Subject: IRS Guidance: Tax-Favored Status of Dependent Coverage

Date: April 28, 2010

As promised, the government is feverishly attempting to issue guidance on the new health care reform law. Yesterday, the IRS issued guidance relating to the tax-favored status of dependent coverage (IRS Notice 2010-38). Part of the Reconciliation law (enacted March 30th) provides that reimbursement of health expenses for dependent children who have not attained age 27 by the end of the taxable year (calendar year) is excludable from the employee's income. For this purpose, a dependent includes:

- A son, daughter, stepson, or stepdaughter of the employee; and
- A legally adopted child, a child placed for adoption, or an eligible foster child.

This Notice clarifies that this exclusion applies to reimbursements, as well as employer premium paid for dependent coverage. This pronouncement clarifies that the tax-favored status applies to employment taxes as well as income taxes. Further, it provides that coverage for these dependents can be purchased on a pre-tax basis through a cafeteria plan, and that their medical expenses can be reimbursed from a flexible medical spending account, as soon as a health plan is amended to provide coverage for older-aged dependents. It further provides that if older-aged dependents are currently on the plan, the tax-favored status is effective on and after March 30, 2010.

With regard to cafeteria plans, the Notice provides that the older-aged dependent coverage can be allowed retroactive to March 30th as long as the cafeteria plan is amended by December 31, 2010, with a retroactive effective date coincident with the date the cafeteria plan covers the older-aged dependents. Further, the pronouncement clarifies that a status change would be permissible for the treatment of these older-aged dependents. If it is the intent of the plan to cover these older-aged dependents, it is very important to review, and amend accordingly, the health plan, the cafeteria plan, and flexible medical spending account, if applicable.

Several examples included in the Notice make it clear that the marital status of the dependent does not negate the tax-favored status of the benefit. While the new law does not require coverage for the spouse or children of the older-aged dependents, if the plan does extend coverage to such individuals, the Notice makes it clear that the cost of coverage for the older aged-dependent's spouse or child is includible in the employee's income.

In addition, this Notice provides similar treatment of dependents for purposes of VEBAs, retiree health benefits through an IRC Section 401(h) plan, and for self-employed individuals.

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AUTHOR: KAREN R. MCLEESE, ESQ.

EARLY RETIREE REINSURANCE PROGRAM

The Department of Health and Human Services (HHS) has just issued interim final regulations, and a Fact Sheet, relating to the Early Retiree Reinsurance Program. This temporary program, established by way of the health care reform laws, provides reimbursement of certain expenses to plan sponsors of group health plans that provide retiree coverage to early retirees, and their eligible spouses and dependents.

To receive reinsurance reimbursements, the plan must be certified, in accordance with criteria set forth by the HHS (see below). Once certified, the program reimburses up to 80% of the cost of benefits in excess of $15,000 and below $90,000. The reimbursement must be used to lower plan costs, or to reduce participant premiums, copayments, deductibles, coinsurance, or other out-of-pocket expenses.

The program expires January 1, 2014.

DEFINITIONS

- ***Eligible group health plans*** are those that provide retiree benefits, whether insured or self-funded, sponsored by a private employer, or by a State or local government. The term also includes group health plans sponsored by an employee organization, a VEBA, or a multi-employer plan.

- An ***early retiree*** means a plan participant of the group health plan, who is:
  1. Aged 55 and older;
  2. Not eligible for Medicare; and
  3. Not an active employee of the employer maintaining or contributing to the group health plan. The determination of whether an individual is not an active employee is made by the plan sponsor, in accordance with the terms of its plan.

  The term also includes the enrolled spouse, surviving spouse, and dependents of the early retiree.

REQUIREMENTS FOR PLANS TO PARTICIPATE IN THE PROGRAM

The program commences on June 1, 2010. To be eligible for the program, a group health plan must be certified by the Secretary of HHS, by way of an application process. The actual application is expected to be available by the end of June.

Following is the type of information that will be requested on the application:

1. Applicant's name and address, tax ID number, and contact information.
2. Plan sponsor agreement, signed by the plan's authorized representative, affirming:

- That federal funds are being sought;
- That fraud, waste, and abuse prevention policies and procedures are in place; and,
- If applicable, a written agreement exists with the insurer relating to the disclosure of claims information.

3. A summary of:
   - How reinsurance funds will be used, such as to reduce premium contributions, co-payments, deductibles, coinsurance, or other out-of-pocket costs for plan participants, to reduce health benefit or health benefit premium costs for the plan sponsor, or to reduce any combination of these costs; and
   - The cost containment mechanisms the plan currently has in place, specifically relating to chronic and high cost medical conditions.
4. A 2-year projection of anticipated eligible reimbursements.
5. A list of all benefit options available to early retirees.

Applications will be processed in the order they are received. An applicant need not submit a separate application for each plan year, but must identify the plan year start and end date cycle (starting month and day, and ending month and day) for which it is applying. An applicant must submit an application for each plan for which it will submit a reimbursement request.

AMOUNT OF REIMBURSEMENT

The reinsurance program reimburses up to 80% of a participant's claim that exceeds $15,000 and is less than $90,000 (these threshold amounts will be indexed annually). The intent of the program is to provide some relief for large claims. Reimbursement will be on a per participant basis. The claims of more than one participant cannot be aggregated to reach the threshold numbers.

TIMING OF CLAIMS

The regulations provide that the claims must be incurred on or after June 1, 2010, to be reimbursed; but claims incurred in a plan year beginning before June 1, 2010 and ending after June 1, 2010, can be used to reach the threshold limit of $15,000. For example, a plan with a plan year of July 1, 2009 to June 30, 2010, with an early retiree for which it has spent $120,000 in health benefit claims prior to June 1, 2010, and then spends another $30,000 in health benefit claims on the early retiree between June 1, 2010 and June 30, 2010, the sponsor would receive credit for $15,000 in claims incurred before June 1, and receive reimbursement of 80% of the $30,000 (for the claims incurred after June 1, 2010), or $24,000.

USE OF REIMBURSEMENTS

The reimbursement proceeds can be used to:

1. Reduce the employer's plan cost, including premium, for coverage;
2. Reduce the employee's plan cost, including premium, co-pays, deductibles, co-insurance, or other out of pocket costs, for plan participants; or
3. A combination of 1 and 2.

Reimbursements cannot be used as general revenue for the plan sponsor.

CLAIM REIMBURSEMENT

Claim reimbursement will be based on actual claims. For insured plans, the insurer can submit claim information directly to HHS, since employers generally would not have this information.

WHAT SHOULD AN EMPLOYER DO?

- ❒ Employers interested in making application for the early retiree reinsurance program should begin gathering the data requested in the application. The regulations make it clear that every attempt should be made to file the application correctly the first time. If the application is rejected, the application process starts over. Since the program appears to be a first come/first serve, it is very important to submit the correct, completed application.
- ❒ Identify the plan's cost containment features.
- ❒ Identify projected permissible reimbursements.
- ❒ Contact insurer, if applicable, to determine how claims information can be shared with HHS.

About the Author: Karen R. McLeese is Vice President of Employee Benefit Regulatory Affairs for CBIZ Benefits & Insurance Services, Inc., a division of CBIZ, Inc. She serves as in-house counsel, with particular emphasis on monitoring and interpreting state and federal employee benefits law. Ms. McLeese is based in the CBIZ Leawood, Kansas office.

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Subject: Health Reform's Coverage for Dependent Children Explained
Date: May 10, 2010

The Patient Protection and Affordable Care Act ("PPACA") provides that if an individual or group health plan (whether insured or self-funded) provides coverage for dependents, a dependent child must be allowed to remain on the plan until he/she reaches his/her 26th birthday. This provision in the law takes effect on the first day of the first plan year beginning on or after September 23, 2010 (January 1, 2011 for calendar year plans).

Generally, a dependent includes a legal child, a child placed for adoption, or a foster child. Coverage is available without regard to whether the parent can claim the child as a dependent, and without regard to the child's marital status. The law does not require coverage for a dependent child's spouse, nor for grandchildren.

Interim Final Regulations
On May 10, 2010, the Departments of Treasury, Labor and Health and Human Services issued interim final regulations, together with a Fact Sheet and FAQs, defining dependent eligibility. Of particular note, these regulations require that a 30-day enrollment opportunity must be provided to:

1. Dependents who were not eligible when the parent first became covered under the plan;
2. Dependents who have lost eligibility; and
3. Dependents currently on COBRA, due to loss of eligibility.

Special Enrollment. The HIPAA-required special enrollment provisions apply to dependent children who become newly eligible by virtue of this law. This means that a newly eligible dependent, and his/her parents, have a special enrollment opportunity to enroll in any of the benefit packages offered by the employer.

Notice Requirement. A written notice explaining the special enrollment opportunity, and the 30-day enrollment period, must be provided no later than the first day of the first plan year beginning on or after September 23, 2010. The notice must include a statement that children whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26 are eligible to enroll in the plan or coverage. The notice may be provided to an employee on behalf of the employee's child. In addition, the notice may be included with other enrollment materials that a plan distributes to employees, provided the statement is prominent.

Cost of Coverage. The older-aged dependent cannot be subjected to a surcharge, premium penalty, or any other plan differential, unless such differentials are imposed on all dependents under the plan. The regulations include several examples to illustrate this point:

Example of Permissible Plan Differential:

- A group health plan offers a choice among the following tiers of health coverage: self-only, self-plus-one, self-plus-two, and self-plus-three-or-more. The cost of

coverage increases based on the number of covered individuals. The plan provides dependent coverage of children who have not attained age 26. In this example, the plan does not violate the uniformity requirement relating to variance based by age. Although the cost of coverage increases for tiers with more covered individuals, the increase applies without regard to the age of any child.

Examples of Impermissible Plan Differential:

- A group health plan offers a choice of self-only or family health coverage. Dependent coverage is provided under family health coverage for children of participants who have not attained age 26. The plan imposes an additional premium surcharge for children who are older than age 18.
- A group health plan offers two benefit packages: an HMO option and an indemnity option. Dependent coverage is provided for children of participants who have not attained age 26. The plan limits children who are older than age 18 to the HMO option.

COBRA Matters. A dependent child who is on COBRA due to loss of eligibility can come back on the plan as a newly eligible dependent at the time the plan becomes subject to this provision, or, at such earlier time as the plan so provides. At the point the child again ages off the plan at age 26, or such later date as the plan so provides, an up to 36-month COBRA continuation period will be available.

Grandfathered Plans. For plans in existence on March 23, 2010 ("grandfathered plans"), dependent coverage must be provided up to the child's 26th birthday, unless the child has access to other employer-provided coverage. The regulations clarify that "*other employer coverage*" does not include coverage of another parent's plan. The goal, of course, is to ensure that parent's plan don't engage in a game of hot potato.

Conclusion. Many insurance plans, and some employers sponsoring self-funded plans, are choosing to comply with the expanded dependent definition early. It is very important to work closely with the insurer to ensure compliance with the contract. Also, it is important for insured plans to understand the coordination between state law and federal law; the federal law and state insurance law must be coordinated, so that the participant receives the most generous benefit.

AUTHOR: KAREN R. MCLEESE, ESQ.

About the Author: Karen R. McLeese is Vice President of Employee Benefit Regulatory Affairs for CBIZ Benefits & Insurance Services, Inc., a division of CBIZ, Inc. She serves as in-house counsel, with particular emphasis on monitoring and interpreting state and federal employee benefits law. Ms. McLeese is based in the CBIZ Leawood, Kansas office.

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Subject: The Small Business Health Care Tax Credit
Date: May 20, 2010

Small businesses and tax-exempt employers that provide health care coverage to their employees under a qualified health care arrangement may now qualify for a special tax credit starting this year. Included in the recent health care reform legislation passed in March, the credit is designed to encourage small businesses that employ low and moderate income workers to offer and maintain health insurance coverage for their employees. To qualify for the credit, the employer must have a plan that requires the employer to contribute at least half the cost of participating employees' health insurance premiums. On May 17, 2010, the Internal Revenue Service issued Notice 2010-44, providing additional clarification and guidance for employers regarding the Small Business Tax Credit.

The maximum amount of the credit is 35% of the premiums paid (25% in the case of tax-exempt employers), which is available to employers with 10 or fewer full time equivalent employees with average annual average wages of $25,000 or less. The credit phases out gradually for companies with up to 25 employees and average wages between $25,000 and $50,000.

Eligibility Criteria

In order to qualify, a business must: (a) have no more than 25 full-time equivalent employees ("FTEs") for the tax year, (b) pay average annual wages of less than $50,000 per employee, and (c) provide qualifying coverage. Qualified tax-exempt organizations[1] that meet the foregoing requirements can also qualify for the credit.

1. Full-Time Equivalent Employees

The number of FTEs is determined by dividing (1) the total hours for which an employee is paid during the year (but not more than 2,080 hours per employee) by (2) 2,080. The result, if not a whole number, is then rounded to the next lowest whole number. The number 2,080 is the number of hours in a 52 week work year, assuming 40 hours per week; effectively, overtime hours are not taken into account for determining the number of FTEs. Since the limitation on the number of employees is based on FTEs, an employer with 25 or more employees could qualify for the credit if some of its employees work part-time.

To illustrate, assume that an employer has five employees who work at least 2,080 hours each, three employees who work 1,040 hours each, and one employee who works 2,300 hours. The employer has seven FTEs, calculated as follows:

(1) Total hours: 15,600 which is the sum of:
    a. 10,400 hours for 5 employees paid for 2,080 hours each (5 x 2,080)

[1] IRC §501(c) organizations exempt from tax under IRC §501(a).

b. 3,120 hours for 3 employees paid for 1,040 hours each (3 x 1,040)
c. 2,080 hours for 1 employee paid for 2,300 hours

(2) FTEs: 7 (15,600 divided by 2,080 = 7.5, rounded to the next lowest whole number)

Aggregation Rules: Certain aggregation rules apply to treat multiple companies as one employer for purposes of the credit. Members of a controlled group (*e.g.*, businesses with overlapping ownership, including attribution of ownership from related persons and entities) or an affiliated service group (*e.g.*, related businesses where one performs services for the other) are treated as a single employer for purposes of the credit. In that case, all employees in the group and all wages paid to them are counted in determining whether a member in the controlled or affiliated service group is a qualified employer.

The Secretary of Health and Human Services and the Secretary of Labor are charged with issuing regulations to determine the hours of service of an employee, including how the new law applies to employees who are not compensated on an hourly basis. For example, regulations will be issued to give guidance on whether vacation and sick leave will be considered hours of service for purposes of the credit calculation.

Excluded Individuals: A sole proprietor, a partner in a partnership, a shareholder owning more than two percent of an S corporation, and any owner of more than five percent of other businesses are not considered employees for purposes of the credit. Also excluded are their family members[2] or a member of the business owner's or partner's household. Seasonal employees working for the employer for not more than 120 days during the tax year are likewise excluded. The wages or hours of excluded individuals are not counted in determining either the number of FTEs or the amount of average annual wages, and premiums paid on their behalf are not counted in determining the amount of the credit.

2. Average Annual Wages

The amount of average annual wages is equal to the aggregate amount of wages paid by the employer to employees during the tax year, divided by the number of FTEs during the tax year. The result is then rounded down to the nearest $1,000. For this purpose, only wages as defined for FICA purposes (without regard to the wage base limitation) are counted. As a result, for example, the amounts contributed to a flexible spending account would not be included.

3. Qualifying Coverage

The employer must have a contribution arrangement in place requiring the employer to pay premiums for each employee enrolled in the health care coverage offered by the employer in an amount equal to a uniform percentage, but not less than 50%, of the premium. Any premium paid pursuant to a salary reduction arrangement under a section 125 cafeteria plan is not treated as paid by the employer and is not counted for the 50% requirement.

Moreover, the expenditures used to calculate the credit are capped by the average premium that the employer would have paid for the same arrangement in the state's small group market. For the 2010 taxable year, the average premium for the state's small group market is set forth in Revenue Ruling 2010-13,[3] and the Department of Health and Human Services may provide additional average premium rates for the small group market for areas within some states (sub-state rates). These additional sub-state rates will be published by the IRS and will not be lower than the applicable rate for each state that is set forth in

[2] "Family members" is defined as a child (or descendant of a child); a sibling or step-sibling; a parent (or ancestor of a parent); a step-parent; a niece or nephew; an aunt or uncle; or a son-in-law, daughter- in-law, father-in-law, mother-in-law, brother-in-law or sister-in-law.

[3] A copy of the chart from Revenue Ruling 2010-13, setting forth the average premium for the small group market in each state for the 2010 taxable year, is attached at the end of this Bulletin.

Revenue Ruling 2010-13.

Computing the Credit

For tax years beginning in 2010 through 2013, the maximum credit is 35% of the employer's eligible premium expenses. After 2013, the credit is increased to 50% of eligible premium expenses, but only if the insurance is offered through an Exchange (discussed below). The applicable credit percentage for tax-exempt 501(c) organizations is 25% for 2010 through 2013, and 35% thereafter. Tax-exempt organizations can apply the credit against certain withheld payroll taxes. If an employer qualifies for the credit, it must reduce its deduction for premiums paid by the amount of the credit claimed.

Credit Phaseout

The full amount of the credit will be available to employers with 10 or fewer employees with average annual wages of $25,000 or less. If the number of FTEs exceeds 10, or if average annual wages exceed $25,000, the amount of the credit is reduced (but not below zero) by the sum of the following amounts:

Employees: Applicable credit amount (times) $\frac{\text{No. of FTEs minus 10}}{15}$

Wages: Applicable credit amount (times) $\frac{\text{Average Annual Wages minus \$25,000}}{\$25,000}$

The sum of the two amounts is subtracted from the otherwise applicable credit to determine the credit to which the employer is entitled. The formula results in a reduction of the credit by 6.667% for each FTE in excess of 10, and 4% for each $1,000 of wages in excess of $25,000. The following table shows how the credit percentage phases out as the number of FTEs increases from 10 to 25 and as average compensation increases from $25,000 to $50,000 in the case of for-profit firms in 2010-2013.

	Average Wage					
FTEs	**≤ $25,000**	**$30,000**	**$35,000**	**$40,000**	**$45,000**	**$50,000**
Up to 10	35%	28%	21%	14%	7%	0%
11	33%	26%	19%	12%	5%	0%
12	30%	23%	16%	9%	2%	0%
13	28%	21%	14%	7%	0%	0%
14	26%	19%	12%	5%	0%	0%
15	23%	16%	9%	2%	0%	0%
16	21%	14%	7%	0%	0%	0%
17	19%	12%	5%	0%	0%	0%
18	16%	9%	2%	0%	0%	0%
19	14%	7%	0%	0%	0%	0%
20	12%	5%	0%	0%	0%	0%
21	9%	2%	0%	0%	0%	0%
22	7%	0%	0%	0%	0%	0%
23	5%	0%	0%	0%	0%	0%
24	2%	0%	0%	0%	0%	0%
25	0%	0%	0%	0%	0%	0%

Claiming the Credit

The credit is claimed on the employer's annual income tax return. It is part of the general business credit and may only be claimed if the taxpayer has taxable income. The credit applies to offset both regular

income tax liability and alternative minimum tax liability, and any unused credit can generally be carried back one year and carried forward 20 years. Because an unused credit cannot be carried back to a year before the effective date of the credit, any unused credit for 2010 can only be carried forward. The credit can be reflected in determining estimated tax payments for the year to which the credit applies in accordance with regular estimated tax rules. Furthermore, for-profit entities can only use the credit against income tax and not employment taxes, so the employer may not reduce withheld income tax, social security tax, or Medicare tax in anticipation of the credit.

Special Rules for Tax-Exempt Employers: The IRS will provide further guidelines on how tax-exempt employers can claim the credit. Generally, however, the credit is a refundable credit for tax-exempt employers, so that even if the employer has no taxable income, the employer may receive a refund so long as it does not exceed the income tax withholding and Medicare tax the employer is required to withhold from employees' wages for the year and the employer share of Medicare tax on employees' wages.

Transition Provisions Beginning in 2010

The IRS and Treasury will be issuing guidance on how the following transition relief applies with respect to the requirements for a qualifying arrangement:

(1) An employer with a nonelective contribution arrangement, whereby it pays at least 50% of the premium for each employee enrolled in coverage, will still be eligible for the credit, although the employer does not pay a uniform percentage of the premium.

(2) The requirement that the employer pay at least 50% of the premium for an employee applies to the premium for single (employee-only) coverage for the employee. Even if an employee's actual coverage is more expensive than single coverage (such as family or self-plus-one coverage), the employer satisfies the 50% requirement if it pays at least 50% of the premium cost for single coverage for that employee.

Tax Years Beginning in 2014

For tax years after 2013, an employer must offer coverage through an insurance Exchange in order to claim the credit, and may only claim the credit for two additional consecutive tax years. Each state is required to establish by January 1, 2014 an American Health Benefit Exchange and Small Business Health Options Program (SHOP Exchange) to provide qualified individuals and small business employers access to qualified health plans. The IRS has been granted authority to issue regulations to prevent the use of successor entities to avoid the two-year limitation on the credit period for the tax years beginning after 2013, and to prevent the use of multiple entities to avoid the credit phaseout rules based on the number of employees and average wages.

Conclusion

The Small Business Tax Credit can provide a great benefit to qualifying employers offering health coverage to their employees. As discussed above, however, determining whether your company qualifies, and if so, the value of your actual benefits, will be no easy task. If you think your business may qualify, contact your CBIZ tax, benefits and insurance, or payroll tax professional soon to get a better idea of exactly how the credit will help you.

Average Premium for the Small Group Market in each State for 2010		
State	Employee-only Coverage	Family Coverage
Alaska	6,204	13,723
Alabama	4,441	11,275
Arkansas	4,329	9,677
Arizona	4,495	10,239
California	4,628	10,957
Colorado	4,972	11,437
Connecticut	5,419	13,484
District of Columbia	5,355	12,823
Delaware	5,602	12,513
Florida	5,161	12,453
Georgia	4,612	10,598
Hawaii	4,228	10,508
Iowa	4,652	10,503
Idaho	4,215	9,365
Illinois	5,198	12,309
Indiana	4,775	11,222
Kansas	4,603	11,462
Kentucky	4,287	10,434
Louisiana	4,829	11,074
Massachusetts	5,700	14,138
Maryland	4,837	11,939
Maine	5,215	11,887
Michigan	5,098	12,364
Minnesota	4,704	11,938
Missouri	4,663	10,681
Mississippi	4,533	10,501
Montana	4,772	10,212
North Carolina	4,920	11,583
North Dakota	4,469	10,506
Nebraska	4,715	11,169
New Hampshire	5,519	13,624
New Jersey	5,607	13,521
New Mexico	4,754	11,404
Nevada	4,553	10,297
New York	5,442	12,867
Ohio	4,667	11,293
Oklahoma	4,838	11,002
Oregon	4,681	10,890
Pennsylvania	5,039	12,471
Rhode Island	5,887	13,786
South Carolina	4,899	11,780
South Dakota	4,497	11,483
Tennessee	4,611	10,369
Texas	5,140	11,972
Utah	4,238	10,935
Virginia	4,890	11,338
Vermont	5,244	11,748
Washington	4,543	10,725
Wisconsin	5,222	12,819
West Virginia	4,986	11,611
Wyoming	5,266	12,163

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Date: June 11, 2010
Subject: Early Retiree Subsidy – Initial Application Date is Approaching

As part of the Affordable Care and Patient Protection Act of 2010, an Early Retiree Reinsurance Program has been established. This temporary program, established by way of the health care reform laws, provides reimbursement of certain expenses to plan sponsors of group health plans that provide retiree coverage to early retirees, and their eligible spouses and dependents. While the Department of Health and Human Services set June 1, 2010, as the new effective date of this program, much is still needed to do in order to qualify for this reinsurance subsidy. It is important to pursue this quickly if you are interested, as only $5 billion of funds are allocated to this program. More questions still remain at this point, including the extent to which the employer may benefit from receiving a subsidy. The clear intent of this program is to have employers pass along the benefits to early retirees currently included in their group plan. The benefits could occur in the form of reduced contributions for coverage, lower deductibles, lower copayments and other forms of subsidies.

The comment period ended June 4th, and according to information posted on the HHS' Office of Consumer Information and Insurance Oversight website, HHS has indicated that the draft application is to remain in its current form, except for adding the date that the initial application must be made, and the location for the application's submission (see FAQ below):

From HHS OCIIO's Early Retiree Reinsurance Program Application FAQs:

> ***4. Where should I send the application for the Early Retiree Reinsurance Program once it is completed?***
> ANSWER: The U.S. Department of Health & Human Services wanted to publish a copy of the application as soon as possible to assist potential applicants in better understanding how to prepare an application, and to give applicants time to assemble information required in the application. As such, the Draft Application is available now. The Official Application will be posted later in June with the only anticipated change being the addition of an address where the Official Application can be sent. Information about how and where to send completed applications, and when sponsors can begin submitting applications, will also be posted on this webpage later in June.

The draft (and possibly final) application is available on the HHS website and can be viewed here. Instructions for completing the application are also available and can be viewed here.

A prior communication, provided a preliminary list of information that would be required to include in the application. According to the Draft Application, following are required items to be submitted to HHS:

Detailed plan information, including:

- Benefit options provided under the plan; and
- Programs and procedures for chronic and high-cost conditions

1. Projected/estimated amount of Early Retiree Reinsurance Program Reimbursements
2. Description of the intended use of the Program Reimbursements
3. Banking Information for Electronic Funds Transfer
4. Plan Sponsor Agreement of the following:
    - Attestation of compliance with the program requirements, including conditions for submission of data for obtaining reimbursement and record retention requirements.
    - Acknowledgement of reimbursement-related and other representations made by designees, if applicable.
    - Certification of an executed written agreement between the plan sponsor and its health insurer or plan regarding disclosure of information, data, documents, and records to HHS, that are necessary for the Plan Sponsor to comply with the requirements of the Program.
    - Acknowledgement by the Plan Sponsor on the use of data, records and related information collected under the Program necessary to determine reimbursements.
    - Acknowledgement that information provided by plan sponsor and any subcontractor, is to obtain federal funds.
    - Agreement by plan sponsor to establish and implement proper safeguards against unauthorized use and disclosure of the data exchanged pursuant to the application, in accordance with HIPAA.
    - Authorization for the Secretary of HHS to initiate reimbursement, credit entries and other adjustments, including offsets and requests for reimbursement to an appointed financial institution.
    - Attestation that, as of the date this Application is submitted, the Plan Sponsor has policies and procedures in place to detect and reduce fraud, waste, and abuse related to the Program.
    - Agreement to provide written 60-day prior notice of any change in ownership.

The final version of the application is expected to be released in the next few weeks.

If you have questions about the above or about other aspects of Health Care Reform, please go to www.cbiz.com/healthquestion and complete our Ask the Expert form.

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Subject: **GRANDFATHERED HEALTH PLAN RULES**

Date: June 17, 2010

One of President Obama's health care reform commitments has been, "*If you like your health coverage, you can keep it.*" The "grandfathered" health plan rules, contained in the Patient Protection and Affordable Care Act (PPACA), are ostensibly the mechanism for accomplishing this.

On June 14, 2010, the Departments of HHS, Labor, and Treasury ("Departments") issued interim final regulations, a Fact Sheet, and FAQs, that further define grandfathered health plans, in both the group and individual market.

What are Grandfathered Group Health Plans?

The primary intent of preserving the grandfathered status of a group health plan is to provide the ability to maintain existing coverage. To be grandfathered, an insured or self-funded group health plan must have been in existence on March 23, 2010, and it must cover at least one individual. Certain provisions of the PPACA do not apply to grandfathered health plans (see chart below). For a more detailed table of provisions applicable to grandfathered health plans, see the Department of Labor's *Table on Applicability of Provisions to Grandfathered Plans*.

EFFECT OF PPACA PROVISIONS ON GRANDFATHERED HEALTH PLANS	
Applicable	***Not Applicable***
❒ Ban on preexisting condition exclusions for children under age 19 (applies to anyone beginning 1/1/14) ❒ Ban on discrimination based on health status ❒ Ban on excessive waiting periods ❒ Ban on lifetime or annual limits ❒ Ban on rescissions ❒ Extension of dependent coverage until age 26 (but before 2014 plan years, only if the adult child is not eligible for other employer-sponsored health plan coverage) ❒ Development and utilization of uniform explanation of coverage documents and standardized definitions ❒ Bringing down cost of health care coverage (for insured coverage)	❒ Coverage for preventive health services ❒ Independent appeals process ❒ Ban on discrimination based on salary ❒ Choice of primary care provider ❒ Coverage of clinical trials

The grandfathered group health plan rules, and generally, the insurance provisions of the health reform law, *do not apply* to:

- Retiree-only plans, those plans covering no active employees;
- Stand-alone dental or vision plans; and
- Most flexible medical spending accounts.

The regulations make it clear that grandfathered status is determined on a benefit package-by-benefit package basis. Therefore, an employer can have some plans that are grandfathered, and others that are not.

What Causes a Group Health Plan to Lose Grandfathered Status?

The regulations provide guidance on what would, or would not cause a plan to lose grandfathered status. Grandfathered health plans are permitted to make routine changes to their plan design in order to keep their status, including:

- Adding new dependents or employees at open enrollment or special enrollment events;
- Imposing cost adjustments to keep pace with medical inflation;
- Adding new benefits;
- Making modest adjustments to existing benefits;
- Voluntarily adopting new consumer protections under the new law, or
- Making changes to comply with State or other Federal laws.

Plans will lose their grandfathered status if they choose to make significant changes that reduce benefits, or increase costs. The types of changes that could cause a group health plan to lose grandfathered status include:

1. **Eliminating all, or substantially all, benefits to diagnose or treat a particular condition**. For example, if a plan provides benefits for a particular mental health condition, the treatment for which is a combination of counseling and prescription drugs, and the plan subsequently eliminates benefits for counseling.

2. **Increase in percentage of a cost-sharing requirement**, such as coinsurance, above the level at which it was on March 23, 2010. For example, amending the plan on or after March 23, 2010 to increase a coinsurance amount from 20% to 25% for inpatient surgery.

3. **Increase of a fixed-amount cost-sharing requirement**, other than co-pays, such as a $500 deductible, or a $2,500 out-of-pocket limit, by a total percentage measured from March 23, 2010, that is more than the sum of medical inflation and 15 percentage points.

4. **Increase in co-pays** by an amount that exceed the greater of:
   - A total percentage, measured from March 23, 2010, that is more than the sum of medical inflation, plus 15 percentage points, or
   - $5 increased by medical inflation measured from March 23, 2010.

   Examples:
   - Amending the plan on or after March 23, 2010 to increase co-pays from $30 per office visit for specialists to $40. Based on the greatest value of the overall medical care component of the CPI-U, this would not cause the plan to lose grandfathered status. However, increasing the co-pay from $30 to $45 effective for a later plan year could cause a plan to lose grandfathered status because the increased amount would exceed the medical inflation amount.
   - Amending the plan on or after March 23, 2010 to increase the co-pay from $10 per office visit for primary care providers to $15. The $5 increase would not cause the plan to lose grandfathered status because the $5 amount is less than the medical inflation amount.

5. **Decrease in contribution rate by employer or employee organization** based on a percentage or formula towards the cost of any tier of coverage for any class of similarly situated individuals by more than five points below the contribution rate on March 23, 2010. *Example:* As of March 23, 2010, a self-insured group health plan provides two tiers of coverage: self-only and family. The employer contributes 80% of the total cost of coverage for self-only, and 60% of the total cost of coverage for family. Subsequently, the employer reduces the contribution to 50% for family coverage, but keeps the same contribution rate for self-only coverage. In this example, the decrease of 10 percentage points for family coverage in the contribution rate based on cost of coverage causes the plan to cease to be a grandfathered health plan. The fact that the contribution rate for self-only coverage remains the same does not change the result.

6. **Change in annual limits** by group health plans in existence on March 23, 2010, such as:
   - Addition of an annual limit on the dollar value of benefits;
   - Decrease in limit for a plan with only a lifetime limit; or
   - Decrease in limit for a plan with an annual limit.

7. **Changing Insurance Companies.** If an employer decides to buy insurance for its workers from a different insurance company, the new plan would not be considered a grandfathered plan. but for a self-funded plan, this does not include changing plan administrators.

Factors not specifically included in the list of restrictions include:
- ❒ Changing premium;
- ❒ Changing plan structure, such as from major medical to health reimbursement account;
- ❒ Changing funding mechanism, such as from insured to self-funded;
- ❒ Changing provider networks; or
- ❒ Changing drug formularies.

The Departments have requested comments on these factors, and ultimately, these issues may be addressed in future guidance.

Transitional Rules

The regulations provide some transitional relief for plan changes contemplated, but not adopted prior to March 23, 2010; specifically, a plan will not lose grandfathered status if changes are pursuant to:
- ➢ A legally binding contract entered into on or before March 23, 2010;
- ➢ A filing on or before March 23, 2010 with a State insurance department; or
- ➢ A written amendment to a plan that was adopted on or before March 23, 2010.

Special transitional rules apply when changes are adopted by a plan between PPACA's enactment date and prior to issuance of the regulations.

Specifically, these regulations provide employers and insurers with a grace period within which to revoke or modify any changes adopted prior to publication of the regulations (June 17, 2010) where the changes might otherwise cause the plan to lose grandfathered status. Under this rule, grandfather status would be preserved if the changes are revoked, and the plan or coverage is modified, effective as of the first day of the first plan or policy year beginning on or after September 23, 2010.

Collective Bargaining Agreements
Insured plans subject to collective bargaining agreements (CBA) ratified before March 23, 2010 will be treated like any other grandfathered plan once the CBA expires. What this means is that all grandfathered CBA plans must comply with the market reforms applicable to non-CBA grandfathered plans without a delayed effective date.

New Recordkeeping and Disclosure Requirements
The regulations impose new recordkeeping and disclosure requirements:

Recordkeeping Requirement
To preserve the status as a grandfathered health plan, plan sponsors are required to:

1. Maintain records documenting the terms of the plan or insurance coverage in connection with the coverage in effect on March 23, 2010, and any other documents necessary to verify, explain, or clarify its status as a grandfathered health plan; and
2. Make such records available for examination by the Departments and participants, upon request.

Disclosure Requirement
Grandfathered health plans are required to include a statement in any plan materials provided to participant and beneficiaries describing the benefit provided under the plan, and that the plan is intended to maintain its grandfathered status. The regulations provide model language that can be used to satisfy this disclosure requirement:

> *This [group health plan or health insurance issuer] believes this [plan or coverage] is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your [plan or policy] may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.*
>
> *Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at [insert contact information].*
>
> *[For ERISA plans, insert:*
> *You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.]*
>
> *[For individual market policies and nonfederal governmental plans, insert:*
> *You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.]*

Effective Date
These interim final regulations become effective on June 17, 2010. Comments on these regulations may be submitted to the Departments within 60 days of the effective date (August 16, 2010).

Enforcement

For purposes of enforcement, the Agencies indicate that they will take into account good faith efforts to comply with the requirements imposed under these rules, and may disregard changes to plans that only modestly exceed those changes described in the regulations.

What Should An Employer Do?

An employer/plan sponsor must weigh the benefits of retaining grandfathered status; thus, being relieved of certain plan changes, as described above, versus the flexibility that derives from being able to make plan changes. In determining how important it is to preserve grandfather health status, employers will want to consider what it gains or loses by virtue of implementing changes. Employer/plan sponsors can decide to:

1. Continue offering the plan or coverage in effect on March 23, 2010, with limited changes, and thereby retain grandfather status; or
2. Significantly change the terms of the plan and comply with the PPACA provisions from which grandfathered health plans are excepted.

AUTHOR: KAREN R. MCLEESE, ESQ.

About the Author: Karen R. McLeese is Vice President of Employee Benefit Regulatory Affairs for CBIZ Benefits & Insurance Services, Inc., a division of CBIZ, Inc. She serves as in-house counsel, with particular emphasis on monitoring and interpreting state and federal employee benefits law. Ms. McLeese is based in the CBIZ Leawood, Kansas office.

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Subject: Patient's Bill of Rights
Date: June 23, 2010

On June 22, 2010, the Departments of Health and Human Services, Labor and Treasury ("Agencies") issued another round of interim final regulations, implementing certain aspects of the health care reform law. The regulations, curiously known as the "Patient's Bill of Rights," address such matters as the ban on annual and lifetime limits, preexisting condition exclusions, and rescissions, as well as some consumer protections, such as choice of primary care provider and emergency room access. Following are highlights from these regulations.

Ban on Annual and Lifetime Limits
Generally, both grandfathered and non-grandfathered plans will no longer be able to impose annual and lifetime limits on essential benefits. The regulations confirm that it is permissible for plans to impose limitations on non-essential benefits. "*Essential benefits*" has not yet been fully defined; but would include certain coverage for specific categories of benefits, meet certain cost-sharing requirements, and provide a certain level of benefits as provided in a "typical employer-sponsored plan."

The regulations set out a transition period for annual limits. From now until January 1, 2014, the following schedule applies to annual limits on the dollar value of benefits:

- $750,000 for plan years between 9/23/2010 and 9/23/2011;
- $1,250,000 for plan years between 9/23/2011 and 9/23/2012; and
- $2,000,000 for plan years between 9/23/2012 and 1/1/2014.

The regulations set out several examples explaining how the annual limits (phase-in) can be satisfied. Of particular note, the regulations provide that if a grandfathered group health plan currently provides a higher limit, for example, in the plan year beginning between 9/23/2010 and 9/23/2011 that is greater than $750,000, and subsequently lowers the limit, the grandfathered health plan status may be lost.

There is indication in the preamble that temporary relief from the annual limitation restrictions will be made available for limited medical plans ("mini-med" plans). The process for applying for such relief has not yet been established. The suggestion in the regulations, though, is that beginning in 2014, the "no annual limit" will apply, without regard to the nature of the plan. This question remains open to future guidance.

Special Enrollment Period for Individuals Whose Coverage is Dropped
For individuals whose coverage has dropped due to reaching the plan's lifetime limit, a special enrollment opportunity must be made available. The affected individual must be allowed to enroll in any of the benefit packages offered by the employer, as long as he/she meets the eligibility criteria. This enrollment period must be for a minimum of 30 days.

The individual must be given notice of the open enrollment opportunity; such notice may be included with other enrollment materials that a plan distributes to employees, provided the statement is prominent. The notice and enrollment opportunity must be provided beginning no later than the first day of the first plan year beginning on or after September 23, 2010; coverage must take effect no later than the first day of the first plan year beginning on or after September 23, 2010.

Applicability and Effective Date

These rules apply to both grandfathered and non-grandfathered health plans. The rules do not apply to account-based plans, such as flexible medical spending arrangements, health savings accounts, medical savings account, or health reimbursement arrangements that are part of a comprehensive group health plan.

These provisions become effective for plan years beginning on or after September 23, 2010; this means January 1, 2011 for calendar year plans.

Ban on Preexisting Condition Exclusions

For plan years beginning on or after September 23, 2010, a preexisting condition exclusion (PCE) cannot be imposed upon children under the age of 19. For plan years beginning on or after January 1, 2014, PCEs cannot be imposed on anyone.

This provision applies to all individual policies, as well as to grandfathered and non-grandfathered group health plans. Plan exclusions can still be imposed; however, the imposition of a new exclusion may cause a plan to lose grandfathered status.

Ban on Plan Rescission

Effective for plan years beginning on or after September 23, 2010, except for fraud or intentional misrepresentation, grandfathered and non-grandfathered plans can no longer rescind coverage due to unintentional or inadvertent errors.

The term, "*rescission*" refers to a cancellation or discontinuance of coverage that has retroactive effect. For example, a cancellation that treats a policy as void from the time of the individual's or group's enrollment, or a cancellation that voids benefits paid up to a year before the cancellation. A cancellation or discontinuance of coverage is not a rescission if the cancellation or discontinuance of coverage has a prospective effect; or is effective retroactively, due to failure to timely pay required premiums or contributions towards the cost of coverage.

The regulations include several examples. Of particular note, the regulations explain that if an individual moves from an eligible class (full-time employee) to an ineligible class (part-time status) but is inadvertently left on the plan, the insurer cannot rescind coverage, assuming the error was inadvertent.

Plans must provide at least 30 days advance written notice to each participant who would be affected before coverage may be rescinded.

Patient Protections

Choice of Health Care Provider

The law requires that if a plan requires designation of a primary care provider (PCP), a participant must be allowed to designate a participating in-network PCP, who is available to accept him/her. The regulations provide that pediatricians can be designated as a child's PCP.

Direct Access to OB/GYN Services

Plans must provide direct access to OB/GYN providers, without prior authorization or a referral from the individual's PCP. Plans may require the OB/GYN provider to agree or adhere to the plan's policies and procedures relating to referrals, obtaining prior authorization, and providing services, pursuant to a treatment plan.

Model Notice of the Right to Designate Providers and Right of Access to OB/GYN Services

If a plan requires designation of a PCP, the plan must notify participants of their rights to designate a pediatrician as their PCP, if they choose to do so. The following model language can be used to satisfy the notice requirement:

> *[Name of group health plan or health insurance issuer] generally [requires/allows] the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. [If the plan or health insurance coverage designates a primary care provider automatically, insert: Until you make this designation, [name of group health plan or health insurance issuer] designates one for you.] For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the [plan administrator or issuer] at [insert contact information].*

For designation of a pediatrician as a PCP, add the following language to the model notice above:

> *For children, you may designate a pediatrician as the primary care provider.*

For plans that provide coverage for OB/GYN services, add the following language to the model notice above:

> *You do not need prior authorization from [name of group health plan or issuer] or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the [plan administrator or issuer] at [insert contact information].*

Access to Emergency Room Services

If a group health plan provides coverage for services rendered in a hospital emergency room, then the plan must also cover emergency services without the need for any prior authorization determination, even if the emergency services are provided on an out-of-network basis, and without regard to whether the health care provider furnishing the emergency services is a participating network provider.

If the emergency services are provided out of network, plans cannot impose any administrative requirement, or limitation on coverage, that is more restrictive than the requirements or limitations that apply to in-network emergency services received from in-network providers. Any cost-sharing requirement, such as co-pays or coinsurance, imposed for out-of-network emergency services cannot be greater than any cost-sharing requirements imposed for in-network emergency services. However, the individual may be required to pay, in addition to the in-network cost sharing, the excess of the amount the out-of-network provider charges over the amount the plan is required to pay. Other out-of-network cost sharing, such as deductibles or out-of-pocket limits, may apply.

Applicability and Effective Date

The right to designate a primary care physician, and the right to access OB/GYN and emergency room services, applies to non-grandfathered group health plans. These provisions become effective for plan years beginning on or after September 23, 2010; this means January 1, 2011 for calendar year plans.

These regulations have been issued as interim final regulations. There is a comment period of 60 days, expected to close around August 27, 2010. Based on comments received, these regulations could be later modified.

AUTHOR: KAREN R. MCLEESE, ESQ.

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Subject: Early Retiree Reinsurance Program Application Process Opened
Date: June 29, 2010

Today, the Department of Health and Human Services officially opened the Early Retiree Reinsurance Program (ERRP) application process, and will begin accepting ERRP applications immediately. For information relating to ERRP, please refer to prior CBIZ Health Reform Bulletins: *Early Retiree Subsidy – Initial Application Date is Approaching* and *Early Retiree Reinsurance Program*.

The Official Application, Instructions, Dos and Don'ts and a Fact Sheet are available from the HHS' Office of Consumer Information and Insurance Oversight (OCIIO) website: http://www.hhs.gov/ociio/regulations/index.html#early_retiree.

HHS will only accept applications submitted on its official application form; the earlier draft version of the application cannot be used. It is very important to complete every required field of the application; incomplete applications will not be accepted. The address to which the signed original ERRP Application, plus Attachments (if any), in hard copy, is to be sent is:

HHS ERRP Application Center
4700 Corridor Place
Suite D
Beltsville, MD 20705

Important note: Do not include birth dates and Social Security Numbers where requested in the Application. This information will be completed through a secure website, once the application is accepted.

The OCIIO will also be holding training events relating to the ERRP, to be announced on its website.

