Stahl & Associates
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Healthcare Reform Handbook

Keeping you compliant 2012 & beyond

Last revised: December 5, 2012

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IMPORTANT: This document is based on information available in December 2012 and is subject to change. We are sharing this information for general informational purposes only. It does not necessarily address all specific issues and should not be construed as, nor it is intended to provide legal or tax advice. Questions regarding specific application of these rules to your plans should be addressed by your legal counsel or tax advisor.

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OVERVIEW, INDIDIVUDAL MANDATE & EXCHANGES

EFFECTIVE: JANUARY 1, 2014

Overview
The following pages will detail what your business needs to do to comply with the upcoming regulations pertaining to the Patient Protection & Affordable Care Act. Those regulations which have already been enacted will contain more detailed information on how to comply. As we receive more guidance on upcoming regulations, modifications will be made to this booklet and more detailed information will be made available.

Individual Mandate
Beginning in 2014, all individuals will required to have health insurance. Those who do not comply will pay a tax penalty, which will vary based on income levels. If a company does not offer a group health plan to cover employees, employees will be required to buy this coverage themselves, through exchanges or the individual market.

If an individual does not comply with the Individual Mandate, the penalty is the greater of:

- For 2014, $95 per uninsured person or 1 percent of household income over the filing threshold
- For 2015, $325 per uninsured person or 2 percent of household income over the filing threshold
- For 2016 and beyond, $695 per uninsured person of 2.5 percent of household income over the filing threshold

If a company's group health plan provides coverage to employees, but it does not provide the required level of coverage or the cost of coverage is determined to be unaffordable, employees may be able to purchase subsided insurance through the exchanges.

Exchanges
Exchanges are arrangements through which employers and individuals have the ability to purchase health insurance. The insurance exchanges are required to be fully functioning by October 1, 2013, and the insurance exchange coverage will become available in 2014. Health Care Reform requires each state to set up an exchange for the purchase of health insurance coverage.

Small employers (either 50 or 100 employees, depending on the exchange), and individuals have the ability to purchase health insurance through the exchanges starting in 2014. Starting in 2017, states can allow businesses with more than 100 employees to purchase coverage through the exchanges.

WOMEN'S PREVENTIVE SERVICES

EFFECTIVE: AUGUST 1, 2012

When non-grandfathered plans become effective or renew on or after **August 1, 2012**, they must include 100 percent coverage of women's preventive services when performed by an in-network physician. All of the following women's health services will be considered preventive (some were already covered) when provided in-network:

- Well-woman visits (annually and now including prenatal visits)
- Screening for gestational diabetes
- Human papillomavirus (HPV) DNA testing
- Counseling for sexually transmitted infections
- Counseling and screening for human immunodeficiency virus (HIV)
- Screening and counseling for interpersonal and domestic violence
- Breastfeeding support, supplies and counseling
- Generic formulary contraceptives, certain brand formulary contraceptives and FDA-approved over the counter female contraceptives with prescription are covered without member cost share. Certain religious organizations or religious employers may be exempt from offering contraceptive services.

MEDICAL LOSS RATIO/ REBATES

EFFECTIVE: AUGUST 2012 for 2011 CALENDAR YEAR

The Affordable Care Act requires insurers to rebate part of the premiums received if the insurer does not spend at least 80 percent of premiums on health care services and activities to improve health care quality. No more than 20 percent of premiums may be spent on administrative costs such as salaries, sales, and advertising. This is referred to as the 80/20 rule for small groups. The same rule applies for large groups, however the ratio of care vs. expenses is 85/15.

If your insurer does not meet the 80/20 or 85/15 standard, your group will receive a rebate. The amount of the particular rebate you receive is determined based on the applicable MLR, as well as the amount of premium attributable to the policy.

If you receive a rebate, ERISA covered plans are required to follow the Department of Labor guidance, which can be found at http://www.dol.gov/ebsa/newsroom/tr11-04.html

The information provided on the following pages applies to those groups who meet **all** of the criteria listed below. If you do not meet these criteria, are a church, governmental entity or school district, you should seek legal counsel regarding how to administer any rebates received.
At least one of the medical benefit options offered to participants is fully insured.

