer)—excluding any periods of special unpaid leave.

Impact on New Employees
The measurement period may begin on the date of hire or first day 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 and 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.

**Duration of administrative period**

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

**Impact on Measurement Period**

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 the employee’s start date.

**Stability Period**

Each employee who average the requisite hours during that measurement period must be treated as full-time during a subsequent 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.

**Duration of stability period**

The stability period following the standard measurement period for such employees must be at least six months, and no shorter in duration than the standard measurement period and it must begin immediately following the standard measurement period and any applicable administrative period.

**Status of stability period**

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.

The following chart indicates the applicable stability period options based on the duration of the standard measurement period and the employee’s status as full-time employee.

<table>
<thead>
<tr>
<th>Standard Measurement Period</th>
<th>Stability Period</th>
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<tbody>
<tr>
<td>3 months</td>
<td>6 months or longer</td>
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<tr>
<td>4 months</td>
<td>6 months or longer</td>
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<tr>
<td>10 months</td>
<td>10 months or longer</td>
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</tbody>
</table>
**Impact of break in service**

If an employee 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.

**Definition of “dependent” (spouses are excluded)**

The proposed regulations define “dependent” as an employee’s child (son, daughter, stepson, stepdaughter, adopted child, child placed for adoption and foster child) up to age 26. The definition of “dependent” in these rules does not include an employee’s spouse, which may cause some employers to drop spousal coverage completely, or impose a spousal surcharge to encourage spouses to seek alternative coverage options, including those available through the public Exchanges.

**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. The three “safe harbors” are outlined below:

**Form W-2 safe harbor**

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 9.5 percent of the employee’s adjusted W-2 wages for the period when the employee was offered such coverage.

**Rate of pay safe harbor**

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 9.5 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.

**Federal poverty line safe harbor**

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.

**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. Health and Human Services (HHS) expects 98 percent of large group plans to meet the minimum value requirement. According to the latest HHS guidance, there are four proposed methods of testing:
1. Using the minimum value calculator developed by HHS at the following link:

2. Offering 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)

3. Using the design-based “safe harbor” checklists (to be released by HHS in the future) to find out whether or not employer-sponsored plans provide minimum value without calculations or actuarial assistance

4. Obtaining an actuarial certification for plans with non-standard features that preclude the use of the minimum value calculator or “safe harbors,” without adjustments

**Potential penalties**

If a large employer fails to provide both affordable and comprehensive coverage, and a full-time employee 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 a large employer does not offer minimum essential coverage to "substantially all" of its full-time employees (and their dependents), and one or more full-time employees receives subsidized coverage on the exchange. The proposed regulations state that a large employer will be treated as offering coverage to full-time employees if it 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).

If any full-time employee goes to the exchange, qualifies for a subsidy and buys coverage, the employer will be required to pay a penalty on all full-time employees not just the employee who went to the exchange. The **monthly penalty** is equal to $2,000 divided by 12, then multiplied by the number of full-time employees employed during the applicable month in which an employee utilizes a subsidy, not counting the first 30 full-time employees. After 2014, the penalty amount may be indexed.

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.

Employees must have an effective opportunity to enroll no less than 1 time per plan year. This means you must have an open enrollment period each year.

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

Section 4980H(b) penalties may apply to large employers 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.
· Or one or more of the full-time employees that is not covered (within the 5% or, if greater 5) receives subsidized coverage on the Exchange.

The monthly penalty is equal to $3,000 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. After 2014, the penalty amount may be indexed.

The difference between minimum value and actuarial value

Minimum value is an important measure applied to large groups for purposes of the Employer-Shared Responsibility Mandate, while the actuarial value is an important measure for individuals and small group insurance. There are several differences between minimum value and actuarial value. For example, large group employers are not required to offer essential health benefits (EHBs), whereas individual and small group health plans are required to include EHBs in their coverage.

The two calculators should produce similar values, since most large group plan sponsors do cover EHBs; however, the calculation of the two measures will be driven by different underlying data.

· Minimum value applies to large groups
Minimum value pertains to large employers (defined as having 50 or more FTEs—see above section for details). Comprehensive and affordable coverage requires that the affordable plan covers a minimum value of 60 percent of the expected healthcare costs. In order to satisfy the employer mandate, 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.

· Actuarial value applies to individuals and small groups
The actuarial value measures the percentage of expected medical costs that a health plan will cover. Actuarial value is calculated based on the cost-sharing provisions for a set of individual or small group benefits to be offered on and off the public exchanges. The actuarial value will align to a “metallic” designation (e.g., bronze, silver, gold and platinum) based on the percentage of expected healthcare costs the health plan covers.

For example, for a plan with a 70 percent actuarial value, consumers would, on average, pay 30 percent of the cost of healthcare expenses through features like deductibles and coinsurance. The total out-of-pocket expense the consumers would pay would vary substantially based on the amount of services they actually use.

Minimum Essential Coverage (MEC) Employer Reporting Requirement

Large employers and insurers are not required to report coverage affordability and access details to the IRS and to individuals in 2014, as previously expected under IRC 6055 and 6056. This reporting will be voluntary until 2015. Further guidance on the reporting requirement is expected.
Chapter 8 - Publicly Available Sites for Reference

To learn more about employer requirements under ACA, access the following links posted on the Internal Revenue Service’s website: http://www.dol.gov/ebsa/healthreform/.

Information is believed to be accurate as of the production date; however, it 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.
**Chapter 9 - Electronic Delivery Safe Harbor Requirement**

*Electronic Delivery Safe Harbor Requirement*

Merely posting a disclosure notice on the employer's website so it is available to employees will not by itself satisfy this disclosure requirement. Emailing the notice directly to each employee is the safest way to assure compliance with the safe harbor guidelines for electronic distribution.

The Exchange Notice may be provided electronically if the requirements of the DOL's electronic disclosure safe harbor described in labor regulations (29 CFR 2520.104b-1(c)) are satisfied. Generally, this safe harbor allows disclosure through electronic media to employees:

- Who have the ability to effectively access documents furnished in electronic form at any location where the employee is reasonably expected to perform duties; or
- For whom access to the employer's electronic information system is an integral part of those duties.

Note: Employers relying on the electronic safe harbor must ensure that the system for furnishing documents results in actual receipt by the employee and must inform the employee of his or her right to request a paper version of the notice.