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Subject: New Model Notices Issued
Date: July 12, 2010

In response to several notice requirements contained in recently issued regulations implementing the new health reform law, the DOL's Employee Benefit Security Administration (EBSA) issued four new model notices, as follows:

Extension of Dependent Coverage to Age 26
Dependents who age off a group health plan must be given a special enrollment opportunity of 30 days (see CBIZ Health Reform Bulletin*: Health Reform's Coverage for Dependent Children Explained*). The 30-day enrollment opportunity must be provided to:

1. Dependents who were not eligible when the parent first became covered under the plan;
2. Dependents who have lost eligibility; and
3. Dependents currently on COBRA, due to loss of eligibility.

Dependent children who become newly eligible by virtue of this law must be given a special enrollment opportunity to enroll in any of the benefit packages offered by the employer.

Notice Requirement. A written notice explaining the special enrollment opportunity, and the 30-day enrollment period, must be provided no later than the first day of the first plan year beginning on or after September 23, 2010. The notice must include a statement that children whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26 are eligible to enroll in the plan or coverage. The notice may be provided to an employee on behalf of the employee's child. In addition, the notice may be included with other enrollment materials that a plan distributes to employees, provided the statement is prominent. Enrollment must be effective as of the first day of the first plan year beginning on or after September 23, 2010.

Model Notice: Click here for *Model Language for Notice of Opportunity to Enroll in connection with Extension of Dependent Coverage to Age 26*

Lifetime Limits
Group health plans are required to provide written notice to individuals when the lifetime limit on the dollar value of all benefits is no longer applicable, and that an individual, if covered, is once again eligible for benefits under the plan. For individuals whose coverage has dropped due to reaching the plan's lifetime limit, a special enrollment opportunity must be made available (see CBIZ Health Reform Bulletin: *Patient's Bill of Rights*).

The affected individual must be allowed to enroll in any of the benefit packages offered by the employer, as long as he/she meets the eligibility criteria. This enrollment period must be for a minimum of 30 days.

The individual must be given notice of the open enrollment opportunity; such notice may be included with other enrollment materials that a plan distributes to employees, provided the statement is prominent. The notice and enrollment opportunity must be provided beginning no later than the first day of the first plan year beginning on or after September 23, 2010; coverage must take effect no later than the first day of the first plan year beginning on or after September 23, 2010.

Model Notice. Click here for *Model Language Notice: Lifetime Limit No Longer Applies and Enrollment Opportunity*

Patient Protections: Choice of PCP and Access to OB/GYN Services

- ***Choice of Health Care Provider.*** The law requires that if a plan requires designation of a primary care provider (PCP), a participant must be allowed to designate a participating in-network PCP or pediatrician, who is available to accept him/her.
- ***Direct Access to OB/GYN Services.*** Plans must provide direct access to OB/GYN providers, without prior authorization or a referral from the individual's PCP.

Model Notice: ***Right to Designate Providers and Right of Access to OB/GYN Services.***
The notice must be provided whenever the plan provides a participant with a summary plan description, or other similar description of benefits under the plan. This notice must be provided no later than the first day of the first plan year beginning on or after September 23, 2010. Click here for model notice: *Patient Protection Model Notice*

Background: CBIZ Health Reform Bulletin: Patient's Bill of Rights

Grandfathered Health Plans
Grandfathered health plans must provide a notice to covered individuals, as a condition of maintaining grandfathered status, explaining what this means (see *CBIZ Health Reform Bulletin: Grandfathered Health Plan Rules*). Such notice may be included in any plan materials provided to participants and beneficiaries, and must include the plan's contact information for questions and complaints.

Model Notice: Click here for *Model Language – Grandfathered Health Plans*

About the Author: Karen R. McLeese is Vice President of Employee Benefit Regulatory Affairs for CBIZ Benefits & Insurance Services, Inc., a division of CBIZ, Inc. She serves as in-house counsel, with particular emphasis on monitoring and interpreting state and federal employee benefits law. Ms. McLeese is based in the CBIZ Leawood, Kansas office.

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CBIZ
Health Reform Bulletin

Subject: Preventive Health Services
Date: July 15, 2010

On July 14, 2010, the Departments of HHS, Labor, and Treasury issued interim final regulations relating to the preventive care provisions of the health reform law (PPACA). These rules require health plans to cover certain preventive services, without imposing any cost-sharing requirements (co-pay, co-insurance, or deductible), when such services are delivered by in-network providers.

These regulations apply to plans on the first day of the first plan year beginning on or after September 23, 2010. The rules apply to non-grandfathered plans, and plans that lose grandfathered status.

Types of Covered Preventive Services
Of particular note, the regulations include a list of the kinds of preventive services that must be provided. The list includes specific covered preventive services for adults, women, including pregnant women, and children, and will be updated periodically. Preventive services include those recommended by:

- The U. S. Preventive Services Task Force;
- The Advisory Committee on Immunization Practices adopted by the Director of the Centers for Disease Control and Prevention; and
- Comprehensive Guidelines Supported by the Health Resources and Services Administration:
  - Periodicity Schedule of the Bright Futures Recommendations for Pediatric Preventive Health Care; and
  - Uniform Panel of the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children.

Services Provided Out-of-Network. The regulations clarify that preventive services provided by an out-of-network provider can be subject to cost-sharing. The regulations also address the preventive care rules as they relate to office visits. In a nutshell, if the preventative service and office visit are charged separately, a cost share can be imposed on the office visit, if appropriate; but not on the preventive service.

Conversely, if the office visit and preventive services are charged together, whether a cost share can be imposed depends on the primary purpose of the office visit. If the primary purpose of the office visit is preventive services, no cost share can be imposed.

Also note a plan may require coverage of preventive services not included in the list of preventive services. As always, the terms of the plan govern, as long as they are compliant with the law.

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Subject: Internal Claims and Appeals, and External Review Process
Date: July 26, 2010

On July 23, 2010, the Departments of HHS, Labor, and Treasury issued interim final regulations relating to the internal claims and appeal, and external review process provisions of the health reform law (PPACA). These rules provide for both a standardized internal process, as well as an external process, that individuals can use to appeal decisions made by their health plan.

These regulations apply to plans on the first day of the first plan year beginning on or after September 23, 2010. The rules apply to non-grandfathered plans, and plans that lose grandfathered status.

Internal Claims and Appeals Process
In general, insured and self-funded group health plans, subject to ERISA, have been required to comply with a structured claims and appeals process, as set forth by the Department of Labor. The new interim rules extend these rules to plans exempt from ERISA, and add the following six requirements:

1. ***Clarification of Adverse Determinations.*** The regulations broaden the definition of an 'adverse benefit determination' to include a rescission of coverage. An adverse benefit determination is eligible for an internal claims and appeals process when there is a benefit denial, reduction, or termination, or a failure to make payment for a benefit, when based on:
    - Eligibility;
    - A non-covered benefit;
    - A preexisting condition exclusion, source-of-injury exclusion, network exclusion, or other limitation; or
    - A benefit that is experimental, investigational, or not medically necessary or appropriate.
2. ***Expedited Notification of Urgent Care Claims***. These rules require urgent care matters to be addressed as soon as possible, but, in no event, longer than 24 hours.
3. ***Full and fair review***. Claimants must be allowed to review their claim file, and to present evidence and testimony as part of the internal claims and appeals process. Plans must provide the claimant, free of charge, with any new or additional evidence relied upon, or generated by the plan, as well as the rationale used to make the determination.
4. ***Avoiding conflicts of interest.*** The rules specify standards that must be satisfied to avoid a conflict of interest between all parties involved in the claims and appeals process.

5. ***Notice of Adverse Determinations***. Plans must provide its notice of adverse determination in a culturally and linguistically appropriate manner (see *Disclosure and Notices*, below). What this means is that plans must ensure that the adverse determination notice provided to a claimant includes:
    - Information sufficient to identify the claim involved;
    - The reason/rationale for the adverse benefit determination;
    - A description of any available internal or external review process; and
    - Contact information for any consumer assistance or ombudsman office to assist individuals with their claim review.
6. ***Deemed exhaustion of internal claims and appeals processes***. If a plan fails to follow the explicit requirements of the law, a claimant will have the right to proceed to the next level of appeal.

External Review Process
In the event of an adverse determination, an individual will have the right to appeal to an independent third party through an external appeal process. Currently, many states have external appeals processes in place. States will be given one year to bring their processes into compliance with this law. States that do not currently offer an external review will have the right to adopt compliant procedures.

In the event that a state does not require insurers to follow an external review process, a federal external review procedure will be required. The federal procedure will also govern self-funded plans exempt from state law and subject to ERISA.

Continuance of Benefits during an Internal or External Claim Review
Plans are required to continue coverage pending the outcome of an appeal. Benefits for an ongoing course of treatment cannot be reduced or terminated without providing advance notice, and an opportunity for advance review.

Disclosure and Notices
Both the internal and external review processes must be described in the summary plan description, or other description of coverage.

Model claim and appeal notices will be developed by the DOL. These notices must be provided in a '*culturally and linguistically appropriate manner'*, depending on the number and majority language of the participants:

- For plans covering fewer than 100 participants at the beginning of a plan year, the insurer/plan must provide notices upon request in a non-English language in which 25% or more of all plan participants are literate only in the same non-English language; or
- For a plan that covers 100 or more participants at the beginning of a plan year, the insurer/plan must provide notices upon request in a non-English language in which the lesser of 500 or more participants, or 10% or more of all plan participants, are literate only in the same non-English language.

In any English versions of notice required to be provided, a plan must also include a statement, in non-English, that its notices can be obtained in the non-English language. Once a request has been made by a claimant, the plan must provide all subsequent notices to the claimant in the non-English language. To the extent the insurer/plan maintains a customer assistance process, such as a telephone hotline, that answers questions or provides assistance with filing claims and appeals, the insurer/plan must provide such assistance in the non-English language.

Additional information:

- EBSA Fact Sheet: *The Affordable Care Act: Protecting Consumers and Putting Patients Back in Charge of Their Care*
- NAIC's *Uniform Health Carrier External Review Model Act*

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Subject: **Expanded 1099 Reporting Requirements for 2012 and Call for Public Comment**

Date: **August 3, 2010**

Beginning in 2012, payments of $600 or more in any taxable year for goods as well as services, and made to any person or entity, including corporations, will be subject to Form 1099 reporting. The new reporting requirements were introduced as part of the health care reform legislation enacted on March 23, 2010, which amends Section 6041 of the Internal Revenue Code (the "Code"). Prior to the amendment, Section 6041 required information returns to be filed by every person engaged in a trade or business who makes payments to another person of rent, salaries, wages and other enumerated amounts that total $600 or more in a taxable year. The amendment significantly expands this reporting requirement to include payments "of amounts in consideration for property" and includes corporations not tax-exempt under Section 501(a) of the Code as "persons" subject to the reporting. Note that certain business purchases made with credit or debit cards are exempted from the Section 6041 reporting requirement under previously issued proposed regulations (REG-139255-08),[1] because such purchases will already be reported by banks and other payment processors.

For this purpose, qualifying payments are generally reported on Form 1099-MISC, which must be filed with the Internal Revenue Service and a copy sent to each entity receiving the qualifying payments. In order to complete the information required on the Form 1099, businesses will have to obtain vendors' Taxpayer Information Numbers (TIN) by using Form W-9, and track payments made to all of their vendors to determine which payments satisfy the threshold for reporting – including tracking payments made by check or credit cards. The 1099 forms for payments made in 2012 will have to be filed and reported by February 28, 2013, or March 31, 2013, if filing electronically, or on such dates as the IRS may require for such information reporting. *(Note: the IRS generally fixes the reporting deadlines for information returns a year before the Form is required to be filed. For 2009, the IRS set the filing date of the return as March 1, 2010, and for 2010, the filing date is February 28, 2011. Anticipate a similar timeframe for 2012 forms.)*

The new provision was inserted as a revenue raiser in the health care reform legislation, offsetting costs of other provisions. The reporting requirement is

[1] IRS Proposed Rules, Hearing Notice (REG-139255-08) on Information Reporting for Payment Card, Third Party Network Transactions, amending Reg. §§31.3406(b)(3)-5 and 1.6050W-1, and amendments of Reg. §§31.3406-0, 31.3406(a)-2, 31.3406(d)-1, 1.6041-1, 31.6051-4, 301.6721-1 and 301.6722-1, relating to information reporting requirements, information reporting penalties, and backup withholding requirements for payment card and third-party network transactions (November 24, 2009).

expected to affect businesses – and increase tax revenues -- in two ways. First, most of the revenue of a business will now be reported to the IRS by third parties, making large understatements of revenue more difficult. Second, a business will be less likely to overstate its expenses, as it will need to report who the recipients of the payments were. On a practical level, however, the new 1099 filing requirements will substantially increase the burden and expense of reporting. The Taxpayer Advocate Service (TAS) submitted a report to Congress expressing the concern that the new requirement will impose significant compliance burdens on businesses, charities and government agencies. Businesses will have to keep track of all purchases they make by vendor, and each individual must issue a Form 1099 to the vendor and the IRS showing the exact amount of total purchases. According to a TAS analysis of the 2009 IRS data, nearly 40 million businesses will be subject to the new reporting requirement. Some observers also note that this will seriously affect small businesses adversely, as recordkeeping requirements will be far too costly and time consuming. Even if debit and credit card payments are excepted, most businesses are not set up to distinguish payments to vendors separately by type of payment.

With businesses groups complaining that the new law will swamp their members in paperwork, there have been some attempts in Congress to repeal the law. Democrats and Republicans both want to repeal it, but have disagreed on how to make up the $19 billion in lost revenue that the new law was estimated to bring in over the next decade. The House recently rejected a bill that would have repealed the provision. There have been similar efforts to repeal the filing requirement in the Senate, with similar results. The IRS has issued Notice 2010-51[2] inviting public comment on the best way to implement the new reporting requirements in a manner that minimizes the burden and avoids duplicate reporting.

It is too early to predict whether the new Form 1099 reporting requirements will survive, or how implementation will be altered by public comment. Fortunately, there is still some time left before companies have to make the changes necessary to develop an effective strategy to handle the new reporting. Do not be caught unaware with this change, however. Diligence will be essential to save money, remain efficient, and become compliant. Stay in contact with your CBIZ MHM professionals, who can advise you on the tax, accounting systems, benefits and payroll aspects of this and other changes in health care reform.

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[2] 2010-29 IRB 83 (July 1, 2010). Deadline for submission of public comment is September 29, 2010.

CBIZ
Health Reform Bulletin

Subject: Break Time for Nursing Mothers
Date: August 3, 2010

As part of the Patient Protection and Affordable Care Act, a federal law was enacted, effective March 23, 2010, that provides for a reasonable break time for nursing mothers to express milk. Specifically, this law requires employers to provide a private place, other than a bathroom, for nursing mothers to express milk during the first year of the child's life. The designated private place must be shielded from view, and free from intrusion from coworkers and the public.

This law requires that the break time only be given to employees who are subject to overtime, i.e., nonexempt employees. It does not require that the time be paid, but it does require that time be given anytime the employee needs to express milk.

Many states have laws requiring a similar break time for nursing mothers that are more generous than the federal law, and these laws will continue to apply in those states.

The law is written to apply to all employers, without regard to size; however, there is a hardship exemption for employers employing fewer than 50 employees if compliance with this law would cause undue difficulty or expense. The 50-employee threshold is defined by total employees employed, not employees in any specific location.

The Wage and Hour Division of the Department of Labor enforces this law; they have released a Fact Sheet explaining this requirement: ***Fact Sheet #73: Break Time for Nursing Mothers under the FLSA*.**

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Subject: **Pre-existing Condition Insurance Plan ("PCIP")**
Date: August 19, 2010

The Patient Protection and Affordable Care Act (PPACA) provides for the establishment of a federal temporary high risk pool to assist individuals who have been denied insurance coverage due to a preexisting condition. Further, the PPACA prohibits individual and group health plans from imposing preexisting condition exclusions on children younger than 19 (for plan years beginning on or after September 23, 2010), and can no longer impose such exclusion on anyone beginning in 2014. The Department of Health and Human Services (HHS) has developed a health insurance program to assist such individuals in obtaining insurance coverage through a Pre-existing Condition Insurance Plan ("PCIP"). The purpose of the PCIP program is to bridge the gap between now and 2014, when the preexisting condition standards are in place in all health plans.

On July 30, 2010, the HHS Office of Consumer Information and Insurance Oversight (OCIIO) released implementation regulations, flushing out the particulars of this Program. These regulations set forth provisions relating to PCIP administration, eligibility, enrollment, benefits, premiums, appeals and oversight.

Eligibility
To be eligible to enroll in a PCIP, the individual must meet the following criteria:

1. Be a US citizen;
2. Be a resident of the State that falls within the service area of a PCIP;
3. Not been covered under creditable coverage (generally defined as most individual or group health plan coverage) during the 6-month period, prior to the date on which the individual is applying for PCIP coverage; and
4. Have a pre-existing condition.

Ban on Insurer Dumping
These regulations make it abundantly clear that insurers and employers are **not** to "dump" high-risk individuals into the PCIP program. Specifically, if HHS determines that an insurer or group health plan has discouraged an individual from remaining on the plan based on his/her health status, and the individual subsequently enrolls in a PCIP, the insurer or plan will be responsible for any medical expenses incurred by the PCIP relating to such individual. In addition, the insurer or group health plan also will be referred to appropriate Federal and State authorities for other enforcement actions that may be warranted, based on the behavior at issue.

Each PCIP will establish procedures to identify and report, to the HHS, instances in which insurers or employer-based group health plans are discouraging high-risk individuals from remaining enrolled in their current coverage. Such method for identifying 'dumping' includes:

- Situations where an enrollee or applicant had prior coverage obtained through a group health plan or insurer, and the individual was provided financial consideration or other reward for disenrolling from his/her coverage, or disincentives for remaining enrolled.
- Situations where enrollees or applicants had prior coverage obtained directly from an insurer or a group health plan, and either of the following occurred:
  - The premium for the prior coverage was increased to an amount that exceeded the premium required by the PCIP (adjusted, based on the age factors applied to the prior coverage), and this increase was not otherwise explained;
  - The health plan, insurer, or employer otherwise provided money, or other financial consideration to disenroll from coverage, or provided a disincentive to remain enrolled in such coverage. Such consideration includes payment of the PCIP premium for an enrollee or applicant.

Additional Information about PCIPs

The HHS website provides an in-depth overview of what PCIPs are available to individuals, including details relating to eligibility, federal and state-run programs, benefits and premium rates, and FAQs.

Effective date. This regulation is effective on July 30, 2010. Comments on the regulations must be received by September 28, 2010.

Sunset date. The PCIP program is scheduled to sunset on January 1, 2014.

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Subject: **Salary-based Discrimination Rules Applicable to Fully Insured Group Health Plans**

Date: August 24, 2010

Among the myriad provisions of the Patient Protection and Affordable Care Act, lies a sleeping python. It is in the form of salary-based discrimination rules that are extended to fully insured group health plans.

Historically, fully insured group health plans have not been subject to salary-based discrimination rules. They have, of course, been subject to Title VII-type discrimination rules, such as age, gender, disability, pregnancy, etc.; but, beyond that, employers have had broad discretion to define benefit eligibility and availability in the manner that they choose.

Beginning at the first plan year on or after September 23, 2010, non-grandfathered plans, or plans that have lost grandfathered status, will be subject to rules that prohibit employers from providing better benefits to, roughly, the top 25% of employees, based on pay. In summary, there is a penalty imposed if highly paid individuals, as defined below, receive a better contribution, or a better benefit, than the rank and file employees. A couple common ways that a plan could discriminate are:

- If the employer contributes a higher percentage of premium for owners, officers, shareholders, or the top 25% of its highly paid employees (not including Excludable Employees, as described below);
- If the employer offers several benefit options, and a disproportionate number of highly-paid individuals select plans providing a richer benefit; or
- Offering a particular treatment only to highly paid employees.

Overview of the IRC §105(h) Rules

According to the IRC §105(h) rules, a fully insured plan must pass an Eligibility Test, and a Benefits Test.

Eligibility Test

The fully insured plan must pass one of the following tests:

1. The plan must benefit 70% or more of all employees.
2. Seventy percent or more of all employees must be eligible to participate in the plan and of those eligible to participate, at least 80% must benefit under the plan.
3. The plan may benefit a classification of employees established by the employer, so long as the classification is not discriminatory in favor of highly paid individuals. The IRS must be satisfied that this classification is nondiscriminatory. This determination is made on a facts-and-circumstances basis.

Excludable Employees
Certain employees may be excluded from Tests 1 and 2, above. These include:

- Part-time or seasonal employees, i.e., those working fewer than 35 hours, or nine months in a year, if regular employees work substantially more than that.
- Employees covered by a collective bargaining agreement where health benefits have been the subject of good faith bargaining.
- Employees who have been employed for less than three years.
- Employees who are under age 25.
- Nonresident aliens with no U.S. source of income.

For purposes of the discrimination rules:

- The control group rules apply.
- A ***highly paid individual*** is one of the following:
  - An individual among the five highest-paid officers.
  - A shareholder owning more than 10% in value of the employer's stock.
  - An individual among the highest-paid 25% of all employees other than Excludable Employees, as described above.

Benefits Test
In order to pass these nondiscrimination tests, both the highly paid individuals and non-highly paid individuals must be provided with the same benefits. A plan may be found to be discriminatory, as to benefits, if:

- The highly paid individuals receive benefits not available to non-highly paid individuals;
- The benefits are in proportion to compensation; or,
- The benefits otherwise discriminate in favor of the highly paid individuals.

Excepted Benefits
The preamble to the grandfathered health plan regulations provides that the insurance provisions of the PPACA will not apply to HIPAA-exempt programs, such as limited scope dental and vision plans. In addition, these rules do not apply to stand alone retiree-only plans, i.e., those plans covering no active employees.

Consequences of a Discriminatory Plan
The consequence of a discriminatory insured plan comes in the form of an excise tax equaling $100 a day per affected employee, with a maximum penalty of $500,000. Because of the onerous nature of this penalty, employers will want to be very careful about losing grandfathered status.

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Subject: **Federal External Claims Review: Interim Procedures and Model Notices**

Date: August 30, 2010

The PPACA requires health plans to comply with new internal claims and appeals procedures, and external review procedures (see *Internal Claims and Appeals, and External Review Process*). These provisions become applicable to both non-grandfathered and plans that lose grandfathered status on the first day of the first plan year beginning on and after September 23, 2010. Interim guidance (*Technical Release 2010-01*) has just been issued, specifically relating to the external review process that is to be used by self-funded plans subject to ERISA[i].

According to this guidance, a self-funded plan, subject to ERISA, can either follow the federal guidelines set forth in the *Technical Release*; or, the plan can follow the relevant State's external review process.

Standard external review for self-insured group health plans

Following are the procedures for an external review:

1. A **request for external review** must be submitted by the claimant within 4 months of receiving a notice of adverse benefit determination.
2. **Preliminary review**. Within 5 business days following the date of receipt of the external review request, the group health plan must complete a preliminary review of the request to determine whether:
    - Both claimant and services were covered by the plan during the time in question;
    - The adverse benefit determination does not relate to the claimant's failure to meet the plan's eligibility requirements;
    - The claimant has exhausted the plan's internal appeal process; and
    - The claimant has provided all the information and forms required to process an external review.

    Within one business day following the completion of the preliminary review, the plan must issue a written notice to the claimant. If the request is complete, but not eligible for external review, such notice must include the reasons for its ineligibility and contact information for the DOL's Employee Benefits Security Administration (toll-free number 866-444-EBSA). If the request is not complete, the notice must describe the information and materials necessary to make the request complete. The plan must allow the claimant to perfect the request for external review within the 4-month filing period, or within the 48-hour period following the receipt of the notification, whichever is later.

3. **Referral to Independent Review Organization**. The group health plan must refer the claimant to an accredited independent review organization (IRO) to conduct the external review. Plans must contract with a minimum of three IROs and rotate claim assignments among them.

   The guidance sets forth the criteria for contracts between plans and IROs. Of particular note, contracted IROs cannot receive any financial incentives from the plan "*based on the likelihood that the IRO will support the denial of benefits."*

   Upon receipt of information submitted by the claimant, the assigned IRO must forward the information to the plan within one business day. The plan may reconsider its adverse benefit determination; however, reconsideration by the plan cannot delay the external review. The plan must then notify the claimant and the IRO of its decision within one business day.

   The IRO is required to review all relevant information and documents in a timely manner. The IRO must then provide written notice of the external review decision within 45 days following receipt of the request for external review.

   IROs must maintain records of claims and notices associated with the external review process for six years; and must make these records available for examination by the claimant, the plan, and appropriate federal or state oversight agencies.

4. **Reversal of plan's decision**. Upon receipt of a notice of a final external decision reversing the adverse benefit determination, the plan must provide coverage or payment for the claim.

Expedited external review for self-insured group health plans

The procedures for requesting an expedited external review are:

1. A group health plan must allow a claimant to ***request an expedited external review*** in the event that an adverse or final adverse benefit determination:
   - Involves a medical condition for which the timeframe for completing an internal or external appeal would seriously jeopardize the life or health of the claimant, or his/her ability to regain maximum function; or
   - Concerns an admission, availability of care, continued stay, or health care item or service relating to emergency care in which the individual has not been discharged from the facility.
2. Immediately upon receipt of the request, the plan must make ***a preliminary review*** determination of whether the request meets the standard external review criteria, and then immediately notify the claimant as to eligibility for an expedited review.
3. Upon a determination that a request is eligible for an expedited external review, the plan will ***refer the matter to a contracted IRO*** for standard review. The plan must provide or transmit all necessary documents and information considered in making the adverse or final internal adverse benefit determination to the IRO electronically, by phone, by fax, or other expeditious method.
4. The IRO must provide ***notice of the final external review decision*** as expeditiously as the claimant's medical condition or circumstances require, but in no event, more than 72 hours following receipt of an expedited external review request. If the IRO does not provide the notice in writing, it must follow-up with a written confirmation of its decision within 48 hours.

Model Notices

The agencies have issued model notices to assist in accomplishing the internal and external review process. These notices are:

- Model Notice of Adverse Benefit Determination
- Model Notice of Final Internal Adverse Benefit Determination
- Model Notice of Final External Review Decision

Plans subject to ERISA must continue to comply with the ERISA claims and appeals procedure. At this time, plan sponsors should review their existing procedures, and incorporate any changes necessitated by these new rules.

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[i] In the case of an insured plan, the insurer is responsible for managing the claims and appeals process. In states that have an existing external appeal process, this process must be followed between now and July 1, 2011. During this time, HHS will make a determination about whether the states' external process is compliant and if not, make recommendations for changes. States without an external review process should seek additional guidance from HHS's "Consumer Health Plan Appeals" website. Self-funded plans exempt from ERISA, are likewise subject the State's internal claims and appeals process, including the external review process.

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Following are the procedures for an external review:

1. A **request for external review** must be submitted by the claimant within 4 months of receiving a notice of adverse benefit determination.
2. **Preliminary review**. Within 5 business days following the date of receipt of the external review request, the group health plan must complete a preliminary review of the request to determine whether:
    - Both claimant and services were covered by the plan during the time in question;
    - The adverse benefit determination does not relate to the claimant's failure to meet the plan's eligibility requirements;
    - The claimant has exhausted the plan's internal appeal process; and
    - The claimant has provided all the information and forms required to process an external review.

    Within one business day following the completion of the preliminary review, the plan must issue a written notice to the claimant. If the request is complete, but not eligible for external review, such notice must include the reasons for its ineligibility and contact information for the DOL's Employee Benefits Security Administration (toll-free number 866-444-EBSA). If the request is not complete, the notice must describe the information and materials necessary to make the request complete. The plan must allow the claimant to perfect the request for external review within the 4-month filing period, or within the 48-hour period following the receipt of the notification, whichever is later.

3. **Referral to Independent Review Organization**. The group health plan must refer the claimant to an accredited independent review organization (IRO) to conduct the external review. Plans must contract with a minimum of three IROs and rotate claim assignments among them.

   The guidance sets forth the criteria for contracts between plans and IROs. Of particular note, contracted IROs cannot receive any financial incentives from the plan "*based on the likelihood that the IRO will support the denial of benefits."*

   Upon receipt of information submitted by the claimant, the assigned IRO must forward the information to the plan within one business day. The plan may reconsider its adverse benefit determination; however, reconsideration by the plan cannot delay the external review. The plan must then notify the claimant and the IRO of its decision within one business day.

   The IRO is required to review all relevant information and documents in a timely manner. The IRO must then provide written notice of the external review decision within 45 days following receipt of the request for external review.

   IROs must maintain records of claims and notices associated with the external review process for six years; and must make these records available for examination by the claimant, the plan, and appropriate federal or state oversight agencies.

4. **Reversal of plan's decision**. Upon receipt of a notice of a final external decision reversing the adverse benefit determination, the plan must provide coverage or payment for the claim.

Expedited external review for self-insured group health plans

The procedures for requesting an expedited external review are:

1. A group health plan must allow a claimant to ***request an expedited external review*** in the event that an adverse or final adverse benefit determination:
   - Involves a medical condition for which the timeframe for completing an internal or external appeal would seriously jeopardize the life or health of the claimant, or his/her ability to regain maximum function; or
   - Concerns an admission, availability of care, continued stay, or health care item or service relating to emergency care in which the individual has not been discharged from the facility.
2. Immediately upon receipt of the request, the plan must make ***a preliminary review*** determination of whether the request meets the standard external review criteria, and then immediately notify the claimant as to eligibility for an expedited review.
3. Upon a determination that a request is eligible for an expedited external review, the plan will ***refer the matter to a contracted IRO*** for standard review. The plan must provide or transmit all necessary documents and information considered in making the adverse or final internal adverse benefit determination to the IRO electronically, by phone, by fax, or other expeditious method.
4. The IRO must provide ***notice of the final external review decision*** as expeditiously as the claimant's medical condition or circumstances require, but in no event, more than 72 hours following receipt of an expedited external review request. If the IRO does not provide the notice in writing, it must follow-up with a written confirmation of its decision within 48 hours.

Model Notices

The agencies have issued model notices to assist in accomplishing the internal and external review process. These notices are:

- Model Notice of Adverse Benefit Determination
- Model Notice of Final Internal Adverse Benefit Determination
- Model Notice of Final External Review Decision

Plans subject to ERISA must continue to comply with the ERISA claims and appeals procedure. At this time, plan sponsors should review their existing procedures, and incorporate any changes necessitated by these new rules.

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[i] In the case of an insured plan, the insurer is responsible for managing the claims and appeals process. In states that have an existing external appeal process, this process must be followed between now and July 1, 2011. During this time, HHS will make a determination about whether the states' external process is compliant and if not, make recommendations for changes. States without an external review process should seek additional guidance from HHS's "Consumer Health Plan Appeals" website. Self-funded plans exempt from ERISA, are likewise subject the State's internal claims and appeals process, including the external review process.

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Subject: **Simple Cafeteria Plans**
Date: September 1, 2010

Included in the PPACA is a provision for a so-called, "simple cafeteria plan". A cafeteria plan, pursuant to IRC §125, is a plan that allows employees to purchase certain benefits on a tax-favored basis. In effect, a cafeteria plan allows an employee to choose between tax-favored benefits, such as health coverage, life insurance coverage, or dependent care assistance, among others, and taxable compensation.

Cafeteria plans are subject to specific discrimination rules. The purpose of these rules is to ensure that highly compensated individuals do not unduly benefit from the program. There can be as many as 10 or more discrimination testing rules that must be satisfied by a particular cafeteria plan. Not only does the cafeteria plan have a series of discrimination rules, but so do its component plans. The simple cafeteria plan exempts the plan from many of these discrimination tests; but, in return for this exemption, the simple cafeteria plan must comply with certain requirements, as described below.

The simple cafeteria plan is exempt from the general cafeteria plan discrimination rules, including the eligibility and benefits test, the key employee concentration test, as well as the discrimination rules applicable to group term life insurance, found in IRC §79d, the rules applicable to self-funded health plans, including flexible medical spending accounts, found in IRC §105(h); and the dependent care assistance plan discrimination rules, found in IRC §129(d).

Important note: it is not clear whether the simple cafeteria plan is exempt from the salary-based discrimination rules applicable to insured plans, added by the PPACA and found in the Public Health Service Act §2716. This section of the law is not specifically mentioned in the simple cafeteria plan rules. Whether this is an oversight or intentional, is unclear and guidance would be welcome.

To qualify for a simple cafeteria plan, the plan must meet all of the following criteria:

1. **Eligible Employer**. To be an employer eligible to sponsor a simple cafeteria plan the employer must have employed an average of 100 or fewer employees on business days during either of the 2 preceding years.

   Growing Employers. Special rules apply to a 'growing employer', in the event that its employee population exceeds 100 employees. The employer can continue to sponsor a simple cafeteria plan; however, in the year following a year in which the employer employs on average 200 or more employees on business days, the plan must be converted to a classic cafeteria plan.

Aggregation Rules. Related employers, as defined in IRC Section 52(a), *Controlled Group of Corporations*, or Section 52(b), *Employees of Partnerships, Proprietorships, Etc., Which Are Under Common Control*, must be combined in determining employer size. In addition, leased employees, as defined in IRC §§414(n) or (o), are counted in determining employer eligibility.

2. **Minimum eligibility and participation requirements.** Simple cafeteria plans must meet minimum eligibility and participation requirements. Specifically, all employees who had at least 1,000 hours of service for the preceding plan year are eligible to participate. Each employee eligible to participate in the plan may, subject to terms and conditions applicable to all participants, elect any benefit available under the plan.

   Excludable Employees
   Certain employees may be excluded from the minimum eligibility and participation requirements; these include:
   - Employees who are under age 21;
   - Employees who have been employed for less than one year;
   - Employees covered by a collective bargaining agreement where health benefits have been the subject of good faith bargaining; and
   - Nonresident aliens with no U.S. source of income.

3. **Contribution requirement.** The employer is required, without regard to whether a qualified employee makes any salary reduction contribution, to make a contribution to provide qualified benefits under the plan, on behalf of each qualified employee. *Qualified employees* are those employees who are neither highly compensated individuals or key employees, as defined by the cafeteria plan rules, and who are eligible to participate in the cafeteria plan.

   There are two types of employer contributions, as follows:

   - The *non-elective contribution* is a uniform percent of compensation, but not less than 2% of the employee's compensation for the plan year.

   - The *matching contribution* is an amount that equals or exceeds the lesser of:
     - Six percent of the employee's compensation for the plan year; or
     - Twice the employee's salary reduction contribution.

   The contribution method selected must be the same for all qualified employees, and must be a true employer contribution, i.e., it cannot include a salary reduction contribution at all.

In conclusion, a simple cafeteria plan may be very useful to an employer who would otherwise have difficulty passing the myriad of discrimination rules otherwise applicable to cafeteria plans. It is not, however, an appropriate vehicle for all employers; particularly for those employers who do not have the financial resources to allocate to the plan.

Following are some questions to be answered in determining whether a simple cafeteria plan is appropriate:

1. Is the employer, including related employers as described above, an eligible employer?
2. In the absence of a cafeteria plan, would it be difficult to satisfy the discrimination testing?
3. What will be the required contribution? Is the employer in a position to satisfy this contribution requirement?

If it is determined that a simple cafeteria plan is appropriate:

1. Define the plan terms, including eligibility requirements and contribution requirements.
2. Adopt a new simple cafeteria plan, or amend an existing cafeteria plan.
3. Communicate the new plan terms to your employees
4. Regularly monitor status as an eligible employer.

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Subject: **Update: EARLY RETIREE REINSURANCE PROGRAM**
Date: September 1, 2010

The Early Retiree Reinsurance Program (ERRP), established as part of the PPACA, is a program designed to encourage employers to establish or maintain retiree health coverage for their retirees, aged 55 to Medicare entitlement. The ERRP will pay the equivalent of up to 80% of an early retiree's claim between $15,000 and $90,000. To be eligible for the program, an application must be filed with HHS; the application process opened on June 29, 2010.

For background information relating to ERRP, please refer to the prior CBIZ Health Reform Bulletins:

- Early Retiree Reinsurance Program Application Process Opened
- Early Retiree Subsidy – Initial Application Date is Approaching
- Early Retiree Reinsurance Program

New ERRP Website and Hotline

HHS has recently unveiled a new secured website (www.ERRP.gov) for submitting and monitoring the status of ERRP applications. Employers and plan sponsors who have submitted their ERRP application can use the secure website to view and change application information; submit their retiree list, costs, and claims; and request payment for a portion of the costs of health benefits for early retirees and their dependents.

In addition, plan sponsors and employers can contact HHS with questions about the ERRP by way of a new hotline number: 877-574-3777 or 877-574-ERRP.

List of ERRP Participating Employers

Also available from the HealthCare.gov website is a list employers and unions participating in the ERRP, by geographic location, and by alphabetical list.

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CBIZ
Health Reform Bulletin

Subject: **Over-the-Counter Medication Prohibition Clarified**
Date: September 7, 2010

Currently, health plans, including medical flexible spending accounts (FSAs), health reimbursement arrangements (HRAs), health savings accounts (HSAs), and Archer medical savings accounts (Archer MSAs), may provide reimbursement for non-prescribed over-the-counter ("OTC") drugs. One of the many things that the health care reform law accomplished was to add a new section to Internal Revenue Code, specifically, IRC Section 106(f). This new Code section states that reimbursement of expenses by these types of health plans for OTC medications is only permissible if the OTC drug is prescribed, or is insulin. This change in the law does not affect the purchase of OTC items not considered medications, such as crutches, bandages, or blood sugar test kits.

On September 3, 2010, the IRS released guidance (Notice 2010-59) clarifying several points with regard to how this provision should be implemented. Most important, the guidance states that this provision is effective January 1, 2011, without regard to the underlying plan year. Individuals participating in a medical FSA will have to be advised that, effective January 1, 2011, non-prescribed OTC medication expenses can no longer be reimbursed. OTC drugs purchased prior to January 1, 2011 can be reimbursed, in accordance with plan terms.

This is also true for HSAs and Archer MSAs. If the OTC medication was purchased prior to January 1, 2011, the accountholder can reimburse him/herself after that date; but purchases made from January 1, 2011 forward, cannot be reimbursed.

Debit Cards Require Rx Substantiation

The Notice also clarifies issues relating to stored value cards, such as health FSA or HRA debit cards. Due to the prescription requirement for OTC drugs, and given that the debit card process currently cannot recognize whether a particular medication purchased includes a prescription, expenses for OTC drugs can only be reimbursed, once appropriate substantiation is provided. The Notice provides transition relief through January 15, 2011, allowing debit cards to be used for prescribed OTC medications, as long as current debit card rules are followed. On or after January 16, 2011, a prescription substantiating the expense must be provided.

Transition rule for Cafeteria Plan Amendments

If an employer's cafeteria plan provides for reimbursement of OTC medications, it may need to be amended to conform to the new OTC drug requirements. The Notice provides a transition period for amending a cafeteria plan. Generally, cafeteria plans can only be amended prospectively; however, as long as the amendment is adopted by June 30, 2011, retroactive to January 1, 2011, then the amendment would be permissible.

At the same time the Notice was published, Revenue Ruling 2010-23 was issued. All this Ruling does is obsolete the Ruling that initially authorized OTC drugs as permissible expenses.

What Should An Employer or Plan Sponsor Do?

- ❒ Plan sponsors should review their definitions of medical expenses, specifically in FSA and HRA plans, and prepare to amend them accordingly; then, communicate relevant changes to plan participants.
- ❒ HSA accountholders should be advised that a distribution for non-qualifying expenses, including OTC medications purchased without a prescription, will result in 20% penalty, beginning January 1, 2011.

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Subject: **Mini-Med Plan Relief from Annual Limit Restriction Offered**
Date: September 21, 2010

One of the requirements of the Patient Protection and Affordable Care Act (PPACA) that becomes applicable to all health plans, grandfathered or not, on the 1st day of the 1st plan year beginning on or after September 23, 2010, is a requirement to remove all so-called "lifetime limitations" and "annual limitations" on essential benefits. There is a phase-in period placed on annual limits. From now until January 1, 2014, the following schedule applies to annual limits on the dollar value of essential benefits:

Annual Limit	Applicable to plan years between
$750,000	9/23/10 and 9/23/11
$1.25 Million	9/23/11 and 9/23/12
$2 Million	9/23/12 and 1/1/14

When the regulations were issued interpreting this provision of the PPACA, the regulators indicated that a waiver process would be established for health plans commonly referred to as "mini-med plans" or "limited medical plans." On September 3, 2010, the HHS Office of Consumer Information and Insurance Oversight issued a Bulletin describing this process.

Mini-med plans, or limited medical plans, refer to a low-cost class of coverage that typically includes lower annual limits than traditional full coverage. These limited benefit plans are sometimes offered to part-time workers, seasonal workers, or volunteers, who might not otherwise afford health coverage.

Process for Obtaining Waiver
First of all, this waiver is only available to plans or policies in existence prior to September 23, 2010. The waiver is only granted one plan or policy year at a time; a waiver must be requested for each subsequent plan or policy year. Beginning January 2, 2014, no further waivers will be allowed.

The Bulletin does not include a specific application form. It does indicate the application must contain the following:

1. Terms of the plan (presumably, a certification of coverage, a summary plan description, or similar document);
2. The number of individuals covered by the plan or policy;
3. The annual limit contained in the plan; and
4. The cost of coverage.

Further, the application must include a brief description of why compliance with the PPACA annual limit requirements would adversely impact participants' ability to maintain coverage. This is to be shown by the increased cost associated with complying with the requirement, and the decrease in participation.

The application must include a certification, signed by the issuer or officer of the plan sponsor, affirming that the plan was in force prior to 9/23/10, and that a loss of coverage for participants would occur if the plan or policy would have to comply with the annual limit restrictions.

Generally, the application must be filed more than 30 days prior to the beginning of the plan year. However, for plan or policy years commencing prior to November 2, 2010, the application must be filed 10 days prior to the beginning of the plan year.

What Should An Employer or Plan Sponsor Do?

- ❒ Employers offering insured mini-med plans should work with their insurers to seek a waiver from the annual limit.
- ❒ Sponsors of self-funded mini-med plans should proceed to obtain a waiver on behalf of the plan.

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Subject: **Early Retiree Reimbursement Program Updates**
Date: October 5, 2010

The Early Retiree Reinsurance Program (ERRP), established as part of the PPACA, is a program designed to encourage employers to establish or maintain retiree health coverage for their retirees, aged 55 to Medicare entitlement. The ERRP will pay the equivalent of up to 80% of an early retiree's claim between $15,000 and $90,000. To be eligible for the program, an application must be filed with HHS; the application process opened on June 29, 2010.

As a follow-up to our prior Health Reform Bulletins, HHS has recently issued important guidance, particularly relevant to plans that have been certified. To date, according to HHS, 3,000 plans have been certified to receive ERRP reimbursements.

Preparing for ERRP Reimbursements
Plan sponsors with approved applications should begin taking steps now to prepare for the reimbursement process. Following are action items for a plan with an approved application:

1. Identify early retirees
2. Identify eligible claims
3. Format retiree data
4. Complete early retiree list setup
5. Submit the early retiree list to HHS' ERRP Center
6. Review response files from HHS' ERRP Center
7. Manage ERRP Early Retiree Information.

Two important preparation steps are accessing and registering with the ERRP secure website, and preparing an early retiree list.

- Designated Authorized Representatives and Account Managers, who will be submitting data and requesting reimbursement on behalf of the plan, should register with the ERRP Center as soon as possible following receipt of application approval.
- Plan sponsors should begin compiling its early retiree list to determine which individuals meet the ERRP eligibility criteria. This list must be completed and submitted to the ERRP Center prior to submitting a reimbursement request. The list can either be uploaded via the secured website, or by connecting with the Center's mainframe.

Submitting Claims
HHS is currently developing the infrastructure needed to accept claims data and reimbursement requests. It is expected that they will announce details relating to the manner and timing for submitting this information in the near future.

Types of Claims Eligible for ERRP Reimbursement
In general, plan sponsors may seek reimbursement for health benefit items and services for which Medicare would reimburse under Parts A, B, and D. Examples of covered items and services under Medicare Parts A and B can be found in Section 1 (pages 15-39) of the *Medicare and You 2010 Handbook*. To determine whether a prescription drug is covered under Medicare Part D, HHS recommends consulting with the relevant regulatory definition (42 CFR §423.100), plus review Chapter 6 of the *Medicare Part D Manual*.