- The medical benefit is a group policy.
- The medical plan is subject to ERISA.
- You, the employer, are the policy holder.
- Premiums are paid from the general assets of the company.
- There is no plan trust.

Our intention is to provide you with a simple, permissible approach to rebate allocation based on current guidance. Other methods may be permissible and we advise you to consult with your financial and legal counsel.

REBATE ALLOCATION

All rebates that insurers pay, including the amounts owed to participants of group health plans go directly to the plan sponsor. The Department of Labor (DOL) has indicated that the portion of the rebate that is attributable to participant contributions (employees & dependents) must be treated as "plan assets". *This is significant because ERISA rules require (in part) that plan assets may not inure to the benefit of the plan sponsor, and may only be used for the exclusive use of the plan participants*. Please see attached chart titled "Plan Asset Rules."
The most common situation, is where both the plan sponsor and participants contribute toward the cost of coverage and that is the scenario that is being addressed in this bulletin.

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MEDICAL LOSS RATIO/ REBATES (CONTINUED)

1. Identify the plan to which the rebate applies

Rebates apply to **each specific plan**. As an example, if you offer an HMO and a PPO, but you received a rebate only on the HMO, then the rebate only applies to the cost paid (by the employer and the participants) for the HMO option. If the rebate applies to both the PPO and HMO, but was calculated separately by the insurer, then the rebates need to be applied separately by the employer.

In many instances insurers have issued separate checks per plan (but not in all cases) so it is incumbent on the plan sponsor to know how much of the rebate received is applicable to each plan.

Employers whose plans provide benefits under multiple polices must be careful to allocate the rebate for a particular policy only to the participants who were covered by that policy. According to the DOL, using a rebate generated by one plan to benefit another plan's participants would be a breach of fiduciary duty.

2. Determine what portion of the rebate belongs to the employer and what portion belongs to the employee.

If employees do not contribute to the plan (100% employer paid), the employer may keep the entire amount. If the employee pays the entire cost, then the rebate would belong 100% to the employee. The most common situation is where both the plan sponsor and participants contribute toward the cost of coverage. In this case, the plan sponsor (employer), must determine the respective portions of the total plan cost contributed by both parties so that the MLR rebate can be appropriately allocated between the participants and the employer.

Example:

Total group health plan premiums paid to a carrier during 2011 = $500,000.

If the employees contributed 25% of the premium ($125,000), then 25% of the rebate amount would be distributed among participants.*

The employer receives a $8,000 rebate check from the carrier. (If multiple plans and multiple rebate checks, remember each plan must be figured individually).

25% of the $8,000 = $2,000 must be returned to the participants.

In the example above, plan sponsors will first need to determine total participant contributions for the year used to calculate the MLR rebate. Current rebates are based on premiums paid to the carrier for calendar year 2011.

*This includes employee payroll deductions, COBRA premiums paid by participants, premiums paid by participants during FMLA leave, and any other payment made toward the premium by a participant. The resulting ratio is then applied to the rebate that must be distributed to plan participants vs. the portion that may be retained by the plan sponsor.

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MEDICAL LOSS RATIO/ REBATES (CONTINUED)

3. Who must receive the participant portion of the rebates?

Decisions on how to allocate the participants' portion of the rebate are subject to ERISA's general standards of fiduciary conduct which require that plan fiduciaries act prudently, solely in the interest of plan participants and their beneficiaries, in accordance with the provisions of the plan, and with impartiality to plan participants.

When a plan provides multiple benefit options under **separate policies** (as noted above, HMO, PPO, etc.), the rebate must be distributed to the participants and beneficiaries that were covered under the policy to which the rebate applies.

The most obvious decision the employer must make is what group of participants should receive the rebate. The most likely approaches are:

1) Returning the rebate to participants covered by the plan in the year which the rebate is received. (Rebate received 2012, return only to those participating in the 2012 plan).
2) Returning the rebate to individuals who participate in the plan both in the year which the rebate was received (2012) **and** the year used to calculate the rebate (2011).
3) DOL guidance points out that it will not be necessary to distribute rebates to former plan participants "if an employer finds that the cost of distributing shares of a rebate to former participants approximates the amount of the proceeds, the fiduciary may properly decide to allocate the proceeds to current participants (only)." In **MOST** cases, the amount of the rebate on a per participant basis will be so small that the administrative cost of distributing it to former participants will exceed the value of the rebate.
4) If the rebate **is** provided to former participants whose contributions were paid on a pre-tax basis, it will be in the form of taxable cash.
5) Also note that COBRA subscribers and subscribers on paid leave including FMLA are considered current participants as the rules apply to rebates.

4. What are the options for distributing the employees' share?

The most frequently asked questions regard whether employees with family coverage receive more of the rebate than participants without family coverage, or should participants with high option plans receive more than participants with low option plans, etc. Here are a few fairly simple answers:

1) The allocation method does NOT need to reflect the actual contribution cost of each employee but should be "reasonable, fair and objective."
2) The distribution allocation is not required to exactly reflect the premium activity of individual plan participants.

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MEDICAL LOSS RATIO/ REBATES (CONTINUED)

5. Determine how to distribute the rebate to participants.
There are alternative methods of distributing the rebate with tax implications associated with each method. **It is expected that premium holidays, and return of the rebate through a bonus or compensation adjustment, will be the most common distribution methods**. Your tax advisor is best prepared to discuss this with you as it applies to your plan. In addition, if you use an outside payroll service, it is advisable to consult with your representative who can advise you on the best method to enter rebates into your payroll program should you wish to do your rebates through your normal payroll processing.

1) **Return the rebate to the participant as a cash payment.** According to the IRS, if premiums were paid through a "pre-tax" deduction (Cafeteria Plan), then a cash rebate would be subject to tax. Rebates returned as cash to participants who contributed to the plan on a post-tax basis will NOT be subject to federal taxation.
2) **Reduce employee contributions.** (Sometimes called a "premium holiday"). If the rebates are "de minimis" or cash payment would give rise to tax consequences for the participant, the rebate may be used to reduce employee contributions. This is "effectively" taxable since the amount of the participants' pre-tax contribution toward current year benefits will decrease, their taxable income will increase by a like amount. This option assumes the decision has been made to distribute the rebate to current plan participants.
   The IRS definition of a de minimis benefit is any property or service you provide to an employee that has so little value (taking into account how frequently you provide similar benefits to your employees) that accounting for it would be unreasonable or administratively impracticable.
3) **Apply the rebate towards the cost of benefit enhancements.** Again, if the rebates are **"de minimis**" or a cash payment would give rise to tax consequences for the participant, the rebate may be used to enhance the plan design. While this approach is permissible, most carriers are not going to allow group plans to implement mid-year design changes, which makes this options impractical for most plans.

6. Determine how the employer's portion of the rebate will be used.
The rebate may be considered plan assets under ERISA. Employers who are unsure of the asset-status of the rebate should consult with their tax advisor. We have included a chart titled "Plan Asset Rules" to help you with your determination. If your portion of the rebate is considered a plan asset under ERISA then you must use the refund for "the exclusive purpose of providing benefits to participants in the plan and their beneficiaries and defraying reasonable expenses of administering the plan."

7. How quickly must I distribute the participant's share?
The rebates will not be required to be held in trust as long as they are distributed to participants within three months of receipt by the plan sponsor. If they are NOT distributed within the three months, then a trust must be used to hold the funds until they are properly distributed.