Types of Claims Ineligible for ERRP Reimbursement
The ERRP website lists examples of items and services that are not covered by Medicare, and thus, not eligible for reimbursement. These items include, by way of example only:

- Custodial care, i.e., personal care by non-medical personnel;
- Routine foot care, such as orthopedic shoes;
- Personal comfort items, such as a TV in a hospital room;
- Routine vision services and appliances, such as glasses or contact lenses;
- Hearing aids and auditory implants;
- Cosmetic surgery, unless required as a result of accidental injury, or for the improvement of functionality of a body part;
- Routine dental services;
- Assisted suicide;
- Certain infertility services;
- Abortion services;
- Drugs non covered by Part D, unless covered under Parts A or B; and
- Items or services furnished outside the US.

Notice of ERRP Participation
All plans that have been certified for the program must provide a notice to all plan participants, both active and retirees, as well as covered family members, explaining that the plan has been approved to receive ERRP reimbursements, and that the resulting reimbursement monies may impact the participant's coverage under the plan. ERRP reimbursement monies can be used to reduce participants' premium contributions, co-pays, deductibles, co-insurance, or other out-of pocket costs, or reduce future increases in cost of the plan.

Content of Notice
HHS has developed a Model Notice to Plan Participants to be used for this purpose (see language for model notice on page 4).

When to Provide the Notice
The notice must be provided immediately after the first reimbursement is received, but can be provided in advance.

How to Provide Notice
The notice may be provided in one of several ways. Hand delivery to the participant, as long as it is addressed to all covered family members, is sufficient. For employees, the notice can be delivered electronically, such as through e-mail, as long as it is clear that the employee is responsible to providing the notice to covered family members.

Common Questions
The ERRP website (www.ERRP.gov) includes several commonly asked questions that may be helpful to plan sponsors. These FAQs are divided into nine different topics:

1. Application
2. Costs and reimbursement
3. Early retirees

4. Fraud, waste and abuse
5. Price Concessions and Cost Adjustments
6. Prohibition on Using Funds as General Revenue
7. System Roles and Privileges
8. Use of Reimbursement
9. Miscellaneous

What Should An Employer or Plan Sponsor Do?

- ❒ Plan sponsors should begin compiling its early retiree list to determine which individuals meet the ERRP eligibility criteria.
- ❒ Authorized Representatives and/or Account Managers should make certain they register with ERRP Center as soon as they receive approval of the ERRP application.
- ❒ Employers should work with its insurer or third party administrator to determine who will submit the claims, so that when the submission process opens in the next few weeks, the appropriate party can begin to submit claims for reimbursement.
- ❒ Identify parties to whom the Notice of ERRP Participation must be sent. Determine how the notice will be delivered to both active and retired employees, and their covered family members.

Background CBIZ Health Reform Bulletins relating to the ERRP:

- ❖ Update: Early Retiree Reinsurance Program (9/1/10)
- ❖ Early Retiree Reinsurance Program Application Process Opened (6/29/10)
- ❖ Early Retiree Subsidy – Initial Application Date is Approaching (6/11/10)
- ❖ Early Retiree Reinsurance Program (5/5/10)

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[HHS Model Notice language]

NOTICE ABOUT THE EARLY RETIREE REINSURANCE PROGRAM

You are a plan participant, or are being offered the opportunity to enroll as a plan participant, in an employment-based health plan that is certified for participation in the Early Retiree Reinsurance Program. The Early Retiree Reinsurance Program is a Federal program that was established under the Affordable Care Act. Under the Early Retiree Reinsurance Program, the Federal government reimburses a plan sponsor of an employment-based health plan for some of the costs of health care benefits paid on behalf of, or by, early retirees and certain family members of early retirees participating in the employment-based plan. By law, the program expires on January 1, 2014.

Under the Early Retiree Reinsurance Program, your plan sponsor may choose to use any reimbursements it receives from this program to reduce or offset increases in plan participants' premium contributions, co-payments, deductibles, co-insurance, or other out-of-pocket costs. If the plan sponsor chooses to use the Early Retiree Reinsurance Program reimbursements in this way, you, as a plan participant, may experience changes that may be advantageous to you, in your health plan coverage terms and conditions, for so long as the reimbursements under this program are available and this plan sponsor chooses to use the reimbursements for this purpose. A plan sponsor may also use the Early Retiree Reinsurance Program reimbursements to reduce or offset increases in its own costs for maintaining your health benefits coverage, which may increase the likelihood that it will continue to offer health benefits coverage to its retirees and employees and their families.

If you have received this notice by email, you are responsible for providing a copy of this notice to your family members who are participants in this plan.

Subject: **Limited PPACA Exemption for Self-Funded, Non-Federal Government Plans**
Date: October 12, 2010

Since the enactment of HIPAA in 1996, if certain conditions are met, a self-funded or partially self-funded health plan sponsored by a State and local government entity, such as a city, township, or school district, can elect to exempt itself from being considered a group health plan for purposes of the HIPAA portability, preexisting condition exclusion limitation, and related provisions of the law. This exemption is only available as it relates to the self-funded portion of the plan.

To be exempt, the self-funded, non-federal government plan must notify the Centers for Medicare and Medicaid Services prior to the beginning of the plan year. The plan must also notify each plan participant at enrollment time, and annually thereafter, of its decision to exempt itself from the law and the consequences thereof. A self-funded, non-federal government plan must comply with the HIPAA certification requirements of the law.

The Patient Protection and Affordable Care Act (PPACA), however, seems to curtail this ability. Due to the confusion caused by this provision, the HHS Office of Consumer Information and Insurance Oversight has issued an interpretive memorandum clarifying the situation, as follows. According to this guidance, for plan years beginning on or after September 23, 2010, a self-funded, non-federal governmental plan can opt out of the following four provisions:

1. Maternity length of stay, pursuant to the *Newborns' and Mothers' Health Protection Act*;
2. Mental health parity laws, pursuant to the *Mental Health Parity Act* and the *Paul Wellstone and Pete Domenici Mental Health Parity and Addition Equity Act*;
3. Mastectomy-related coverage, pursuant to the *Women's Health and Cancer Rights Act*; and
4. Health coverage continuation rights for students on medical leave, pursuant to *Michelle's Law*.

This opt-out provision applies to both grandfathered and non-grandfathered plans. For plans subject to a collective bargaining agreement in effect before March 23, 2010, the provisions apply beginning the first day of the first plan year occurring after the current agreement expires.

The Memo includes a non-enforcement period to allow plans to become compliant. The non-enforcement period ends for plan years beginning on or after April 1, 2011. The non-enforcement provision does not, however, preclude a participant from challenging an employer who attempts to continue to opt out of relevant provisions.

Clarification of Claims and Appeals and External Review Process

With regard to the PPACA rules governing internal claims and appeals, and the external review process, HHS issued technical guidance on September 23, 2010, affirming that self-funded, non-federal government plans may follow the procedures set forth in Technical Release No. 2010-01, issued August 23, 2010. What this means is that a self-funded, non-federal government plan can either follow the federal procedures for external review, or voluntarily comply with a state's external review process, if available. These directives apply until further guidance is issued.

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CBIZ
Health Reform Bulletin

Subject: **Agencies Issue PPACA Clarifications**
Date: October 12, 2010

In an on-going effort to assist employers and plans in complying with the PPACA, the governing Agencies (Departments of HHS, Labor and Treasury) responsible for implementing the Patient Protection and Affordable Care Act (PPACA) have issued three sets of frequently asked questions (FAQs). These FAQs are just that; they are not regulations, but they do give an indication as to how the agencies are interpreting the law. With regard to several PPACA notice requirements, EBSA has released the relevant notices in Spanish. In addition, the IRS recently released two pronouncements: one relating to the salary-based discrimination rules applicable to insured group health plans, and the other relating to a delay in the mandatory Form W-2 reporting of employer-provided health care costs.

PPACA Implementation FAQs

Of particular note, in the first set of FAQs, is the statement that it is the intent of the Agencies to assist employer plans and individuals with PPACA compliance; their intent is not punitive, but rather assistive. This should give some degree of comfort that a good faith effort to comply with the law will be acceptable.

Grandfathered Health Plans (FAQs Part I: Qs 2 – 6 and FAQs Part II: Qs 1-5)

Determining grandfathered status continues to be fertile ground for many questions. In response, the FAQs provide as follows:

- These FAQs affirm that grandfathered status is only lost based on one or more of the six standards listed in the regulations:
    1. Eliminating all, or substantially all, benefits to diagnose or treat a particular condition.
    2. Increase in percentage of a cost-sharing requirement, such as coinsurance, above the level at which it was on March 23, 2010.
    3. Increase of a fixed-amount cost-sharing requirement, other than co-pays, such as a $500 deductible, or a $2,500 out-of-pocket limit, by a total percentage measured from March 23, 2010, that is more than the sum of medical inflation and 15 percentage points.
    4. Increase in co-pays by an amount that exceed the greater of:
        - A total percentage, measured from March 23, 2010, that is more than the sum of medical inflation, plus 15 percentage points, or
        - $5 increased by medical inflation measured from March 23, 2010.
    5. A decrease in employer contribution by more than 5 percentage points, measured from March 23, 2010.
    6. Change in annual limits by group health plans in existence on March 23, 2010, such as:
        - Addition of an annual limit on the dollar value of benefits;
        - Decrease in limit for a plan with only a lifetime limit; or
        - Decrease in limit for a plan with an annual limit.

Changes that are not listed above, and certainly, adding enhancements to the plan, would not cause loss of grandfathered status.

One of the 'disconnects' that has occurred in determining grandfathered status relates to a change in employer contribution. The FAQs offer a process whereby insurers can ask employers to keep them informed of any change in employer contribution. The intent is to provide insurers with the requisite information to determine grandfathered status.

The "change in insurer" event that can cause loss of grandfathered status has raised many questions. To this end, the FAQs indicate that future guidance may clarify circumstances in which a change of insurer will not cause loss of grandfathered status.

Other Highlights of FAQs – Part I

Claims and Appeals: Clarifications and Revised Model Notice of Adverse Determination (also see Part I, FAQs 7-13 relating to Claims and Appeals).

Technical Release No. 2010-02 provides clarification and relief with regard to some of the technicalities of the claims and appeals and external review requirements that will become applicable to non-grandfathered plans. Between now and July 1, 2011, there is an enforcement grace period regarding the following standards:

- Timeframe for making urgent care claims decisions;
- Providing notices in a culturally and linguistically appropriate manner;
- Requiring broader content and specific information included in notices; and
- Requiring substantial compliance with all of the claims and appeal regulations.

This Technical Release does not relieve the plan from complying with the rules; but rather it relieves them of any enforcement for failure to comply with the specific technicalities of the above requirements.

In addition, the DOL issued a *Revised Model Notice of Adverse Benefit Determination*, clarifying the timeframe for the initial benefit determination. The first notice provided was somewhat confusing on this point.

With regard to independent review organizations (IRO), these FAQs clarify that:

- A self-funded plan can contract with a third party administrator to then contract with an IRO to accomplish the external review process. However, such contract would not relieve the plan sponsor from responsibility if there is a failure to provide an external review process to an individual.
- It is permissible to contract with an IRO located out of state, if there is none located in the particular state.

Coverage for Dependents (FAQ Part I, Q-14)
This FAQ clarifies that a dependent, for purposes of the extension of dependent coverage to age 26, includes a biological child, a stepchild, an adopted child, or a foster child. Eligibility restrictions can be placed on individuals who do not fall within one of these categories. It is important to note that state insurance law or plan provision may expand the definition of eligible dependent beyond the federal standard.

Other Highlights of FAQs – Part II

Wellness Programs (Part II, Q-5)
This FAQ confirms that a wellness premium discount will not cause loss of grandfathered status; but, cautions that a change in co-payment or other cost-sharing may cause a loss of grandfathered status. The FAQ also cautions that any wellness incentive or disincentive must comply with the HIPAA nondiscrimination rules.

Dental, Vision and Retiree-only Plan Exceptions (Part II, Q-6 and Part III, Qs 1-2)
FAQ-6 confirms that the insurance provisions of the PPACA will not apply to HIPAA-exempt programs, such as limited scope dental and vision plans. To meet the "limited scope" exemption under HIPAA, the plan must specifically, and only provide benefits for, in the case of dental plans, issues relating to the function and structure of the mouth, and for vision coverage, issues relating to the function and structure of the eye.

Further, to qualify for these exemptions, the plan must be a separate and independent policy; or, if it is not a separate and independent policy, for example, in the case of a self-funded situation, the dental or vision plan must not be integral with the health plan. What this means is that the participants must have the right to elect or decline the dental or vision coverage, and if elected, there must be a separate cost for the dental or vision coverage.

In the third set of FAQs, the Agencies affirmed that this exception extends to plans covering "*less than 2 participants who are current employees*". Retiree-only plans, thus, are excepted from the insurance market provisions of the PPACA.

Plan Rescission (Part II, Q-7)
This FAQ addresses the issue of plan rescission. Generally a rescission is a retroactive termination of coverage. The only time coverage can be retroactively terminated is failure to pay premium, or for fraud or intentional misrepresentation. Of particular note, this Q&A provides some relief for administrative issues. For example, if, administratively, records are only reconciled monthly, a modest retroactive termination, due to the administrative issue, would be permissible.

Likewise, if a plan is subject to COBRA continuation, and is not notified of a divorce and the premium goes unpaid, the DOL would not consider a plan's termination of coverage retroactive to the divorce to be a violation of the rescission rules.

PPACA Notices Available in Spanish

In response to several notice requirements relating to the Patient Protection and Affordable Care Act (PPACA), the DOL's Employee Benefit Security Administration (EBSA) issued the relevant model notices in Spanish:

- Health Coverage for Young Adults
- Grandfathered Health Plans
- Patient Protections
- Lifetime Limits
- Adverse Benefit Determination
- Final Internal Adverse Benefit Determination
- Final External Review Decision

For information about these required notices and links to the English versions, please refer to these CBIZ *Health Reform Bulletins*:

- New Model Notices Issued
- Federal External Claims Review: Interim Procedures and Model Notices

IRS Pronouncements

- ***Salary-based Discrimination Rules applicable to Insured Plans.*** The PPACA extends the salary based discrimination rules to insured plans (see Salary-based Discrimination Rules Applicable to Fully Insured Group Health Plans). On September 21, 2010, the IRS issued Notice 2010-63; this Notice asks for comments about how this provision should be administered.

  It does provide a couple of points of clarification, particularly, as it relates to penalties. Specifically, the IRS pronouncement affirms that the penalty for a discriminatory insured plan is the imposition of a $100 per day excise tax, not to exceed 10% of the aggregate amount paid or incurred by the employer during the preceding tax year for the group plan, or $500,000, whichever is less.

  The Notice also affirms that the penalty is determined based on the individuals against whom the discrimination occurs. In other words, anyone who does not receive the discriminatory benefit is counted in the assessment of the penalty. While employers employing fewer than 50 employees who sponsor insured group health plans are subject to the salary-based discrimination rules, they are not subject to the excise tax and the self-reporting requirement.

- ***IRS delays W-2 reporting of employer health coverage.*** The IRS just issued some relief for employers (IRS Notice 2010-69) relating to the Form W-2 reporting requirement. The PPACA requires that the aggregate cost of employer-provided health coverage be reported on the Form W-2, beginning with the 2011 plan year. According to this Notice, for the 2011 year, the W-2 reporting requirement will be voluntary, rather than mandatory.

  The aggregate cost of health coverage will be calculated in the same manner as the COBRA premium is calculated, less the 2% administrative fee. This information is to be reported on the Form W-2 (draft W-2 here), in Box 12, using Code DD.

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Subject: **Amendment to Grandfathered Health Plan Rules**
Date: November 17, 2010

Five months ago, the Departments of HHS, Labor, and Treasury ("Agencies") issued interim final regulations relating to grandfathered health plans (see CBIZ Health Reform Bulletin, *Grandfathered Health Plans Rules*). To be grandfathered, an insured or self-funded group health plan must have been in existence on March 23, 2010.

The regulations set forth guidance as to what events would, or would not, cause a plan to lose grandfathered status. Grandfathered health plans are permitted to make routine changes to their plan design without jeopardizing their status, such as:

- Adding new dependents or employees at open enrollment or special enrollment events;
- Making modest adjustments to existing benefits;
- Voluntarily adopting new consumer protections under the new law, or
- Making changes to comply with State or other Federal laws.

The Agencies have clarified that only the conditions listed in the regulations will cause loss of grandfathered status. Among these conditions is, for a fully insured plan, the change from one insurer to another. This week, the Agencies re-visited the premise that a change of insurer results in an automatic loss of grandfathered status. According to the Amendment to the grandfathered health plan regulations, an insured plan can change insurers without loss of grandfathered status, as long as:

1. No other change in the plan design would result in loss of grandfathered status; and
2. The new insurer is provided documentation relating to the previous plan. This can be in the form of a summary plan description, a certificate of coverage, or similar document.

The amendment applies to insurer changes occurring on or after November 15, 2010. There is some indication that these grandfather health plan regulations may be further modified sometime in early 2011. Whether the 'change of insurer' provision will be made retroactive at that time, is an open question.

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Subject: **State Tax Treatment of Older-aged Dependent Coverage**
Date: December 16, 2010

As 2010 comes to a close, issues relating to the taxability of health coverage provided to older-aged dependents must be pondered. As part of the *Patient Protection and Affordable Care Act*, health plans that provide coverage for dependents must allow a dependent child to remain on the plan until he/she reaches his/her 26th birthday (see CBIZ Bulletin, *Health Reform's Coverage for Dependent Children Explained*). Part of the Reconciliation law provides that the cost of health coverage for older-aged dependents is not includible in the employee's income (see CBIZ Bulletin, *IRS Guidance: Tax-Favored Status of Dependent Coverage)*. Therefore, for federal tax purposes, the issues are relatively straight forward.

States Conforming to Federal Tax Law
Some states automatically follow the tax treatment imposed by federal law. In these particular states, the cost of health coverage for older-aged dependents will not be subject to state tax; these states are:

Alabama, Colorado, Connecticut, Delaware, Illinois, Kansas, Louisiana, Maryland, Michigan, Missouri, Montana, Nebraska, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, Rhode Island, Utah, Vermont, and Washington, DC.

Non-conforming States
In states that do not automatically follow the federal law, state income taxes (not federal), would have to be imputed into an employee's income if the covered older-aged child does not meet the definition of dependent in that particular state. States that have yet to change their tax laws to parallel or conform to the federal tax law are:

Arizona, Arkansas, California, Georgia, Hawaii, Idaho, Indiana, Iowa, Kentucky, Maine, Massachusetts, Minnesota, Oregon, South Carolina, Virginia, West Virginia, and Wisconsin.

To date, only three of these states have addressed the issue of state income tax treatment of dependent coverage:

- In **California**, legislation would have to be enacted to conform the state tax law to the federal law; therefore, the cost of providing coverage to older-aged dependents would be includible in the employee's income and subject to state tax (see pages 126-130 of *Summary of Federal Health Care Acts -- 2010* from the California Franchise Tax Board)

- **Minnesota.** Currently, Minnesota tax law requires employers to withhold the "fair market value of insurance benefits provided to nondependent adult children of employees". Until the Legislature reconvenes in January, 2011 to enact legislation that would conform Minnesota tax law to the federal law, the Minnesota Department of Revenue will not require employers to withhold taxes from these federally exempt employer benefits provided in the 2010 tax year. For further recommendations on how to process these amounts, both from and employer and employee stand-point, see *Employer provided health insurance and adoption benefits* from the Minnesota Department of Revenue's publication, *What's new for employers for tax year 2010?*

- **Wisconsin**. Similarly, until the Wisconsin Legislature enacts legislation to conform its state tax law to the federal tax law, the cost of providing coverage to a child under age 27 would be includible in the employee's income unless the child meets the federal definition of "qualifying child" or "qualifying relative". For details, see *Tax Information Relating to Health Care Benefits for Children Under Age 27* from the Wisconsin Department of Revenue.

What Should An Employer Do?

- ❒ As year-end payrolls are being completed and Form W-2s are being prepared, employers should work with the payroll and tax advisers to make certain that all appropriate taxes are imposed.
- ❒ Consider utilizing an affidavit or certification of dependent status in states that do not follow the federal law. The affidavit/certification should reflect the definition of dependent for tax purposes in the particular state. See pages 3-4 of this Bulletin for a sample affidavit/certification that uses the federal definition of qualifying child and qualifying relative; many states use this definition.

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Very Important Note: ***This form is a sample only. It must be revised to comply with the terms of your plan, or your particular situation or circumstances. Your legal counsel should review this document before it is used.***

SAMPLE AFFIDAVIT OF DEPENDENT STATUS
FOR TAX YEARS BEGINNING 1/1/09

Date: _____

Employee Name: _____

For purposes of employer-sponsored group health coverage, if an individual does not meet the Federal tax definition of a dependent, then the fair market value of such dependent coverage would be includable in the employee's income for Federal tax purposes.

The Federal tax definition of a dependent[1] is one who meets the definition of either 1) a qualifying child, or 2) a qualifying relative:

Who is a Qualifying Child? For tax years beginning on or after January 1, 2009, a *qualifying child* for purposes of IRC §152 must meet the following criteria:

1. The individual is the taxpayer's child or stepchild (whether by blood or adoption), foster child, sibling or stepsibling, or a descendant of one of these.
2. The individual resides for over 50% of the taxable year with the taxpayer.
3. The individual is younger than the taxpayer claiming the child, and either:
    a. Under the age of 19 by the end of the calendar year;
    b. A full-time student who has not attained age 24 by the close of the calendar year; or,
    c. Permanently disabled, without regard to age.
4. The individual did not provide more than 50% of his/her own support for the year;
5. The individual cannot file a joint return (this means that most married children could not qualify as a qualifying child); and
6. If more than one person is eligible to claim the individual, and if no parent claims the individual, a non-parent can claim the individual as a 'qualifying child' as long as he/she has a higher adjusted gross income than any parent.

Who is a Qualifying Relative? A qualifying relative for purposes of IRC §152 must meet the following criteria:

1. The individual is a relative of the taxpayer, as defined in IRC §152(d); or other than a spouse, someone who has the same principal place of abode and is a member of the taxpayer's household.
2. The taxpayer provides more than 50% of the individual's total support for the year.
3. The individual is not a qualifying child of another taxpayer.

[1] Special rules apply in the case of divorce.

Certification of Dependent Status

I certify that the following dependent(s) meet the criteria of Qualifying Child or Qualifying Relative, as defined above:

[List names of dependents]

I certify that the following dependent(s) ***do not*** meet the criteria of Qualifying Child or Qualifying Relative, as defined above:

[List names of dependents]

I understand that if any of the dependents listed above ***do not*** meet the definition of qualifying child or qualifying relative, then he/she may be eligible for coverage under the following plan(s), in accordance with the terms of the particular plan(s). However, I agree to be responsible for paying any taxes imposed on the fair market value of such coverage:

[List plan names]

_____
Signature of Employee

_____
Date

Subject: **Mini-Med Plans: Increased Transparency and Disclosure**
Date: December 20, 2010

The HHS' Office of Consumer Information and Insurance Oversight (OCIIO) recently issued two bulletins relating to mini-med plans that seek a waiver from complying with the PPACA's ban on the imposition of annual or lifetime limits on essential benefits. Our prior Heath Reform Bulletin, *Mini-Med Plan Relief from Annual Limit Restriction Offered*, describes the waiver process. It is important for employers to understand that if a "mini-med plan" or a "limited benefit plan" has obtained a waiver from the annual limit requirement, a participant disclosure notice must be provided. Generally, this notice will be issued by the insurer. An OCIIO bulletin, issued December 9, 2010, sets forth some details relating to this disclosure.

Participant Notification

As a condition for receiving a waiver of the annual limits requirement, plans are required to notify participants that the plan does not meet the restricted annual limits for essential benefits. Such notice must include the dollar amount of the annual limit, along with a description of the plan benefits to which it applies. The OCIIO provides the following model language that can be used by plans. This notice must be displayed prominently in clear, conspicuous 14-point bold type, on the front of plan materials:

> *The Affordable Care Act prohibits health plans from applying arbitrary dollar limits for coverage for key benefits. This year, if a plan applies a dollar limit on the coverage it provides for key benefits in a year, that limit must be at least $750,000.*
>
> *Your health insurance coverage, offered by [name of group health plan or health insurance issuer], does not meet the minimum standards required by the Affordable Care Act described above. Instead, it puts an annual limit of:*
>
> > *[dollar amount] on [all covered benefits]*
> > *and/or*
> > *[dollar amount(s)] on [which covered benefits – notice should describe all annual limits that apply].*
>
> *In order to apply the lower limits described above, your health plan requested a waiver of the requirement that coverage for key benefits be at least $750,000 this year. That waiver was granted by the U.S. Department of Health and Human Services based on your health plan's representation that providing $750,000 in coverage for key benefits this year would result in a significant increase in your premiums or a significant decrease in your access to benefits. This waiver is valid for one year.*

If the lower limits are a concern, there may be other options for health care coverage available to you and your family members. For more information, go to: www.HealthCare.gov.

If you have any questions or concerns about this notice, contact [provide contact information for plan administrator or health insurance issuer].

[For plans offered in States with a Consumer Assistance Program] In addition, you can contact [contact information for consumer assistance program].

Timing of Notice

- For plans already approved for a waiver, or would receive a waiver for plan years beginning prior to February 1, 2011, the notice must be provided to current and eligible participants by February 7, 2011.
- For waivers covering plan years that begin on or after February 1, 2011, the notice must be provided to eligible participants as part of any plan materials, including summary plan descriptions.

Additional Guidance

In addition, the OCIIO issued a supplemental bulletin clarifying that only in two circumstances may so-called "mini-med plans" be issued after September 23, 2010. These limited circumstances are:

1. Situations in which a state requires a limited medical plan to be offered, and the state has sought a waiver for these products; or
2. A group plan that has obtained a waiver transfers from one insurer to another, without loss of grandfathered status (see *Amendment to Grandfathered Health Plan Rules*).

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CBIZ
Health Reform Bulletin

Subject: **Additional Guidelines to the Small Business Tax Credit**
Date: December 22, 2010

As part of the Patient Protection and Affordable Care Act (PPACA), a tax credit is made available to certain small employers who offer qualifying health coverage to their employees (see CBIZ Health Reform Bulletin, *Small Business Health Care Tax Credit*). Recently, the IRS released some additional welcome guidance on how this credit is to be implemented, specifically:

- New Form 8941 and Instructions for calculating the *Credit for Small Employer Health Insurance Premiums;*
- Frequently asked Questions; and
- IRS Notice 2010-82.

Following is a summary of some points of particular interest from this guidance:

Employers entitled to the credit. Small businesses and tax-exempt employers that provide health care coverage to their employees under a qualified health care arrangement are entitled to a credit for taxable years beginning after December 31, 2009. To be eligible, the business must:

1. Employ 25 or fewer full-time equivalent employees ("FTEs") for the tax year;
2. Pay average annual wages of less than $50,000 per employee; and
3. Maintain a *qualifying arrangement*. In a "qualifying arrangement" the employer pays premiums for each employee enrolled in health insurance coverage offered by the employer in an amount equal to a uniform percentage (minimum 50%) of the premium cost of the coverage.

A §521 farmers cooperative is eligible to claim the credit as a taxable employer, if it otherwise meets the definition of an eligible small employer.

A small eligible employer need not be engaged in a trade or business, i.e., a household employer may be eligible for the credit.

Determining Full-time Equivalent Employees

Employee-spouses of sole proprietors, partners with 5% interest in a partnership, 2% shareholders in an S corporation, and 5% owners of the business, are excluded from being taken into account as employees for purposes of determining an employer's FTE, average wages and premiums paid.

Health premiums paid for a leased employee are not taken into account by the service recipient in computing the service recipient's credit.

Unless specifically excluded, all employees during the year for which the credit is being claimed are taken into account in computing an employer's FTEs and annual average wages, including, for example:

- Former employees who terminated employment during the year for which the credit is being claimed
- Employees covered under a collective bargaining agreement, and
- Employees who do not enroll in their employer's health insurance plan (whether or not they are covered under another health insurance plan).

Determining Wages

All wages, including overtime pay (wages for hours >$ 2,080), are taken into account in computing the employer's average annual wages.

An employee's hours of service may be calculated in three ways:

1. Counting actual hours worked;
2. Using a days-worked equivalency; or
3. Using a weeks-worked equivalency.

Employers need not use the same method for all employees, and may apply different methods for different classifications of employees, if classifications are reasonable and consistently applied. For example, an employer may use the actual hours worked method for all hourly employees, and the weeks-worked equivalency method for all salaried employees. Employers may also change methods for each taxable year.

Plans for which the credit is available. The credit is only available for insured plans; it is not available for self-funded plans. Therefore, the credit is not available for employer contributions to flexible medical spending accounts, health reimbursement arrangements, health savings accounts, or other similar account-based plans.

Multi-Employer Plans. Contributions to a multiemployer plan used to pay health insurance premiums for covered employees qualify for the credit even if insurance premiums are paid by the plan and not directly to the employee. If 100% of the cost of coverage is paid from non-elective employer contributions, and not by employees, each employer in the multiemployer plan is considered to be contributing a uniform percentage of 100% of the premium of each covered employee. If the multiemployer plan provides welfare-type benefits (i.e. life insurance or short- or long-term disability benefits) in addition to health insurance, only contributions used to purchase health insurance are permitted to be taken into account in determining the credit and employer must allocate contributions among the benefits provided.

Church Plans. Church-sponsored welfare benefit plans subject to state insurance law regulation satisfy health insurance coverage requirements. Small church employers paying health care premiums for its employees may qualify for the credit.

Uniformity Requirements

One of the criteria to receive the credit requires the employer to contribute a uniform percentage of the premium. Notice 2010-82 provides several illustrations about how this uniformity requirement can be satisfied.

Generally, this guidance provides uniformity calculations for composite plans, and list bill plans; and provides guidance on single tier and multi-tier plans. To understand these calculations, it is important to understand what these terms mean.

- A *composite plan* means a plan in which a uniform premium is assessed for any tier of coverage.
- A *list bill plan* is one in which premium is determined based on individual characteristics, and may differ for each plan participant.
- *Tier coverage* is a unit that differs only by the number of individuals in a family unit. For example, employee, employee plus one, or employee plus family.

According to this guidance, a **composite plan with a single tier of coverage** will meet the uniformity requirement if the employer contributes at least 50% of the premium for the single tier.

In a **composite multi-tier plan**, the uniformity requirement can be satisfied in one of two ways; either:

1. The employer contributes a uniform percent of each tier of coverage, or
2. The employer contributes at least 50% of the single tier of coverage.

If the plan is **list billed**, the uniformity requirement can be satisfied either by:

1. The employer contributing at least 50% of each participant's premium, thus resulting in different employer contributions for each individual; or,
2. The employer contributing at least 50% of the single tier of coverage of the employer calculated composite rate. The *employer's calculated composite rate* is determined by adding the premium for each eligible individual, without regard to whether the individual actually participates in the plan, divided by the number of eligible individuals.

If the employer offers **multiple list billed plans**, the uniformity requirement can be satisfied for each plan separately. The premium is either:

- Fifty percent of the single premium list bill, or at least 50% of the employer calculated composite premium; or
- Fifty percent of the employer calculated composite premium for each tier of coverage.

Multiple plan options. If the employer offers multiple plan options, each plan option must satisfy the uniformity requirement, independent of the other plan option. Alternatively, an employer can define a referenced-plan, and its contribution toward the referenced-plan can then be allocated to the plan of the participant's choice. In this event, an anti-abuse rule must be satisfied, pursuant to which, the employer contribution to the referenced-plan has to be at least 66% of the single composite premium for each of the other plans.

The credit is limited by the average premium for the small group market in the State (or area within the State) in which the employee enrolls for coverage. In calculating the credit for employees in multiple states, the employer applies the average premium for the small group market in the State (or area within the State) separately for each employee, using the average state premium for the State in which the employee works.

> Note: *The Department of Health and Human Services determines the average state premium for the small group market in each state. For the 2010 tax year, these amounts are listed in the Form 8941 Instructions and Revenue Ruling 2010-13.*

The cap used for each employee, whether self-only or family, depends on the coverage taken. This is not affected by whether the employer's contribution for that employee is determined with reference to the self-only plan, or whether an employer satisfies the uniformity requirement.

Conclusion

The small employer health insurance tax credit is available to qualifying employers for the 2010 tax year through 2013. Beginning 2014 when the exchanges are established, a credit is available for two years for employers who obtain health coverage through the exchange. Employers interested in obtaining the credit should review the FAQs, the Form 8941, and relevant guidance issued by the IRS.

About the Authors:

Aimee San Ramon is a Senior Associate with CBIZ MHM, LLC. Ms. San Ramon is based in the CBIZ Bethesda, Maryland office.

Karen R. McLeese is Vice President of Employee Benefit Regulatory Affairs for CBIZ Benefits & Insurance Services, Inc., a division of CBIZ, Inc. She serves as in-house counsel, with particular emphasis on monitoring and interpreting state and federal employee benefits law. Ms. McLeese is based in the CBIZ Leawood, Kansas office.

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Subject: **Implementation of Salary-based Discrimination Rules Delayed**

Date: December 23, 2010

The Patient Protection and Affordable Care Act (PPACA) imposes salary-based discrimination rules on insured health plans (see our CBIZ Bulletin, *Salary-based Discrimination Rules Applicable to Fully Insured Group Health Plans*). The IRS, with the endorsement by the Departments of Labor and Health and Human Services, has just issued Notice 2011-01, delaying the effective date of these rules. No penalties will be imposed until after implementing regulations are issued.

This position is being taken due to the density of these rules and the need for guidance before they can be properly implemented. This should come as a nice holiday gift to those dealing with these complexities.

Remember, the salary-based discrimination rules applicable to self-funded health plans that have been in effect for 30 years, are not changed by the PPACA, nor are they changed by this guidance, and remain in full force and effect.

About the Author: Karen R. McLeese is Vice President of Employee Benefit Regulatory Affairs for CBIZ Benefits & Insurance Services, Inc., a division of CBIZ, Inc. She serves as in-house counsel, with particular emphasis on monitoring and interpreting state and federal employee benefits law. Ms. McLeese is based in the CBIZ Leawood, Kansas office.

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Subject: **Agencies Issue Additional PPACA Clarifications**

Date: December 23, 2010

In their on-going effort to assist employers in complying with the Patient Protection and Affordable Care Act (PPACA) and other laws, the issuing Agencies (DOL, HHS and IRS) have just provided some sub-regulatory guidance, in the form of Questions and Answers. Of particular note, are the following:

Automatic Enrollment in Health Plans

The PPACA requires employers employing 200 or more employees to automatically enroll full-time employees, and to retain enrollment for those already covered by the plan. According to the law, this provision became effective on the law's enactment date (March 23, 2010). The Agencies have indicated that employers will not be required to comply with this provision until implementing regulations are issued.

60-day Advanced Notice of Material Change in Benefits

The PPACA requires a 60-day advance notice of any material change in benefits. According to these FAQs, plans will not be obligated to comply with this requirement until the uniform benefit summary is issued. To date, the uniform benefit summary has not been issued.

Differences in Dependent Coverage

The PPACA requires that if a plan covers dependents, then certain dependents must be covered until his/her 26th birthday. This guidance clarifies that if certain categories of dependents receive a more favorable benefit than all other covered lives, including spouses of employees, this difference is OK. The example used in the FAQ is the waiver of an office visit co-pay for children under the age of 19. According to the example, a co-pay is not imposed on office visits for children under the age of 19, even in situations in which the office visit is not for preventive service; whereas, for dependents aged 19 and older, as well as for spouses of employees, a co-pay is imposed. According to this guidance, this kind of arrangement is permissible.

Mental Health Parity and HIPAA health-based Discrimination Rules

Finally, the FAQs reiterate the applicability of the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) to employers employing 50 or more employees. They also address the HIPAA rules relating to health-based discrimination rules, specifically as they relate to wellness programs. While these FAQs don't break new ground, they do provide affirmation about how these rules should be implemented.

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Subject: **Limited Relief for Debit Card Purchases of OTC Medications**
Date: January 10, 2011

As part of the Patient Protection and Affordable Care Act, over-the-counter (OTC) medications, excluding insulin, cannot be reimbursed from medical spending accounts, such as flexible medical spending accounts, health reimbursement arrangements, or health savings accounts, unless a prescription for the OTC medication has been issued. Medical supplies, such as crutches, band-aids, or blood sugar test kits, can continue to be reimbursed from medical spending accounts, without a prescription. According to IRS Notice 2010-59, after January 15, 2011, debit cards can no longer be used for the purchase of these items, given the complexity of proving (substantiating) the prescription (see *Over-the-Counter Medication Prohibition Clarified*).

More recently, the IRS issued Notice 2011-5 and FAQs, somewhat tempering the prior Ruling. According to this Notice, after January 15, 2011, health FSA and HRA debit cards may continue to be used to purchase OTC medications at drug stores and pharmacies, at non-health care merchants that have pharmacies, and at mail order and web-based vendors that sell prescription drugs, if, prior to purchase:

1. The prescription for the OTC medication is presented, in any format, to the pharmacist; and such medication is duly dispensed by a licensed pharmacist, together with an assigned Rx number. The pharmacy or vendor retains a record that includes the Rx number, the name of the purchaser or individual to whom the medication is prescribed, and the date and amount of the purchase;
2. The records are available to the employer or its agent upon request; and
3. The debit card system does not accept a charge for an OTC medication unless an Rx number has been assigned.

If the above requirements are met, the debit card transaction will be considered fully substantiated at the time and point-of-sale.

If the OTC medication is purchased from a vendor that has a health care related merchant code, debit card transactions will be considered fully substantiated at the time and point-of-sale, as long as:

1. The pharmacy or vendor retains a record that includes the Rx number, the name of the purchaser or individual to whom the medication is prescribed, and the date and amount of the purchase; and
2. The records are available to the employer or its agent upon request.

Health FSA and HRA debit cards may be used to purchase OTC medications at so-called, "90% Pharmacies", as long as the expenses are properly substantiated. A *90% pharmacy* is an entity that does not maintain an inventory information approval system, and 90% of its gross receipts during the prior taxable year are derived from qualifying medical expenses.

A debit card cannot be used for the purchase of OTC medication from any facility other than those described above.

This should come as welcome relief to plans that have endorsed the use of debit cards in their account-based plans. These rules notwithstanding, some employers may wish to exclude OTC medications altogether from their health spending account plans, given the potential increase in cost that may occur from employees seeking prescriptions for such medications.

About the Author: Karen R. McLeese is Vice President of Employee Benefit Regulatory Affairs for CBIZ Benefits & Insurance Services, Inc., a division of CBIZ, Inc. She serves as in-house counsel, with particular emphasis on monitoring and interpreting state and federal employee benefits law. Ms. McLeese is based in the CBIZ Leawood, Kansas office.

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CBIZ
Health Reform Bulletin

Subject: Delay in Claims and Appeals Enforcement
Date: March 22, 2011

One of the provisions of the Patient Protection and Affordable Care Act (PPACA) is the expansion of the internal claims and appeal, and external review rules. The PPACA not only augments the internal claims and appeals rules applicable to ERISA plans by adding an external review requirement, among other things, but it also extends these rules to plans exempt from ERISA, such as state and local government plans, and church plans. These rules apply to non-grandfathered plans (those not in existence on 3/23/10), as well as to plans that lose grandfathered status.

In September, 2010, the Agencies issued Technical Release No. 2010-02 that provided for a non-enforcement grace period until July 1, 2011 for certain claim and appeal standards (see *Claims and Appeals: Clarifications and Revised Model Notice of Adverse Determination* from the CBIZ Health Reform Bulletin, *Agencies Issue PPACA Clarifications*). This Technical Release did not relieve the plan from complying with the rules; but rather relieved them of any enforcement for failure to comply with the specific technicalities of the above requirements.

On March 18, 2011, the Department of Labor issued Technical Release No. 2011-01. This guidance provides additional relief from certain provisions relating to claims and appeals, and the external review standards. According to this guidance, generally, the rules will be enforced effective for plan years beginning on or after January 1, 2012. The primary purpose for the delay is to give the government agencies (HHS, DOL, and IRS) time to issue further implementation guidance. The specific parts of the rules included in the non-enforcement grace period include:

1. Timeframe for making urgent care claim decisions;
2. Providing notices in a culturally and linguistically appropriate manner;
3. Substantial compliance with claims and appeals standards; and
4. Disclosure of diagnosis and treatment codes, together with their corresponding meanings, to be included in detailed notifications of benefit determinations.

Different from the original guidance, this non-enforcement guidance will not obligate plans to make a good faith attempt to comply during the delay period.

The enforcement grace period applicable to other disclosure standards is extended from July 1, 2011 until the first day of the first plan year beginning on or after July 1, 2011 (January 1, 2012 for calendar year plans). These standards include:

1. Disclosure of information sufficient to identify a claim (other than the diagnosis and treatment codes);
2. Reasons for an adverse benefit determination;
3. Description of available internal appeals and external review processes; and

4. Contact information of any available office of health consumer or ombudsman assistance program. To assist plan sponsors with this information, the Technical Release includes a current list of *States with Consumer Assistance Programs* on pages 7-12.

This non-enforcement delay is, again, an indication of the Administrative Agencies' commitment to facilitate compliance with the law, as efficiently as possible.

Additional CBIZ Health Reform Bulletins on Claims and Appeals and External Review:

- Limited PPACA Exemption for Self-Funded, Non-Federal Governmental Plans (10/12/10)
- Federal External Claims Review: Interim Procedures and Model Notices (8/30/10)
- Internal Claims and Appeals, and External Review Process (7/26/10)

About the Author: Karen R. McLeese is Vice President of Employee Benefit Regulatory Affairs for CBIZ Benefits & Insurance Services, Inc., a division of CBIZ, Inc. She serves as in-house counsel, with particular emphasis on monitoring and interpreting state and federal employee benefits law. Ms. McLeese is based in the CBIZ Leawood, Kansas office.

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CBIZ
Health Reform Bulletin

Subject: **IRS Issues Interim Guidance on W-2 Reporting**
Date: March 30, 2011

One of the provisions of the Patient Protection and Affordable Care Act (PPACA) requires employers to report the aggregate cost of health coverage on the employee's Form W-2. This reporting requirement is informational-only, and **does not** create a taxable event. This provision was to be applicable for the 2011 reporting year; generally, for the W-2 required in January, 2012. In IRS Notice 2010-69 issued in October, 2010, the requirement was made voluntary for 2011 (see *IRS delays W-2 reporting of employer health coverage* from the CBIZ Health Reform Bulletin, *Agencies Issue PPACA Clarifications*).

On March 29, 2011, the IRS issued interim guidance (IRS Notice 2011-28) explaining this reporting requirement. This guidance will be applicable for the 2012 reporting year, generally, for the W-2 required to be issued in January, 2013; and, may be relied upon by those choosing to voluntarily comply with the reporting requirement.

What employers have to comply?
This guidance provides further relief for certain employers. Specifically, employers required to file fewer than 250 Form W-2s are relieved from compliance until the 2013 reporting year; generally, the W-2s would be required to be issued in January, 2014.

The guidance clarifies that the reporting requirement does not currently apply to:
- Self-funded plans exempt from federal COBRA;
- Federal or state government-sponsored plans maintained primarily for military members and their families; or
- Plans sponsored by Federally-recognized Indian tribal governments.

Of specific importance to employers, the reporting requirement only applies if the employer is otherwise obligated to provide a W-2. This has particular relevance to an employer who provides post-employment health coverage, such as retiree health coverage. In this instance, the aggregate cost of the retiree or other post-employment health coverage would only have to be reported if the employer is otherwise obligated to provide a W-2.

What plans are subject to the W-2 requirement?
Generally, the reporting requirement applies to employer-provided health plans. It does not apply to:
- Long term care plans;
- Stand-alone, non-integrated dental or vision plans;
- Contributions to health savings accounts, Archer medical savings accounts, health reimbursement arrangements, or salary reduction contributions to flexible medical spending accounts;
- Certain non-health benefit plans, such as long term care, disability income, liability, workers compensation, automobile medical payment, specified disease or illness policies, fixed indemnity policies; or
- Multiemployer plans.

What costs must be reported?
The costs to be reported include both the employer and employee share of the premium, without regard to whether the premium is paid with salary reduction dollars through a cafeteria plan (IRC §125 plan). However, as noted above, salary reduction contributions to a flexible medical spending account need not be reported. The aggregate cost of health coverage includes the cost of coverage for non-dependents.

The aggregate cost can be calculated in one of the following ways:

1. If the plan is insured, the insurance premium can be used.
2. Using the method for calculating COBRA premium, excluding the 2% administrative fee.
3. Using a modified COBRA premium calculation when an employer charges less than the full COBRA rate; the amount to be reported on the W-2 is a good faith determination of the COBRA rate.

This Notice, together with past guidance, should give employers ample time to work with their payroll and health plan providers to ensure that the required disclosures can be made at the appropriate time.

About the Author: Karen R. McLeese is Vice President of Employee Benefit Regulatory Affairs for CBIZ Benefits & Insurance Services, Inc., a division of CBIZ, Inc. She serves as in-house counsel, with particular emphasis on monitoring and interpreting state and federal employee benefits law. Ms. McLeese is based in the CBIZ Leawood, Kansas office.

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CBIZ
Health Reform Bulletin

Subject: **Grandfathered Status and ERRP Updates**
Date: April 4, 2011

Agencies Issued New FAQs: Grandfathered Status

The Agencies (DOL, HHS and IRS) have recently issued some additional sub-regulatory guidance relating to the Patient Protection and Affordable Care Act in the form of Frequently Asked Questions. These 6 new FAQs relate primarily to determining grandfathered status as follows:

FAQ#1 - Elimination of a Benefit Option. One of the issues that has raised many questions relates to the matter of when terminating a benefit option would cause a plan to lose grandfathered status. According to the interim final grandfathered regulations issued in June, 2010, (see CBIZ Health Reform Bulletin, *Grandfathered Health Plans Rules*), grandfathered status is lost if a benefit option is eliminated and the employees are moved to another plan option. There is an exception to this rule if there is a 'bone-fide employment based reason' for terminating the plan option. According to the new FAQ, examples of events that would *not* cause loss of grandfathered status include:

- When a benefit package is being eliminated because the issuer is exiting the market or no longer offers the product to the employer, such as failure to satisfy a minimum participation requirement;
- When low or declining participation by plan participants in the benefit package makes it impractical for the plan sponsor to continue to offer the benefit package;
- When a benefit package is eliminated from a multiemployer plan, as agreed upon as part of the collective bargaining process; or
- When a benefit package is eliminated for any reason, and multiple benefit packages covering a significant portion of other employees remain available to the employees being transferred.

This list is not exhaustive; but rather is by way of example only.

FAQ#2 - Change in Drug Formularies. This FAQ addresses the issue of when changing or modifying tiers of drug coverage will cause loss of grandfathered status. The FAQ affirms that if a plan has multiple tiers of drug coverage, and if a drug subsequently changes status, moving that drug from one tier to another tier will not cause loss of grandfathered status. The example given relates to a drug for which there is no generic option. If later, a generic option becomes available, moving that drug to a different tier will not cause loss of grandfathered status.

FAQ#4 and 5 – Date of Losing Grandfathered Status. Two of the FAQs relate to when grandfathered status is lost. Both FAQs affirm that if a plan is amended in such a way that would cause loss of grandfathered status, the loss of grandfathered status occurs on the effective date of the amendment, not the date the amendment is adopted.

FAQ 6 – Change in Employer Contribution. This FAQ addresses change in employer contribution as it relates to loss of grandfathered status. Grandfathered status is lost if the employer contribution rate decreases by more than 5 percentage points. If the employer contribution is determined based on a formula, grandfathered status is lost if the formula changes in such as way as to cause the employer contribution to change by more than 5 percentage points. Grandfathered status is not lost merely because the cost of coverage changes

ERRP Update: Early Retiree Reinsurance Program to Cease Accepting Applications

In other news, the Department of Health and Human Services (HHS) has indicated that they will stop accepting applications for the Early Retiree Reinsurance Program (ERRP), effective May 6, 2011. The ERRP is designed to encourage employers to establish or maintain health coverage for their early retirees aged 55-64, and their eligible spouses and dependents. The purpose of the program is to provide reimbursement of certain expenses to plan sponsors of group health plans that provide retiree coverage.

HHS has determined that the five billion dollar funding allocated to the Program will be exhausted, based on the needs of applicants up to this point. The law allows HHS to cease receiving applications when it believes the funds will be exhausted. A plan sponsor who would like to apply to the ERRP must submit its complete application no later than 5PM ET on May 5, 2011. Applications received after May 5, 2011, will not be accepted. The Program expires January 1, 2014.

Background CBIZ Health Reform Bulletins on ERRP:

- Early Retiree Reinsurance Program (5/5/10)
- Early Retiree Subsidy – Initial Application Date is Approaching (6/11/10)
- Early Retiree Reinsurance Program Application Process Opened (6/29/10)
- Update: Early Retiree Reinsurance Program (9/1/10)
- Early Retiree Reimbursement Program Updates (10/5/10)

About the Author: Karen R. McLeese is Vice President of Employee Benefit Regulatory Affairs for CBIZ Benefits & Insurance Services, Inc., a division of CBIZ, Inc. She serves as in-house counsel, with particular emphasis on monitoring and interpreting state and federal employee benefits law. Ms. McLeese is based in the CBIZ Leawood, Kansas office.

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Subject: **Repeal of Free-Choice Vouchers and Form 1099 Reporting Requirement**

Date: April 18, 2011

Two laws have recently been passed that impact the Patient Protection and Affordable Care Act (PPACA). Both laws relate to the repeal of certain aspects of health care reform law. One law relates to the repeal of the free-choice voucher provision; and, the second law repeals the Form 1099 reporting requirement.

Free-Choice Vouchers

As background, the PPACA would have required, beginning in 2014, that if certain conditions are met, the employer would have had to pay a voucher to allow an employee to purchase health coverage through an Exchange (according to the PPACA, states would be required to establish Exchanges by 2014). This would be true if the cost of health coverage through the Exchange would be more cost-effective than that which could be obtained from the employer, and as long as the employee meets certain financial criteria. This voucher requirement has been repealed (H.R. 1473, "*Department of Defense and Full-Year Continuing Appropriations Act*").

The repeal of the voucher requirement does not impact the tax penalty that could be imposed on certain employers, beginning in 2014. The tax penalty would be imposed if the employer offers no health coverage, or inadequate coverage, or if the employer offers minimum essential coverage, but the employee could obtain coverage more cost-effectively through Exchanges.

Form 1099 Reporting Requirement

Secondly, beginning in 2012, the PPACA would have required businesses that pay $600 or more for goods and/or services to a single payee, whether a corporation or otherwise, to file a Form 1099, reporting the payments (see *Expanded 1099 Reporting Requirements for 2012 and Call for Public Comment*). Historically, only services have been subject to Form 1099 reporting, and payments to corporations were exempt. Reporting the payments for goods was added, however, as part of PPACA as a means of raising revenue to help offset the costs of other reform provisions. This aspect of the PPACA has been repealed. [Public Law 112-9 (H. R. 4), "*Comprehensive 1099 Taxpayer Protection and Repayment of Exchange Subsidy Overpayments Act of 2011"]*

Effective Date

Both of these provisions are effective as though they were never included in the PPACA.

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CBIZ
Health Reform Bulletin

Subject: **Update: Mini-Med Plan Waivers**
Date: June 22, 2011

One of the requirements of health care reform contained in the Patient Protection and Affordable Care Act (PPACA) is that health plans, both grandfathered and non-grandfathered, can impose no annual or lifetime limits on essential benefits. While the law requires no annual limits, there is a phase-in period for compliance with this requirement between now and 2014. During this time, a plan can impose limits in accordance with the following schedule:

Annual Limit	Applicable to plan years between
$750,000	9/23/10 and 9/23/11
$1.25 Million	9/23/11 and 9/23/12
$2 Million	9/23/12 and 1/1/14

When the regulations were issued interpreting this provision of the PPACA, the regulators indicated that a waiver process would be established for health plans, commonly referred to as "mini-med plans" or "limited medical plans". HHS would waive compliance with the annual limit provision if such restriction would result in a significant decrease in access or benefits, or a significant increase in premium.

To date, essential health benefits have not been defined; though, the law does provide classification types of coverage that would constitute essential coverage:

1. Ambulatory patient services;
2. Emergency services;
3. Hospitalization;
4. Maternity and newborn care;
5. Mental health and substance use disorder services, including behavioral health treatment;
6. Prescription drugs;
7. Rehabilitative and habilitative services and devices;
8. Laboratory services;
9. Preventive and wellness services and chronic disease management; and
10. Pediatric services, including oral and vision care.

It is believed that the viability of certain plans would be jeopardized by the imposition of the annual and lifetime limit requirements. In order to preserve health benefits for individuals covered by these types of plans, between now and 2014 when it is anticipated that expanded coverage would be more available, a waiver process was established. In September, 2010, the HHS' Center for Consumer Information and Insurance Oversight (CCIIO) issued guidance on how a plan requests a waiver (see *Mini-Med Plan Relief from Annual Limit Restriction Offered*).

On June 17, 2011, the CCIIO issued supplemental guidance, *Concluding the Annual Limit Waiver Application Process*, relating to waivers (new application forms, extension forms and instructions are here).

- **No New Waivers**. The CCIIO will no longer accept applications for new waivers after September 22, 2011. Plans applying for a new waiver must complete and submit the Waiver Application, and submit a signed attestation. New Applicants applying for a waiver must submit the waiver application form, attestation, and any supplemental information by e-mail to "AnnualLimitWaiver@cms.hhs.gov" (use "New Waiver Application" as the subject of the email).

  As of June 17, 2011, CCIIO will stop accepting waiver applications based on prior CCIIO application forms. CCIIO will begin accepting applications from New Applicants on June 24, 2011. The deadline for receipt of new waiver applications is September 22, 2011. Waiver applications received from a New Applicant after September 22, 2011 will not be accepted.

- **Extension of Existing Waivers**. Plans that have received a waiver relating to the $750,000 limit for a plan years between September 23, 2010 and September 23, 2011, can request an extension of its waiver by completing a Waiver Extension form, and providing the following:
  1. Updated contact information of the applicant;
  2. Enrollment information;
  3. The plan's stated current annual limit; and
  4. A signed attestation.

  Entities requesting the extension must submit the Waiver Extension form and attestation by e-mail to "AnnualLimitExtension@cms.hhs.gov" (use "Waiver Extension" as the subject of the e-mail).

  CCIIO will begin accepting elections for Waiver Extensions on June 24, 2011. The deadline for receipt of Waiver Extension forms is September 22, 2011. Elections for a Waiver Extension received after September 22, 2011 will not be accepted. Plans that do not elect a Waiver Extension will be required to comply with the annual limit restrictions.

  Plans may elect to extend an existing waiver until January 1, 2014. A Waiver Extension applies only to plan years between September 23, 2011 and January 1, 2014. Beginning on or after January 1, 2014, all plans will have to comply with annual and lifetime limit requirements.

In addition, both new and existing applicants requesting extensions are subject to:

- An **Annual Reporting Requirement.** The annual report must be submitted to CCIIO by December 31, 2012; the second annual report must be submitted by December 31, 2013; and
- A **Recordkeeping Requirement**. Records must be maintained to substantiate or prove information contained in the waiver application.

Annual Notice Requirement

As a condition of maintaining waiver status, plans are required to annually notify affected individuals that the plan does not meet the restricted annual limits for essential benefits.

The Annual Notice must be provided to eligible participants, and included in plan materials that describe the terms of coverage, such as summary plan descriptions, for each plan year for which the waiver applies. Below are the timeframes for providing the Annual Notice:

- New Applicants approved after June 17, 2011 for plan years between September 23, 2010 and September 23, 2011 that do not meet the $750,000 annual limit requirement;
- Each plan year for a New Applicant or entity receiving a Waiver Extension between September 23, 2011 and September 23, 2012 that do not meet the $1.25 million annual limit requirement; and
- Each plan for a New Applicant or entity receiving a Waiver Extension between September 23, 2012 and January 1, 2014 that do not meet the $2 million annual limit requirement.

Model Notice Language

Following is updated model language that must be used to notify affected participants. This language must be prominently displayed in clear, conspicuous, 14-point bold type on the front of plan materials:

The Affordable Care Act prohibits health plans from applying dollar limits below a specific amount on coverage for certain benefits. This year, if a plan applies a dollar limit on the coverage it provides for certain benefits in a year, that limit must be at least [$750,000/$1.25 million/$2 million, as applicable].

Your health coverage, offered by [name of group health plan or health insurance issuer], does not meet the minimum standards required by the Affordable Care Act described above. Your coverage has an annual limit of:

[dollar amount] on [all covered benefits]
and/or
[dollar amount(s)] on [which covered benefits – notice should describe all annual limits that apply].

This means that your health coverage might not pay for all of the health care you expenses you incur. For example, a stay in a hospital costs around $1,853 per day. At this cost, your insurance would only pay for [insert amount] days.

Your health plan has requested that the U.S. Department of Health and Human Services waive the requirement to provide coverage for certain key benefits of at least [$750,000/ $1.25 million/ $2 million, as applicable] this year. Your health plan has stated that meeting this minimum dollar limit this year would result in a significant increase in your premiums or a significant decrease in your access to benefits. Based on this representation, the U.S. Department of Health and Human Services has waived the requirement for your plan until [the ending date of the plan or policy year beginning before January 1, 2014].

If you are concerned about your plan's lower dollar limits on key benefits, you and your family may have other options for health care coverage. For more information, go to: www.HealthCare.gov.

If you have any questions or concerns about this notice, contact [provide contact information for plan administrator or health insurance issuer].

[For plans offered in States with a Consumer Assistance Program] In addition, you can contact [contact information for consumer assistance program].

Stand-alone HRAs

There is an outstanding question about whether the annual and lifetime limit requirements of the PPACA apply to health reimbursement arrangements (HRAs). HRAs integrated with health plans that comply with the PPACA are not required to satisfy the annual and lifetime limits, according to the interim final regulations. HRAs that only reimburse HIPAA-excepted benefits, such as dental or vision coverage, need not comply, nor do retiree-only HRAs, those that only cover retirees. It is unclear whether stand-alone HRAs that reimburse medical expenses other than those described above, must comply. Therefore, plan sponsors of stand alone HRAs may want to consult with their legal counsel about obtaining a waiver.

Prior Health Reform Bulletins related to Mini-Med Plans:

- Mini-Med Plans: Increased Transparency and Disclosure (12/20/10)
- Mini-Med Plan Relief from Annual Limit Restriction Offered (9/21/10)

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CBIZ
Health Reform Bulletin

Subject: **Modifications to Claims and Appeals, and External Review Processes**
Date: July 11, 2011

The Patient Protection and Affordable Care Act (PPACA) includes rules relating to health claims and appeals, and the right to an external review. These rules, applicable to non-grandfathered plans, are effective for plan years beginning on or after September 23, 2010; however, the Agencies provide for non-enforcement periods applicable to certain provisions (see CBIZ Health Reform Bulletin, *Delay in Claims and Appeals Enforcement*).

For plans subject to ERISA, these rules expand the currently applicable claim and appeal rules. For plan excepted from ERISA, these provisions are, in large part, new. A variety of guidance related to these rules has been issued thus far (see *Background CBIZ Health Bulletins*, below).

Most recently, regulations and a technical bulletin have been issued making some important changes to the previously issued guidance. Summarized below is some of the guidance most important to employer-sponsored health plans.

Urgent Care: Expedited Notification of Benefit Determinations
Originally, the law would have required that urgent claims be addressed within 24 hours, which is more restrictive than ERISA requirement of 72 hours. These regulations restore the 72-hour response requirement, but make it clear that urgent care claims must be addressed as soon as possible, but in no event later than 72 hours.

Inclusion of Diagnosis and Treatment Codes
The original law would have required that diagnosis and treatment codes be included in the denial letter. Due to privacy concerns, among other things, these regulations provide that diagnosis and treatment codes need not be included in the denial letter, but must be provided upon request.

Culturally and Linguistically Appropriate Notices
The law requires that denial information be provided in a culturally and linguistically appropriate manner. These regulations temper the rules a bit, as follows.

The non-English requirement is now based on the number of non-English speakers residing in a geographic area, rather than by the number of non-English speakers in the plan. The regulations include a county-by-county determination of this requirement; this information will be updated annually. Four languages, Spanish, Tagalog, Chinese and Navajo, are included in this determination/calculation.

According to the county chart included in the regulations, the following states have counties for which the foreign language requirement would apply:

States with County Population(s) that speak a particular Non-English Language and speak English less than "very well"		
Alaska	Idaho	North Carolina
Arkansas	Illinois	Oklahoma
Arizona	Kansas	Oregon
California	Nebraska	Texas
Colorado	Nevada	Utah
Florida	New Jersey	Virginia
Georgia	New Mexico	Washington
Iowa	New York	Puerto Rico

For individuals in need of non-English communications, plans subject to the language requirement must provide oral communications in the relevant language in the form of a telephone hotline or similar customer assistance process, with the ability to provide written translation, upon request.

The law would have required that all subsequent communications be provided in the relevant language. Although this provision has been eliminated, plans are required to provide subsequent communications in the appropriate language when requested by the claimant.

Inclusion of Available Consumer Assistance or Ombudsman Programs
Plans are required to disclose the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman to inform participants with the internal claims and appeals and external review processes. To assist plans with this disclosure, the Agencies provide a list of available Consumer Assistance Programs. Periodic updates of this list will be posted on EBSA's website, as well as the HHS' Center for Consumer Information & Insurance Oversight's website. In addition to the CAP list, EBSA also encourages plans to include EBSA's contact information in their notices as well (1-866-444-EBSA, extension 3272, or www.askebsa.dol.gov).

Revised Model Notices
The Agencies have issued revised model notices to include a one-sentence statement in the language(s) required in a particular county about the availability of translation services:

- Revised Model Notice of Adverse Benefit Determination
- Revised Model Notice of Final Internal Adverse Benefit Determination
- Revised Model Notice of Final External Review Decision

Adherence to the Strict Compliance Standard
The law suggests that strict adherence to the internal claim appeal and review process is necessary to reserve the right to bring further legal action. Generally, if there is a failure to comply with the claims and appeals process, an individual would immediately be allowed to proceed to an external review. These regulations provide that insignificant or minor errors will not allow the claimant to immediately proceed to an external review.

External Review
Matters Subject to External Review
These regulations limit the matters subject to external review under a self-funded plan, sought on or after September 20, 2011, to medical judgment and rescission. The governing Agencies reserve the right to broaden the playing field with regard to other matters that could be subject to external review; but, have indicated that any expansion will be imposed prospectively.

Independent Review Organizations- Safe Harbor for Self-Funded Plans
One of the components of the external review is the use of an independent review organization (IRO). The regulations provide a safe harbor for self-funded plans, as follows. Plans will be required to contract with at least two IROs by January 1, 2012, and with at least three IROs by July 1, 2012, and to rotate assignments among them. While this is a safe harbor, plans not choosing to rotate their IROs in this manner will likely be subject to DOL and IRS scrutiny to ensure that the independent IRO requirement is satisfied.

State Compliance
States that currently have external review process will have until December 31, 2011 to bring their process into conformity with the 16 consumer protection standards listed in the NAIC's Uniform Health Carrier External Review Model Act. If a state's external review process is not compliant for plan years beginning on or after December 31, 2011, then the state will have to follow the federal external review process. Self-funded plans subject to ERISA, and certain other plans, must follow the federal external review process.

Links to DOL EBSA's PPACA Internal Claims and Appeals and External Review Regulations and Technical Release, issued 6/24/11:

- Amendment to Interim Final Rule (pdf version)
- Technical Release 2011-02
- Revised Model Notice of Adverse Benefit Determination
- Revised Model Notice of Final Internal Adverse Benefit Determination
- Revised Model Notice of Final External Review Decision
- Updated List of Consumer Assistance Programs as of 05/23/11

Background CBIZ Health Reform Bulletins relating to Claims and Appeals and External Review:

- Delay in Claims and Appeals Enforcement (3/22/01)
- Agencies Issue PPACA Clarifications (10/12/10)
- Limited PPACA Exemption for Self-Funded, Non-Federal (10/12/10)
- Federal External Claims Review: Interim Procedures and Model Notices (9/30/10)
- Internal Claims and Appeals, and External Review Process (7/26/10)

About the Author: Karen R. McLeese is Vice President of Employee Benefit Regulatory Affairs for CBIZ Benefits & Insurance Services, Inc., a division of CBIZ, Inc. She serves as in-house counsel, with particular emphasis on monitoring and interpreting state and federal employee benefits law. Ms. McLeese is based in the CBIZ Leawood, Kansas office.
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Subject: **Preventive Care Coverage Expanded to include Women's Health Services**
Date: August 3, 2011

The Patient Protection and Affordable Care Act (PPACA) requires individual and group health plans to provide preventive coverage, without imposing any cost-sharing requirements (co-payment, co-insurance, or deductible), when such services are delivered by in-network providers. These rules apply to both non-grandfathered individual and group health plans, including both insured and self-funded plans; the rules do not apply to grandfathered plans. About a year ago, the governing Agencies issued interim final rules defining the parameters of certain preventive services (see CBIZ Health Reform Bulletin, *Preventive Health Services*).

On August 3, 2011, the governing Agencies released a proposed amendment to the interim final regulations, modifying the definition of preventive health care, specific to women's health care. These regulations would require coverage of:

1. Annual well-women care visits, including preconception and prenatal care.
2. Gestational diabetes screening for certain high-risk pregnant women.
3. Human papillomavirus/DNA test screening every 3 years, beginning at age 30.
4. Annual counseling for sexually transmitted infections.
5. Annual counseling and screening for human immune-deficiency virus.
6. Contraceptive methods and counseling, including coverage for prescribed FDA-approved contraceptive methods and sterilization procedures. Group health plans sponsored by certain religious employers would be exempt from the requirement to cover contraceptive services. A religious employer is defined as one that:
    - Has the inculcation of religious values as its purpose;
    - Primarily employs persons who share its religious tenets;
    - Primarily serves persons who share its religious tenets; and
    - Is a non-profit organization, as defined by IRC Section 6033.
7. Breastfeeding support and counseling during pregnancy and/or in the postpartum period, and costs for renting breastfeeding equipment.
8. Annual screening and counseling for interpersonal and domestic violence.

These regulations become effective on the first plan year beginning on or after August 1, 2012.

Additional information:

- HHS Fact Sheet: Guidelines for expanding women's preventive services
- HHS' Health Resources and Services Administration's Guidelines

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CBIZ
Health Reform Bulletin

Subject: **Proposals on Exchanges, Premium Assistance and Uniform Benefit Summary**
Date: August 19, 2011

In recent days, the governing Agencies (HHS, DOL and IRS) responsible for implementing the Patient Protection and Affordable Care Act (referenced as the "Affordable Care Act" or "ACA") have been busy. A number of proposed guidance have been issued, specifically relating to Exchanges, premium assistance ("Health Insurance Premium Tax Credit"), and perhaps of most interest to employers, the uniform benefits summary, now dubbed the Summary of Benefits and Coverage (SBC).

Exchanges

As background, the ACA provides that, beginning in 2014, states will have the opportunity to establish State-Based Exchanges. These Exchanges can be organized as public sector instrumentalities or non-profit entities. They can be placed under the jurisdiction of existing structures; they can be multi-state or regional. In the absence of a state establishing an Exchange, the federal government would provide the framework. There are two types of Exchanges: State-Based Exchanges and Small Business Health Options Program (SHOP) Exchanges.

State-Based Exchanges

Eligible entities determined to carry out the functions of a **State-Based Exchange** are those who are incorporated and subject to the laws of one or more states, and who have demonstrated experience and benefit coverage on a state or regional basis in the individual and small group health insurance markets; or, a state Medicaid agency. For this purpose, insurers are not considered eligible to qualify as Exchanges. A state can combine the two Exchanges, or run them separately. According to the proposed regulations, states would have significant freedom in designing their Exchange.

The Exchange is the vehicle through which qualified health plans are offered. Individuals and employers would be able to purchase health coverage through an Exchange.

SHOP Exchanges

The **Small Business Health Options Program (SHOP)** would be operated by an Exchange through which a qualified small employer can provide its employees and their dependents with access to one or more QHPs. For this purpose, a *small employer* is one who employs between 1 and 100 employees on business days during the preceding year.

Approval of Exchanges

An Exchange must be approved by HHS. According to these proposals, the Exchange must submit a request for approval by January 1, 2013, in order to begin offering qualified health plans by 2014. HHS would provide conditional approval of an Exchange if a state is not quite prepared to demonstrate its readiness by January 1, 2013. States can also apply to operate an Exchange for 2015, or subsequent years.

Premium Assistance: Health Insurance Premium Tax Credit

Certain individuals, specifically those whose household income is between 100 and 400% of federal poverty level, may be entitled to premium assistance, known as the "health insurance premium tax credit," to help in the purchase of health coverage through an Exchange. The governing Agencies have issued proposed regulations defining who qualifies for the new premium tax credit. These regulations, as they are developed, are in proposed form only; and thus, it is not yet time to dwell on the specifics of the regulations. The proposals relating to premium assistance do suggest a couple of points of importance to employers.

Also beginning in 2014, employers employing 50 or more full time equivalent employees may become subject to an excise tax if the employer does not offer coverage that satisfies standards (to be determined), or if the coverage is "unaffordable." One of the issues that has caused employers most angst is determination of what is *unaffordable*. The law provides that if the cost of employer-provided coverage is more than 9.5% of household income, then it will be deemed unaffordable. Employers do not know their employees' household income. The proposal suggests that future guidance will provide for a safe harbor for determining household income; this safe harbor may look something like this: If the cost of individual coverage does not exceed 9.5% of the employee's W-2 wages, the employer would not be assessed a penalty. Again, this is only a suggestion for future guidance. Unless and until regulations are issued and finalized, we will not know; but, this does give a good indication that there may be some relief for employers as they plan for 2014.

Uniform Summary of Benefits and Coverage

The ACA requires that a uniform benefits summary be developed and made available. The Agencies have issued a proposed template for this uniform benefits summary, referred to as a summary of benefits and coverage (SBC), and a proposed uniform glossary of coverage and medical terms to be used in the SBCs. These are not finalized documents yet; they are only proposed. According to the proposal, the documents would have to be provided by insurers issuing individual and group health plans, and by employers or their designated plan sponsors or third party administrators of self-funded plans.

Timing of SBC Disclosure. The SBCs would be provided to applicants, enrollees, and individual policyholders prior to coverage, 30 days before any renewal, and 60 days before any material change in benefits. The Agencies continue to look at how the SBCs can be provided in conjunction with already required summary plan descriptions, so as to minimize administrative burdens.

Method of providing SBC. It is proposed that the documents could be provided in paper or electronically, as long as the Department of Labor's electronic disclosure rules are satisfied.

About the Author: Karen R. McLeese is Vice President of Employee Benefit Regulatory Affairs for CBIZ Benefits & Insurance Services, Inc., a division of CBIZ, Inc. She serves as in-house counsel, with particular emphasis on monitoring and interpreting state and federal employee benefits law. Ms. McLeese is based in the CBIZ Leawood, Kansas office.

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CBIZ
Health Reform Bulletin

Subject: **Relief for Stand-Alone Health Reimbursement Arrangements**
Date: August 23, 2011

Some welcome new guidance for stand-alone health reimbursement arrangements (HRAs) has just been issued by the HHS' Center for Consumer Information and Insurance Oversight (CCIIO). As background, the Affordable Care Act prohibits health plans from imposing annual and lifetime limits. Certain plans, primarily so-called "mini-med plans," can seek a waiver from the prohibition of annual and lifetime limit provision. Earlier guidance on this issue exempted integrated HRAs. CCIIO has now issued a class exemption for stand-alone HRAs that were in existence on September 23, 2010.

The new guidance clarifies that any stand-alone HRAs in existence on or before September 23, 2010 will not be required to seek a waiver. This exemption will apply until January 1, 2014. There is an outstanding question about the viability of stand-alone HRAs in 2014 and beyond.

It is important to note that HRAs exempt from applying for an annual limit waiver must still comply with recordkeeping standards and the annual notice requirements:

- Records must be maintained to substantiate the waiver exemption.
- Plans are required to annually notify affected individuals that the plan does not meet the restricted annual limits for essential benefits. The Annual Notice must be provided to eligible participants, and included in plan materials that describe the terms of coverage, such as summary plan descriptions, for each plan year for which the exemption applies.

While there aren't many stand-alone HRAs, this guidance should come as welcome news to sponsors of those few types of arrangements currently existing.

Prior CBIZ Health Reform Bulletins related to Annual and Lifetime Waivers:

- Update: Mini-Med Plan Waivers (6/22/11)
- Mini-Med Plans: Increased Transparency and Disclosure (12/20/10)
- Mini-Med Plan Relief from Annual Limit Restriction Offered (9/21/10)

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CBIZ
Health Reform Bulletin

Subject: **ACA Updates: CLASS Act Suspended, Increase in ERRP Cost Thresholds and Amounts, and What Are Essential Benefits?**

Date: October 18, 2011

Suspension of CLASS Act

Long term care needs were addressed in the health care reform law through the Community Living Assistance Services and Supports Act (CLASS Act). The Department of Health and Human Services (HHS) was charged with establishing a national, voluntary long term care insurance program beginning in 2012 whereby a participating individual would contribute to the CLASS Program for 5 years (vesting period) before benefits (up to $50/day cash benefit) became available. The payments could be used to purchase non-medical services and support necessary to maintain community residence, including, home modifications, assistive technology, accessible transportation, homemaker services, respite care, personal assistance services, home care aides, and nursing support.

The CLASS Program was to be financed entirely through voluntary payroll deductions. All working adults would be automatically enrolled in the program, unless they choose to opt-out. Employers could voluntarily choose to provide enrollment tools and process the premiums for the Program.

Kathleen Sebelius, the Secretary of HHS, issued a statement last week indicating that implementation of the CLASS Program is now indefinitely suspended. The reasons for suspension relate to actuarial and solvency concerns - a way to provide an affordable benefit through the CLASS Program that is financially sound and self-sustaining has not been found. Thus, the CLASS Program is suspended indefinitely.

Early Retiree Reinsurance Program: Increased Cost Thresholds and Amounts

The Centers for Medicare and Medicaid Services announced an increase in the cost threshold and cost amounts applicable to the Early Retiree Reinsurance Program (ERRP). The ERRP reimburses up to 80% of the cost of benefits in excess of $15,000 and below $90,000. Beginning October 1, 2011, the cost threshold is increased to $16,000; the cost amount threshold increased to $93,000.

Background CBIZ Health Reform Bulletins about the ERRP:

- Grandfathered Status and ERRP Updates (4/4/2011)
- Early Retiree Reimbursement Program Updates (10/5/10)
- Update: Early Retiree Reinsurance Program (9/1/10)
- Early Retiree Reinsurance Program Application Process Opened (6/29/10)
- Early Retiree Subsidy – Initial Application Date is Approaching (6/11/10)
- Early Retiree Reinsurance Program (5/5/10)

Essential Benefits – What Are They?

As part of the ACA, no lifetime and ultimately, no annual limits may be imposed on the dollar value of "essential benefits" provided under group health plans, including grandfathered plans. In addition, it is anticipated that the defined essential benefit package will be used to determine the basic health benefit coverage sold through the Exchanges. Thus far, implementing regulations have not been issued defining essential benefits. "*Essential coverage*" is the term used to define categories of coverage. For example, the categories of coverage for which no lifetime or annual limit can be imposed. The law provides the following types of classifications of coverage that constitute essential coverage:

1. Ambulatory patient services.
2. Emergency services.
3. Hospitalization.
4. Maternity and newborn care.
5. Mental health and substance use disorder services, including behavioral health treatment.
6. Prescription drugs.
7. Rehabilitative and habilitative services and devices.
8. Laboratory services.
9. Preventive and wellness services and chronic disease management.
10. Pediatric services, including oral and vision care.

The Institute of Medicine (IOM) was charged with reviewing and coming up with a proposal for HHS on how to define essential benefits. They have completed their study, and have given general guidance on how essential benefits should be defined. Of particular note, IOM has determined that essential benefits should be based on that which is covered by a typical small employer, rather than that which is covered by a large employer. Often, large employers have richer benefits; presumably, the IOM recommendation is, at least in part, ensuring that coverage is not cost-prohibitive. According to the IOM criteria, essential benefits should:

- Be affordable to individuals, small employers, and taxpayers;
- Maximize the number of uninsured and address particular vulnerable populations;
- Encourage better care practices;
- Focus on high value services;
- Address medical concerns of enrollees; and
- Protect against financial risks due to catastrophic events or illness.

Specific components of the benefits should be safe, medically-effective, demonstrate meaningful improvement, and cost-effective. In addition, the IOM recommends that the criteria for defining and updating essential health benefits be transparent, participatory, equitable and consistent, sensitive to value, responsive to new information, attentive to stewardship, encouraging to innovation, and data driven.

It is anticipated that HHS will establish an initial core essential benefit package by May, 2012.

About the Author: Karen R. McLeese is Vice President of Employee Benefit Regulatory Affairs for CBIZ Benefits & Insurance Services, Inc., a division of CBIZ, Inc. She serves as in-house counsel, with particular emphasis on monitoring and interpreting state and federal employee benefits law. Ms. McLeese is based in the CBIZ Leawood, Kansas office.

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CBIZ
Health Reform Bulletin

Subject: **ACA Updates:**

- **Supreme Court to Ponder Health Care Reform Law**
- **Summary of Benefits and Coverage: Required When?**
- **New Health Finder Tool for Small Employers**

Date: November 28, 2011

Supreme Court to Ponder Health Care Reform Law

The Supreme Court of the United States has decided to review four questions of law deriving from the health care reform law (the *Patient Protection and Affordable Care Act*, referenced as the Affordable Care Act or "ACA"). The questions that the Supreme Court will consider are as follows:

1. ***Constitutionality***. Is the individual mandate (the requirement that most Americans maintain minimum essential coverage or be subject to a tax) constitutional? Or, did Congress exceed its authority by imposing the individual mandate? Specifically the Court will be looking at whether the individual mandate violates the Commerce clause of the US Constitution.
2. ***Medicaid Expansion***. Is the expansion of Medicaid impermissible? Medicaid is the state-run health program for the poor and indigent. It is funded in part by the federal government and in part by the states. The ACA will require states to allow people to be eligible for Medicaid if the individual's income falls below 133% of the federal poverty level, and if a state fails to expand Medicaid in this manner, federal funding would be lost.
3. ***Anti-injunction***. Is there a cause of action that can be reviewed at this point; or, must the matters be delayed until 2014 and beyond, at which point, the individual mandate will have taken effect, and individuals may have been subjected to a tax, and the Medicaid expansion will have occurred? In other words, at this point, is it necessary to punt until someone is actually harmed by the law?
4. ***Severability***. Can certain aspects of the ACA, specifically, the individual mandate and the Medicaid expansion, be severed from the rest of the law; or, are these aspects of the law so integratively intertwined with the rest of the law that the law must stand or fall in its totality? In other words, can certain aspects of the ACA be overturned while other aspects remain standing?

It is anticipated that the Supreme Court will hear these arguments in the early spring of 2012. The Supreme Court has allocated 5 to 5.5 hours for these arguments. A decision is expected next summer.

Summary of Benefits and Coverage: Required When?

The governing Agencies issued proposed regulations addressing the summary of benefits and coverage (SBC) on August 22, 2011 (see *Proposals on Exchanges, Premium Assistance and Uniform Benefit Summary*). A plan is not obligated to comply with the SBC rules until these regulations are finalized. The Agencies posted an FAQ last week affirming this position. It is anticipated that the Departments' final regulations, once issued, will include an applicability date that gives group health plans and health insurance issuers sufficient time to comply.

New Health Finder Tool for Small Employers

HHS has established a new web-based tool that can be used by small businesses to compare locally available health plan coverages and costs. The tool (http://finder.healthcare.gov/) provides information about an estimated 2,700 plans available from over 530 insurers.

Once a small business enters its state of domicile and zip code, the type of data returned includes:

1. Average cost and out-of-pocket limits per worker;
2. Deductibles and range of co-pays and benefits associated with coverage; and
3. Optional coverages available such as compatible HSA plans, or other add-on options, such as maternity benefits, mental health services, and prescription drugs.

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Subject: **1) Final Minimum Loss Ratio Regulations Issued and 2) ERRP Closes**
Date: December 12, 2011

Final Minimum Loss Ratio Regulations Issued
One of health care reform's more challenged provisions relates to what is known as the minimum loss ratio (MLR) rules. These rules require insurers issuing individual and group health plans to spend a certain amount of premium dollars on medical care and health care quality improvements. And, if the insurer does not meet the required target, a rebate is owed to the policyholder and subscriber.

Generally, the MLR rules require insurers to spend at least 85% of premium dollars paid by the large group market (over 100 employees) on medical claims; 80% in the small group (100 or fewer employees) and individual markets.

The MLR rules apply only to insured health plans. They do not apply to self-funded plans, nor do they apply to non-health insurance products.

These rules became applicable to insurers issuing individual and group health plans on January 1, 2011.

On December 7, 2011, the governing agencies (HHS and DOL) issued several pieces of implementation guidance in the form of two sets of final regulations, one set applicable to non-Federal governmental plans, and one set applicable to government plans and plans subject to ERISA together with a Technical Release. Of particular interest to employers, these regulations address how rebates are to be allocated. These final regulations become applicable on January 1, 2012; the first rebate is due in August 2012.

Method for Sharing Rebates
Generally, in the case of government plans and plans subject to ERISA, the rules allow the rebate paid to the policyholder to be shared proportionately with the plan participants. In the case of a non-governmental, non-ERISA plan, such as a church plan, the rebate can be paid to the policyholder only after the insurer receives "written assurance" from the policyholder that the rebates will be used to benefit individuals covered under the plan. Otherwise, the insurer must distribute the rebates directly to the individuals covered by the group health plan during the MLR reporting year on which the rebate is based.

Generally, the regulations require that the rebate be shared with participants proportionate to the participant's contribution. The regulations provide ways in which the rebate can be tax-favored; specifically, by using the rebate to offset future premium.

The plan can, by its written terms, define how the rebate is to be used, such as for administrative expenses, as a premium credit, etc. The plan must, of course, ensure that ERISA's exclusive benefit rule is satisfied. What this means is that plan assets must be used for the exclusive benefit of plan participants. In the absence of explicit detail in the plan, the DOL issued a Technical Release to provide guidance to ERISA plans on the proper use of rebates.

If the plan or trust is the policyholder, the rebate must be paid to the trust. If the employer/plan sponsor is the policyholder, and the employer pays the entire premium, the employer is entitled to receive the entire rebate. Conversely, if the participant pays the entire premium, the participant is entitled to the entire rebate. If the employer pays a fixed percent of the premium, and the participant is responsible for the balance, the participant is entitled to an amount of the rebate that does not exceed the participant's prior contribution to the plan. If the participant pays a fixed amount, and the employer pays the balance, the employer would be entitled to the portion of the rebate that does not exceed the employer contribution.

If there is no trust in which to deposit rebates, then the rebates must be used within 3 months; or, the rebates can be used to reduce future premium. This may be, in many cases, the most practical use of rebate money.

If the group health plan has been terminated at the time of rebate payment, and the insurer is unable to locate the policyholder, then the insurer must distribute the rebate directly to the individuals covered under the plan, in equal amounts proportionate to the premium paid by the policyholder, without regard to the amounts paid by the covered individuals.

Notice of Rebates

The MLR rules require insurers issuing group health plans to provide notice of any rebate of premium to both the policyholder and individuals covered under the plan. The Secretary of HHS will develop a model notice to be used for this purpose. The notice must include the following information:

1. A general description of the MLR concept;
2. The purpose of setting an MLR standard;
3. The applicable MLR standard together with the insurer's MLR;
4. The insurer's aggregate premium revenue, minus any Federal and State taxes and licensing and regulatory fees that may be excluded from premium revenue;
5. The rebate percentage and the amount owed to covered individuals based upon the difference between the insurer's MLR and the applicable MLR standard;
6. A statement explaining that the total aggregate rebate for the group health plan is being provided to the policyholder;
7. If the plan is subject to ERISA, a statement that the policyholder may have additional obligations under ERISA's fiduciary responsibility provisions relating to handling of rebates and contact information for question pertaining to the rebate.
8. If the policyholder is a non-Federal governmental plan, a statement that the proportion of the rebate attributable to subscribers' contribution to premium must be used for the benefit of subscribers.
9. If the policyholder is a group health plan that is not a governmental plan and is not subject to ERISA, a statement that the policyholder has provided written assurance that the proportion of the rebate attributable to subscribers' contribution to premium will be used for the benefit of current subscribers.

If the policyholder did not provide such written assurance, then the issuer must distribute the rebate evenly among the policyholder's subscribers covered by the policy during the MLR reporting year on which the rebate is based.

ERRP Update – Program Closes

CMS announced several months ago that the $5 billion dollar funding allocated to the Early Retiree Reinsurance Program (ERRP) was close to exhaustion. CMS stopped accepting applications for reimbursements as of May 6, 2011 (see *Grandfathered Status and ERRP Updates*, 4/4/2011).

On December 9, 2011, CMS announced that it has paid out $4.5 billion in reimbursement requests since the program began in June, 2010. CMS has determined that no claim incurred on or after January 1, 2012 will be reimbursed from the program since the balance of the money available will have been exhausted.

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CBIZ

Health Reform Bulletin

Subject: **Year-end Wrap Up**

Date: December 21, 2011

As the Affordable Care Act (ACA) is approaching its second birthday, it is appropriate to reflect on where we have come and what we can anticipate in the coming year.

In 2011, the governing Agencies (HHS, IRS and CMS) were busy issuing a multiplicity of guidance relating to health care reform, including:

1. Effective January 1, 2011, flexible medical spending accounts, health savings accounts, and health reimbursement arrangements could no longer reimburse over-the-counter (OTC) medications unless the OTC medication was insulin, or prescribed. Guidance was issued, specifically relating to how debit and credit cards could be used for these kinds of expenses, in satisfaction with the prescription requirement.
2. Delay in enforcing certain aspects of the internal claims and appeals process, and external review process until January 1, 2012. These rules were later modified again, specifically relating to expedited notification of urgent claim matters, use of diagnosis and treatment codes, adherence of a strict compliance standard, matters subject to external review, and furnishing the required notices and determinations in a culturally and linguistically appropriate manner.
3. Guidance on reporting the aggregate cost of health coverage on the Form W-2
4. Clarification of events that would cause a plan to lose grandfathered status, specifically when a benefit option is eliminated, when there is a change in the plan's drug formulary, or when there is a change in employer contribution.
5. Notification that CMS will no longer accept applications from plan sponsors pursuant to the Early Retirement Reinsurance Program beyond May 5, 2011. More recently, CMS announced that $4.5 billion of the allotted $5 billion in program monies have all but been exhausted and will no longer provide reimbursements after January 1, 2012.
6. Repeal of the free choice voucher provision and Form 1099 reporting requirement
7. Updates relating to the waiver process established for mini-med plans, limited benefit plans, and stand-alone health reimbursement arrangements seeking a waiver from the annual limit restriction provisions of the ACA.
8. The preventive care coverage mandate was expanded to include women's health services, such as annual well-women care visits, counseling and contraceptive coverage, without the imposition of any cost-sharing requirements.
9. Proposals on Exchanges, premium assistance, and uniform summary of benefits and coverage.
10. Suspension of the CLASS Act, a national voluntary long term care insurance program.

11. Final minimum loss ratio (MLR) rules that require insurers issuing individual and group health plans to spend at least 85% of premium dollars paid by the large group market (over 100 employees) on medical claims; 80% in the small group (100 or fewer employees) and individual markets. Insurers who fail to meet the required target must pay a rebate the policyholder and subscriber.

The Courts were in the action, as well:

- The Supreme Court announced that it will review four aspects of the health care reform law in the Spring of 2012: the constitutionality of the individual mandate provision, cessation of federal funding to expand state-run Medicaid, whether harm need be shown prior to reviewing the impact of the law (anti-injunction issue), and whether the entire law should be repealed, or whether only certain parts of it should be severed. The Supreme Court has scheduled the hearings to begin March 26, 2012, and continue daily through March 28, 2012. The Court has allotted 5.5 hours of oral arguments of the health care reform lawsuits spread over the three day period. The first topic to be heard will be the anti-injunction issue, followed by the constitutionality of individual mandate, and lastly, the severability issue. A ruling is expected sometime in Summer, 2012.
- To date, Appeal Courts have ruled on six challenges to the health care reform law; three more currently await rulings.
- The rulings issued from District Courts resulted in 3 cases where Court overturned the law or part of it; 6 cases where Court ruled the law was constitutional and dismissed the case; 9 cases where the Court dismissed the case for lack of standing or procedural problems; and 8 cases in which Court decisions are still pending.