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MEDICAL LOSS RATIO/ REBATES (CONTINUED)

Summary

Employers are not required to send a specific notice to employees regarding the rebates; however, insurance carriers must notify plan participants if the employer is receiving a rebate. The notice sent by carriers will not include the specific amount but will state that a rebate has been sent to the employer and that a portion may be distributed to participants.
As the employer, you may want to consider sending an employee communication that clarifies how and when you will distribute the rebate or, if that has not been determined, at least notify employees that the amount will most likely be very small. Employees may incorrectly assume that they will be receiving a significant rebate based on the information in the carrier notices.
If you receive a rebate you should prepare a record describing how the rebate amount payable to employees was determined and to whom it was distributed.
Regardless of whether or not you receive a MLR rebate this year, you should establish a policy regarding how such rebates will be administered. Plan administrators should do the following:

- Review your plan documents (summary plan description (SPD) and plan documents (PD)) for the group medical plan to determine if there is any existing written policy that may conflict with how you decide to administer the rebate. Consult with any third party that prepares your plan documents.
- Amend the plan document to include a description of how the rebates will be administered if received. A sample plan amendment is attached. The amendment must be formally adopted. If there is no plan, no written plan or policy, or a failure to comply with the written policy, the entire rebate will be considered plan assets and additional ERISA fiduciary provisions will apply.

Please see following pages for Plan Asset Rules and a sample plan amendment.

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MEDICAL LOSS RATIO/ REBATES (CONTINUED)

PLAN ASSET RULES

Factors	Rebate as Plan Assets?
Policy issued to plan or trust; no specific plan or policy language	Yes, 100 percent
Specific plan or policy language addressing ownership or division of rebates or refunds	Yes, to extent provided by plan or policy language
Policy issued to employer; plan or policy language can fairly be read to give employer ownership in some or all of a refund or rebate	No, to extent plan or policy language gives employer ownership
Premiums paid entirely from plan assets; no specific plan or policy language	Yes, 100 percent
Policy issued to employer; no specific plan or policy language, and:	
• Premiums paid 100 percent by employer	No
• Premiums paid 100 percent by participants	Yes, 100 percent
• Premiums shared by employer and participants by fixed percentage (ex: employer pays 60 percent, participant pays 40 percent)	Yes, for percentage equal to percentage of premiums paid by participants
• Employer pays fixed amount of premiums, participants pay balance (ex: employer pays $5,000/year toward coverage; participant pays any balance)	Yes, up to a total amount paid by participants; balance not plan assets
• Participants pay fixed amount of premiums, employer pays balance (ex: participant pays $5,000/year toward coverage; employer pays any balance)	No, up to a total amount paid by employer; balance is plan assets

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MEDICAL LOSS RATIO/ REBATES (CONTINUED)

SAMPLE PLAN AMMENDMENT

In accordance with the requirements of the Patient Protection and Affordable Care Act (Affordable Care Act), the Enter Plan Name will implement the following procedure upon receipt of a rebate due to a medical issuer's failure to comply with the medical loss ratio (MLR) standard.

(Below is sample text. This text may need to be modified so that it accurately describes how the plan will actually administer the rebate.)

1. The rebate amount will be distributed as a cash amount to affected plan participants as determined by the Employer and will be subject to any applicable taxes; or
2. If the rebate amount is de minimis or will result in tax consequences to either the participant or the Employer, the rebate may be used to offset the participant's future contribution amount, not to exceed the three-month period of time following the date the rebate is received.

The determination regarding which of the above methods will be used, will be made by the Plan each year based on the facts and circumstances of that year.

This amendment is effective as of _____
(Date)

_____
(Signature)

_____
(Printed Name and Title of Signee)

_____
(Date Signed)

SUMMARY OF BENEFITS & COVERAGE

EFFECTIVE: SEPTEMBER 23, 2012

The Affordable Care Act has provided regulations and standards for the way benefit options are offered and communicated to your employees. The Summary of Benefits and Coverage (SBC) is designed to provide benefit and coverage information in a clear, easy-to-understand language in a consistent format to help employees make informed coverage decisions.

What is an SBC?
An SBC is a four page, double-sided document that describes available health plans in easy to understand language. It includes:

- Features and descriptions of covered benefits including cost-sharing provisions, and coverage limitations and exceptions
- Directions on how to access a Uniform Glossary. This provides definitions of common terms used in benefit coverage options.