And not to be left out in the cold, the States have been busy, too. To date, 28 States have been awarded federal grants to establish State-run Exchanges.

In addition, over 44 state legislatures filed hundreds of legislative measures this year opposing elements of the ACA, or proposing alternative policies, such as:

- Enacting laws that would prohibit state agencies or officials from applying for federal grants, or using state funds to implement ACA provisions unless authorized by adopted state law;
- Creation of an Interstate Freedom Compact to join forces across state lines to coordinate or enforce opposition; and
- Bills proposing the power of nullification of the ACA within state boundaries.

So, with all this behind us, what should we be anticipating in 2012?

- **Form W-2 Reporting of Health Coverage.** Certainly on the agenda for human resource departments is compliance with the Form W-2 reporting requirement. It will be very important for payroll systems to track their employee's participation in the health plans. Employers will report the aggregate cost of both the employer and employee share of actual coverage the individual has (see *IRS Issues Interim Guidance on W-2 Reporting*).

- **Uniform Summary of Benefits and Coverage.** The ACA requires all individual and group health plans (both ERISA plans and non-ERISA health plans), to provide a summary of benefits and coverage to participants of the plan. The government came out with proposed regulations on August 17, 2011. Due to numerous comments questioning how this provision can be

implemented, the governing Agencies have stated there is no compliance requirement until regulations are issued; and they have indicated that adequate time after regulations are issued will be given to allow plans to comply.

- ❒ **Patient-centered Outcomes Research Fee**. Effective for policy/plan years ending after September 30, 2012 (for calendar year plans, the fee will first be applicable for the 2012 plan year), a fee will be imposed upon health plans to fund patient-centered outcome research. The fee is to be paid by the insurer for a fully insured plan, by the plan sponsor for a self-funded plan.

  The initial fee will be $1 per covered life, increasing to $2 per covered life (indexed) for policy/plan years ending after September 30, 2013. This fee will cease to be assessed for policy/plan years ending after September 30, 2019. For a calendar year plan, this would be the 2018 plan year.

  At this point, we do not know how "average number of covered lives" will be defined nor do we have guidance about when or where the fee should be paid; we only know the years on which it is to be assessed.

- ❒ **Cap on Flexible Medical Spending Accounts.** Effective January 1, 2013, calendar year salary reduction contributions to flexible medical spending accounts (FSA) are limited to $2,500. At this point, there is no guidance on what, if any, impact this might have on reimbursement levels. Hopefully, between now and 2013, guidance will be forthcoming.

  In the meantime, plans with 'off-calendar year' plan years may want to amend their plans to reflect this $2,500 cap on salary reductions for the plan year beginning in 2012. Alternatively, a plan could wait until the 2013 plan year to make this amendment; though, the employer would have to ensure that for the 2013 calendar year, salary reduction contributions are limited to $2,500.

- ❒ **Independent Claims and Appeals, and External Review Process**. Insured non-grandfathered group health plans should be aware that the insurers will be implementing the ACA's claims, appeals and external review rules. Self-funded plans should work with their third party administrator to make certain that these requirements can be satisfied.

- ❒ **Women's Preventive Health Care**. Make certain that the women's preventive care requirements can be implemented for plan years beginning on or after August 1, 2012.

- ❒ **Notice of Grandfathered Status**. Grandfathered group health plans should make certain that their Notice of Grandfathered Status is included in plan materials provided to participants, including enrollment materials. The notice must also include the plan's contact information for questions and complaints.

- ❒ **Salary-based Discrimination Rules**. The ACA provides that salary based discrimination rules will apply to insured plans. About a year ago, the governing agencies suspended this provision until future guidance is issued. A recent informal non-binding comment by an IRS representative suggests that these rules will not be re-visited in the immediate future. In other words, there are more pressing ACA matters being addressed by the Agencies.

In particular, the Agencies are working hard on trying to figure out how the individual eligibility for premium assistance or cost-share through the Exchanges will be balanced with the employer's health

plan offering. And, in particular, how the excise tax penalty assessment that would be imposed on employers employing 50 or more full time equivalent employee would be assessed if an employer's employee is eligible for premium assistance or cost share through the Exchange.

Defining Essential Benefits

To wrap up the year, the HHS' Center for Consumer Information and Insurance Oversight issued an *Essential Health Benefits Bulletin* giving States significant discretion in defining the "essential benefits" package. The definition of essential benefits is important in that it will provide a standardized framework of benefit coverage that must be included in health plans, beginning in 2014. The essential benefit baseline applies to non-grandfathered plans in the individual and small group markets issued both in- and outside of Exchanges. Self-insured group health plans, health insurance coverage offered in the large group market, and grandfathered health plans are not required to cover the essential health benefits.

The ACA requires the following types of classifications of coverage to constitute essential coverage:

1. Ambulatory patient services;
2. Emergency services;
3. Hospitalization;
4. Maternity and newborn care;
5. Mental health and substance use disorder services, including behavioral health treatment;
6. Prescription drugs;
7. Rehabilitative and habilitative services and devices;
8. Laboratory services;
9. Preventive and wellness services and chronic disease management; and
10. Pediatric services, including oral and vision care.

According to the Bulletin, States can utilize one of the following categories for defining essential benefits:

- One of the three largest small group plans in the state;
- One of the three largest state employee health plans;
- One of the three largest federal employee health plan options; or
- The largest HMO plan offered in the state's commercial market.

On the one hand, the Bulletin delays the guidance that one might wish to have; on the other hand, it sanctions States' preference for control over defining essential benefits.

Note, both grandfathered and non-grandfathered plans are prohibited from imposing lifetime limits, and restricted on imposing annual limits on essential benefits. We're still awaiting guidance on how essential benefits will be interpreted for this purpose.

Certainly, there is much to stay tuned for as 2011 winds to a close, and 2012 ramps up.

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Health Reform Bulletin

Subject: **Additional IRS Guidance on W-2 Reporting Requirement**
Date: January 6, 2012

While 2012 is yet in its infancy, the IRS has released additional guidance relating to the Form W-2 health coverage reporting requirement imposed by the Affordable Care Act. In 2011, the IRS issued interim guidance explaining the W-2 requirement (see the CBIZ Health Reform Bulletin, *IRS Issues Interim Guidance on W-2 Reporting*). On January 3, 2012, the IRS issued Notice 2012-09 which modifies the prior 2011 guidance (IRS Notice 2011-28). Below are some of the pertinent modifications and clarifications made to the W-2 requirement.

Employers Exempt from the W-2 Reporting Requirement

Generally, certain types of employers are relieved, at least temporarily, from the reporting requirement. These include among others, Indian tribes and employers required to issue fewer than 250 Form W-2s. The 2012 guidance clarifies that:

- Federally-recognized Indian tribal governments, including employers that are tribally chartered corporations wholly-owned by a Federally-recognized Indian tribal government, are not subject to the W-2 reporting requirement.
- The small employer exception for employers who file fewer than 250 W-2s, which is based on the exemption from the electronic requirement to file W-2s, will continue to apply, until future guidance is issued.

Coverage Subject to the W-2 Reporting Requirement

- With regard to **flexible medical spending accounts** ("FSA"), the 2012 guidance clarifies that FSAs funded strictly with salary reduction contributions are not subject to the reporting requirement. If the FSA is funded with dollars, such as non-elective dollars or flex dollars (other than salary reduction dollars), then the amount to be reported on the W-2 excludes the salary reduction contributions.
- **Dental and vision plan coverage**. The guidance clarifies that limited scope dental and vision plans that are excepted from the HIPAA portability law are likewise excepted from the W-2 reporting requirement. To meet the "limited scope exemption" under HIPAA, the plan must specifically, and only provide benefits for, in the case of dental plans, issues relating to the function and structure of the mouth, and for vision coverage, issues relating to the function and structure of the eye. Further, to qualify for these exemptions, the plan must be a separate and independent policy; or, if it is not a separate and independent policy, for example, in the case of a self-funded situation, the dental or vision plan must not be integral with the health plan. What this means is that the participants must have the right to elect or decline the dental or vision coverage, and if elected, there must be a separate cost for the dental or vision coverage.

- **EAP, Wellness Programs and On-site Clinics.** With regard to coverage provided under an employee assistance program (EAP), a wellness program, or on-site medical clinic, if such coverage does not qualify as a "health plan", for example, a referral only-EAP, then there is no W-2 reporting requirement. If such EAP, wellness program, or on-site medical clinic coverage does qualify as a health plan and premiums are charged to individuals on COBRA or comparable continuation coverage, then these amounts must be reflected on the W-2.
- **Hospital Indemnity or Fixed Dollar Coverage.** The amount of any hospital indemnity or fixed dollar plan coverage when funded in whole or in part by the employer, including salary reduction dollars, must be reported on the W-2. However, if such coverage is fully paid with after-tax employee dollars, then these amounts do not have to be reported.

Calculating the Amount of Coverage

The guidance makes several clarifications about how to calculate the amount to be reported.

- If the employer uses a composite rate for active employees, but a strict COBRA rate for COBRA participants, the amount to be reported on the W-2 can be the composite rate, or the COBRA rate, as long as it is consistently used.
- Amounts to be reported are determined based on the actual coverage the employee has throughout the year. If the employee has single coverage for half the year, and family coverage for half the year, this must be reflected. Similarly, if an individual joins a plan mid-month, the pro-rated cost of coverage for that month should be reported. Several examples in the IRS Notice illustrate these circumstances (Q&As 28, 29 and 30).
- If the COBRA rate minus the 2% administrative fee is used for the W-2 reporting, and if the COBRA 12-month determination period differs from the calendar year, the amount to be reported on the W-2 would have to reflect that which it charged during the relevant calendar year. In other words, the rate may not be the same throughout the calendar year.
- If an employer learns of a change in coverage after the end of the calendar year, such as the occurrence of divorce, the employer is not obligated to modify the W-2 to reflect the change. In other words, the employer can report, on the W-2, the information that it has as of December 31st.

In ***determining the aggregate reportable cost***, the W-2 reporting is not required to reflect:

- Amounts includible in an individual's income as a result of any self-funded plan discrimination test failures; nor
- Health premium payment amounts includible in a Subchapter S over-2% shareholder's income.

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CBIZ
Health Reform Bulletin

Subject: **ACA Updates**:
- **Final Rules And Format For Uniform Summary Of Benefits And Coverage**
- **Faqs On 90-Day Waiting Period Limitation, Shared Responsibility Requirement, And Automatic Enrollment Provision**

Date: **February 10, 2012**

Final Rules: Summary of Benefits and Coverage

The governing Agencies (HHS, IRS and DOL) responsible for interpreting and regulating the Affordable Care Act (ACA), have been busy these last days issuing guidance to employers. Of particular note, we now have guidance on ACA's requirement for a uniform summary of benefits and coverage (SBC).

As background, ACA requires individual and group health plans to provide a written 4-page (can be double-sided but cannot be smaller than 12-point font) uniform summary of benefits and coverage. Plans must begin using this SBC for the first open enrollment period occurring on or after September 23, 2012. For calendar year plans, this would be the open enrollment period occurring in late 2012 for 2013 calendar year. If a plan does not have an open enrollment period, the SBC would be required for special enrollment events occurring on or after the first day of the first plan year after September 23, 2012.

What's in the SBC?

SBCs must include the following information:

1. Uniform definitions of standard insurance and medical terms for purposes of comparing and understanding health coverage;
2. A description of the coverage, including cost sharing, for each category of benefits;
3. The exceptions, reductions, and limitations of the coverage;
4. The cost-sharing requirements of the coverage, including deductible, coinsurance, and copayment obligations;
5. The renewability and continuation of coverage provisions;
6. Coverage examples that illustrate benefits provided under the plan for common benefit scenarios, such as pregnancy or a chronic medical condition;
7. A statement that the plan provides minimum essential coverage (only applicable to coverage beginning on or after January 1, 2014);
8. A statement that the SBC is a summary only, and that the plan document or insurance policy, certificate, or contract must be consulted to determine the governing contractual terms of the coverage;
9. Contact information, including phone numbers and internet address for consumers to ask questions, and to request a copy of the plan document or insurance policy, certificate, or contract. In addition, the relevant contact information must be provided for obtaining the plan's list of network providers, and information about a plan's prescription drug formulary, if applicable.

10. An internet address and contact phone number for obtaining the uniform glossary, as well as a statement about the availability of paper copies of the glossary.

SBC Templates
The governing agencies provide templates for the SBCs and uniform glossary that can be used:

- Summary of Benefits and Coverage Template
- Uniform Glossary of Coverage and Medical Terms

Additional instructions for completing the SBC, sample completed SBCs and coverage examples are available from both HHS and DOL websites.

Who Provides the SBC?
Generally, for insured plans, the SBCs will be provided by the insurer. For self-funded plans, the plan sponsor will be responsible for issuing SBCs.
It is important for plans subject to ERISA to remember that they are still obligated to comply with all of the reporting and disclosure requirements of ERISA, including the summary plan descriptions and summary of material modifications. This guidance affirms that an SBC can be incorporated with another document, such as an SPD (summary plan description), as long as it is clearly identified as the SBC and is placed at the beginning of the document into which it is incorporated. This should come as welcome news to those responsible for ERISA plans.

What's the Timeframe for Providing the SBCs?
The SBCs must be provided in the following timeframes:

From Insurer to Plan Sponsor

1. Upon application for coverage. The SBC must be provided upon application for coverage as soon as practicable but no later than 7 days following receipt of the application.
2. By the first day of coverage if there are any changes made to the information contained in the SBC.
3. Upon contract renewal, the insurer must provide a new SBC if written application is required for the renewal no later than the date the application materials are distributed. If the contract automatically renews, the SBC must be provided within 30 days prior to the beginning of the first day of the new plan year.
4. Upon request. The SBC must be provided upon the plan sponsor's request as soon as practicable but no later than 7 days following receipt of the request.

From Plan Sponsor to Plan Participants
Plan sponsors must provide the SBC to all participants and beneficiaries for each benefit package to which the participants and beneficiaries are eligible in the following timeframes:

1. Upon application. The SBC must be provided together with any written enrollment materials distributed to participants. If written enrollment materials are not distributed, then the SBC must be distributed no later than the first date on which the participant is eligible to enroll in coverage.
2. By the first day of coverage if there are any changes made to the information contained in the SBC.
3. SBCs must be provided to special enrollees within 90 days of enrollment.
4. Upon contract renewal, the insurer must provide a new SBC if written application is required for the renewal no later than the date the application materials are distributed. If the contract

automatically renews, the SBC must be provided within 30 days prior to the beginning of the first day of the new plan year.
5. Upon request. The SBC must be provided upon the participant's request as soon as practicable but no later than 7 days following receipt of the request.

Notice of Material Modification. If a group health plan makes any material modification in any of the terms of the plan or coverage that would affect the content of the SBC, that is not reflected in the most recently provided SBC, and that occurs other than in connection with a renewal or reissuance of coverage, the plan must provide notice of the modification to enrollees no later than 60 days prior to the date on which the modification will become effective.

Multiple Benefit Packages. If a group health plan offers multiple benefit packages, SBCs need only be provided for the particular plan for which the individual is covered. However, participants can request an SBC to another benefit package; in this event, the SBC must be provided as soon as practicable but no later than 7 days following receipt of the request.

How are SBCs Distributed?
SBCs can be provided to participants in paper form, as well as electronically, such as by e-mail or internet posting. If delivered electronically to individuals in the workplace, the DOL's electronic distribution rules must be satisfied:

1. The individual has ready access to a system (a computer).
2. A plan administrator must ensure receipt of the document. Suggestions include use of return-receipt or notice of undelivered mail features, or conducting periodic reviews or surveys to confirm receipt of transmitted information.

For electronic disclosure to individuals outside the workplace, certain conditions must be met. The individual must:

1. Consent, in writing, to the electronic disclosure. The consent must identify the type(s) of document to which it applies. The consent must occur after the individual has been given information about the electronic disclosure. Individuals have the right to withdraw a consent at any time, without charge.
2. Provide his/her e-mail address to receive the electronic disclosure, if applicable.
3. Be given applicable hardware and software requirements necessary to access the electronic disclosure. If any of these parameters change, an updated notice must be provided to the affected individual, and a new consent must be obtained.

All electronic disclosures must provide a clear statement that a paper copy of the document can be requested.

If a document includes any personal information, appropriate safeguards must be in place to ensure the confidentiality of the information. Use of a password or an individual identifier, as well as encrypting personal information, would be reasonable methods that could be used to ensure confidentiality.

FAQs: 90-day Waiting Period Limitation, Shared Responsibility Requirement and Automatic Enrollment Provision

The ACA governing agencies issued a set of Frequently Asked Questions (IRS Notice 2012-17 and EBSA Technical Release 2012-1, "Notice and Release") relating to several ACA provisions, specifically, the 90-day waiting period limitation, the employer's obligation under the shared responsibility requirement, and the automatic enrollment provision.

As background, in 2014, individual and group health plans cannot impose waiting periods under a plan exceeding 90 days. In addition, large employers, those employing 50 or more full-time equivalent employees, could be subject to a shared responsibility penalty if the employer fails to offer minimum essential coverage, or if the coverage offered is unaffordable (link to bulletin). Very large employers, those with 200 or more employees, will be required to automatically enroll their employees in health coverage with the individuals having the right to opt out of the coverage. It is very important to note that information contained in both the Notice and Release simply an iteration of how the governing agencies are thinking about developing implementing regulations. These documents are not regulation and are not binding in any way. Nevertheless, it gives some indication about how the governing agencies plan to interpret the law.

90-day Waiting Period Limitation

For plan years beginning on or after January 1, 2014, the maximum waiting period that can be imposed by grandfathered (those plans in existence on March 23, 2010) and non-grandfathered health plans or plans that have undergone significant change (link to bulletin) is 90 days. The Notice and Release confirms that the 90 day waiting period limitation applies to individuals eligible for coverage under the plan. It does not require that a plan offer coverage to any particular group of employees (though, see the Shared Responsibility discussion below).

Generally, the 90-day period is a strict 90-day period though the Notice and Release suggest that the government is looking at allowing the 90-day period to begin after certain eligibility conditions occur, such as attaining full-time status, a bona fide job category, or receipt of a required license. Once an individual has achieved the eligibility standard, then the 90-day period would be a strict 90-day period.

Shared Responsibility Requirement

For purposes of determining coverage affordability, the law provides that the cost of coverage cannot exceed 9.5% of household income. The Notice and Release restates the position that the government is looking at allowing employers to use W-2 earnings for purposes of this calculation.

Generally, the shared responsibility penalty applies if the employer offers inadequate coverage, or if the coverage is unaffordable for the employee. This penalty is triggered if any employee working 30 or more hours per week goes to the exchange and qualifies for premium assistance. The governing agencies address how to determine whether an individual will trigger a penalty in several ways.

First, the Notice and Release suggests that during the 90-day waiting period, a penalty would not be triggered, even if the individual qualifies for premium assistance through the exchange. The Notice and Release goes on to suggest that the agencies might contemplate an "intent" type provision whereby if an individual is hired on a part-time basis, but works full-time during an employer's busy season, such as the holidays, but then drops down to part-time during the second 90 days of employment, then the penalty would not be triggered during that second 90-day period, as long as the fluctuation in hours is not a way to avoid the intent of the law.

The Notice and Release also suggest that the agencies are considering using a stability period (a look-back period), not to exceed one year. What this would mean is that if an individual would qualify during the look-back (stability) period, then the individual would be deemed to work 30 or more hours per week for the "measurement period."

Automatic Enrollment in Health Plans

Employers subject to the Fair Labor Standards Act and who employ 200 or more employees are required to automatically enroll new full-time employees in one of their health benefit plans. Although this provision became effective on ACA's enactment date (March 23, 2010), the governing agencies have indicated in prior guidance, as well as reiterated in the Notice and Release, that employers will not be required to comply with the provision until implementing regulations are issued, which may be after 2014.

About the Author: Karen R. McLeese is Vice President of Employee Benefit Regulatory Affairs for CBIZ Benefits & Insurance Services, Inc., a division of CBIZ, Inc. She serves as in-house counsel, with particular emphasis on monitoring and interpreting state and federal employee benefits law. Ms. McLeese is based in the CBIZ Leawood, Kansas office.

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CBIZ
Health Reform Bulletin

Subject: **Preventive Health Services for Women: Regulations Final – Limited Exception for Certain Church Plans**
Date: February 13, 2012

More health care reform guidance has been finalized, of sorts, specifically relating to required coverage for preventive health care services, and more specifically, women's health services.

As background, non-grandfathered plans, including plans that lose grandfathered status, must provide coverage for preventive health services, without cost, to participants. Last summer, the governing Agencies issued a proposed amendment expanding certain preventive services applicable to women (see the CBIZ Health Reform Bulletin, *Preventive Care Coverage Expanded to include Women's Health Services*, 8/3/2011). For plan years beginning on or after August 1, 2012 (January 1, 2013 for calendar year plans), plans must include coverage for these women's health services:

1. Annual well-women care visits, including preconception and prenatal care.
2. Gestational diabetes screening for certain high-risk pregnant women.
3. Human papillomavirus/DNA test screening every 3 years, beginning at age 30.
4. Annual counseling for sexually transmitted infections.
5. Annual counseling and screening for human immune-deficiency virus.
6. Contraceptive methods and counseling, including coverage for prescribed FDA-approved contraceptive methods and sterilization procedures.

Group health plans sponsored by certain religious employers are exempt from the requirement to cover contraceptive services. This very narrow exemption applies to religious organizations that specifically serve that particular religious population. For this purpose, a religious employer is defined as one that:

1. Has the inculcation of religious values as its purpose;
2. Primarily employs persons who share its religious tenets;
3. Primarily serves persons who share its religious tenets; and
4. Is a non-profit organization, as defined by IRC § 6033.

This 'religious employer' definition is particularly problematic in that it leaves a wide group of church organizations without the ability to use the exception. Examples of church organizations that would *not* fit within this narrow exception include, but are not limited to, hospitals, colleges and universities, private primary and secondary schools, and social service organizations. As a general matter, these organizations serve people of multiple denominations, and their services relate to medicine, education, social service among others.

In response to this concern, on January 20, 2012, the Obama Administration announced a one-year delay for plans sponsored by religious employers to give such plans time to figure out compliance. If the religious employer does not offer contraceptive coverage in its plan, it would be required to notify its employees about the excepted coverage, and provide information about contraceptive services available at community health centers, public clinics, and certain hospitals receiving income-based support. This created further concern by organizations that have a religious opposition to such coverage. Of particular concern is requiring these organizations to pay for such coverage.

On Friday, February 10, 2012, the Obama Administration announced that, during the transition year, regulations will be proposed and finalized that will exempt religious organizations from the requirement to include the contraceptive coverage in their health plans and relieve them of the obligation to pay for such coverage.

The Obama Administration has indicated that women working for these religious organizations will, however, still be entitled to such coverage at no cost, directly from the insurer. Thus far, there has been no guidance on how this will be addressed for self-funded plans. It should also be noted, as mentioned above, that grandfathered plans, those in existence on March 23, 2010 that have not undergone significant change are generally exempt from the requirement to provide preventive services at no cost.

Clearly, many issues remain to be resolved; but at least for this near term, plans sponsored by employers with religious connections and with objection to this type of coverage are relieved from the obligation to provide it. Stay tuned for further developments on this issue.

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CBIZ
Health Reform Bulletin

Subject: **1) Summary of Benefits and Coverage: Clarifying FAQs Issued**
2) Administration Seeks Comments on Women's Preventive Services

Date: March 21, 2012

Summary of Benefits and Coverage: Clarifying FAQs Issued

About a month ago, final regulations were issued relating to the summary of benefits and coverage (see CBIZ Health Reform Bulletin, *Final Rules: Summary of Benefits and Coverage*, 2/10/12). In an on-going effort to assist in compliance with the health care reform law, the governing agencies (Departments of Health and Human Services, Labor and Treasury) issued 24 Frequently Asked Questions relating to implementation of the Summary of Benefits and Coverage ("SBC"). The agencies have promised to issue more guidance as it becomes appropriate.

A bit disappointing to many is that the effective date of issuance of the SBCs remains the same. Plans must begin issuing an SBC for the first open enrollment period occurring on or after September 23, 2012. For calendar year plans, this would be the open enrollment period occurring in late 2012 for 2013 calendar year. If a plan does not have an open enrollment period, the SBC would be required for special enrollment events occurring on or after the first day of the first plan year after September 23, 2012.

But, the good news is that the governing agencies have indicated their primary motive is to assist and facilitate compliance, rather than impose penalties. Therefore, a good faith effort to comply with the rules should be the theme of the day.

Below are highlights of some of these FAQs:

Number of SBCs. FAQs 3 and 4 address the issue of whether a single SBC can be used to describe different tiers of coverage, such as single or family coverage, as well as variable cost-sharing requirements, such as deductibles, co-payments and co-insurance levels. As long as the tiers of coverage and cost share requirements are presented in an understandable option type format, then only one SBC needs to be prepared.

Further, if a health plan offers component plans such as a medical flexible spending account (FSA), a health savings account (HSA), a health reimbursement account (HRA) or a wellness program, a summary of these component plans can be described in a single SBC (see FAQ #6).

Providing the SBC to COBRA Continuees

Group health plan coverage offered to qualified COBRA continuees cannot differ in any way from the benefits offered to similarly situated active participants under the plan. This means that the qualified beneficiary must be notified about plan changes just as active participants are so notified. Open enrollment opportunities available to a non-COBRA participant must likewise be available to a

COBRA continuee. FAQ 8 clarifies that an SBC must be provided to a COBRA continuee upon the occurrence of certain events, such as when the individual participates in a region-specific HMO and moves out of the HMO's service area.

Timeframe for Providing SBCs

FAQ 9 reiterates the 5 timeframes set forth in the regulations in which SBCs must be provided:

1. ***Upon application***. The SBC must be provided together with any written enrollment materials distributed to participants, such as forms or requests for information distributed in paper, through a website, or by e-mail. If written enrollment materials are not distributed by either paper or electronically, then the SBC must be distributed no later than the first date on which the participant is eligible to enroll in coverage.
2. By the ***first day of coverage*** if there are any changes made to the information contained in the SBC provided upon application.
3. SBCs must be provided to ***special enrollees*** within 90 days from enrollment.
4. ***Upon contract renewal***. An SBC must be provided at the same time open enrollment information is distributed to participants when the plan requires active election for coverage, or when other coverage options are available. If the contract automatically renews without an opportunity to elect other coverage options, then the SBC must be provided within 30 days prior to the beginning of the first day of the new plan year.
5. ***Upon request***. The SBC must be provided upon the participant's request as soon as practicable but no later than 7 business days following receipt of the request.

Electronic Distribution of the SBC

FAQ 10 describes how an SBC can be provided electronically. There are three requirements that must be met in order to provide an SBC electronically to participants and beneficiaries who are eligible for coverage but not enrolled:

1. The SBC must be prepared in a readily accessible format, such as html, MS Word, or pdf format;
2. A paper version of the SBC is available free of charge upon the individual's request; and
3. The plan sponsor timely notifies participants and beneficiaries about the availability of the SBC on its web portal, and provides the internet address to the SBC. This disclosure can be accomplished by an e-card or postcard furnished by e-mail. The FAQ 12 provides model language that can be used in an e-card or postcard to notify individuals about the SBC:

   Model Language: 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.website.com/SBC. A paper copy is also available, free of charge, by calling 1-XXX-XXX-XXXX (a toll-free number).

For plans subject to ERISA, the DOL rules relating to electronic disclosure of an SBC must be followed, as described below:

Electronic methods can be used for disclosure not only to participants, but to beneficiaries as well, as long as the affected individual has ready access to a system (a computer). A plan administrator must ensure receipt of the document. Suggestions include use of return-receipt or notice of undelivered mail features, or conducting periodic reviews or surveys to confirm receipt of transmitted information.

For electronic disclosure to individuals outside the workplace, certain conditions must be met. The individual must:

1. Consent, in writing, to the electronic disclosure. The consent must identify the type(s) of document to which it applies. The consent must occur after the individual has been given information about the electronic disclosure. Individuals have the right to withdraw his/her consent at any time, without charge.
2. Provide his/her e-mail address to receive the electronic disclosure, if applicable.
3. Be given applicable hardware and software requirements necessary to access the electronic disclosure. If any of these parameters change, an updated notice must be provided to the affected individual, and a new consent must be obtained.

All electronic disclosures must provide a clear statement that a paper copy of the document can be requested.

Confidentiality. If a document includes any personal information, appropriate safeguards must be in place to ensure the confidentiality of the information. Use of a password or an individual identifier, as well as encrypting personal information, would be reasonable methods that could be used to ensure confidentiality.

Use of Specific Language (FAQs 13 and 14)
The final regulations require SBCs to be provided to individuals in a culturally and linguistically appropriate manner, similar to the language requirements applicable to the ACA's claim and appeal rules. An SBC sent to an address in a county where 10% or more of its population are literate in a non-English language must meet 3 criteria:

1. Oral language services in the non-English language must be available;
2. Notices provided upon request must be in the non-English language; and
3. In any English versions of notice required to be provided, a plan must also include a statement, in non-English, that its notices can be obtained in the non-English language.

The HHS' Center for Consumer Information and Insurance Oversight maintains a list of counties in which language translations would be appropriate. It also provides written translation of the model SBC language in Spanish, Chinese, Tagalog and Navajo languages.

SBC vs. SPD
FAQ 15 make it clear that an SBC cannot simply reference a summary plan description (SPD). In a nutshell, the requirements of an SBC and the requirements of an SPD for plans subject to ERISA must be satisfied. The regulations do provide that the SBC can be provided as part of an SPD; but one cannot be used in lieu of the other.

Format Changes to the Model SBC
FAQs 17-19 address format changes made to the model SBC. Certain minor changes to headers and footers, as well as changes to the table or page set-up, are permissible.

Administration Seeks Comments on Women's Health Preventive Services
On March 21, 2012, the Departments of HHS, Labor and Treasury issued an advanced notice of proposed rulemaking relating to women's preventive services. The Agencies are requesting comments on how best to design a program that will ensure women have access to the full scope of preventive care services, including contraceptive coverage, without requiring nonprofit organizations with a religious opposition to contraceptive coverage from having to provide or pay for such services. Included in the request for comments is how to facilitate this for self-funded plans. Comments from the public will be accepted through June 19, 2012.

Background CBIZ Health Reform Bulletins about Women's Health Services:

- *Preventive Health Services for Women: Regulations Final – Limited Exception for Certain Church Plans* (2/13/12)
- *Preventive Care Coverage Expanded to include Women's Health Services* (8/3/2011)

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CBIZ
Health Reform Bulletin

Subject: **Overview of Final Exchange Regulations**
Date: March 28, 2012

Last summer, the Department of Health and Human Services (HHS) released proposed regulations relating to the establishment of Exchanges (see *Proposals on Exchanges, Premium Assistance and Uniform Benefit Summary*). On March 27, 2012, HHS published final rules outlining the framework of these Exchanges, as well as eligibility and enrollment standards for qualified health plans (QHP) offered through the Exchanges, and affordability programs, including premium tax credits.

Beginning in 2014, the Affordable Care Act requires that States have an Exchange in place; and if a State does not, then a federal Exchange will be imposed. An Exchange is intended to be a one stop marketplace available to individuals and certain employers for the purchase of health coverage. Eligible employers are able, but not obligated, to buy coverage through the Exchange.

Exchanges can be organized as public sector instrumentalities or non-profit entities. They can be placed under the jurisdiction of existing structures; they can be multi-State or regional.

There are two types of Exchanges: State-based Exchanges available to individuals and Small Business Health Options Program (SHOP) Exchanges available to small employers. A State can establish an Exchange to accommodate both individuals and small employers, as long as the regulatory standards for both types of Exchanges are met.

STATE-BASED EXCHANGES

A State can participate in an HHS-approved regional Exchange that spans two or more States, regardless of whether the States are contiguous. States are also permitted to establish one or more subsidiary Exchanges within its boundaries. Each State Exchange must receive HHS approval by January 1, 2013 in order to offer QHPs on January 1, 2014.

Qualified Health Plans

The Exchange is responsible for certifying QHPs that can be offered through the Exchange. The regulations establish standards for QHPs under Exchanges, and address other health insurance insurer requirements.

QHPs must meet certain ACA benefit design standards, such as provide essential health benefits and cost-share requirements, and meet the bronze, silver, gold, or platinum actuarial levels of benefits and coverage. A bronze plan is required to have an actuarial value of 60%; a silver plan, 70%; a gold plan, 80%; and a platinum plan, 90%.

Essential Health Benefits

Beginning in 2014, certain plans must include 10 specific categories of benefits, referred to as “essential health benefits”, as follows:

1. Ambulatory patient services.
2. Emergency services.
3. Hospitalization.
4. Maternity and newborn care.
5. Mental health and substance use disorder services, including behavioral health treatment.
6. Prescription drugs.
7. Rehabilitative and habilitative services and devices.
8. Laboratory services.
9. Preventive and wellness services and chronic disease management.
10. Pediatric services, including oral and vision care.

States have significant discretion in defining the essential benefits package which provides a standardized framework of benefit coverage that must be included in qualified health plans offered through Exchanges beginning in 2014.

Cost-Share Requirements
QHPs available through an Exchange are subject to cost-share requirements. The cost-share amount must equate to qualified high deductible health plan (HDHP) coverage. For out-of-pocket purposes, cost-sharing includes deductibles, coinsurance, co-pays and the like. For 2014, the deductible amounts are $2,000 for single coverage and $4,000 for coverage for more than one. These numbers will be adjusted for years beginning in 2015 and beyond.

Insurers issuing QHPs through an Exchange must offer at least one silver and one gold QHP, as well as a child-only QHP that has the same level of coverage as any QHP offered through the Exchange to individuals who, as of the beginning of the plan year, have not attained the age of 21.

The final regulations permit insurers to also offer limited scope dental plans as a stand-alone product or one integrated with a QHP.

Insurers offering QHPs are subject to standards relating to rate and participation, accreditation, transparency of coverage, network provider adequacy, as well as rules relating to enrollment, termination of coverage, payment of premium, notices and applications, prescription drug distribution and cost reporting, termination of coverage, marketing, and plan certification renewals.

Eligibility Determinations for Exchange Participation and Insurance Affordability Programs. Exchanges are required to establish a process to determine eligibility for individuals enrolling in a QHP, Medicaid, or CHIP, a process to determine eligibility for participation in the insurance affordability programs, and a process to determine whether an applicant is eligible for qualifying coverage under an employer-sponsored plan.

Exchange Reporting
Part of the eligibility determination process includes a notice obligation by the Exchange to employers about whether their employees are eligible for an advance payment of the premium tax credit or cost-sharing reductions. The notification would identify the employee and indicate:

1. The employee's eligibility for the premium tax credit;
2. The employer's potential excise tax penalty liability if it employs 50 or more full-time employees; and
3. The employer's right to appeal the determination.

If the Exchange determines that an individual is eligible for advance payments of the premium tax credit or cost-sharing reductions based on a finding that an individual's employer does not provide minimum essential coverage, or provides minimum essential coverage that is unaffordable, or does not meet the minimum value requirement, then the Exchange is obligated to transmit the individual's name and taxpayer ID number to the Department of Health and Human Services.

Initial, Annual and Open Enrollment Periods

Qualified individuals are permitted to enroll in a QHP or change QHPs during the initial open enrollment period, an annual open enrollment period, or a special enrollment period.

According to the regulations, the initial open enrollment period is scheduled for October 1, 2013 through March 31, 2014. Individuals must enroll in a QHP by December 15, 2013 for coverage to be effective January 1, 2014. The regulations set forth other effective coverage dates, based upon the date the individual enrolls in the plan.

For benefit years beginning on or after January 1, 2015, the annual open enrollment period would mirror the Medicare Part D annual open enrollment timeframe of October 15th through December 7th of the year preceding the year of coverage. Exchanges are required to notify enrollees of the annual open enrollment period by September 30th of each year.

An Exchange is permitted to automatically enroll individuals, subject to HHS scrutiny.

Special Enrollment Periods

Exchanges must provide for special enrollment periods, during which qualified individuals may enroll in QHPs or change QHPs upon the occurrence of certain events. These events are:

1. Acquisition of a new dependent through marriage, or birth or adoption of a child.
2. Loss of minimum essential coverage, including similar qualifying events giving rise to trigger COBRA coverage such as:
    - Termination or reduction in hours of employment;
    - Death;
    - Divorce or legal separation;
    - Loss of dependent status under the plan;
    - The individual no longer resides, lives, or works in an HMO's service area;
    - A situation in which an individual incurs a claim that would meet or exceed the lifetime limit under the plan;
    - The plan no longer offers benefits to a class of similar situated individuals that includes the individual;
    - Termination of employer contributions; or
    - Exhaustion of COBRA continuation coverage.

    Loss of coverage does not include failure to timely pay premium, including COBRA premium, or situations allowing for rescission of coverage.
3. The individual is determined newly eligible or newly ineligible for advance payments of the premium tax credit or has a change in eligibility for cost-sharing reductions, regardless of whether such individual is already enrolled in a QHP. The Exchange must permit individuals whose existing coverage through an eligible employer-sponsored plan will no longer be affordable or provide minimum value for his/her employer's upcoming plan year to access this special enrollment period prior to the end of his/her coverage through such eligible employer-sponsored plan.
4. Change in citizenship status.

5. Failure to enroll in QHP due to an unintentional error, misrepresentation, or inaction by the Exchange or HHS.
6. A resulting violation of a material provision of the QHP contract in relation to the enrollee.
7. A qualified individual or enrollee gains access to new QHPs as a result of a permanent move.
8. An Indian, as defined under law, may enroll in a QHP or change from one QHP to another one time per month.
9. A qualified individual or enrollee meets other "exceptional circumstances" in accordance with HHS guidelines.

SHOP EXCHANGES

The **Small Business Health Options Program (SHOP)** would be operated by an Exchange through which a qualified small employer can provide its employees and their dependents with access to one or more QHPs.

For this purpose, a *small employer* is one who employs between 1 and 100 employees on business days during the preceding calendar year and who employs at least one employee on the first day of the plan year. For plan years beginning before January 1, 2016, a State may elect to define a small employer by substituting 50 employees for 100 employees.

A SHOP Exchange is designed to assist qualified employers, as well as facilitate the enrollment of qualified employees into QHPs. A SHOP differs from a State-based Exchange with regard to:

1. Enrollment and eligibility functions;
2. Certain uniform level of coverage for all employees through an employer's choice of one or more available QHPs;
3. Premium payment administration;
4. QHP certification;
5. Uniform rate restrictions;
6. QHP availability in merged and unmerged markets;
7. Expansion into large markets beginning in 2017, in certain circumstances;
8. Uniform group participation rules; and
9. Requiring a premium calculator tool that allows individuals to compare available QHPs following application of any applicable employer contribution, in lieu of any advance payment of the premium tax credit and any cost-sharing reductions.

A qualified small employer is eligible to purchase coverage through a SHOP if such employer elects to offer, at a minimum, all full-time employees coverage in a QHP through a SHOP; and either:

- Has its principal business address in the Exchange service area and offers coverage to all its employees through that SHOP; or
- Offers coverage to each eligible employee through the SHOP service area where the employee's primary worksite is located.

Standards for Employers Participating in a SHOP

The final regulations set forth standards for qualifying employers selecting QHPs for their employees. The final regulations do allow for continued eligibility in QHP coverage for growing small employers. A small employer can also participate in more than one SHOP.

Participating employers are required to meet certain SHOP standards, such as:

1. Timely distributing enrollment information to employees;
2. Timely remitting employer premium contributions, and

3. Notifying the SHOP of any changes in employee or their dependent's eligibility status under the plan.

Annual Employer Election Period. The SHOP must provide qualified employers with an annual employer election period in which a qualified employer may change its participation in the SHOP for the next plan year, including:

- The method by which an employer makes QHPs available to its employees;
- The employer contribution towards the premium cost of coverage;
- The level of coverage offered to qualified employees; and
- The QHPs offered to qualified employees.

Standards for SHOP

A SHOP must determine and verify both employer and employee eligibility for participation purposes through an application process. Once the determination has been made, the SHOP then provides written notification to both the employer and employees of their acceptance into the SHOP. Once accepted, a SHOP must provide for enrollment of individuals into QHPs in accordance with certain timeframes for selecting and effectuating coverage. An employer wishing to withdrawal from a SHOP must follow certain termination procedures.

Other duties of a SHOP include a 10-year record retention requirement, a monthly reconciliation of enrollment information and employer participation in QHPs, notifying employers when an employee terminates QHP coverage, and an IRS reporting obligation.

SHOP Initial, Annual and Special Enrollment Periods

A SHOP must provide for the same initial and annual enrollment periods as an Exchange. In addition, a SHOP must also provide for a rolling enrollment in the SHOP wherein a qualified employer is permitted to purchase coverage for its small group at any point during the year. The employer's plan year must consist of the 12-month period beginning with the qualified employer's effective date of coverage.

Annual employee enrollment period. A SHOP must provide for a 30-day annual open enrollment period to qualified employees prior to the end of the employer's plan year and following the employer's annual election period. An employee who becomes newly qualified for QHP coverage outside of the initial or annual open enrollment period must be given an enrollment period to seek QHP coverage beginning on the first day of becoming a qualified employee.

Special enrollment periods. A SHOP must provide for special enrollment periods as required of Exchanges, except when the individual:

1. Is determined newly eligible or newly ineligible for advance payments of the premium tax credit or has a change in eligibility for cost-sharing reductions, regardless of whether such individual is already enrolled in a QHP.
2. Incurs a change in citizenship status.

Guaranteed Renewability of QHPs. A QHP available through a SHOP must allow enrolled individuals to continue coverage under that QHP, except where the individual terminates coverage or enrolls in another QHP option, or, the QHP is no longer available.

Insurers offering QHPs through a SHOP must adhere to certain standards relating to rating and premium payments, enrollment periods, participation and termination of coverage.

CONSUMER ASSISTANCE TOOLS AND PROGRAMS

Exchanges are required to set up and maintain certain consumer assistance tools and programs, including:

1. A toll-free call center.
2. An active internet website that provides individuals the ability to view all QHPs offered through the Exchange with up-to-date information on the following:
    - Standardized comparative information on each available QHP, including premium and cost-sharing information, summaries of benefits and coverage, and identification of whether the QHP is a bronze, silver, gold, or platinum level plan or a catastrophic plan;
    - The results of any enrollee satisfaction surveys;
    - Quality ratings of plans;
    - Medical loss ratio information, as reported to HHS;
    - Transparency of coverage measures reported to the Exchange during certification; and
    - Provider directories.

The website must also:

- Meet certain accessibility standards to individuals with disabilities, as well as to individuals with language barriers.
- Provide financial information specific to the Exchange, such as licensing and regulatory fees, administrative costs and monies lost to waste, fraud, and abuse.
- Provide applicants with information about Navigators. A Navigator, as its name implies, is to assist consumers in an impartial way to navigate through the Exchange process. Each Exchange is required to establish a Navigator that meets certain regulatory standards and criteria through which grants will be awarded to those eligible public or private entities establishing one.
- Allow for eligibility determinations.
- Allow individuals to select a QHP.
- Provide an electronic calculator to facilitate the comparison of available QHPs after the application of any advance payments of the premium tax credit and any cost-sharing reductions.
- Conduct consumer outreach and educational activities.

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CBIZ
Health Reform Bulletin

Subject: **Fees on Health Insurance Policies and Self-Insured Plans: Patient-Centered Outcomes Research Trust Fund**
Date: April 18, 2012

As part of the Affordable Care Act (ACA), a research fee is to be imposed on both insured and self-funded health plans. The purpose of these fees is to fund a Patient-Centered Outcome Research Trust Fund. This Trust Fund, in turn, supports a Patient-Centered Outcomes Research Institute to assist patients, clinicians, purchasers, and policymakers in making informed health decisions by advancing comparative clinical effectiveness research.

On April 17, 2012, the Internal Revenue Service issued proposed regulations relating to the imposition of this fee. While these regulations are proposed, they do give some guidance of how the government is working on the issue, and it may be the only guidance available at the time the first fee is imposed. The guidance indicates that if any significant changes are made to these proposed regulations, the changes would be prospective in nature.

Plans Subject to the Fees
In general, the fees apply to accident and health insurance policies, including insured and self-funded group health plans and HMO contracts, covering individuals residing in the United States. The fees will be assessed on the insurer of an insured plan; the plan sponsor will be required to pay the fee on behalf of a self-funded plan.

The proposed regulations make retiree-only plans subject to these fees. This is a bit of a departure from the ACA provision that excludes retiree-only plans from the market reform provisions of the law.

The types of benefit plans *not subject* to the fees include:

- Excepted benefits such as limited scope dental and vision plans;
- Employee assistance programs, disease management programs, and wellness programs if the program does not provide significant benefits in the nature of medical care or treatment;
- Expatriate group health plans primarily covering employees who work and reside outside the United States; and
- Stop loss and indemnity reinsurance policies.

Reimbursement-type plans
With regard to reimbursement type plans, health reimbursement arrangements (HRA) and medical flexible spending account (FSA) plans are subject to these fees. However, FSA plans that qualify as HIPAA-excepted plans are *not* subject to these fees.

If an employer offers multiple self-funded plans, such as a comprehensive health plan and an HRA in which both plans are established and maintained by the same plan sponsor with the same plan year, then the number of individuals participating in both plans need only be counted once. For example, if an individual, we'll call him "Joe", participates in both components of the self-funded plan (comprehensive health plan and HRA), then Joe need only be counted once. Conversely, if an HRA is coordinated with an insured plan, then double payment of the fees would be required. In other words, the insurer would pay for Joe's participation in its calculation of the fee for the insured plan; and the plan sponsor would count Joe in its calculation for the HRA.

Calculating the Fee
The fee is calculated based on the average number of covered lives under the plan. The initial fee will be $1 per covered life. For policy/plan years ending after October 1, 2013, the fee will be $2 per covered life (indexed). This fee will cease to be assessed for policy/plan years ending after September 30, 2019. For a calendar year plan, this would be the 2018 plan year.

The fee is based on the number of covered lives under the plan.

For insured plans, the proposed regulations set forth four methods of determining the average number of covered lives; they are:

1. An **"actual count method"** which is calculated by the sum of covered lives for each day of the policy/plan year and dividing the sum by the number of days in the policy/plan year.
2. A **"snapshot method"** whereby the average number of covered lives is computed by adding the total number of covered lives on one date in each quarter of the policy year, or an equal number of dates for each quarter, and dividing the total by the number of dates on which the count was made.
3. A "**member months method**" whereby an insurer would determine the average number of covered lives under all individual policies in effect for a calendar year divided by 12.
4. A **"state form method"** could be used by certain insurers. The calculation is derived by data the insurer annually files with the relevant state licensure department, such as a state insurance department.

For self-funded plans, the plan sponsor can choose one of three methods for determining the average number of covered lives. The plan sponsor can use the actual count method or the snapshot method, as described above; or, the Form 5500 method. The Form 5500 method is based on the average number of covered participants at the beginning and end of the plan year, as reported on the relevant Form 5500 for the applicable plan year.

Whatever method is chosen for calculating the average number of covered lives, the insurer or plan sponsor must consistently use that same method in its calculation for all policies or plans reported on a single return. The actual count method or snapshot method could be changed from one policy or plan year to the next.

Collection of the Fee
The fee is to be paid once a year in connection with IRS Form 720, *Quarterly Federal Excise Tax Return*. For insured plans, the Form 720 is due by July 31st following the close of the policy year. For self-funded plans, the Form 720 is due by July 31st of the calendar year following the plan year end.

Effective Date
The fee applies to policy/plan years ending on or after October 1, 2012. For a calendar year plan, the fee will first be applicable for the 2012 plan year.

These proposed regulations are reliance regulations, i.e., insurers and plan sponsors may rely on this guidance until final regulations are issued. Comments about these proposed regulations will be accepted by the IRS through July 16, 2012. The IRS is planning a public hearing on these regulations on August 8, 2012.

Conclusion
Plan sponsors will want to begin indentifying the plans that are subject to the fees. In an effort to minimize the impact of these fees, consideration should be given to making certain that excepted benefits, such as limited scope dental and vision coverage, are kept independent of the health plan. Multiple self-funded plans, on the other hand, might be wrapped together to minimize the impact of the fees.

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Subject: **ACA Updates: 1) Summary of Benefits and Coverage and 2) Minimum Loss Ratio Rules - Notice Requirement**
Date: May 17, 2012

The health care reform law continues to generate regulations and clarifications.

Summary of Benefits and Coverage
Most recently, the governing agencies have issued some additional *Frequently Asked Questions* relating to the Summary of Benefits and Coverage ("SBC"). An SBC is a document required to be provided both by individual and group health plans. Of particular note, this guidance again underscores a good faith compliance standard in the first year. In other words, penalties will not be assessed as long as the plan is making a good faith effort to comply.

The FAQs clarify that if a plan is comprised of insurance products from multiple vendors, the plan sponsor can assemble the various SBCs from each vendor. The FAQs suggest a cover letter that indicates multiple SBCs being used to reflect the plan would be prudent. It is important to note that after the first year, information from the various vendors must be compiled into a single SBC, according the FAQs. The plan sponsor can accomplish this, or it can ask one of its vendors to accomplish this.

SBCs may be provided to covered participants electronically. The DOL provides an additional safe harbor for electronic delivery:

- SBCs may be provided electronically in connection with an online enrollment or renewal of coverage under the plan.
- SBCs also may be provided electronically to participants who request an online version.

In either situation, the individual must have the option to receive a paper copy upon request. For plans subject to ERISA, the DOL rules relating to electronic disclosure still applies (see *Electronic Distribution of SBC* in this CBIZ Health Reform Bulletin, *Summary of Benefits and Coverage*).

Due to a clerical error, the *SBC Template* has been updated. The revised documents can be accessed from both the DOL's and CCIIO's websites; the revised editions are labeled "corrected on May 11, 2012" in the lower right corner of the first page.

The agencies are developing a streamlined calculator that can be used in producing the coverage examples contained in the SBCs.

Minimum Loss Ratio Guidance

One of the requirements of the ACA is that insured plans must spend at least 85% of premium dollars paid by the large group market (over 100 employees) on medical claims; 80% in the small group (100 or fewer employees) and individual markets. If the plan does not meet the required target, a rebate is owed to the policyholder and subscriber.

There has been an outstanding question as to whether plans that meet this standard, i.e., do not owe a rebate, have any notice obligations. A new set of final and interim final regulations clarify that for this first year, plans that do not owe a rebate are required to issue a notice. The regulations include model language that can be used in the notice. Important to many is that this notice is only required during this first year. The MLR notice can be included with other plan materials, such as open enrollment documents, provided to enrollees on or after July 1, 2012.

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CBIZ
Health Reform Bulletin

Subject: **Guidance Issued relating to $2,500 FSA Salary Reduction Cap**
Date: May 31, 2012

Some much anticipated and very welcome guidance has been issued by the IRS relating to the $2,500 flexible medical spending account (FSA) cap. As background, the Affordable Care Act limits, to $2,500, the amount that can be contributed to an FSA through salary reduction. This provision takes effect for the 2013 taxable year.

In the newly released guidance (IRS Notice 2012-40), the taxable year is defined as the FSA's plan year. It was previously thought that January 1, 2013 was to be the determinative date, without regard to the plan year. Fortunately, the government is interpreting 'taxable year' to mean the taxable year of the FSA plan. What this means is that the $2,500 cap will apply to plan years beginning on or after January 1, 2013. The IRS has indicated that the $2,500 amount will be indexed for plan years beginning on or after January 1, 2014.

Generally, cafeteria plans and FSA plans must be amended prospectively (in advance of the effective date of the change). This guidance provides that plans have until December 31, 2014 to amend the FSA plan retroactive to the first plan year beginning on or after January 1, 2013. However, plans must be administered in accordance with the change beginning on the first day of the first plan year beginning on or after January 1, 2013.

In addition to this welcome news, the guidance provides a couple of other clarifications, as follows.

The guidance clarifies that the $2,500 limit applies to each participant. What this means is, if two spouses are employed, each spouse has his/her own right to make a $2,500 salary reduction contribution, assuming the plan allows it, even if the spouses are employed by the same employer.

If an employee is eligible for multiple FSAs offered by employers of a control group or affiliated group, the employee is limited to one $2,500 limit. Conversely, if the individual is employed by unrelated employers, and is eligible to participate in multiple FSAs, the individual would be entitled to the relevant cap under each FSA.

The guidance affirms that the $2,500 limit applies to salary reduction contributions only; it does not apply to non-elective employer contributions, such as flex credits. However, if flex credits are available to be taken in another form, such as cash, these amounts would be included in the maximum.

The guidance clarifies that if the plan includes a 2½ month grace period during which time claims can be incurred, the $2,500 limit will not be impacted.

It is important to note that the guidance does state a plan year cannot be changed solely for the purpose of delaying the applicability of the $2,500 cap.

Finally, the guidance states that if a good faith mistake is made in complying with the $2,500 limit, then the IRS will grant certain relief from the failure to comply, as long as corrections are timely made.

All of this should come as welcome guidance. Nevertheless, it is important to begin now to ensure compliance for the 2013 plan year.

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Subject: **1) Implementation Guidance on Medicare Tax assessed on High Earners; and 2) Upcoming Supreme Court Ruling on Health Care Reform**
Date: June 27, 2012

Implementation Guidance on Medicare Tax assessed on High Earners
One of the ways expanded access required by the Affordable Care Act (ACA) will be funded is through an increase in Medicare tax for high wage earners. The Medicare tax increase, which takes effect January 1, 2013, imposes a 0.9% increase in the individual's Medicare tax rate, applicable on earnings in excess of $200,000 in a calendar year. This additional Medicare tax increase does not apply to the employer's share of the Medicare tax.

The IRS recently issued a set of Q&As that are intended to provide guidance on the implications of this tax. Following are highlights of this guidance.

Below is a chart of individuals liable for the additional tax, based on their filing status:

Filing Status	*Income Threshold Amount*
Single	$200,000
Married filing jointly	$250,000
Married filing separately	$125,000
Head of household (with qualifying person)	$200,000
Qualifying widow(er) with dependent child	$200,000

The employer must begin withholding the additional Medicare tax only when the individual has reached the $200,000 threshold. The employer withholds the additional tax even if, ultimately, the individual is not liable for the tax. For example, if an employee earns $210,000 and the spouse earns $25,000, the employer would be obligated to withhold the employee's share of the Medicare tax on the $10,000 in excess of the $200,000. However, the individual would not owe it because the couple's earnings do not exceed the $250,000 (married filing jointly) threshold.

The additional Medicare tax monies will be credited against the individual's total tax liability as reflected on his/her Form 1040.

The employer is not required to notify employees that it will begin withholding the tax. Again, monies are only withheld after the individual has reached the threshold level of earnings and it is only assessed on earnings in excess of these thresholds.

The guidance clarifies that there is no exemption for nonresident aliens or U.S. citizens living abroad. Therefore, earnings on which the Medicare tax is assessed for these individuals are likewise subject to this additional tax.

Employers should begin working with their payroll departments and providers to make certain that the requisite triggers are put in place to ensure proper withholding is accomplished.

Upcoming Supreme Court Ruling on Health Care Reform

The much anticipated Supreme Court ruling on the health care reform law may come on Thursday, June 28, 2012. There is also a small possibility that it will not come on that date.

Be assured that we at CBIZ are ready to help you navigate the next phases in this evolution. While we certainly do not know how the Supreme Court will rule, we do know that we humans will continue to need health services, that health services will continue to be delivered, and that employers will want to participate in this process in a way that is both beneficial to their workforce and cost effective.

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CBIZ

Health Reform Bulletin

Subject: **Today's Supreme Court Ruling**

Date: **June 28, 2012**

June 28, 2012 will surely go down in history as a pivotal point for health care, and specifically, health care access in America. It is today that the Supreme Court of the United States has deemed that the Patient Protection and Affordable Care Act (ACA) represents a valid exercise of Congressional authority.

In a 5-4 decision, the Justices upheld the individual mandate on the grounds of Congress' power to tax and spend. The Court did not uphold the individual mandate under the Commerce Clause of the Constitution. This distinction may well prove to be very important in future matters.

But, for today, what this means is that the ACA, enacted in March, 2010 remains the law of the land. And, at least for the foreseeable future, all systems are 'Go' for its continued implementation.

As a practical matter, what this means is that the governing agencies, specifically the Departments of Health and Human Services, Labor and Treasury will continue to issue regulations to implement the law.

One of the centerpieces of the law is the establishment of Exchanges beginning in 2014, the same year in which the individual mandate (the requirement for most Americans to maintain a minimum level of coverage) will take effect. If a state cannot accomplish the establishment of exchanges by 2014, then a federal Exchange will be imposed. An Exchange is intended to be a one stop marketplace available to individuals and certain employers for the purchase of health coverage. Eligible employers are able, but not obligated, to buy coverage through the Exchange.

While the Court has upheld the law in its entirety, it has very narrowly construed the provisions relating to Medicaid expansion. The law provides that in order to receive federal funds, states will be obligated to expand Medicaid to a significantly larger population, specifically, those who fall below 133% of the federal poverty level. The Supreme Court held that the government cannot withhold federal funds that states are entitled to the extent that the state complies with the current Medicaid requirements, regardless of whether the state implements the expanded requirements. The federal government may withhold any additional funds to which a state

would become entitled, however, if the state would not agree to expand Medicaid to a broader group of people.

The Supreme Court's decision returns the debate over health care to Congress, and it is sure to be a hotly debated topic in this election year. In summary, what the Supreme Court has ruled is that the law has remained in full force and effect with the limited narrowing of the Medicaid provision. All changes made by the law that have already been implemented remain in-force.

For employers, what is most important now is to:

1. Prepare for distribution of their Summaries of Benefits and Coverage, which will be required for plan renewals and plan years beginning on or after September 23, 2012;
2. Prepare for the reporting of the aggregate cost of health coverage for the 2012 reporting year on the Form W-2s, required to be issued in January, 2013;
3. Amend flexible medical spending account plans to comply with the $2,500 cap, applicable for plan years beginning on or after January 1, 2013;
4. Prepare to begin the additional Medicare tax withholding for certain high income earners;
5. Specifically for employers employing 50 or more full-time employees, to look down the road to 2014, with an eye on what impact the shared responsibility tax may have on their business and employee population.

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CBIZ
Health Reform Bulletin

Subject: **Medical Loss Ratio Rebates**
Date: July 10, 2012

One of the goals of the Affordable Care Act is to incent health insurers to use the bulk of premium dollars for medical services; these provisions are known as the medical loss ratio (MLR) rules. The following Questions and Answers will attempt to distill a complicated topic into some practical information.

What are the MLR Rules?
Specifically, insured plans must spend at least 85% of premium dollars paid by the large group market (over 100 employees) on medical claims; 80% in the small group (100 or fewer employees) and individual markets. If the plan does not meet the required target, a rebate is owed to the policyholder and subscriber. To this end, it is important to think about how the rebate can be used and how it must be allocated between employer and employee.

Who is subject to the MLR Rules?
The MLR rules only apply to insured grandfathered and non-grandfathered health plans.

What is the effective date of the MLR Rules?
These medical loss ratio rules first applied to the 2011 plan year and the first rebate is due by August 1, 2012.

As an employer-policyholder, what do I do if I receive a refund?
As a general statement, any rebate owed to the policyholder must be shared proportionately among those who paid for the coverage, specifically between the employer and the insured. In very simple terms, if the employer pays 60% of the premium and the employee pays 40% of the premium, the rebate must be shared 60/40.

For **plans subject to ERISA**, it is important to know whether the rebate constitutes plan assets. If the ERISA plan is funded through a trust, the rebate is a plan asset and must be returned to the trust to be used for the exclusive benefit of plan participants. Generally, plan assets must be held in trust. To avoid the trust requirement, the rebate must be used to purchase benefits within 3 months of receipt.

If the ERISA plan is *not* funded through a trust, the portion of the rebate that relates to employee contribution is plan assets and must be used for the exclusive benefit of plan participants.

For **non-federal government plans**, the rebate would be paid to the policyholder (generally, the employer) and must be used to benefit plan participants to the extent the participants contributed to the coverage.

For **non-ERISA, non-government plans**, such as church plans, the rebate must be paid directly to plan participants unless the entity agrees in writing to allocate the premium in accordance with the participant's contribution.

How can the rebate be used?
The rebate can be used to provide a premium credit, sometimes called a "premium holiday". Or, the rebate can be paid in cash.

For ERISA plans only, the rebate can be used as a benefit plan enhancement, such as to purchase additional benefits. It may be permissible for ERISA plans to use the rebate to offset administrative expenses if the relevant plan so provides.

What are the tax consequences of the rebate?
Generally, if the premium for the year to which the rebate applies was paid with pre-tax dollars through a cafeteria plan, as is most typically the case for employer plans, the rebate, generally, is taxable.

If the rebate is used to provide a premium holiday, the tax consequence is benign in that it is simply handled by the increased salary that the individual receives by virtue of not having to pay premium.

If the rebate is paid in cash, it is taxable cash.

For ERISA plans utilizing the rebate to provide benefit enhancements, if the benefits constitute health benefits, then the enhancements should be excludible from the employee's income.

Next Steps
The plan document is the first place to look to determine how a rebate can be used. Some plan documents include specific guidance. In the absence of specific guidance, and given the administrative and tax issues that can arise, it is probably most efficient to provide a premium holiday. If this is going to be done, it is very important to review any applicable cafeteria plan to ensure it allows election adjustments due to a change in cost of coverage. Most cafeteria plans do include a provision that allows salary reduction elections to be automatically increased or decreased due to a change in cost. If the change of cost is significant, many cafeteria plans allow a revocation of existing election and a new election to be made.

Plan sponsors should work closely with their legal and tax advisers to resolve any questions regarding the proper allocation and taxation of rebates.

Background CBIZ Health Reform Bulletins on MLR Rules:

- ACA Updates: 1) Summary of Benefits & Coverage; 2) Minimum Loss Ratio Rules - Notice Requirement (5/17/12)
- 1) Final Minimum Loss Ratio Regulations Issued and 2) ERRP Closes (12/12/11)

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CBIZ
Health Reform Bulletin

Subject: **Guidance Issued Relating to 90-day Waiting Period and Defining Full-time Employee**
Date: September 4, 2012

On the eve of the Labor Day holiday, the Agencies issued some health care reform guidance specifically relating to the 90-day waiting period and the definition of full-time employee for purposes of the shared responsibility provision. This guidance, while not in the form of final regulation, can be relied upon through 2014. The guidance makes it clear that plans are not obligated but may rely on this guidance, and any future guidance will be prospective in nature.

90-day Waiting Period

As background, the Affordable Care Act (ACA) requires beginning with the first plan year commencing on or after January 1, 2014, the maximum waiting period that can be imposed by any plan, grandfathered or not, insured or self-funded, is 90 days. The guidance issued by the Agencies (IRS Notice 2012-59, DOL Technical Release 2012-02, and CCIIO Guidance) provide that the 90-day period begins at the point that the individual has "*met the plan's substantive eligibility conditions (such as being in an eligible job classification or achieving job-related licensure requirements specified in the plan's terms)".*

If, for example, an individual is part-time, and if part-time people are not eligible for health benefits, and the individual moves to a full-time classification for which benefits are available, the 90-day wait begins at that point.

For individuals hired with a variable work schedule and for whom it is not possible to determine whether the individual will qualify, a measurement period of anywhere from 3 to 12 months, as defined by the employer, can be used to determine whether the individual qualifies under the terms and conditions of the employer plan. This measurement period is similar to the measurement period described below.

The guidance makes it clear that the employer cannot impose qualification standards as a way to avoid commencement of the 90-day wait. In other words, employment classifications must have a legitimate business purpose.

Defining Full-time Employee – Shared Responsibility

In conjunction with the 90-day waiting period guidance, the Department of Treasury issued Notice 2012-58, which particularly addresses how to determine whether an individual is regularly scheduled to work 30 or more hours per week for purposes of the shared responsibility requirement.

As background, the law provides that an employer employing 50 or more employees who fails to offer health coverage that meets a minimum value and is affordable will be subject to an excise tax if one or more of its employees qualify for premium assistance through the exchange. The guidance states that working 130 hours per month is deemed to equate to 30 hours per week. Further, for purposes of determining affordability, this guidance affirms that W-2 earnings can be used.

As proposed in prior releases (see *FAQs: 90-day Waiting Period Limitation and Shared Responsibility Requirement* in this CBIZ Health Reform Bulletin), this guidance allows the use of a look-back period, which can be as much as 12 months. If an individual is deemed to work an average of 30 hours per week during the look-back period, the individual qualifies for health coverage during the stability period (look-forward period).

The guidance specifically addresses "variable hour" employees. This should be particularly useful in industries that have a significant portion of their workforce whose hours are not consistent, such as construction and retail industries. A new employee would be considered a variable hour employee if, based on the facts and circumstances at the time of hiring, he/she is not expected to work an average of 30 hours per week during the initial measurement period. For example, a retail worker hired to work at least 30 hours during a holiday period may not be expected to continue working 30 hours per week once the holiday season ends. Once a variable employee is deemed to qualify as a full-time employee, the individual must be tested under the guidance to determine whether the individual meets the full-time employee criteria.

The guidance gives many examples of various scenarios that should be reviewed in any instance in which the look-back and stability periods are anticipated to be used. The employer can define different measuring periods for varying classification of employees such as union and non-union employees, salaried and hourly employees, employees of different entities, and employees located in different states.

This guidance also discusses seasonal employees, and states that the government continues to look at how seasonal employee should be defined.

During any waiting period or other qualification period, an employee who otherwise qualifies for premium assistance or cost-share through the exchange will not be denied these benefits. Further, the employer will not be penalized for failing to offer coverage during these qualification periods.

Conclusion

This guidance should be consulted by any employer that has questions about how to comply with the 90-day waiting period, and the definition of full-time employee, both of which take effect in 2014.

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CBIZ
Health Reform Bulletin

Subject: **Reminder: Fast Approaching Form W-2 Reporting Requirement**
Date: November 1, 2012

With 2012 quickly coming to an end, the Affordable Care Act's (ACA) requirement to report the aggregate cost of health coverage on the Form W-2 is upon us. As background, ACA requires that the aggregate cost of health coverage be reported on the Form W-2. The first reporting requirement applies to the 2012 year, due by January 31, 2013.

For purposes of this reporting obligation, "aggregate cost" means both the employer and employee's share of the cost of health coverage. Generally, if the plan is insured, the full insurance premium is used for this purpose. If the plan is self-funded, the COBRA rate less the 2% administrative fee is used. The reporting is to be done in Box 12 of the W-2 using Code DD.

The reporting requirement applies to most types of health coverage. There are exceptions for certain types of coverage such as health reimbursement arrangements and salary reduction contributions to flexible medical spending accounts. For a more detailed list of plans subject to, or exempt from the Form W-2 requirements, see the Chart posted on the IRS website (Form W-2 Reporting of Employer-Sponsored Health Coverage), as well as the Questions and Answers. It is also important to remember that if an individual's health coverage changes during the year, such as from single coverage to family coverage, this must be tracked so that it can accurately be reflected on the W-2.

For more information, please refer to these CBIZ Health Reform Bulletins:

- *Additional IRS Guidance on W-2 Reporting Requirement* (1/6/12)
- *IRS Issues Interim Guidance on W-2 Reporting* (3/30/11)

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CBIZ
Health Reform Bulletin

Subject: **A Primer on ACA's Variable Employee Rules**
Date: November 5, 2012

One of the centerpieces of the Affordable Care Act is commonly referred to as ***shared responsibility***. These provisions will take effect January 1, 2014, and includes both an individual responsibility component, and for employers employing 50 or more full time equivalent employees, it requires employers to offer adequate coverage at an affordable rate, or risk being subject to a tax.

The individual mandate requires one to maintain a minimum level of health coverage for themselves and their dependents, or pay a penalty for each month they fail to do so.

For purposes of the shared responsibility requirement, employers employing 50 or more full-time equivalent employees (working 30+ hours per week) must either provide adequate coverage at an affordable rate, or pay an excise tax. The penalty is calculated as follows:

- If an employer offers no coverage or inadequate coverage and employs at least one credit employee*, the excise tax penalty is calculated monthly as (number of full-time employees – 30) x $166.67 (equivalent of $2,000 per year).
- If the employer offers minimum value coverage (60%) at an affordable rate (9.5% of household earnings - Form W-2 income), then: no penalty.
- If coverage fails minimum value, or is unaffordable, then the monthly excise tax penalty is the lesser of:
  - Number of credit employees* x $250 (equivalent of $3,000 per year), or
  - (Number of full-time employees – 30) x $166.67 (equivalent of $2,000 per year)

  **A credit employee is one who works at least 30 hours per week and who is eligible for a premium tax credit or cost sharing assistance for buying insurance through an exchange.*

One of the significant concerns that has been raised with regard to implementation of this requirement relates to what has become known as variable employees. A ***variable employee*** is one for whom it cannot be reasonably determined at the time of hiring whether the individual will be regularly scheduled to work at least 30 hours per week. Examples of individuals who would likely fall into the variable employee category include, among others, substitute teachers and construction workers.

In August 2012, the governing agencies issued some guidance specifically applicable for the initial year of compliance (IRS Notice 2012-59, DOL Technical Release 2012-02, and CCIIO Guidance). This guidance offers a safe harbor that can be used for purposes of establishing whether an individual is regularly scheduled to work 30 or more hours per week.

In effect, the guidance allows an employer to establish a "measurement period". If during a measurement period, an individual is determined to have worked 30 or more hours per week, then that individual is deemed to be regularly scheduled to work 30 or more hours per week during the "stability period". Put another way, the measurement period is a look-back; and, if the person qualifies during the look-back, then the individual is deemed qualified during the stability period, without regard to whether the individual actually meets the standard during the stability period. The stability period then becomes the measurement period for the next stability period.

The employer can design a "standard measurement period" for on-going employees and an "initial measurement period" for new employees. The initial measurement period can only be used for individuals who have not been employed for a full standard measurement period. The measurement period must be the same for all individuals in a particular classification of employee. The rules only allow four types of classifications of employee; they are:

1. Collective bargaining vs. non-collective bargaining;
2. Salary vs. hourly;
3. Distinct business entities; and
4. Geographic distinction employee populations that reside in different states.

The measurement period can be anywhere from 3 to 12 months long. The stability period must match the measurement period, though it can be no shorter than 6 months. The stability period must be the same for new and on-going employees.

In addition, an "administrative period" of no longer than 90 days is permitted, as long as the maximum period never exceeds 13 months. The administrative period between the measurement and standard period is used for activities such as open enrollment.

For employees who are hired without a set schedule, the use this look-back (measurement period) and stabilization period should be useful to employers in determining their responsibilities under the law.

90-Day Waiting Period Restriction

As a separate matter, it should also be noted that beginning on the first day of the first plan year occurring on or after January 1, 2014, the maximum waiting period that can be imposed by any plan, not limited to employers employing 50 or more employees, is 90 days. Recently issued guidance provides that the 90-day period begins at the point that the individual has "*met the plan's substantive eligibility conditions (such as being in an eligible job classification or achieving job-related licensure requirements specified in the plan's terms)".* If, for example, an individual is part-time, and if part-time people are not eligible for health benefits, and the individual moves to a full-time classification for which benefits are available, the 90-day wait begins at that point.

For individuals hired with a variable work schedule and for whom it is not possible to determine whether the individual will qualify, a measurement period of anywhere from 3 to 12 months, as defined by the employer, can be used to determine whether the individual qualifies under the terms and conditions of the employer plan. This measurement period is similar to the measurement period described above.

The guidance makes it clear that the employer cannot impose qualification standards as a way to avoid commencement of the 90-day wait. In other words, employment classifications must have a legitimate business purpose.

Next Steps

In preparing for January 1, 2014, employers should:

1. Assess their workforce and determine which, if any, classifications of employees might fall within the definition of variable employee.
2. Define an appropriate measurement period from 3 to 12 months.
3. Establish a stability period that is at least 6 months in duration or longer, if the measurement period is longer.
4. If the group of variable employees typically works fewer than 30 hours per week, the employer might want to put mechanisms in place to ensure this standard is maintained. For variable employees who do, on average, work more than 30 hours per week, determine whether health benefits will be offered, understanding the potential liability if benefits are not offered.

Background CBIZ Health Reform Bulletins:

- Guidance Issued Relating to 90-day Waiting Period and Defining Full-time Employee (9/4/12)
- ACA Updates: FAQs: 90-day Waiting Period Limitation, Shared Responsibility Requirement and Automatic Enrollment Provision (2/10/12)

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CBIZ
Health Reform Bulletin

Subject: **Proposed Regulations: Wellness Programs, Essential Health Benefits and Rating Restrictions, Guaranteed Issue and Renewal Rules**

Date: November 28, 2012

Now that the election is behind us, the Agencies are furiously issuing guidance. Three sets of proposed regulations have recently been issued. Specifically, these rules address wellness programs, essential health benefits, and the rating restrictions, guaranteed issue and renewal rules of the Affordable Care Act (ACA).

WELLNESS PROGRAMS

As background, the ACA enhances rules relating to wellness programs. These provisions become applicable for plan years beginning on or after January 1, 2014.

Last week, the governing ACA Agencies (HHS, DOL and IRS) issued proposed implementing regulations, together with a fact sheet, relating to wellness programs. These proposed regulations suggest that the wellness rules will apply to both grandfathered and non-grandfathered plans.

In general, these regulations follow the rules previously established for wellness programs under the HIPAA law, with one noteworthy exception – the financial incentive or deterrent is significantly increased, as more fully described below.

Generally, there are two types of wellness programs: a participation-only program and an outcome-based/health-contingent program.

A ***participation-only wellness program*** rewards individuals for participating in the program. Neither the HIPAA law nor the ACA imposes particular standards on participation-only programs, except that the program must be available to all similarly situated individuals. Examples of such programs include:

- Cost or fees for a fitness center membership.
- A reward for participation in a diagnostic testing program, as long as the reward is not outcome-based.
- A program to encourage preventive care through waiver of deductible or co-pays such as prenatal care or well-baby visits. Note, however, non-grandfathered plans are required to provide certain preventive health services without the imposition of cost sharing.
- A program for reimbursement of a smoking cessation program, as long as it is not outcome-based.
- A reward for attending monthly health education seminars.

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An ***outcome-based wellness program***, also known as a health-contingent wellness program, requires that a certain health-related standard be achieved. This type of program, both under the HIPAA law and ACA, must meet five criteria. The only real distinction between the HIPAA and ACA criteria is that the financial incentive can be as much as 30% beginning January 1, 2014; or, if the program relates to tobacco free standards, the incentive can be as much as 50 percent. It is important to note that if an outcome-based/health contingent wellness program combines both types of incentives, the maximum reward or penalty cannot exceed 50% of the cost of coverage. Conversely, if a wellness program combines a participation-only component (as described above) and an outcome-based/health contingent component, then no restriction applies to the participation-only portion. Therefore, the maximum incentive could exceed the 30% or 50% threshold as long as the portion of the program that is contingent falls within these standards.

In addition to the financial incentive, there are four additional criteria for an outcome-based/health contingent wellness program; they are:

1. The program must be reasonably designed to promote health or prevent disease, and cannot be overly burdensome. The program cannot be designed in a way that would cause it to be suspect, or be a subterfuge to evade the purposes of the law.
2. The program must give individuals the ability to qualify for the program, at least once annually.
3. The program must be available to all individuals and offer reasonable alternative methods of compliance for those who cannot comply because of health reasons. The program may request proof of the inability to comply. Following are examples of reasonable alternative standards:
    - If a program requires completion of an educational program, the plan must make the educational program available instead of requiring an individual to find such a program unassisted, and cannot require an individual to pay for the cost of the program.
    - If the reasonable alternative standard is a diet program, plans are not required to pay for the cost of food but must pay any membership or participation fee.
    - If an alternative is recommended by the employer's medical adviser, and if the individual's personal physician attests that the plan's recommendations are not medically appropriate for that individual, the plan must provide a reasonable alternative standard that accommodates the physician's recommendations of medical appropriateness. Plans may impose standard cost sharing under the plan or coverage for medical items and services furnished based upon the physician's recommendations.

    To the extent a plan's initial standard for obtaining the full or a portion of a reward is based on the results of a measurement, test, or screening relating to a health factor, such as a biometric examination or a health risk assessment, then the plan must provide a reasonable means of qualifying for the reward to those individuals unable to meet the standard.
4. In any plan material that describes wellness programs, the availability of alternative standards must be described. The plan must disclose in all plan materials describing the terms of the program the availability of other means of qualifying for the reward or the possibility of waiver of the otherwise applicable standard. If plan materials merely mention that a program is available, without describing its terms, then this disclosure is not required. Following is some model language that can be used to satisfy the notice requirement:

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

The regulations provide additional model language that could further describe aspects of the program, such as programs aimed at cholesterol reduction, fitness programs, and smoking cessation programs.

ESSENTIAL HEALTH BENEFITS

For plan years beginning on or after January 1, 2014, the ACA requires certain plans to include coverage for an "essential health benefits package" to cover 10 specific categories of benefits. This definition of essential benefits is important in that it provides a standardized framework of benefit coverage that must be included in health plans. The 10 categories are:

1. Ambulatory patient services.
2. Emergency services.
3. Hospitalization.
4. Maternity and newborn care.
5. Mental health and substance use disorder services, including behavioral health treatment.
6. Prescription drugs.
7. Rehabilitative and habilitative services and devices.
8. Laboratory services.
9. Preventive and wellness services and chronic disease management.
10. Pediatric services, including oral and vision care.

On November 26, 2012, the Department of Health and Human Services issued proposed regulations relating to the essential health benefits package. As provided in prior guidance (see *Defining Essential Benefits* in this CBIZ Health Reform Bulletin), as well as in these proposed regulations, states can utilize one of several plan design categories for defining essential benefits. The CCIIO website has posted a list of the various state-selected benchmark plans, as well as the default benchmark plan in the event that a state fails to select one.

States may require qualified health plans offered through an exchange to offer certain benefits in addition to essential health benefits. A base-benchmark plan that does not include items or services within one or more categories must be supplemented, in accordance to HHS criteria.

Affected Plans

The proposed regulations clarify that only individual and small insured plans, and plans offered through the exchange, must comply with essential health benefit package requirement. To the extent that self-funded plans and large insured plans offered outside the exchange offer essential health benefits, these essential benefits cannot be subject to annual and lifetime limits.

Cost-sharing Requirements

The regulations clarify certain provisions relating to cost-share requirements. Generally, the law provides that cost-sharing restrictions, such as deductible and out-of-pocket limits will be imposed on plans.

For plan years beginning on or after January 1, 2014, the annual deductible cannot exceed $2,000 for self-only coverage, or $4,000 for coverage other than self-only. These regulations clarify that the deductible restrictions only apply to individual and small group health plans, and plans offered through the exchange. These deductible limits do not apply to large plans offered outside the exchange or to self-funded plans.

The annual out of pocket limits must match those limits applicable to health savings accounts (HSA). While we do not know the HSA limits for 2014 yet, the high-deductible health plan annual out-of-pocket limit for self-only coverage in 2013 is $6,250; $12,500 for family coverage. The out of pocket limits apply to all types of plans; though, with the exception of emergency services, these restrictions only apply to in-network services.

For subsequent years, the deductible and out-of-pocket limits may be adjusted annually to reflect cost increases.

Actuarial valuation calculation for determining level of coverage

The proposed regulations include some clarifications relating to calculation of actuarial valuation. Actuarial value (AV) refers to a percentage measurement of expected health care costs covered by the plan and used to determine an overall measurement of the plan's generosity. For example, a plan with an 80% AV would be expected to pay, on average, 80% of expected medical expenses for the essential health benefits. The individuals covered by the plan would be expected to pay, on average, the remaining 20% of the expected expenses in the form of deductibles, co-payments, and coinsurance. The law defines AV relative to coverage of the essential health benefits for a standard population.

Qualified health plans offered to individuals and small employer group markets both in and outside an exchange must meet the bronze, silver, gold, or platinum actuarial levels of benefits and coverage. A bronze plan is required to have an AV of 60%; a silver plan, 70%; a gold plan, 80%; and a platinum plan, 90%.

The CCIIO has released a proposed actuarial value calculator, together with an AV Methodology for purposes of determining whether a plan's AVs is based on a national standard population.

Determining Minimum Value

Under the law, a plan fails to provide minimum value if the plan's share of the total allowed costs of benefits provided under the plan is less than 60% of such costs. Determining minimum value is important to employers, particularly those employing 50 or more full-time equivalent employees, in that if the employer plan fails the minimum value test, or is unaffordable, a shared responsibility tax may be triggered. For the purposes of determining whether an employer's group health plan provides a minimum value of benefits, the plan can utilize a minimum value calculator or safe harbor to be established by HHS/IRS, or the plan can seek an appropriate actuarial certification.

RATING RESTRICTIONS, AND GUARANTEED AVAILABILITY AND RENEWABILITY RULES

Similar to the HIPAA insurance market reforms, the ACA expands on certain provisions relating to fair health insurance premiums, guaranteed availability, guaranteed renewability, risk pools, and catastrophic plans. The Department of Health and Humans Services issued *Health Insurance Market Reform regulations* to implement the ACA's reform mechanisms. These provisions do not apply to grandfathered plans. Following are highlights of these market reform rules.

Fair Health Insurance Premiums

For plan years beginning on or after January 1, 2014, insurers issuing individual and small group health plans covering 100 or fewer employees, may only vary premium rates based upon:

- Individual or family coverage;
- The rating area;
- Age. Certain variations of age bands are permissible, i.e., one band for under age 21; a yearly band for those aged 21 to 63; and a single band for those aged 64 and above; and
- Tobacco use. Rates can't vary by more than 1.5:1 for like individuals who vary in tobacco usage.

States imposing narrower ratio parameters relating to coverage, rating areas, age or tobacco usage must be approved by CMS.

While these restrictions generally do not apply to large group health plans, they would apply to a large health plan offered through the exchange.

Guaranteed Availability of Coverage

Similar to the HIPAA guaranteed availability provision, the ACA requires insurers offering health insurance coverage in the individual and group market to offer all approved products to individuals and employers. Beginning January 1, 2014, insurers are required to accept any individual or employer applying for coverage under these products, regardless of health status, risk, or medical claims and costs, with limited exceptions. ACA expands the guaranteed availability requirement beyond the small group market to include the individual and large group market as well.

In addition, the regulations establish new open and special enrollment periods in addition to those required under HIPAA. The proposed regulations require insurers to maintain a year-round enrollment period for employers to purchase group coverage. In the individual market, plans would have open enrollment periods consistent with those required by qualified health plans offered through an exchange. Insurers are also required to establish special enrollment periods in connection with events that would trigger eligibility for COBRA continuation coverage. In this instance, the current HIPAA 30 calendar day election period would extend to 60 calendar days, consistent with the exchange standard.

Guaranteed Renewability of Coverage

The proposed ACA regulations relating to guaranteed renewability of coverage are similar to those imposed under HIPAA. However, the ACA rules apply to both individual policies and contracts issued to both small and large groups. Specifically, renewal of contracts can only be denied in the following instances:

1. Failure to pay premium;
2. Fraud or intentional misrepresentation by the employer or employee;
3. Material noncompliance with contract terms such as contribution or participation requirements;
4. The insurer terminates the plan, i.e., ceases to do business within a geographic area;
5. In the case of a network plan, there are no enrollees residing or working within the network service area; or
6. An employer's membership in the bona fide association ceases, but only if the coverage is terminated uniformly without regard to any health status-related factor relating to any covered individual.

CONCLUSION

While these regulations are just proposed at this point, they do give some indication as to how the government is viewing implementation of the law. The comment periods relating to these proposed regulations ends soon (December 26, 2012 for regulations relating to essential health benefits and market reform provisions; January 26, 2013 for the proposed wellness regulations). Hopefully, more definitive guidance will be provided shortly thereafter. In the meantime, these rules can be used as a roadmap for making plan design decisions in the interim.

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CBIZ
Health Reform Bulletin

Subject: **Additional Medicare Tax - Clarifications and Proposed Regulations Issued**
Date: December 10, 2012

Two provisions of the Affordable Care Act (ACA) that will take effect soon, specifically on or after January 1, 2013, relate to new Medicare taxes. One imposes a 0.9% increase in the amount of Medicare tax paid by high income earners; the other imposes a 3.8% tax on investment income.

The IRS and Treasury Department have released implementing guidance on this Medicare tax in the form of proposed regulations and questions and answers.. Comments on both sets of proposed regulations must be received by March 5, 2013. Following are highlights of this guidance.

MEDICARE TAX ON HIGH EARNERS

As background, the ACA imposes an increase in Medicare tax for high wage earners to help fund expanding access. The Medicare tax increase, which takes effect January 1, 2013, imposes a 0.9% increase in the individual's Medicare tax rate, applicable on earnings in excess of $200,000 in a calendar year (see CBIZ Health Reform Bulletin, *Implementation Guidance on Medicare Tax*, 6/27/12).

The proposed regulations and additional questions and answers are intended to provide implementation guidance specific to employers and payroll vendors, as well as individuals.

Below is a chart of individuals liable for the additional tax, based on their filing status:

Filing Status	*Income Threshold Amount*
Single	$200,000
Married filing jointly	$250,000
Married filing separately	$125,000
Head of household (with qualifying person)	$200,000
Qualifying widow(er) with dependent child	$200,000

The employer must begin withholding the additional Medicare tax beginning at the point the individual's income reaches the $200,000 threshold, without regard to whether they will ultimately be subject to the tax. For timing purposes, the withholding begins in the pay period in which the individual's income exceeds the threshold amount.

The additional 0.9% withholding is required on all wages subject to Medicare in excess of $200,000 *Income*, for these purposes, means an individual's total wages, including taxable noncash fringe benefits (see IRS Publication 15, *Employer's Tax Guide*, for additional information on calculating withholding on taxable noncash fringe benefits).

There is no employer match or contribution for the additional tax withheld. Employers are not only obligated to withhold the tax even if employees may not be liable for the additional Medicare tax, but employers would be required to pay the tax if it fails to withhold the amounts, unless paid by the employee.

The proposed regulations clarify that an employee is liable for the additional Medicare tax on wages to the extent that the tax is not withheld by his/her employer. For example, if an employee and his/her spouse each had wages of $200,000 or less, such that their employers did not withhold the additional Medicare tax from individual's wages, but their combined wages exceed the threshold for a joint return (i.e., $250,000), the employee and his/her spouse are liable to pay additional Medicare tax.

An employee who anticipates the additional Medicare Tax liability may request his/her employer to withhold an additional amount of tax on the Form W-4.

As noted in prior guidance, employers are not required to notify an employee when it begins withholding the additional tax.

The Q&As outline special withholding rules and processes that apply in certain circumstances, such as when:

- Income is derived from both wages and tips; or income is derived from both wages and third-party sick pay;
- Income is derived from multiple subsidiaries, from related corporations, or from leasing companies.
- Group-term life insurance coverage in excess of $50,000 and the cost of the coverage, in combination with other wages, exceeds $200,000 for terminated employees and retirees; and
- Calculating the timing of deferrals to a nonqualified deferred compensation (NQDC) plan for purposes of determining threshold limits.

The IRS indicates that it will be revising the Form 941 for employers to report wages paid during the quarter exceeding the $200,000 threshold, as well as their withholding liability for tax on those wages. Employers can correct any errors, interest-free, made in calculating the additional withholding tax, such as underpayments or overpayments, on the Form 941-X. There are no anticipated changes to the Form W-2.

NET INVESTMENT INCOME TAX

Beginning January 1, 2013, a new additional 3.8% Medicare tax on net investment income is imposed on individuals, estates and trusts. The IRS and Treasury Department released implementing guidance on this tax in the form of proposed regulations and questions and answers.

Who is Subject to the Tax?