What are my requirements?
The government now requires employers to provide an SBC to all eligible applicants and enrollees. Your carrier will prepare and furnish an SBC document for fully insured groups, but it is still the responsibility of the group to share the SBC with all employees and dependents. Self-insured employers are responsible for creating and distributing their own SBCs. Employers are responsible for distributing the SBCs to **all eligible participants and beneficiaries**, including COBRA qualified participants and beneficiaries.

What are the deadlines for providing the SBC?

- Beginning on the first day of the **first open enrollment period** that begins on or after **September 23, 2012**, plans must provide the SBC to participants and beneficiaries who enroll or re-enroll during the open enrollment period.
- Beginning on the first day of the **first plan year** that **begins on or after September 23, 2012**, plans must provide the SBC to participants who enroll in coverage other than through the open enrollment period, such as newly eligible and special enrollees.

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SUMMARY OF BENEFITS & COVERAGE (CONTINUED)

When should I provide the SBC?

The SBC should be provided to participants and beneficiaries in the following instances:

Upon Application	The SBC must be provided with application materials that are distributed with enrollment, whether in paper form, through a website, or email. If you do not distribute written application materials, the SBC must be provided no later than the first date the participate is eligible to enroll in coverage.
By First Day of Coverage (If There Are Changes)	If there is any change to the information required to be in the SBC that was provided with enrollment materials, you must update and provide a current SBC no later than the first day of coverage.
Special Enrollees	The SBC must be provided to special enrollees (HIPAA qualifying event) no later than the date on which a summary plan description is required to be provided.
Upon Renewal	If participants and beneficiaries must actively elect to maintain coverage during open enrollment, or have the opportunity to change coverage, you must provide the SBC at the same time you distribute open enrollment materials. If there is no requirement to renew and no opportunity to change coverage options, renewal is considered automatic and the SBC must be provided no later than 30 days prior to the first day of the new plan or policy year.
Upon Request	The SBC must be provided upon request as soon as possible, and no later than seven business days following the request.

How should I notify participants and beneficiaries of the SBC?

To ensure compliance, we recommend not only providing SBCs in enrollment materials and applications, but also sending a letter or postcard to each eligible employee's home, addressed to both the employee and dependents. If you know that a dependent's address is different than the employee/participant's address, you must send a separate SBC to the dependent at their last known address. A sample communication piece for these letters/postcards from the Department of Labor is located at the end of the Summary of Benefits & Coverage FAQs.

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SUMMARY OF BENEFITS & COVERAGE (CONTINUED)

If I have three plan options, do I need to provide a separate SBC for each option?
Yes. A separate SBC must be created and distributed for each benefit option offered under your plan. An SBC for each option must also be provided to all individuals eligible for those options.

Can the SBC be provided electronically through an online enrollment system?
Yes, SBCs may be provided electronically to participants and beneficiaries in connection with their online enrollment. However, beneficiaries would also need access to the online enrollment system. The individual must also have the option to receive a paper copy upon request. The SBC can be distributed electronically in other formats as well. Please see the Department of Labor's website for a full list of electronic distribution rules:
http://www.dol.gov/ebsa/faqs/faq-aca8.html

Am I required to provide a separate SBC for each coverage tier (example: employee only, employee + one coverage, family coverage)?
No, plans and issuers may combine information for different coverage tiers in one SBC as long as the appearance is understandable. The coverage examples should use the cost sharing for the employee-only coverage tier.

Are employers required to provide SBCs to individuals who are COBRA qualified beneficiaries?
Yes, COBRA qualified beneficiaries should be provided SBCs.

Do we have to provide an SBC for our dental or vision coverage?
No, you will not have to provide an SBC for your dental or vision coverage.

For more information, please visit the Department of Labor's website at
http://www.dol.gov/ebsa/healthreform/index.html

Below is sample language recommended by the Department of Labor for use when sending a postcard or letter to participants and beneficiaries at home, notifying them of the Summary of Benefits and Coverage.