Individuals are subject to the additional tax if their net investment income and modified adjusted gross income (AGI) exceed the following thresholds:

Filing Status	*Income Threshold Amount*
Single	$200,000
Married filing jointly	$250,000
Married filing separately	$125,000
Head of household (with qualifying person)	$200,000
Qualifying widow(er) with dependent child	$200,000

Estates and trusts are subject to the additional tax if they have undistributed net investment income and adjusted gross income over the dollar amount at which the highest tax bracket for an estate or trust begins for such taxable year ($11,650 for the 2012 tax year).

What is Investment Income?

For purposes of this tax, *investment income* includes: interest, dividends, capital gains, rental and royalty income, non-qualified annuities, income from businesses involved in trading of financial instruments or commodities, and businesses that are passive activities to the taxpayer. Certain gains are also taken into account in computing net investment income, such as:

- Gains from the sale of stocks, bonds, and mutual funds;
- Capital gain distributions from mutual funds;
- Gain from the sale of investment real estate; and
- Gains from the sale of interests in partnerships and S corporations (to the extent of certain built in gains in entity assets)..

Reporting the Income

The Form 1040 is used by individuals for reporting and paying the net investment income tax. The tax applies to investment earnings in 2013, and is reported on the Form 1040 filed in 2014 for the 2013 year. Estates and trusts will use the Form 1041 for reporting and paying the investment income tax.

CONCLUSION

Employers should begin working with their payroll services and payroll departments to make certain withholding can begin at the proper time. While there is no obligation to notify employees of the additional withholding, the employer may wish to do so to avoid later questions. It should be noted that while an individual may be subject to both the additional 0.9% wage tax and the 3.8% net investment income tax, the types of income on which they are assessed differ.

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CBIZ
Health Reform Bulletin

Subject: **Final Regulations Issued: 1) Patient-Centered Outcomes Research Fees and 2) Medical Device Tax**
Date: December 10, 2012

PATIENT-CENTERED OUTCOMES RESEARCH FEES: FINAL REGULATIONS ISSUED

The Affordable Care Act (ACA) imposes a research fee on both insured and self-funded health plans. The purpose of these fees is to fund a Patient-Centered Outcome Research Trust Fund. This Trust Fund, in turn, supports a Patient-Centered Outcomes Research Institute to assist patients, clinicians, purchasers, and policymakers in making informed health decisions by advancing comparative clinical effectiveness research.

The Internal Revenue Service (IRS) issued proposed regulations in April of this year relating to the imposition of this fee (see CBIZ Health Reform Bulletin, *Fees on Health Insurance Policies & Self-Insured Plans: Patient-Centered Outcome Research Trust Fund*), followed by the issuance of final regulations on December 6, 2012. These final regulations follow, in large part, the proposed regulations with certain modifications. These regulations are effective December 6, 2012 and apply to policy and plan years ending on or after October 1, 2012, and before October 1, 2019.

Plans Subject to the Fees

Virtually, all health plans, whether insured or self-funded are subject to the fees. This includes plans sponsored by single employers, as well as multiple employer plans and multi-employer plans.

Individuals to be counted include those who have coverage under the plan by virtue of current employment status, as well as those who have coverage by virtue of prior employment; this would include individuals on both state and federal (COBRA) continuation coverage, as well as retirees and any affected dependents of any of these individuals.

The types of benefit plans *not subject* to the fees include:

- HIPAA-excepted benefit plans such as limited scope dental and vision plans;
- Employee assistance programs, disease management programs, and wellness programs if the program does not provide significant benefits in the nature of medical care or treatment;
- Expatriate group health plans primarily covering employees who work and reside outside the United States (however, foreign nationals working in the US *are* counted in the calculation of the fee); and
- Stop loss and indemnity reinsurance policies.

With regard to reimbursement type plans, health reimbursement arrangements (HRA) and medical flexible spending account (FSA) plans are subject to these fees. However, FSA plans that qualify as HIPAA-excepted plans are *not* subject to these fees.

The fees will be assessed on the insurer of an insured plan; the plan sponsor will be required to pay the fee on behalf of a self-funded plan. Because the law provides that the fees are to be paid by the plan sponsor, at least for plans subject to ERISA, it cannot be paid from plan assets. The DOL's Employee Benefit Security Administration is expected to take a position on this issue, at some point.

Calculating the Fee

The fee is calculated based on the average number of covered lives under the plan. The initial fee will be $1 per covered life. For policy/plan years ending after October 1, 2013, the fee will be $2 per covered life (indexed). This fee will cease to be assessed for policy/plan years ending after September 30, 2019. For a calendar year plan, this would be the 2018 plan year.

Determining the Average Number of Covered Lives

For insured plans, with the exception of the snapshot method, the final regulations keep the proposed methodologies for determining the average number of covered lives; they are:

1. An "**actual count method**" which is calculated by the sum of covered lives for each day of the policy/plan year and dividing the sum by the number of days in the policy/plan year.
2. A "**snapshot method**". Under the proposed regulations, this method would have been computed based on the total number of covered lives on one date in each quarter of the policy year, or an equal number of dates for each quarter, and dividing the total by the number of dates on which the count was made. The final regulations made some changes to this method in an effort to ensure that the "snapshot" accurately reflects plan coverage. Specifically, the counts will be based on a date during the first, second, or third month of each quarter. The date used for the second, third, and fourth quarters must be within three days of the date in that quarter that corresponds to the date used for the first quarter, and all dates used must fall within the same policy/plan year.
3. A "**member months method**" whereby an insurer would determine the average number of covered lives under all individual policies in effect for a calendar year divided by 12.
4. A "**state form method**" could be used by certain insurers. The calculation is derived by data the insurer annually files with the relevant state licensure department, such as a state insurance department.

For self-funded plans, a plan sponsor can choose the actual count method or snapshot method, as above; or the Form 5500 method which is based on the average number of covered participants at the beginning and end of the plan year, as reported on the relevant Form 5500 for the applicable plan year.

CHART FOR DETERMINING PATIENT-CENTERED OUTCOME RESEARCH FEES

TYPE OF PLAN	PLAN SPONSOR OBLIGATION	INSURER OBLIGATION
Insured health plan	n/a	$x per average covered life
Self-funded plan	$x per average covered life	n/a
Multiple integrated self-funded health plans, such as comprehensive plans, HRA, FSA, self-funded prescription drug plan, etc.	$x per average covered life *Note: Count a life once for integrated plans*	n/a

Chart for Determining Patient-Centered Outcome Research Fees, con't

TYPE OF PLAN	PLAN SPONSOR OBLIGATION	INSURER OBLIGATION
Non-integrated self-funded health plan(s)	$x per covered life per plan	n/a
Insured health plan plus HIPAA-excepted FSA or HRA *Note: No fee assessed if the HRA or FSA is HIPAA-excepted benefit (see definition below)*	n/a	$x per average covered life under insured plan only
Insured health plan plus *non-*HIPAA-excepted HRA or FSA	$x per employee participating in the non-excepted HRA or FSA *Note: Count only employees; not dependents*	$x per average covered life in the insured plan

Notes about this chart:

- An *integrated health plan* refers to plan design wherein an employer offers multiple self-funded plans, such as a comprehensive health plan and an HRA in which both plans are established and maintained by the same plan sponsor with the same plan year. For integrated plans, the number of individuals participating in both plans need only be counted once for purposes of the fee.
- With regard to *HIPAA-excepted benefit plans*, FSAs are excepted from HIPAA when the employer offers other group health plan coverage, and the maximum benefit payable to a participant under the health FSA is less or equal to the greater of:
  - $500 (plus any participant contribution, if applicable) or
  - Two times the participant's salary reduction election for the year.

  Also excepted from HIPAA are FSAs or HRAs that only reimburse excepted benefits, such as dental-only or vision-only benefits.

Collection of the Fee

The fee is to be paid once a year in connection with IRS Form 720, *Quarterly Federal Excise Tax Return*. For insured plans, the Form 720 is due by July 31st following the close of the policy year. For self-funded plans, the Form 720 is due by July 31st of the calendar year following the plan year end.

Effective Date

The fee applies to policy/plan years ending on or after October 1, 2012. For a calendar year plan, the fee will first be applicable for the 2012 plan year.

What Should a Plan Sponsor Do?

- ❒ Determine which plans are subject to the fee.
  - For insured plans, the insurer is responsible for paying the fee; though, be aware that this cost could ultimately affect premium.
  - For self-funded plans, be prepared to pay the fee on the Form 720 due by July 31st of the year following the close of the plan year.
- ❒ If multiple self-funded health plans exist, consider integrating them to reduce liability for the fee.

FEES ON PHARMACEUTICAL MANUFACTURERS AND IMPORTERS: FINAL REGULATIONS

The ACA imposes an annual nondeductible fee on pharmaceutical manufacturers and importers of certain branded prescription drugs or biologics offered for sale in the U.S. The tax is imposed on the sale of a taxable medical device at the rate of 2.3% of the price for which the device is sold.

On December 7, 2012, the IRS issued final regulations relating to these fees. According to these regulations, a *taxable medical device* is one that is intended for humans and defined in accordance with the Federal Food, Drug, and Cosmetic Act (FFDCA) and by the Food and Drug Administration (FDA).

The term taxable medical device *does not* include:

- Eyeglasses, contact lenses, and hearing aids.
- Any device purchased by the general public at retail pharmacies, grocery stores, cosmetic supply stores and similar businesses for individual consumer use (the "retail exemption"). Examples include items available over-the-counter (OTC), i.e., without a prescription or without professional medical administration or oversight, such as OTC lab tests and devices, and durable medical equipment, prosthetics, orthotics, and supplies. The regulations provide examples of items that fall within this retail exemption, such as adhesive bandages, absorbent tipped applicators, denture adhesives, and snake bite kits.

Additional information and FAQs are available on the IRS' Medical Device Excise Tax webpage.

The tax applies to the sales of taxable medical devices on and after January 1, 2013.

About the Author: Karen R. McLeese is Vice President of Employee Benefit Regulatory Affairs for CBIZ Benefits & Insurance Services, Inc., a division of CBIZ, Inc. She serves as in-house counsel, with particular emphasis on monitoring and interpreting state and federal employee benefits law. Ms. McLeese is based in the CBIZ Leawood, Kansas office.

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CBIZ
Health Reform Bulletin

Subject: **1) Premium Stabilization Program Proposals and 2) Chart of Health Plan Fees and Taxes**
Date: December 18, 2012

On December 7, 2012, the Department of Health and Human Services issued proposed regulations relating to several aspects of the Affordable Care Act (ACA). These proposals make clarifications to premium stabilization programs and their effect on the minimum loss ratio rules, to standards relating to federally facilitated SHOP exchanges, and to standards relating to advance payments of premium tax credits and cost sharing reductions. Comments on these regulations must be received by December 31, 2012. Below are highlights of these proposals:

HEALTH INSURANCE PREMIUM STABILIZATION PROGRAM

The three components of ACA's premium stabilization program, known as transitional reinsurance, risk corridors, and risk adjustment are intended to protect against adverse selection of newly enrolled populations in the exchange and to, in effect, level the playing field to accommodate higher risks.

TRANSITIONAL REINSURANCE POOL

The goal of a transitional reinsurance program is to stabilize premiums in the individual market due to anticipated immediate enrollment of higher risk individuals beginning in 2014. The reinsurance money will be used to offset the expenses of the newly eligible individuals.

States that operate an Exchange are required to establish a transitional reinsurance pool, to be in effect for 3 years (2014 through 2016). In the absence of a State establishing a reinsurance pool, the federal government will do so. All insurers, and third party administrators on behalf of self-funded plans, are required to contribute to this reinsurance pool. The total contribution amounts to be collected from 'contributing entities' is estimated to be $10 billion in 2014, $6 billion in 2015, and $4 billion in 2016. Monies collected will be diverted into the reinsurance pool, the US Treasury, and to pay for administrative expenses associated with the collection of fees.

Plans Subject to the Fees

Virtually, all sized health plans, whether insured or self-funded are subject to the fees. This includes plans sponsored by single employers, as well as multiple employer plans and multi-employer plans.

Certain account-based plans *are not* required to make reinsurance contributions, including health reimbursement arrangements that are integrated with comprehensive group coverage and flexible medical spending account plans. Health savings accounts (HSA) are excluded; however, a high deductible health plan used in conjunction with the HSA is considered major medical insurance and thus, subject to reinsurance contributions.

Employee assistance plans, disease management programs, and wellness programs are generally not subject to reinsurance contributions if the program does not provide significant benefits in the nature of medical care or treatment.

Determining Contribution Amount
The contribution amount is calculated by multiplying the average number of covered lives during the applicable year for all plans and coverage by the contribution rate (as determined by HHS) for the applicable year. HHS estimates the 2014 contribution rate to be $5.25 per covered life per month, or approximately $63, annually.

Counting Covered Lives
The regulations outline procedures for counting covered lives in insured and self-funded group health plans, as well as multiple plans sponsored by the same plan sponsor, and multiple plans that are treated as single employer plans. These counting procedures are similar, but differ, to those used in calculating Patient Outcome Research Fees (see CBIZ Health Bulletin, *Final Regulations Issued: Patient-Centered Outcomes Research Fees*).

Insured plans must use one of the following methods for determining the average number of covered lives under the plan:

- ❒ *Method 1.* Add the total number of covered individuals on each day of the first 9 months of the benefit year and divide that total by the number of days in the first 9 months;
- ❒ *Method 2.* Add the total number of covered individuals on any date during the same corresponding month in each of the first three quarters of the benefit year, and divide that total by the number of dates on which a count was made. The same months must be used for each quarter (for example January, April and July) and the date used for the second and third quarter must fall within the same week of the quarter as the corresponding date used for the first quarter; or
- ❒ *Method 3.* Multiply the average number of policies in effect for the first nine months of the benefit year by the ratio of covered individuals per policy in effect. The calculation is derived by data the insurer annually files with its relevant state licensure department, such as a state insurance department.

Plan sponsors of ***self-funded plans*** have several options for counting covered lives under the plan. It can choose Method 1 or 2, as above; or one of the following methods:

- ❒ Add the total number of covered lives on any date during the same corresponding month in each of the first three quarters of the benefit year, and then divide the total by the number of dates on which a count was made. However, the count on a particular date is further differentiated by adding those with self-only coverage to those with non-self-only coverage and a factor of 2.35 (this number can be used to account for covered lives which is useful particularly in the instance that the employer doesn't have information on covered dependents). The same months must be used for each quarter (for example, January, April, and July); or
- ❒ A Form 5500 method which is based on the average number of covered participants at the beginning and end of the plan year, as reported on the relevant Form 5500 for the applicable plan year.

To determine the number of covered lives of reinsurance contribution enrollees under a group health plan with a self-insured coverage option and an insured coverage option for a benefit year, a plan must use one either Method 1 or 2, as described above.

Annual Enrollment Count, Notification and Payment of Reinsurance Contributions
An insurer or plan sponsor, through its third party administrator (TPA), is required to submit an annual enrollment count of the average number of covered lives to HHS by November 15th of each year. HHS will then notify the insurer or plan sponsor/TPA of its contribution amount no later than December 15th of the reporting year. The insurer or plan sponsor/TPA must then remit payment to HHS within 30 days of receiving the HHS notification of the amount due.

Unlike the Patient-Centered Outcome Research Fees (see CBIZ Health Reform Bulletin, *Final Regulations Issued: Patient-Centered Outcomes Research Fees*), so far it appears that the Department of Labor does consider the transitional reinsurance fee contributions a permissible plan expense.

In related guidance, the IRS has indicated that contributions made under the reinsurance programs by insurers and sponsors of self-funded group health plans are generally deductible as ordinary and necessary expenses, subject to any applicable disallowances or limitations under the Code (see *ACA Section 1341 Transitional Reinsurance Program FAQs*).

Effect of Premium Stabilization on Minimum Loss Ratio Rules
The proposed regulations make several changes in the medical loss ratio (MLR) rules as it relates to insurer reporting of earned premium and MLR rebates. Of particular note relating to rebates:

- For purposes of calculating MLR rebates, insurers are permitted to deduct certain federal and state taxes, as well as licensing and regulatory fees. The proposed regulations also permit insurers to adjust rebate amounts as a result of payments or receipts for risk adjustment, risk corridors and reinsurance programs.
- For the 2011 through 2013 reporting years, insurers must provide MLR rebates to enrollees no later than August 1st (beginning in 2014, by September 30th) following the end of the relevant MLR reporting year.

Temporary Risk Corridor Program
Qualified health plan (QHP) issuers are required to establish and administer a temporary risk corridor program for a 3-year period from 2014 through 2016. QHP issuers will receive payment from HHS in certain circumstances when a QHP's allowable costs for any benefit year exceed the target amount. The proposed regulations permit QHPs to include profits and taxes within its risk corridors calculations. This program is intended to protect QHP issuers in the individual and small group market against inaccurate rate setting and uncertainty in the Exchange by limiting the extent of issuer losses and gains.

Permanent Risk Adjustment Program
An on-going permanent risk adjustment program is intended to provide adequate payments and reduce risk premium to health insurance issuers that attract high-risk populations, such as individuals with chronic conditions; as well as stabilize premiums in the individual and small group markets once the ACA's insurance market reforms are implemented. The proposed regulations establish the criteria and methodology to be used by States in determining the actuarial risk of plans within a State that are offered both inside and outside of the Exchange.

SHOP Exchanges
Beginning in 2014, qualified small employers will be able to provide their employees and their dependents with access to one or more QHPs through a Small Business Health Options Program (SHOP) exchange. The proposed regulations clarify certain standards and processes for implementing SHOP exchanges, as follows:

- For SHOP purposes, a *small employer* is one who employs between 1 and 100 employees on business days during the preceding calendar year and who employs at least one employee on the first day of the plan year. For plan years beginning before January 1, 2016, a state may elect to define a small employer by substituting 50 employees for 100 employees. The regulations clarify that solely for purposes of determining employer size, an employer must also include, in addition to its full-time employees for any month, the number of full-time equivalent employees, determined by dividing the aggregate number of hours of service of employees who are not full-time employees for the month, by 120.
- For plan years beginning prior to January 1, 2016, states may elect to define a small employer as one with 1-50 employees; a large employer as one with 51 or more employees. This criteria applies to federally-operated SHOP exchanges for plan years beginning October 1, 2013.
- The proposed regulations set forth certain standards for minimum participation and minimum contribution in QHPs offered through a federally-facilitated SHOP. Specifically, unless otherwise provided by state insurance law, the regulations impose a 70% minimum participation standard based on the number of qualified employees accepting coverage under the employer's group health plan, divided by the number of employees enrolled in other coverage. SHOPs can choose one of several methods for determining minimum contribution levels based on QHP design.

CHART OF ACA IMPOSED HEALTH PLAN FEES AND TAXES

The ACA imposes many taxes, fees and other assessments. The chart on pages 5-8 reflects a summary of these costs specifically assessed on health plans and plan sponsors. Some of the information in the chart is based on proposed guidance and subject to change. In certain instances, no guidance has been issued.

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Provision	Applicability	Amount	Entity Paying the Fee or Tax	Effective Date
Patient-Centered Outcome Research Fee Group health plans must pay a fee based on the average number of lives covered under the plan.	❒ Insurers of all-sized fully-insured plans ❒ All-sized employers of self-funded plans *Also applies to:* ▪ Retiree-only plans ▪ COBRA and state continuation coverage ▪ Non-integrated health reimbursement arrangements (HRA) ▪ Medical flexible spending accounts (FSA) subject to HIPAA Plans *not subject* to the fees include: ▪ HIPAA-excepted benefit plans such as limited scope dental and vision plans ▪ FSAs excepted from HIPAA ▪ Employee assistance programs, disease management programs, and wellness programs if the program does not provide significant benefits in the nature of medical care or treatment ▪ Expatriate group health plans primarily covering employees who work and reside outside the U.S. (however, foreign nationals working in the US *are* counted in the calculation of the fee) ▪ Stop loss and indemnity reinsurance policies	Initial fee is $1 per covered life. For policy/plan years ending after 9/30/13, the fee will be $2 per covered life (indexed).	➢ By insurer of fully insured plan ➢ By plan sponsor of self-funded plan	Plan years ending after 9/30/12 *No fee assessed for policy/plan years ending after 9/30/19 (for calendar year plans, this means the 2018 plan year)* PCOR fees paid once a year in connection with IRS Form 720, *Quarterly Federal Excise Tax Return:* ➢ For insured plans, Form 720 due by July 31st following the close of the policy year. ➢ For self-funded plans, Form 720 due by July 31st of the calendar year following the plan year end.

Provision	Applicability	Amount	Entity Paying the Fee or Tax	Effective Date
Transitional Reinsurance Fund *(Premium Stabilization Program)* Mechanism intended to allocate insurance risk and thereby mitigating the impact of potential adverse selection and stabilize premium in both the individual and small group markets	❒ Insurers of all-sized fully-insured plans ❒ All-sized employers of self-funded plans Also applies to post-employment plans that are primary to Medicare, such as early retiree plans *Plans not subject to fees include:* ▪ HRAs integrated with comprehensive group coverage ▪ Flexible medical spending account plans (FSA) ▪ Health savings accounts (HSA) except an HDHP used in conjunction with HSA is considered major medical insurance and thus, subject to reinsurance contributions ▪ Employee assistance plans, disease management programs, and wellness programs if the program does not provide significant benefits in the nature of medical care or treatment. ▪ Post-employment plans where Medicare is primary to group plan.	Specific rates set annually by HHS. ➢ In 2014, $5.25 per covered life per month based on calendar year, or approximately $63 annually ➢ Amount scheduled to decrease in 2015 and 2016.	➢ By insurer of fully insured plan ➢ By plan sponsor of self-funded plan. If the self-funded plan uses a third party administrator (TPA), the TPA is the required reporting entity, with the right to pass the expense onto the plan.	1/1/14 No fee assessed beyond 2016
Annual Fee – Health Insurers An annual fee imposed upon insurers covering U. S. health risks. Assessed fees apportioned amongst all applicable insurers, based on a ratio of net premiums for insuring U. S. risks during preceding calendar year as compared to the aggregate net premiums for that same year.	❒ Insurers writing health insurance covering US citizens. Plans *not subject* to fees include plans sponsored by non-profit entities, such as VEBAs. *(Note: Although employers who sponsor self-funded plans are exempt from these fees, there may be potential impact on stop-loss coverage by affected insurers).*	*(To be determined – awaiting guidance)*	Insurers	Annual fee required to be paid each calendar year beginning 1/1/14

Provision	Applicability	Amount	Entity Paying the Fee or Tax	Effective Date
Employer Shared Responsibility A nondeductible excise tax assessed on large employers who do not provide minimal essential coverage, or affordable coverage to their full time employees	❒ Employers with at least 50 full time employees or equivalents. "*Full-time employees*" include: ▪ Employees that work at least 30 hours per week ▪ A percentage of employees who are not full time employees (aggregate number for hours/month worked by part time employees divided by 120)	❒ If employer does not offer minimal essential coverage and at least one employee goes to Exchange and receives premium tax credit, the penalty is $2,000* per year per full-time employee (less first 30) ❒ If employer offers minimal coverage that is unaffordable (i.e., employee's premium exceeds 9.5% of household income), or coverage does not meet minimum value, and at least one employee goes to Exchange and receives premium tax credit, the penalty is lesser of: ▪ $3,000* per year for each full time employee using Exchange and qualifying for premium credit, or ▪ $2,000* per year per full time employee (less first 30) **Amounts subject to annual indexing*	Employer	1/1/14
Excise Tax – Failure to Comply with ACA Insurance Market Reforms *Examples*: extension of dependent coverage to age 26, ban on preexisting condition exclusions, plan rescissions, and excessive waiting periods, annual and lifetime limitations, coverage for preventive health services, patient protection standards, claims, appeals and external review process, etc.	❒ Plan sponsors of all-sized fully-insured plans and self-funded plans Plans *not subject* to market reform provisions include HIPAA-exempt programs, such as: ▪ Retiree-only plans ▪ Limited scope dental and vision plans	➢ Penalty is $100 per employee/per day of noncompliance. ➢ Minimum excise tax for a compliance failure is $2,500, up to $15,000 if violations exceed "de minimis" standard. ➢ Unintentional failures for single employer plan is lesser of 10% of amount paid during the preceding tax year by the employer for group health plans, or $500,000.	Plan Sponsor	Plan years beginning on or after 9/23/10 Plan sponsors liable for the excise tax are required to self-report ACA violations on the Form 8928, *Return of Certain Excise Taxes Under Chapter 43 of the Internal Revenue Code*

Provision	Applicability	Amount	Entity Paying the Fee or Tax	Effective Date
Excise Tax on High Cost Employer-Sponsored Health Coverage A 40% non-deductible excise tax imposed on the value of high cost employer sponsored health coverage ("Cadillac" health plans) exceeding certain threshold limits ($10,200/individual; $27,500/family) [indexed].	❒ Plan sponsors of all-sized fully-insured plans and self-funded plans	*(To be determined – awaiting guidance)*	Employer calculates the excise tax and provides it to the insurer or TPA, who then pays the tax.	1/1/18

CBIZ
Health Reform Bulletin

Subject: **Shared Responsibility Guidance**
Date: January 9, 2013

On January 2, 2013, the IRS issued proposed regulations, together with a set of Frequently Asked Questions relating to the Affordable Care Act's shared responsibility requirement. These proposed regulations follow, in large part, the various sets of guidance issued thus far. The proposed regulations are reliance regulations which means they can be relied upon now. Any changes to these regulations would be prospective in nature with adequate time given to adjust.

As background, one of the centerpieces of the ACA is the shared responsibility requirement that takes effect in 2014. The shared responsibility provision requires employers employing 50 or more employees to offer adequate coverage at an affordable rate, or risk becoming subject to an excise tax.

There are two separate excise taxes that could be imposed. There is the 'no coverage' excise tax, and the 'inadequate or unaffordable' excise tax.

- The '**no coverage'** excise tax applies if an employee working 30 or more hours per week is offered no coverage or coverage that is less than minimum value, and if the employee qualifies for premium assistance, which means the individual falls below 400% of the federal poverty level and is not eligible for minimum essential coverage ("MEC"). MEC includes most types of employer coverage, as well as government-sponsored coverage, such as Medicaid or Medicare, among others.
- The '**inadequate or unaffordable'** excise tax penalty would apply if the employer offers MEC but it either does not meet minimum value, as more fully described below, or is unaffordable, as more fully described below.

What Employers are subject to the Shared Responsibility Requirement?
The shared responsibility rules apply to all public and private 'large employers' employing an average of at least 50 full-time employees (including full-time equivalent employees) on business days during the preceding calendar year.

Determining applicable status. An employer's status as an applicable large employer for a calendar year is determined by taking the sum of the total number of full-time employees (including any seasonal workers) for each calendar month in the preceding calendar year and the total number of full-time equivalent employees (including any seasonal workers) for each calendar month in the preceding calendar year, and dividing by 12. The result, if not a whole number, is then rounded to the next lowest whole number. If the result of this calculation is less than 50, the employer would not be deemed to be an applicable large employer for the current calendar year. If the result of this calculation is 50 or more, the employer would be deemed an applicable large employer for the current calendar year, unless a seasonal worker exception applies. Special rules apply to employers who were not in existence in the prior calendar year.

First year transition relief. For purposes of determining applicable status for the first year of implementation, an employer can determine whether it is an applicable large employer for 2014 by calculating the number of its employees employed on business days in any consecutive six-month period in 2013, as chosen by the employer.

Seasonal worker exception. For purposes of counting employees, the regulations provide an exception for employers employing seasonal workers. If an employer's workforce exceeds 50 full-time employees for 120 days or fewer during a calendar year, and the employees in excess of 50 who were employed during that period were seasonal workers, the employer would not be considered an applicable large employer.

> *Example:* An employer employs 40 full-time employees for the entire 2015 calendar year plus 80 seasonal full-time workers who work from September through December, 2015, resulting in a rounded average of *66 employees for the year. Because the total number of full-time employees and seasonal workers does not exceed 50 for more than 4 calendar months (120 days) during the year, the employer would not be considered a large employer in 2016.
>
> ***(40 X 8 {months} = 320) + (120 X 4 {months} = 480) = 800, then divide by 12 (months) = 66.67***
> ***Full Time Employees Full time & Seasonal***

Control Group Rules Apply. For purposes of determining whether an employer is an applicable 'large employer', the IRC control group rules apply, i.e., all employees of a controlled group of entities under IRC Section 414(b) or (c), or an affiliated service group under IRC sections 414(m) or (o) are taken into account in determining whether the members of the controlled group or affiliated service group together are an applicable large employer. It should be noted, however, that any penalty imposed against entities of a control group or affiliated service group are applied separately to the individual entity.

It should also be noted that the term 'employer' also includes a predecessor employer and a successor employer.

What Type of Health Coverage must be Offered?

Generally, minimum essential coverage ("MEC") that must be offered to employees includes the type of coverage available under most insured and self-funded employer-sponsored group health plans, without regard to grandfathered status.

What is Affordable Coverage?

Coverage under an employer-sponsored plan is deemed affordable to a particular employee if the employee's required contribution to the plan does not exceed 9.5% of the employee's household income for the taxable year. For this purpose, household income means the modified adjusted gross income of the employee and any members of the employee's family (which would include any spouse and dependents) who are required to file a federal income tax return.

Because the employer does not know household income, the regulations provide for three safe harbors that employers can use for purposes of determining affordability; they are:

1. A **Form W-2 determination** in which the employer's lowest cost self-only coverage providing minimum value does not exceed 9.5% of the employee's Form W-2 wages for the calendar year. This method is determined at the end of the calendar year, and on an employee-by-employee basis. In addition, to qualify for this safe harbor, the employee's required contribution must remain a consistent amount or percentage of all Form W-2

wages during the calendar year (or for plans with fiscal year plan years, within the portion of each plan year during the calendar year) so that an employer cannot make discretionary adjustments to the required employee contribution for a pay period. A periodic contribution that is based on a consistent percentage of all Form W-2 wages may be subject to a dollar limit specified by the employer. An adjusted calculation is used when coverage is only offered for a partial year.

2. A **rate of pay method** in which the minimum value cannot exceed 9.5% of an amount equal to 130 hours, multiplied by the employee's hourly rate of pay as of the first day of the coverage period (generally, the first day of the plan year). For salaried employees, the monthly salary is used instead of the 130 hour standard. This method is permissible only if it doesn't cause an overall reduction to the individual's hourly or monthly wage during the calendar year. This methodology might be useful if the employer's workforce hours fluctuate frequently.
3. A **Federal poverty line (FPL) standard** in which the minimum value does not exceed 9.5% of the individual federal poverty line rate for the applicable calendar year, divided by 12. The FPL calculation may be useful to employers that want to know for planning purposes in advance, what the maximum can be charged the employee to avoid a potential penalty.

What is the Minimum Value Standard?

For purposes of these rules, coverage is deemed to meet the minimum value standard if it covers a minimum of 60% of the total allowed cost of benefits expected to be incurred under the plan, The IRS and HHS will make a minimum value calculator available to employers for determining whether their plan provides minimum value.

Who Must Be Offered Coverage?

In a nutshell, an employer is required to offer minimum essential coverage to at least 95% of its full-time employees (employees plus their dependents beginning in 2015 and beyond), or risk becoming subject to the 'no coverage' penalty.

- If an employer offers minimum essential coverage to at least 95% of its full-time employees, then the 'no coverage' penalty would not be triggered, whether the trigger is lack of available coverage, or the coverage offered is inadequate or unaffordable.
- If the employer offers minimum essential coverage to at least 95% of its full-time employee population, and at least one of those employees goes to exchange and qualifies as a credit employee, then the 'inadequate or unaffordable' penalty would apply.
- If the employer offers coverage to *less than* 95% of its full-time employee population, the 'no coverage' or the inadequate or unaffordable' penalty could apply, depending on the circumstance.

It should be noted that for these purposes, *dependent* includes the employee's son, daughter, stepchild or foster child up to their 26th birthday. Dependent does not include the spouse of an employee. Failure to offer dependent coverage will not result in a penalty in 2014 as long as the employer is working toward offering dependent coverage.

Who are Full-time Employees?

The regulations define *employee* as a common-law employee. It does not include a leased employee, a sole proprietor, a partner in a partnership, or a 2-percent S corporation shareholder.

A *full-time employee* is defined as one who works for an employer an average of at least 30 hours per week. An employee who works 130 hours of service in a calendar month is deemed to meet

the monthly equivalent of the 30 hours of service per week standard, as long as this equivalency rule is applied consistently.

A *full-time equivalent employee* refers to those employees working less than 30 hours per week. It should be noted that full-time equivalent employees are included in the count for purposes of determining employer size. However, it is not mandatory to offer health coverage to these individuals unless the employer chooses to do so.

The guidance provides that individuals working outside the United States, whether a US citizen or otherwise, will not trigger a shared responsibility penalty, nor are they included in determining employer size.

How are Hours of Service Calculated?

For purposes of determining the number of hours of service an employee works, not only are actual working hours counted, but also hours in which an employee is paid but does not work, such as vacation, holiday, sick leave, disability leave, layoff, military duty or other paid leave of absence.

In determining whether an individual is regularly scheduled to work 30 or more hours per week:

- For employees paid on an *hourly basis*, the employer would calculate actual hours of service from records of hours worked, and hours for which payment is made or due.
- For employees paid on a *non-hourly basis*, the employer would calculate hours of service by using one of the following 3 methods:
    1. Using *actual hours of service* from records of hours worked, and hours for which payment is made or due;
    2. Using a *days-worked equivalency* whereby the employee is credited with eight hours of service for each day for which the employee would be required to be credited with at least one hour of service; or
    3. Using a *weeks-worked equivalency* whereby the employee is credited with 40 hours of service for each week for which the employee would be required to be credited with at least one hour of service.

  An employer is not required to use the same method for all non-hourly employees, and may apply different methods for different classifications of non-hourly employees, provided the classifications are reasonable and consistently applied. Similarly, an employer member in a control group status, for example, would not be required to apply the same method of calculation for non-hourly employees used by other employer members of the group provided that the classifications are reasonable and consistently applied by the employer members of the control group.

  The regulations make it clear that calculating the days-worked equivalency or weeks-worked equivalency cannot be used in such a way that would cause an employee to lose full-time status. For example, an employer cannot use a days-worked equivalency for an employee working three 10-hour days per week because the days-worked equivalency would reduce the hours of service to 24 hours per week.

Leaves of Absence. The proposed regulations provide a method for averaging hours for employees who return to work following an unpaid leave of absence, such as unpaid Family and Medical Leave, and military leave (USERRA). In this instance, the employer would determine the individual's average hours of service per week, excluding the unpaid leave period. In the

alternative, the employer could credit the hours of unpaid leave equal to the individual's average weekly rate.

Special Rules for School and Colleges

Special rules apply to educational organizations, such as primary, secondary, preparatory, or high schools, and colleges and universities, with regard to calculating periods of employment breaks during the academic terms. In a nutshell, if during the regular school year, an employee works 30 or more hours per week, the individual will be deemed to work 30 or more hours per week during the summer.

The regulations leave open the opportunity to future guidance to other types of unique work forces, such as adjunct professors and airline pilots. In the meantime, an employer must use reasonable efforts to determine whether an individual works 30 or more hours per week. For example, with regard to adjunct professors, the employer must count class preparation time, not just actual class time. In other words, the regulations go to great lengths to ensure that employers do not find loopholes to avoid the intent of the law.

When Must Coverage be Offered?

For full-time employees, coverage must be offered within 90 days of employment (3 months, according to the regulations). For all plans, both large and small, the maximum waiting period can be no longer than 90 days for plan years beginning on or after January 1, 2014. An employer would not risk the imposition of an excise tax as long as coverage provided within this time frame.

It should be noted that one of the requirements of making an offer of coverage is that employees have a reasonable opportunity to enroll at least once per year.

An employer's obligation with respect to offering minimum essential coverage ceases if, during the course of the plan year, coverage terminates due to the employee's failure to timely pay his/her share of premium.

What Happens if an Individual's Full-time Status is not known at Date of Hire?

The rules allow the use of a look-back period. If an individual is deemed to work 30 or more hours per week, the individual is deemed to be a full-time employee during a stability period. A look-back period can be between 3 and 12 months. The stability period must be at least 6 months but no shorter than measurement period.

For a new hire, an initial measurement period can be used rather than the standard measurement period. The initial measurement period can be measured from date of hire or shortly thereafter. The standard measurement period is one defined by the employer and can be the calendar year or any other period defined by the employer.

For individuals hired with a variable or seasonal work schedule, and for whom it is not possible to determine whether the individual will qualify, an employer can use a measurement period, as defined by the employer, to determine whether the individual qualifies under the terms and conditions of the employer plan.

- A *variable hour employee* is one whose working hours are variable or otherwise uncertain such that it cannot be determined whether the individual will be working a minimum 30 hours per week during the initial measurement period.
- A *seasonal worker* is one who works on a seasonal basis, as defined under the federal wage and hour law, and retail workers employed exclusively during holiday seasons.

The measurement period and stability period must be the same for all individuals in a particular classification of employees. The rules only allow four types of classifications of employee; they are:

1. Collectively bargained employees and non-collectively bargained employees;
2. Each group of collectively bargained employees covered by a separate collective bargaining agreement;
3. Salaried employees and hourly employees; and
4. Employees whose primary places of employment are in different States.

The rules provide for an optional administrative period of up to 90 days that may be imposed in between the end of a measurement period and the start of a stability period. Any administrative period imposed must overlap with the prior stability period to avoid a potential gap in coverage.

What Happens if an Individual's Employment Status Changes?

Generally, the individual remains in the same employment status for the duration of the measurement period. For variable or seasonal employees, if the change in employment status occurs within the initial measurement period, they would have to be re-classified within 4 months of the change in employment status.

For re-hired employees, an employee who terminates service and is re-hired is deemed to meet full-time status if the period between termination of service and re-hire is at least 26 consecutive weeks (employers may choose to apply a shorter period of time).

How are Employers Notified about Potential Penalties?

The regulations provide a methodology for how an employer will be notified by the IRS of its shared responsibility penalty. Generally, this determination will be made after the date the individual taxpayers file their tax returns.

How are the Penalties Calculated?

- ❒ **No coverage excise tax penalty**. If an employer fails to offer minimum essential health coverage to at least 95% of its full-time employees (employees plus their dependents beginning in 2015 and beyond) for any calendar month, and employs at least one credit employee*, the excise tax penalty is calculated monthly as (number of full-time employees minus the first 30) multiplied by $166.67 (equivalent of $2,000 per year).

- ❒ **Inadequate or unaffordable excise tax penalty**. If the employer offers health coverage to at least 95% of its full-time employees and employs at least one credit employee*, and such coverage fails to meet a minimum value standard or is unaffordable, then the monthly excise tax penalty is the lesser of:
  - ➢ Number of credit employees* multiplied by $250 (equivalent of $3,000 per year), or
  - ➢ (Number of full-time employees minus the first 30) multiplied by $166.67 (equivalent of $2,000 per year)

*A *credit employee* is one who works at least 30 hours per week and who is eligible for a premium tax credit or cost sharing assistance for buying insurance through an exchange.

What is the Effective Date of the Shared Responsibility Requirements?
Generally, the shared responsibility requirement takes effect January 1, 2014 without regard to the plan year.

Transition Relief for 'Non-Calendar Plan Year' Plans. The IRS provides transitional relief to plans, which on December 27, 2012, had a plan year different from the calendar year. For example, if a plan year runs July 1st to June 30th, the plan will not risk being subject to a shared responsibility penalty until the first day of the plan year beginning in 2014 (July 1, 2014 in this example), as long as coverage was offered to at least one-third of the employer's employee population (including both full and part-time employees) during the most recent open enrollment period, or the non-calendar year plan covered at least one-fourth of the employer's employee population.

What Should an Employer Do?

1. Determine employer size.
2. Determine which employees are full-time (30+ hours per week or 130 hours per month).
3. Determine which employees are part-time (fewer than 30 hours per week or 130 per month).
4. Determine which employees are variable or seasonal.
5. Decide whether to take advantage of a look-back (measurement) and stability period.
   - If using a measurement/stability period:
     - Define it for new employees (initial) and define it for on-going employees (standard).
     - Add to new hire practice, a determination of whether the individual is full-time, part-time, variable or seasonal. If variable or seasonal, track hours worked during measurement period.
   - If you're not using a measurement/stability period, analyze status each month.
6. Define methodology for determining affordability: Form W-2 method, the rate of pay method or the Federal poverty line (FPL) standard.
7. Make certain employees are given an effective opportunity to enroll in the plan (at least once per plan year).
8. Know your risk. How many full-time employees are offered minimum essential coverage? Is it affordable? To avoid a penalty risk, offer adequate coverage at an affordable rate. It is the offer, not the take-up rate that matters.

About the Author: Karen R. McLeese is Vice President of Employee Benefit Regulatory Affairs for CBIZ Benefits & Insurance Services, Inc., a division of CBIZ, Inc. She serves as in-house counsel, with particular emphasis on monitoring and interpreting state and federal employee benefits law. Ms. McLeese is based in the CBIZ Leawood, Kansas office.

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CBIZ
Health Reform Bulletin

Subject: **Sub-Regulatory Guidance and FAQs Issued on Notice of Exchange, Stand-Alone HRAs, PCOR Fees, and Fixed Indemnity Plans**

Date: January 25, 2013

As has been true since the enactment of the Affordable Care Act (ACA), the governing agencies are using their authority to issue sub-regulatory guidance, often in the form of questions and answers, to provide guidance on how the government believes regulations will be issued. To this end, *FAQs About Affordable Act Implementation Part XI* have just been issued. Of particular note are:

Notice of Exchange

The law requires employers to issue a Notice to employees explaining:

- The existence of the Exchange
- If the employer's health plan provides less than minimum value, the individual may be entitled to government assistance for purchasing coverage through the Exchange
- If the employee chooses to purchase coverage through the Exchange, he/she may lose any employer contribution toward employee coverage.

This Notice was to be provided to employees by March 1, 2013. The Department of Labor has stated that the requirement to issue the Notice is delayed until future regulations are issued. It is expected that these regulations will be issued in late summer or early fall – closer to the time that Exchanges will be open for business.

Stand-Alone Health Reimbursement Arrangements

One of the provisions of the Affordable Care Act is that a health plan can impose no lifetime, and eventually, no annual limits on essential health benefits. A question has risen as to the applicability of the no limit requirement on Health Reimbursement Arrangements (HRAs) *(see HRB 39 – Relief for Stand-Alone Health Reimbursement Arrangements)*. The Department of Labor has indicated that it expects to issue guidance clarifying the types of HRAs that will be considered integrated, and therefore not subject to the no-limit provision. Specifically, the Department expects to issue guidance stating that an HRA used to fund individual policies, including employer sponsored individual policies purchased with HRA dollars will not qualify as an integrated plan. What this means is that these types of HRAs would be subject to the no lifetime or annual limit requirement. Further, the Department states that it expects to issue guidance stating that, to be integrated, the HRA participant must be enrolled in the related comprehensive health plan in order for the HRA to be exempt from the no lifetime and annual limit requirement.

Finally the guidance clarifies that amounts credited in a standalone HRA prior to January 1, 2014, can continue to be used to reimburse medical expenses. In a nutshell, what this guidance suggests is that only integrated HRAs, i.e., an HRA that is used in conjunction with a

comprehensive health plan and only covers participants enrolled in the comprehensive health plan will be viable in 2014 and beyond. Other types of HRAs would have to comply with the no annual or lifetime limit requirements applicable to other comprehensive health plans.

Patient-Centered Outcomes Research Fee

As a reminder, the Affordable Care Act imposes a per-covered-life Patient-Centered Outcomes Research fee (PCOR) to fund the Patient-Centered Outcomes Research Trust Fund. This fee commences for plan years ending after September 30, 2012 and continues through plan years ending before October 1, 2019 *(see CBIZ Health Reform Bulletin 60, Patient-Centered Outcomes Research Fee)* and *CBIZ Health Reform Bulletin 49, Fees on Health Insurance Policies & Self-Insured Plans: Patient-Centered Outcome Research Trust Fund)*. Generally, the government has indicated that this fee cannot be paid from plan assets. The newly issued guidance addresses the specific issue of multi-employer and limited other circumstances in which the plan trustees have no existence other than for the specific purpose of providing benefits In these very limited circumstances, the Department of Labor has indicated that the PCOR fee can be paid from plan assets. But again, in all other instances, the PCOR cannot be paid from plan assets.