Availability of Summary Health Information

As an employee, the health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury.
Your plan offers a series of health coverage options. Choosing a health coverage option is an important decision. To help you make an informed choice, your plan makes available a Summary of Benefits and Coverage (SBC), which summarizes important information about any health coverage option in a standard format, to help you compare across options.
The SBC is available on the web at: www.yourwebsite.com. A paper copy is also available, free of charge, by calling XXX-XXX-XXXX.

ADDITIONAL MEDICARE TAXES

EFFECTIVE: JANUARY 1, 2013

Additional Medicare taxes will be implemented starting in 2013 that will affect both individuals and employers. The current Medicare Tax is 2.9% of compensation, and both employers and employees currently pay 1.45% with no income limit.

Additional .9% Medicare Tax on Compensation
Starting in 2013, individuals whose earned income is greater than $200,000 per year, and couples whose earned income is greater than $250,000 per year, will pay an additional .9% Medicare Tax on compensation, (a total of 2.35% Medicare tax). Compensation includes wages, tips, commissions, and self-employment income.

Employers must begin withholding higher employee taxes when earnings reach $200,000. The employer is liable for the tax if they fail to withhold.

Additional 3.8% Medicare Tax on Investment Income
Starting in 2013, a new 3.8% Medicare payroll tax will apply to unearned income (investment income) for those whose adjusted gross income is more than $200,000 (individual) or $250,000 (couple). Investment income includes interest, dividends, and capital gains.

W -2 REPORTING

EFFECTIVE: JANUARY 2013 for 2012 Forms W -2

Employers will be required to report the cost of employer-sponsored group health plan coverage on their employees' Forms W-2. For employers who file more than 250 Forms W-2, the requirement is mandatory for 2012 (that must be issued in 2013). It is optional for employers who file fewer than 250 Forms W-2 until further guidance is issued.

The reporting includes major medical and generally any other nontaxable "group health plan" coverage for which COBRA coverage is offered, other than stand – alone dental and vision coverage. The reported cost is a total cost, including employer and employee portions.

The list below details what is required to be reported on the Forms W – 2, and what does not need to be included.

What needs to be included:

- Major Medical
- Medicare Supplemental
- Medicare Advantage
- Mini med plan
- On-site medical clinics
- Employer contributions to health FSA
- Employer contributions to hospital or fixed indemnity plan, or specified disease or illness insurance
- Wellness benefits
- Employee Assistance Plan
- Executive medical Coverage

What does NOT need to be included:

- Non integrated dental or vision
- Long term care
- HSA
- HRA
- Health FSA coverage funded solely through employee salary reduction elections
- Accident, disability, and AD&D
- Coverage under a self-insured group health plan that is not subject to COBRA (such as a church plan)
- Employer contributions to multiemployer plans
- Commercial insurance including Workers Compensation, liability, credit-only, and automobile medical insurance
- Coverage provided by the government for members of the military and their families
- Excess reimbursements of highly compensated individuals
- Health insurance costs for self-employed individuals
- Health insurance costs for self-employed individuals

FLEXIBLE SPENDING ACCOUNT CONTRIBUTION LIMITS

EFFECTIVE: JANUARY 1, 2013

An individual's annual maximum election for a Flexible Spending Account will be limited to $2,500 starting in the plan year 2013. The amount may be adjusted for inflation beginning in 2014.

EMPLOYEE EXCHANGE NOTICE

EFFECTIVE: MID YEAR 2013

Employers will be required to provide all new hires and current employees a written notice about the health benefit exchange and some of the consequences if an employee decides to purchase a qualified health plan through the exchange in lieu of the employer-sponsored coverage.

No guidance has yet to be given, and as a result, we are unsure exactly when the notice will be required.

PLAY OR PAY MANDATE

EFFECTIVE: JANUARY 1, 2014

Overview
The Play or Pay Mandate requires large employers to offer full-time employees and their dependents minimum health coverage or health coverage that is considered ‘”affordable.” If an employer fails to satisfy the requirement, and an employee receives a premium tax credit from a state exchange, the employer will be subject to a penalty.

Who is considered a large employer?
Large employers are those with 50 or more full-time employees. A full-time employee is one that works 30 hours a week or more. However, the hours worked by part time employees are counted to determine whether you have at least 50 full-time employee equivalents and are subject to the mandate. To determine the number of “full-time equivalents”, take the total number of monthly hours worked by part time employees and divide it by 120. This will give you the number of full-time equivalent employees.

An employer that has 50 or more full time employees as a result of seasonal employment can avoid being treated as an applicable employer. An employer will not be considered to employ more than 50 full time employees if:

- the employer’s workforce only exceeds 50 full time employees for 120 days, or fewer, during the calendar year; and
- the employees in excess of 50 who were employed during that 120 day (or fewer) period were seasonal workers.

Through the end of 2014, employers are permitted to use a “look-back measurement/stability period” safe harbor to determine which of your employees are considered full-time employees.

What coverage should be provided?
Medical coverage must provide minimum value and be affordable. Coverage provides minimum value if it pays at least 60% of the cost of covered services.

In order to be affordable, the employee premium contribution for **single** coverage cannot exceed 9.5% of the employee’s “household income” OR the employee’s W-2 wages. The premium contribution applies only to single coverage. Therefore, even if the employee contribution for family coverage exceeds 9.5% of the employee’s household income or W-2 wages, it is still considered to be affordable.

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PLAY OR PAY MANDATE (CONTINUED)

What are the penalties?
If an employer fails to "play" by not offering coverage to ALL full time employees and their dependents, AND at least one full-time employee receives federal premium assistance for purchasing coverage through an insurance exchange, then the employer will "pay" an annual penalty tax of $2,000 per full-time employee, excluding the first 30 full time employees. For example, an employer with 100 full-time employees that does not offer any coverage, will be required to pay a penalty for 70 employees, amounting to $140,000.

If an employer provides minimal essential coverage that is not affordable, they will "pay" an annual penalty of $3,000 per employee that receives subsidy through an exchange. This penalty is capped at the amount the employer would pay if they had not offered any coverage. For example, if an employer with 100 full-time employees offers coverage that is not affordable for all employees, and 20 of those employees receive subsidies through the exchange, the penalty would be $3,000 per employee, or $60,000 per year. Regardless of how many employees receive subsidies at an exchange, this employer would pay no more than the $140,000 penalty as calculated above if they were to not offer any coverage.

An employee may qualify for federal premium assistance if his or her income is less than 400% of the federal poverty level (approximately $88,000 for a family of four).

How do we know whether our plan's share of the total allowed cost of benefits is at least 60%?
The IRS released three methods to determine whether the employer coverage meets the 60% threshold. They are:

1. Actuarial Value or Minimum Value Calculator
The U.S. Department of Health & Human Services has developed the Actuarial Value (AV) calculator to be used for Qualified Health Plans and individual and small group markets. The calculator is available on the CCIIO website at **http://cciio.cms.gov/resources/regulations/index.html.** It is located under "Plan Management" and labeled "Actuarial Value Calculator with Continuance Tables." The Department of Health & Human Services is also developing the Minimum Value calculator (MV) for fully insured large group and self-funded plans to use to calculate the 60%, but it has not yet been released.

2. Design Based Safe Harbors
The IRS will develop design-based safe harbors in the form of checklists that would provide a way for plan sponsors to see if they cover 60% of the costs – without the need of actuarial calculators. If your plan's terms are consistent or more generous than any one of the checklists', your plan would provide the minimum value.

3. Actuarial Certification
Plans with nonstandard features that are not able to use the actuarial value or minimum value calculator, or the safe harbor checklists, would have to obtain certification of the plan's value by an actuary.

ESSENTIAL HEALTH BENEFITS

EFFECTIVE: JANUARY 1, 2014

Individual and small group health plans will be required to cover essential health benefits beginning in 2014. The benefits will be defined by each state, but will have to include the 10 following categories:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Mental health and substance abuse disorders/behavioral health treatment
- Maternity and newborn care
- Prescription drugs
- Rehabilitative and habilitative services/devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

In addition, small group health plans' annual deductibles will not be able to exceed $2,000 (individual)/ $4,000 (family). Individual and small group health plans' maximum out-of-pocket expense cannot exceed limits that apply to HSA-qualifying high deductible health plans. The out-of-pocket maximum limits for 2013 are $6,250 (individual) and $12,500 (family).

PRE-EXISTING CONDITION LIMITS

EFFECTIVE: JANUARY 1, 2014

Starting January 1, 2014, no limits on coverage for pre-existing conditions will be allowed for anyone enrolled in a medical plan regardless of age.

WELLNESS PROGRAM INCENTIVES

EFFECTIVE: JANUARY 1, 2014

Currently, if a wellness program requires an individual to meet a standard related to a health factor in order to obtain a reward, the reward must be limited to 20% of the applicable cost of the coverage. The 20% limit applies to all of a plan's wellness programs that require individuals to meet a standard related to a health factor. For example, if the plan has a 15% reward for meeting a body mass index target, and a 10% reward for meeting a cholesterol target, it must decrease the total reward available to 20%. However, this 20% limit will be raised to 30% in 2014. Therefore, the reward for meeting a health standard must be limited to 30% of the applicable cost of the coverage.

AUTOMATIC ENROLLMENT

EFFECTIVE: AFTER 2014

Large employers will be required to automatically enroll new full-time employees and to re-enroll current employees in a company medical plan. In this provision, a large employer is one that employs more than 200 full-time employees.

Employees must be given the time and opportunity to opt out of this coverage and a waiting period of up to 90 days is allowed before the coverage begins.

Employers will not be required to comply with this requirement until after the final regulations are issued, which is expected to be in 2014.

NONDISCRIMINATION REQUIREMENTS

EFFECTIVE: AFTER 2014 – IMPLEMENTATION CURRENTLY DELAYED

Group health plans may not discriminate in favor of highly compensated employees. The rules of the nondiscrimination requirements will be similar to those in Code Section 105(h) that apply to self-funded group health plans.

Effective date and exact rulings will be determined in future guidance.

ADDITIONAL FEES & TAXES

Fee	Effective Date	Plans Affected	Summary
Health Insurer Fee	2014 & Beyond	Fully Insured Only	Health insurers will have to pay an annual fee to offset at least a portion of the expense related to premium subsidies and tax credits to be made available to qualifying individuals purchasing health insurance coverage on the exchanges beginning in 2014. Final guidance has not been issued, but the estimated impact is about 2.4 percent of premium the first year. Some carriers will cover this cost, others will incorporate it into premiums in renewals and new business.
Transitional Reinsurance Contribution Premium	2014 – 2016	Fully Insured & Self Funded	Used to fund state non-profit reinsurance entities to help finance the cost of high-risk individuals in the individual market. The estimated fee will be about $6 per employee per month. For fully insured plans, the fee will be collected through premium rates. Self insured plans will be required to pay this directly to the government.
Patient – Centered Outcomes Research Fee	2012 – 2019	Fully Insured & Self Funded	Will be used to fund clinical outcomes effectiveness research. The fee will be $1 per covered life in the plan's first year that ends on or after 10/1/2012, and will increase to $2 per covered life in 2013. The fee is subject to adjustment for increases in future years. Some carriers will cover this cost for fully insured plans, others will include it in premium. Self insured plans will be required to pay it directly to the IRS by filing a federal excise Form 720.
High – Value Plan Tax	2018 & Beyond	Fully Insured & Self Funded	Fees assessed on high-premium health plans. Plans that cost annually more than $10,200 (single) or $27,500 (family) are subject to a 40% excise tax on the amount above those costs. The amounts are adjusted for cost of living, age & gender, and increases in 2019 and beyond by CPI + 1%.

Please contact Stahl & Associates Insurance if you have any questions regarding any of the mandates in this booklet, or about healthcare reform in general. We look forward to serving you as the implementation of healthcare reform continues, and will do all that we can to keep you informed.

Brittany Stahl
727.391.9791
110 Carillon Parkway
St. Petersburg, FL 33716

www.stahlinsurance.com