Fixed Indemnity Plans

The Department of Labor has issued several FAQs relating to fixed indemnity plans. Generally, a fixed indemnity plan in its purest sense is one that reimburses a fixed amount upon the occurrence of an event, such as a hospitalization, without regard and in no way tied to actual receipt of care. These types of plans generally are not subject to ACA nor are they subject to HIPAA. The Department of Labor indicates in these FAQS that the marketplace is attempting to circumvent this rule by calling plans fixed indemnity plans when in fact reimbursement is made or is otherwise tied to actual receipt of care. In effect, the Department has indicated that it will double down its efforts with state insurance departments to make certain that the intent of the Affordable Care Act is not thwarted through these types of arrangements. This is just another example of how the government is trying to stay ahead of creative methods of trying to circumvent the law.

About the Author: Karen R. McLeese is Vice President of Employee Benefit Regulatory Affairs for CBIZ Benefits & Insurance Services, Inc., a division of CBIZ, Inc. She serves as in-house counsel, with particular emphasis on monitoring and interpreting state and federal employee benefits law. Ms. McLeese is based in the CBIZ Leawood, Kansas office.

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CBIZ
Health Reform Bulletin

Subject: **Women's Preventive Services Update Impacting Religious Organizations**
Date: February 6, 2013

The ACA governing agencies are proposing a way to provide the full panoply of women's health services without unduly burdening religiously affiliated organizations who object to providing contraceptive coverage, as imposed by the preventive services mandate. On February 6, 2013, the Agencies released proposed regulations and a Fact Sheet addressing these issues.

As background, the ACA requires non-grandfathered plans to cover women's preventive health services without any cost-sharing (see *Preventive Care Coverage Expanded to include Women's Health Services*, 8/3/2011). For plan years beginning on or after August 1, 2012 (January 1, 2013 for calendar year plans), plans are required to include coverage for these women's health services, including contraceptive services.

Group health plans sponsored by certain religious employers are exempt from the requirement to cover contraceptive services. This exemption applies very narrowly to churches, temples and similar houses of worship. The regulations propose a clarification to the definition, as described below. The clarification is intended to provide protection to houses of worship that engage in such activities such as food pantries or other outreach programs.

The definition of a religious employer also left organizations with religious affiliations, such as hospitals, colleges and universities, private primary and secondary schools, and social service organizations who cannot meet the exception exposed to providing the women's preventive services mandate. Temporary relief from this requirement was issued last year (see *Preventive Health Services for Women: Regulations Final – Limited Exception for Certain Church Plans*, 2/13/12). The Agencies are now issuing a proposal to offer a more long term solution.

Religious Employer Re-defined. The proposed regulations re-define religious employer to primarily include churches, other houses of worship, and their affiliated organizations, as defined in IRC Section 6033(a)(3)(A)(i) and (iii).

Accommodation for Religious Organizations
The proposed regulations provide a waiver from the requirement to provide contraceptive services for religious organizations that don't qualify for the full exemption. To obtain the waiver, the religious organization must:

1. Oppose providing coverage for some or all of any contraceptive services required by the women's services mandate on account of religious objections;
2. Be organized and operate as a nonprofit entity;
3. Hold itself out as a religious organization; and
4. Maintain a self-certification form (see below), for each plan year to which the accommodation is to apply.

Organizations that meet this criteria would not be required to endorse, pay for, or otherwise facilitate coverage of the objectionable benefit; but such benefits would continue to be made available to women through a separate individual policy.

Self-Certification Form
HHS provides the form and instructions for obtaining the self-certification (CMS-10459 - Coverage of Certain Preventive Services Under the Affordable Care Act). The self-certification must be executed by an authorized individual of the organization, and specify the types of contraceptive services that the organization does not wish to administer or fund.

Insurer Obligations
An insurer receiving a copy of the self-certification form would be required to provide coverage for any contraceptive services identified in the form through a separate policy for each plan participant and beneficiary. The insurer is then obligated to include a separate written notice to participants of the availability of the contraceptive coverage in its application and enrollment materials. Below is the model language that can be used in the notice:

> "*The organization that establishes and maintains, or arranges, your health coverage has certified that your group health plan qualifies for an accommodation with respect to the federal requirement to cover all Food and Drug Administration-approved contraceptive services for women, as prescribed by a health care provider, without cost sharing. This means that your health coverage will not cover the following contraceptive services: [contraceptive services specified in self-certification]. Instead, these contraceptive services will be covered through a separate individual health insurance policy, which is not administered or funded by, or connected in any way to, your health coverage. You and any covered dependents will be enrolled in this separate individual health insurance policy at no additional cost to you. If you have any questions about this notice, contact [contact information for health insurance issuer].*"

If plan is self-funded, the regulations propose that the third party administrator (TPA) would facilitate this process. The insurer providing the coverage would receive an additional adjustment in the user fees charged by the federal exchange in an amount that would offset the TPA's charge for performing the service. The insurer would then pass the amount on to the TPA as a condition for receiving a user fee adjustment.

Student health insurance coverage sponsored by higher education institutions
Student health insurance coverage arranged by a group health plan sponsored by an exempt religious organization's higher education institution would be handled in the same manner as above; except the model notice would change the reference "plan participants and beneficiaries" to "student enrollees and their covered dependents".

Comment period. The Agencies are seeking comments on these proposals through April 8, 2013.

Until these rules are finalized, organizations with a religious affiliation can continue to follow the relief described in this Health Reform Bulletin, *Preventive Health Services for Women: Regulations Final – Limited Exception for Certain Church Plans*.

Conclusion

While this proposal may provide relief to religiously affiliated organizations, it does not provide any relief to private sector entities with moral or religious objections to providing contraceptive services. Numerous lawsuits have been filed on this topic and are winding their way through the court system. It is certainly possible that this issue will reach the Supreme Court at some point.

About the Author: Karen R. McLeese is Vice President of Employee Benefit Regulatory Affairs for CBIZ Benefits & Insurance Services, Inc., a division of CBIZ, Inc. She serves as in-house counsel, with particular emphasis on monitoring and interpreting state and federal employee benefits law. Ms. McLeese is based in the CBIZ Leawood, Kansas office.

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CBIZ
Health Reform Bulletin

Subject: **1) Individual Minimum Essential Coverage and 2) Affordability Standard**
Date: February 6, 2013

The centerpiece of the ACA is health coverage expansion. One of the ways that this is to be achieved is through a mandate that virtually all people residing in this country maintain a minimum level of coverage or pay a tax. The Agencies have recently issued two sets of proposed regulations and one final regulation targeted at explaining how this coverage mandate will be accomplished.

INDIVIDUAL SHARED RESPONSIBILITY REQUIREMENT – MINIMUM ESSENTIAL COVERAGE

On January 30, 2013, the IRS issued proposed regulations and questions and answers relating to the Individual Shared Responsibility provision. Below is an overview of this guidance.

Who are the individuals required to maintain Minimum Essential Coverage?

As mentioned above, beginning in 2014, all individuals residing in the U.S. must maintain a minimum level of coverage, or risk a shared responsibility payment. A taxpayer would also be responsible for maintaining coverage for a child or other individual claimed as a dependent on the taxpayer's federal tax return. Spouses who file their taxes jointly are likewise generally responsible for maintaining this minimum level of coverage.

Following are the potential penalties for failure to maintain a minimum essential coverage:

Year	Penalty
2014	Greater of: ❒ $95 per adult and $47.50 per child (up to $285 for a family); or ❒ 1.0% of family income
2015	Greater of: ❒ $325 per adult and $162.50 per child (up to $975 for a family) or ❒ 2.0% of family income
2016 and beyond	Greater of: ❒ $695 per adult and $347.50 per child (up to $2,085 for a family) or ❒ 2.5% of family income

Who is exempt from maintaining minimum essential coverage?

The regulations provide for 9 categories of individuals exempt from the requirement to maintain minimum essential coverage; they are:

1. A member of a religious sect that is recognized as conscientiously opposed to accepting any insurance benefits.
2. A member of a recognized health care sharing ministry.
3. A member of a federally recognized Indian tribe.

4. An individual whose household income falls below the minimum threshold for filing a tax return.
5. An individual who experiences a short gap in coverage of less than three consecutive months during the year.
6. An individual who incurs a hardship, as certified by an Exchange, which makes him/her unable to obtain coverage.
7. An individual who cannot afford coverage because the premium cost exceeds 8% of the his/her household income.
8. An individual who is incarcerated (jail, prison, or similar penal institution or correctional facility)
9. An individual who is not a U.S. Citizen, a U. S. national, nor an alien lawfully present in the U.S.

For other individuals seeking an exemption, the HHS issued proposed regulations relating to the process to be used by Exchanges in conducting eligibility determinations and granting exemptions from the shared responsibility payment.

In an effort to facilitate the maintenance of minimum essential coverage, certain individuals whose income falls between 100 and 400% of the federal poverty level will be entitled to government assistance unless the individual is exempt.

What is Minimum Essential Coverage?
Minimum essential coverage generally includes coverage under:

- ❒ **Employer-sponsored group health plans**, whether insured or self-funded, and grandfathered plans, as well as COBRA coverage (if actually elected) and retiree coverage. It also includes group health coverage sponsored by non-profit and for-profit entities, and governmental entities, including local governments.

  It should be noted that HIPAA-excepted coverage alone will not qualify as minimum essential coverage; HIPAA-excepted coverage includes:
  - Limited-scope dental benefits, vision benefits, or long term care benefits provided under a separate policy or contract, and are otherwise not an integral part of a group health plan.
  - Other types of limited benefit plans, such as accident-only plans, disability income coverage, liability insurance, workers' compensation, credit-only insurance, and coverage for on-site medical clinics.
  - Non-coordinated benefits providing specified disease or illness coverage, hospital indemnity insurance, or fixed dollar indemnity insurance that meets certain criteria.
  - Supplemental benefits, such as Medicare supplemental coverage (Medigap or MedSupp).

- ❒ **Government-sponsored plans** such as Medicare, Medicaid, Children's Health Insurance Program (CHIP), TRICARE, and various Veteran's health programs

- ❒ **Individual health policies**, including a qualified health plan offered by an Exchange.

- ❒ **Other similar types of comprehensive health coverage** recognized by HHS as minimum essential coverage

When does the individual mandate become effective?
The individual shared responsibility provision becomes applicable on January 1, 2014.

EMPLOYER SHARED RESPONSIBILITY REQUIREMENT – DETERMINING AFFORDABLE COVERAGE
Beginning January 1, 2014, a large employer employing 50 or more employees must offer adequate coverage at an affordable rate to its employees, or risk being subject to an excise tax (see CBIZ Health Reform Bulletin, *Shared Responsibility Guidance,* 1/9/13).

On January 30, 2013, the IRS issued final regulations specifically relating to defining the "affordability" standard. These regulations affirm that affordability is based on the cost of single coverage in the employer's least expensive plan. While large employers must offer coverage to their full-time employees (those working 30 or more hours per week) and their dependents (children under age 26), the affordability, according to these regulations, is based only on single coverage. This should come as welcome news to employers.

CONCLUSION
While much of this guidance relating to the obligation to maintain a minimum level of coverage would not unduly impact employers, employers will be interested to know the types of plans that qualify as minimum essential coverage. Employers will also likely be pleased to know, at least for now, affordability is based on the cost of single coverage.

About the Author: Karen R. McLeese is Vice President of Employee Benefit Regulatory Affairs for CBIZ Benefits & Insurance Services, Inc., a division of CBIZ, Inc. She serves as in-house counsel, with particular emphasis on monitoring and interpreting state and federal employee benefits law. Ms. McLeese is based in the CBIZ Leawood, Kansas office.

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CBIZ
Health Reform Bulletin

Subject: **Final Essential Health Benefit Regulations and Tools for determining Actuarial Value and Minimum Value in Plans**
Date: February 25, 2013

In keeping with the on-going march toward Affordable Care Act compliance in 2014, the Department of Health and Human Services has issued several important pieces of guidance recently, including final Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation.

ESSENTIAL HEALTH BENEFITS

Non-grandfathered plans in the individual and small group markets, issued both in - and outside of exchanges ("marketplace") must cover essential health benefit packages (EHBs), beginning in 2014. Self-insured group health plans, health insurance coverage offered in the large group market, and grandfathered health plans are not required to cover the essential health benefits. However, to the extent that self-funded plans and large insured plans offered outside the marketplace offer EHBs, these essential benefits cannot be subject to annual and lifetime limits.

Coverage for the essential health benefits package must cover 10 specific categories of benefits. The 10 categories are:

1. Ambulatory patient services.
2. Emergency services.
3. Hospitalization.
4. Maternity and newborn care.
5. Mental health and substance use disorder services, including behavioral health treatment.
6. Prescription drugs.
7. Rehabilitative and habilitative services and devices.
8. Laboratory services.
9. Preventive and wellness services and chronic disease management.
10. Pediatric services, including oral and vision care.

Coverage for Mental Health and Substance Abuse Services

Though health plans offered by employers employing fewer than 50 employees are generally not subject to the federal mental health parity laws (*Mental Health Parity Act of 1996* (MHPA) and the *Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of* 2008 (MHPAEA), these plans will be required to provide mental health benefits, in accordance with the EHB standards.

Benchmark Plan Designs

States can utilize one of several plan design categories for defining essential benefits (see CBIZ Health Reform Bulletin, *Proposed Regulations: Wellness Programs, Essential Health Benefits and Rating Restrictions, Guaranteed Issue and Renewal Rules*, 11/28/12). As of February 25, 2013, twenty-six states have chosen their base-benchmark plans. In states that do not select their own benchmark plan, the default base-benchmark plan will be based on the largest plan and product by enrollment in the State's small group market.

Additional information on the specific benefits, limits, and prescription drug categories and classes covered by the EHB-benchmark plans, and state-required benefits, is available on the Center for Consumer Information and Insurance Oversight (CCIIO) website.

Cost-sharing Requirements

DEDUCTIBLES. For plan years beginning on or after January 1, 2014, the final regulations clarify that the annual deductible imposed by plans cannot exceed $2,000 for self-only coverage, or $4,000 for coverage other than self-only. These deductible restrictions only apply to individual and small group health plans, and plans offered through the marketplace. These deductible limits do not apply to large group plans offered outside the marketplace or to self-funded plans.

These regulations, while they reserve the right to make modifications, provide that contributions to flexible medical spending arrangements (FSAs) cannot be used to buy down the deductible levels by the amount available under the FSA.

OUT-OF-POCKET LIMITS. The annual out of pocket limits must match those limits applicable to health savings accounts (HSA). While we do not know the HSA limits for 2014 yet (typically, these figures are available in May or early June), the high-deductible health plan annual out-of-pocket limit for self-only coverage in 2013 is $6,250; $12,500 for family coverage. The out of pocket limits apply to all sized plans; though, with the exception of emergency services, these restrictions only apply to in-network services.

For subsequent years, the deductible and out-of-pocket limits may be adjusted annually to reflect cost increases.

Actuarial Valuation Calculation for determining level of coverage

Non-grandfathered health plans offered to individuals and small employer group markets both in and outside an marketplace must meet the bronze, silver, gold, or platinum actuarial levels of benefits and coverage. A bronze plan is required to have an actuarial value (AV) of 60%; a silver plan, 70%; a gold plan, 80%; and a platinum plan, 90%. *Actuarial value* refers to a percentage measurement of expected health care costs covered by the plan and used to determine an overall measurement of the plan's generosity.

The CCIIO has released an updated Actuarial Value Calculator, together with an Actuarial Value Calculator Methodology, for purposes of determining whether a plan's actuarial value is based on a national standard population.

Determining Minimum Value

Under ACA, a plan fails to provide minimum value if the plan's share of the total allowed costs of benefits provided under the plan is less than 60% of such costs. Determining minimum value is important to employers, particularly those employing 50 or more full-time equivalent employees, in that if the employer plan fails the minimum value test, or is unaffordable, a shared responsibility tax may be triggered (see CBIZ Health Reform Bulletin, *Shared Responsibility Guidance*, 1/9/13).

For the purposes of determining whether an employer's group health plan provides a minimum value of benefits, the plan can utilize a minimum value calculator, a designed-based safe harbor checklist to be established by HHS/IRS, or the plan can seek an appropriate actuarial certification. The CCIIO has released Minimum Value Calculator, together with a Minimum Value Calculator Methodology for purposes of determining a plan's minimum value.

The final regulations provide that employer contributions to health savings accounts (HSA) and first year contributions to health reimbursement arrangements (HRAs) can count toward meeting a plan's minimum value.

The final regulations also provide for a plus or minus 2% margin, applicable to AV calculations and MV calculations, as well as to deductibles in the small group market, to allow plans a bit of wiggle room for compliance.

About the Author: Karen R. McLeese is Vice President of Employee Benefit Regulatory Affairs for CBIZ Benefits & Insurance Services, Inc., a division of CBIZ, Inc. She serves as in-house counsel, with particular emphasis on monitoring and interpreting state and federal employee benefits law. Ms. McLeese is based in the CBIZ Leawood, Kansas office.

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CBIZ
Health Reform Bulletin

Subject: 1) **Whistleblower Protections for ACA Violations; 2) Final Health Insurance Market and Rate Review Rules**
Date: February 28, 2013

In what is becoming a weekly or even semi-weekly occurrence, the government is once again issuing guidance to further the implementation of the Affordable Care Act ("ACA").

WHISTLEBLOWER PROVISIONS

Of particular note for employers is the guidance relating to the "whistleblower" provisions of the law (Section 1558 of the Affordable Care Act). As background, the ACA includes a whistleblower provision, protecting employees from adverse employment action or retaliation from either obtaining government assistance through premium assistance or a cost share by participating in the Exchange (Marketplace), as well as protection from reporting alleged violations of ACA compliance by employers. The Department of Labor's Occupational Safety and Health Administration (OSHA) issued interim final rules on February 27, 2013, along with a fact sheet for filing whistleblower complaints, and invites public comment until March 19, 2013.

An employee may not be punished or retaliated against for challenging an employer's compliance with the Title I, or market reform provisions of the ACA. Included among these provisions are:

- Coverage of dependents;
- Discrimination based on health status;
- Coverage for pre-existing conditions (beginning in 2014); and
- Annual and lifetime limits for health plans

Further, the whistleblower law protects individuals from retaliation for seeking government assistance, which would come in the form of health coverage premium assistance or a cost share by purchasing coverage through the exchange (marketplace). Individuals who fall below 400% of the poverty level may be entitled to such government assistance if their employers do not offer adequate coverage at an affordable rate, as is more fully described in *Shared Responsibility Guidance* (CBIZ Health Reform Bulletin, 1/9/13)

Adverse employment action or retaliation includes anything that affects any of the terms, conditions or privileges of employment, including the provision of benefits. Examples are: threatening or refusing to hire or re-hire; firing; demoting; reducing hours, or denying employee benefits. These are but a few examples of what might constitute retaliation.

These regulations set out the procedures that an individual would follow to file a complaint. The complaint must be filed with OSHA within 180 days of alleged retaliation. OSHA then has 60 days to respond to the complaint. The individual may also file a lawsuit if OSHA fails to make a

decision within 210 days of the filing date of the complaint, or within 90 days following OSHA's written determination.

While these regulations are interim, employers must comply with them now. These rules do not, in any way, limit an individual's rights under other laws, such as ERISA Section 510 that prohibits interference with one's protected rights.

HEALTH INSURANCE MARKET RULES; RATE REVIEW

Final rules relating to the ACA's market reform and rate review provisions were also issued on February 27, 2013. These final rules, similar to the proposed rules issued last year (see *Proposed Regulations: Rating Restrictions, Guaranteed Issue and Renewal Rules*, 11/28/12), address the provisions that will soon take effect relating to guaranteed availability and guaranteed renewal of health insurance and premium rate restrictions, and is applicable to non-grandfathered plans.

Permissible Rate Bands

Health insurance premiums in the individual and small group market can only be based on:

1. Family size (individual or family coverage)
2. Geography
3. Age. Following are permitted age-bands:
    - Child age bands. A single age band for individuals aged 0-20.
    - Adult age bands. One-year age bands for individuals aged 21-63.
    - Older adult age bands. A single age band for individuals aged 64 and older.
4. Tobacco use. Such rate band cannot vary by more than 1.5:1 and may only be applied with respect to individuals who legally use tobacco, as permitted under federal and state law. For purposes of this section, tobacco use means use of tobacco on average four or more times per week within a 6-month period. This includes all tobacco products with the exception of tobacco used for religious or ceremonial purposes.

These rules apply to small insured plans offered in or outside the marketplace. The rules will also apply to large insured plans, but only if offered through the marketplace.

The rules provide insurers with guidance on the restrictions that apply to rate hikes, as well as guidance relating to the single risk pool applicable in the individual market and small group market. A state can decide to combine its individual and small group market into one risk pool.

In addition, the regulations provide guidance relating to catastrophic policies available in certain situations, as well as rules relating to student health coverage.

While these rules primarily apply to insurers, they may be anecdotally interesting to employers. It should also be noted that these regulations, similar to the rating regulations issued in 2011, provide that in the case of an Association Health Plan (AHP) or a multiple employer welfare arrangement (MEWA), that employer size is determined on an employer-by-employer basis. Therefore, a small employer participating in an AHP would be subject to the small group health insurance rules.

These final rules apply to health plans with plan years beginning on or after January 1, 2014.

About the Author: Karen R. McLeese is Vice President of Employee Benefit Regulatory Affairs for CBIZ Benefits & Insurance Services, Inc., a division of CBIZ, Inc. She serves as in-house counsel, with particular emphasis on monitoring and interpreting state and federal employee benefits law. Ms. McLeese is based in the CBIZ Leawood, Kansas office.

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CBIZ
Health Reform Bulletin

Subject: **Final Rules Relating to Multiple Employer Welfare Arrangements and Form M-1**

Date: March 8, 2013

The Affordable Care Act (ACA) strengthens the regulation of multiple employer welfare arrangements (MEWAs), primarily by increasing reporting and disclosure requirements and creating a cross-reference between the Form M-1 required to be filed by MEWAs, and the Form 5500 required of plans subject to ERISA. In addition, the law gives the Secretary of Labor the right to police MEWAs by granting authority to the Secretary to issue an ex parte cease and desist order (without prior notice or hearing) in the event there is concern that the MEWA may be at risk of harming the public. On March 1, 2013, the Department of Labor's Employee Benefits Security Administration (EBSA) issued final rules, along with a fact sheet regarding these requirements.

MODIFICATIONS TO THE FORM M-1 FILING REQUIREMENT

As background, a MEWA is a plan covering two or more unrelated employers, including self-employed individuals. A MEWA can be established in a number of ways:

1) By business leagues or associations, such as chambers of commerce or other independent promoters. The MEWA is open to a diverse group of employers. In this instance, each participating employer is responsible for its ERISA compliance (non-plan MEWA); or
2) In a more, rare instance the MEWA, in effect, is the plan sponsor. This occurs in situations in which there is a commonality of interest among all participating employers and the employers control the activity of the MEWA (plan MEWA). In this instance, ERISA applies at the MEWA level.

It is primarily unscrupulous promoters the first category of MEWA that has created concern, in that a number of MEWAs have resulted in loss to the participating plans and plan participants. For this reason, the rules and compliance obligations applicable to MEWAs have been strengthened.

Several years ago, a reporting requirement (by way of the Form M-1) was imposed upon MEWAs to insure that the MEWA complies with the Health Insurance Portability and Accountability Act (HIPAA) rules and subsequent laws, including the ACA. Generally, the Form M-1 must be filed annually and is due by March 1 of the following year. These new regulations require that the Form M-1 must be filed electronically. To accommodate the change to electronic filing, the Form M-1 filing date, due for the 2012 year, is moved from March 1, 2013 to May 1, 2013, with the ability to extend the filing date to July 1, 2013. The Department of Labor has provided a Form M-1 online filing system and FAQs on its website.

Also of note, the Form M-1 has undergone significant revisions primarily relating to administration of the MEWA and reporting on its financial condition.

These regulations apply to administrators of both non-plan and plan MEWAs and Entities Claiming Exception (ECEs). An ECE is an entity claiming to be exempt from the MEWA rules in that it is established pursuant to one or more collective bargaining agreements.

These regulations do not apply to:

- A MEWA or ECE licensed or authorized to operate as a health insurance insurer in every state which it offers or provides coverage for medical care to employees;
- A MEWA or ECE that provides coverage that consists solely of HIPAA excepted benefits, including but not limited to non-health benefits;
- A MEWA or ECE that is a group health plan not subject to ERISA (i.e. Governmental plan, church plan);
- An entity that provides coverage to the employees of two or more trades or businesses that share a common control interest of at least 25%;
- An entity that provides coverage to the employees of two or more employers due to a change in control of business (such as a merger or acquisition); and
- An entity that provides coverage to persons (excluding spouses and dependents) who are not employees of the plan sponsor (such as board of directors or independent contractors) and the number of such persons does not exceed 1% of the total number of employees.

According to these regulations, the administrator of a MEWA is required to file the Form M-1 30 days prior to operating in any state. In addition, the administrator must file the Form M-1 30 days prior to:

- Knowingly operating in any additional State or States that were not indicated on a previous Form M-1 filing;
- Operating with regard to the employees of an additional employer (or employers, including one or more self-employed individuals) after a merger with another MEWA;
- The date the number of employees receiving coverage for medical care under the MEWA is at least 50 percent greater than the number of such employees on the last day of the previous calendar year; or
- Experiencing a material change.

The administrator of an ECE is required to file the Form M-1:

- During the three year period following an origination event,
- 30 days before it begins operating with regard to the employees of two or more employers (including one or more self-employed individuals),
- Within 30 days of:
  - When the ECE begins operating following a merger with another ECE (unless all of the ECEs that participate in the merger previously were last originated three years prior to the merger);
  - When the number of employees receiving coverage for medical care under the ECE is at least 50 percent greater than the number of such employees on the last day of the previous calendar year (unless the increase is due to a merger with another ECE, as stated above);
  - Knowingly operating in any additional state or states that were not indicated on a previously required form m-1 filing; or
  - Experiencing a material change.

MODIFICATIONS TO THE FORM 5500 FILING REQUIREMENT

All MEWAs subject to the M-1 filing requirement are obligated to file a Form 5500, without regard to size or funding. A new section (Part III) will be added to the Form 5500 for years 2014 and later, requiring that the entity report on its compliance with the M-1 filing requirement. Failure to answer these questions will result in the Form 5500 filing being rejected. For the 2013 Form 5500, the new section will need to be included as an attachment to the annual report. The final rules and the new Part III can be found here.

EX PARTE CEASE AND DESIST ORDER REQUIREMENTS

The Department of Labor has also issued regulations granting the Secretary of Labor the right to issue a cease and desist order and a summary seizure order, giving the Secretary the right to seize assets of the MEWA, if the Secretary believes the MEWA is engaging in fraudulent conduct, including but not limited to, misrepresentation of benefits or misrepresentation of the financial condition of the MEWA. This regulation is intended to protect the insured from any malfeasance on the part of the MEWA promoters.

In conclusion, all plans covering two or more unrelated employers should review their status as a MEWA and make sure that all Form M-1 and Form 5500 filing requirements are accomplished. Again, just for the 2013 Form M-1 filing (reporting the 2012 year), the due date has been delayed from March 1 to May 1, 2013.

About the Author: Karen R. McLeese is Vice President of Employee Benefit Regulatory Affairs for CBIZ Benefits & Insurance Services, Inc., a division of CBIZ, Inc. She serves as in-house counsel, with particular emphasis on monitoring and interpreting state and federal employee benefits law. Ms. McLeese is based in the CBIZ Leawood, Kansas office.

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CBIZ
Health Reform Bulletin

Subject: **1) Implementation Guidance Addressing Premium Stabilization Program, MLR Changes, Federal Exchange User Fees, Advance Premium Tax Credit and Cost-Sharing Methodologies, Marketplace/Exchange Options for Small Businesses, and Multi-State Plan Program; 2) Applicability of ACA to Expatriate Group Health Coverage**

Date: March 12, 2013

In recent days, the governing agencies charged with implementation of the Affordable Care Act (ACA), have issued a veritable flood of guidance. These final rules and accompanying Fact Sheet, provide guidance, primarily directed at insurers, who will be offering health insurance products both in and outside the exchange/marketplace. Some of the guidance, though, has import for employers and is summarized as follows:

PREMIUM STABILIZATION PROGRAM

Beginning in 2014, everyone legally present in this country must maintain a minimum level of coverage or pay a tax, with but few exceptions. It is anticipated that due to this requirement, there will be an influx of covered lives in the insurance marketplace. To this end, the law attempts to stabilize the marketplace by spreading the risk more broadly across all insurers; the premise, of course, is to ensure that not all of the burden of high risk falls in a limited segment of the market.

There are three components to the Premium Stabilization Program:

1. A **transitional reinsurance program** to stabilize premiums in the individual market due to anticipated immediate enrollment of higher risk individuals beginning in 2014;
2. A **temporary risk corridor program** to protect qualified health plan (QHP) issuers in the individual and small group market against inaccurate rate setting and uncertainty in the exchange/marketplace by limiting the extent of issuer losses and gains; and
3. A **permanent risk adjustment program** to provide adequate payments and reduce risk premium to health insurance issuers that attract high-risk populations, such as individuals with chronic conditions; as well as stabilize premiums in the individual and small group markets.

TRANSITIONAL REINSURANCE PROGRAM

The rules relating to the transitional reinsurance program have particular bearing on employers, in that the cost is likely to be borne by employers. The transitional reinsurance program is to stabilize premiums in the individual market due to anticipated immediate enrollment of higher risk individuals beginning in 2014. The reinsurance money will be used to offset the expenses of the newly eligible individuals. States that operate an Exchange are required to establish a transitional reinsurance pool, to be in effect for the 3-year period of 2014 through 2016. In the absence of a state establishing a reinsurance pool, the federal government will do so.

Both insured plans, through their insurers, and self-funded plans must contribute to the reinsurance pool. These final regulations, in large part, follow the proposed regulations as described in *Premium Stabilization Program Proposals* (CBIZ Health Reform Bulletin, 12/18/12).

For a self-funded plan, the contributing entity is the plan sponsor/employer. The plan can contract with a third party administrator (TPA) to calculate the premium and even to submit the payment, but ultimately it is the plan/employer who is responsible for funding it. The administrative services agreement with TPAs should be reviewed and updated if these services are to be included.

Plans Subject to the Fee

Generally, the reinsurance fee applies to all major medical coverage. These final regulations affirm that it applies to insured and self-funded plans, including a self-funded multiple employer welfare arrangement and COBRA coverage. It does apply to retiree-only coverage to the extent that the retiree plan is primary to Medicare. If Medicare is primary to the retiree plan, the fee will not apply.

Plans to which the fee *does not apply* include:

- Limited scope dental and vision plans;
- Expatriate coverage;
- Health savings accounts (investment account);
- Medical flexible spending account (FSA);
- Integrated health reimbursement arrangement (HRA);
- Employee assistance programs;
- Disease management programs;
- Wellness plans;
- Stop loss insurance;
- Indemnity coverage;
- Indian tribal coverage (however, coverage provided through a commercial venture, such as a casino, would be subject to the fee), and
- TRICARE.

Counting Covered Lives in Fully Insured Plans

The regulations affirm that the fee can be paid from plan assets. It is a deductible expense and not an excise tax. The fee is calculated on a calendar year basis, and is based on the first 9 months of the year. The fee is based on the number of covered lives under the plan. Insured plans must use one of the following methods for determining the average number of covered lives under the plan:

- ***Method 1***. Add the total number of covered individuals on each day of the first 9 months of the benefit year and divide that total by the number of days in the first 9 months;
- ***Method 2***. Add the total number of covered individuals on any date during the same corresponding month in each of the first three quarters of the benefit year, and divide that total by the number of dates on which a count was made. The same months must be used for each quarter (for example January, April and July) and the date used for the second and third quarter must fall within the same week of the quarter as the corresponding date used for the first quarter; or
- ***Method 3***. Multiply the average number of policies in effect for the first nine months of the benefit year by the ratio of covered individuals per policy in effect. The calculation

is derived by data the insurer annually files with its relevant state licensure department, such as a state insurance department.

Counting Covered Lives in Self-Funded Plans

Plan sponsors of self-funded plans have several options for counting covered lives under the plan. It can choose **Method 1 or 2**, as above; or one of the following methods:

- Add the total number of covered lives on any date during the same corresponding month in each of the first three quarters of the benefit year, and then divide the total by the number of dates on which a count was made. However, the count on a particular date is further differentiated by adding those with self-only coverage to those with non-self-only coverage and a factor of 2.35 (this number can be used to account for covered lives, which is useful, particularly in the instance that the employer doesn't have information on covered dependents). The same months must be used for each quarter (for example, January, April, and July); or
- A Form 5500 method, which is based on the average number of covered participants at the beginning and end of the plan year, as reported on the relevant Form 5500 for the applicable plan year.

An insurer, or plan sponsor through its TPA, is required to submit an annual enrollment count of the average number of covered lives to HHS by November 15th of each year. HHS will then notify the insurer or plan sponsor/TPA of its contribution amount no later than December 15th of the reporting year. The insurer or plan sponsor/TPA must then remit payment to HHS within 30 days of receiving the HHS notification of the amount due.

CHANGES TO MINIMUM LOSS RATIO RULES

The ACA's minimum loss ratio (MLR) rules require insured plans to use a certain amount of premium dollars to pay claims, or they must rebate the excess monies to the policy holders (see CBIZ Health Reform Bulletin, *Medical Loss Ratio Rebates*, 7/10/12). These regulations make small modifications to the MLR calculation, primarily to account for the premium stabilization rules described above. Beginning with the rebate due in 2014, based on the 2013 reporting year, the date the rebate is required to be paid is moved from August 1st to September 30th of each year.

FEDERAL EXCHANGE USER FEES

One of the methodologies for expanding access to health coverage is through the establishment of state-based exchanges ("marketplaces"). The states have had the opportunity to establish their own exchange or to engage in a state/federal partnership. In the event that a state does not establish an exchange, a federal exchange will be available in that state. There are, at the time of this publication, 26 states in which the federal exchange will be implemented. These regulations impose a monthly user fee of 3.5% of premium spread across all health insurance products offered in the state to help fund the federal exchange.

The state exchange/marketplace is available to individuals. In addition, small employers can purchase health coverage through a Small Employer Health Options Program (SHOP) offered through the exchange. Initially, a small employer is defined in accordance with the state definition of small employer health insurance plan. Beginning in 2016, small employer will be defined as an employer employing fewer than 100 employees. These regulations clarify that for purposes of counting employees, the employer counts full-time employees, defined as those working 30 or more hours per week, as well as full-time equivalent employees. Full-time equivalencies are calculated by adding up part-time hours to equate to full-time, in the same

manner as these terms are defined in this *Shared Responsibility Guidance* (CBIZ Health Reform Bulletin, 1/9/13). However, until the federal definition is used in 2016, the state can continue using whatever counting methodology it currently uses for purposes of determining small employer health insurance.

In addition, these regulations provide special enrollment events, available to individuals participating through the SHOP exchange, and are aligned with the Health Insurance Portability and Privacy Act (HIPAA) special enrollment events. Generally, a HIPAA special enrollment event includes marriage, birth or adoption, loss of coverage due to termination of employment, death and divorce. The HIPAA special enrollment election period for the SHOP exchange is 30 days, or 60 days for special enrollment due to loss of Medicaid eligibility or becoming eligible for premium assistance through Medicaid or the Children's Health Insurance Program.

ADVANCE PREMIUM TAX CREDIT AND COST-SHARING METHODOLOGIES

These regulations provide guidance to insurers on the advance premium tax credit and the cost sharing available to certain lower income individuals. Generally, an individual who falls between 100% and 400% of the federal poverty level may be entitled to an advance tax credit, which will be paid directly to a qualified health plan. In addition, certain individuals are entitled to coverage of certain health costs. These rules, generally, will not impact employers, though, the regulations do affirm that if an individual is eligible for adequate coverage at an affordable rate through his/her employer, the individual will not be eligible to receive the premium assistance or cost share.

MARKETPLACE/EXCHANGE OPTIONS FOR SMALL BUSINESSES

The Small Business Health Options Program (SHOP) is designed to help qualified small employers in providing health insurance options for their employees. The proposed rule would require SHOPs to provide qualified employers the option to offer qualified employees a choice of any qualified health plan (QHP) at a single metal level starting with plan years beginning on or after January 1, 2015. For plan years beginning in calendar year 2014, qualified employers would offer qualified employees coverage under a single QHP in federally-facilitated SHOP, and state-based SHOPs would have the flexibility to offer either employer or employee choice in 2014.

MULTI-STATE PLAN PROGRAM (MSPP)

The ACA directs the Office of Personnel Management (OPM) to establish a Multi-State Plan Program (MSPP). The goal of this Program is to foster competition among plans competing in the individual and small group markets on the exchange. This MSPP option may be attractive to small employers who have locations in more than one state.

On March 11, 2013, OPM issued final regulations setting forth the criteria and implementation of this Program. OPM will contract with participating insurers who offer at least two multi-state plans, including one sponsored by a non-profit entity, through the exchange. The rules provide for a 4-year phase-in period for contracted insurers to make coverage available in all states. The first option should be available beginning in October 2013, for a January 2014 effective date.

APPLICABILITY OF ACA TO EXPATRIATE GROUP HEALTH COVERAGE

The Department of Labor's Employee Benefit Security Administration (EBSA) has issued an FAQ providing for temporary transitional compliance relief specific to expatriate plans. This guidance provides that, at least for plans ending prior to December 31, 2015, expatriate plans will not be required to comply with subtitles A and C of Title I of the ACA. These subtitles address many of the insurance market-type reforms, such as extension of dependent age, prohibition of imposing annual and lifetime limits and preexisting condition exclusions, prohibition of plan rescission, coverage for preventive services, as well as certain reporting and disclosure obligations, such as the summary of benefits and coverage. What this means is that as long as the plan was in compliance with the federal laws governing plan compliance prior to the enactment of ACA, such as federal mental health parity provisions, the ERISA claims and appeal procedures, the HIPAA non-discrimination provisions, and any reporting and disclosure obligations under ERISA, then the plan could be eligible for certain transitional relief in complying with the ACA. Note, however, this exemption only applies to insured group health plans covering primary insureds and their covered dependents who live outside the United States for at least 6 months of the year. This leaves open questions about the applicability of many of the provisions to self-funded expatriate plans.

About the Author: Karen R. McLeese is Vice President of Employee Benefit Regulatory Affairs for CBIZ Benefits & Insurance Services, Inc., a division of CBIZ, Inc. She serves as in-house counsel, with particular emphasis on monitoring and interpreting state and federal employee benefits law. Ms. McLeese is based in the CBIZ Leawood, Kansas office.

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CBIZ
Health Reform Bulletin

Subject: **Ninety-Day Waiting Period Limitation, Certificates of Creditable Coverage, HHS Draft Application for Exchange Participation, and Internal Claims and Appeals Process and External Review**

Date: March 26, 2013

NINETY-DAY WAITING PERIOD LIMITATION

One of the Affordable Care Act's (ACA) provisions that take effect in 2014 is a restriction on the maximum waiting period that can be imposed before coverage takes effect. This is known as the "waiting period." For plan years beginning on or after January 1, 2014 (January 1 for a calendar year plan), the maximum waiting period that can be imposed is 90 days. This provision applies to virtually all types of plans, including insured and self-funded plans, whether grandfathered or not, and without regard to plan size.

The Agencies (Department of Labor's Employee Benefits Security Administration, the Internal Revenue Service and the Department of Health and Human Services) have issued a set of proposed regulations defining this ninety-day wait. These regulations in large part follow some temporary guidance issued in September, 2012 (see CBIZ Health Reform Bulletin, *Guidance Issued Relating to 90-day Waiting Period and Defining Full-time Employee*, 9/4/12). If final regulations are more restrictive, they will take effect no earlier than January 1, 2015.

Of particular note, the regulations propose that the 90 day period be construed strictly. The 90 days is 90 calendar days, including weekends and holidays. Health coverage must be made available no later than the 91st day. If the 91st day happens to fall on a weekend, coverage, of course, could be effective on the previous work day, but could not be made effective on the next following work day. In other words, a plan can round back but not up.

The regulations proposed define "waiting period" in the same way as the Health Insurance Portability and Accountability Act (HIPAA), meaning the time that must pass before coverage takes effect. A plan can base condition for eligibility of coverage on completion of a goal, such as attainment of a license.

However, for employers subject to the Shared Responsibility requirement (see CBIZ Health Reform Bulletin, *Shared Responsibility Guidance*, 1/9/13), caution should be exercised, in that the individual working on achieving the goal may still be considered a full-time employee and an excise tax penalty could be triggered, if adequate coverage at an affordable rate is not offered within 13 calendar months following hire date. In other words, the ninety-day waiting period and the shared responsibility provision are not identical. Special planning may be required to ensure not running afoul of either provision.
It should also be noted that the regulations propose that any eligibility condition, such as an hours worked requirement, that is determined to be intended as a way to avoid the ninety-day wait, will be deemed to violate the law.

CERTIFICATES OF CREDITABLE COVERAGE

Another health plan provision that takes effect on the first day of the first plan year occurring on or after January 1, 2014, is a requirement that no preexisting condition be imposed on anyone. Again, this applies to plans of all sizes, insured or self-funded, and grandfathered or not.

Ever since the enactment of HIPAA, health plans have been required to provide a Certificate of Creditable Coverage to anyone whose coverage ends under a health plan. The purpose of the Certificate of Creditable Coverage is to provide proof of continuous coverage. Since no preexisting condition exclusion can be imposed, these regulations suggest that the Certificate of Creditable Coverage is no longer necessary.

The regulations propose that effective January 1, 2015 plans will no longer be required to provide these certificates. Certificates will continue to be required during 2014, in that plans with plan anniversaries late in the year, will continue to be subject to the preexisting condition limitation for much of 2014.

HHS DRAFT APPLICATION FOR EXCHANGE PARTICIPATION

The ACA provides several avenues for obtaining health coverage, among these are purchasing health insurance through the marketplace, sometimes referred to as the exchange. Also, available to some individuals is government provided financial assistance, and to others, coverage may be available through Medicaid or CHIP.

The marketplace is charged with the responsibility of determining what entitlements may be available to an individual and his/her family. To this end, HHS has issued a draft application. The purpose of which is to serve as a single point of entry for the purchase of health coverage through the marketplace. This application would be used to access eligibility for programs such as Medicaid or CHIP, as well as determining eligibility for government assistance in the form of premium assistance or cost-sharing.

While this application is only in draft form, employers may be interested in the section requiring information on the employer plan, such as date employee is eligible for coverage, name of the lowest cost self-only health plan that meets the "minimum value standard," and how much and how often premiums are paid. This, in part, will be used to determine whether the individual seeking coverage has access to adequate coverage at an affordable rate from the employer. Employers subject to the Shared Responsibility requirement (those employing 50 or more full-time and full time equivalent employees) may wish to familiarize themselves with this information (see, CBIZ Health Reform Bulletin, *Shared Responsibility Guidance*, 1/9/13).

INTERNAL CLAIMS AND APPEALS PROCESS AND EXTERNAL REVIEW

The ACA requires non-grandfathered plans, both those subject to ERISA and those exempt from ERISA, to comply with an Internal Claims and Appeals Process and External Review.

These rules are summarized in the following CBIZ Health Reform Bulletins:

- *Modifications to Claims and Appeals, and External Review*, 7/11/11
- *Delay in Claims and Appeals Enforcement*, 3/22/11
- *Agencies Issue PPACA Clarifications*, 10/12/10
- *Limited PPACA Exemption for Self-Funded, Non-Federal*, 10/12/10
- *Federal External Claims Review: Interim Procedures and Model Notices*, 8/30/10
- *Internal Claims and Appeals, and External Review Process*, 7/26/10

Recently issued, Technical Release 2013-01, by DOL's Employee Benefits Security Administration, extends previously issued guidance until January 1, 2016. Issuers and self-funded nonfederal government plans will be in compliance, if they comply with an applicable state external review process that meets the temporary NAIC-similar process standards.

Beginning January 1, 2016, a state external review process will need to satisfy the standards of conformity with the 16 consumer protection standards listed in the NAIC's Uniform Health Carrier External Review Model Act or issuers (and, if applicable, self-funded nonfederal government plans) in that state will need to comply with a federally-administered external review process.

About the Author: Karen R. McLeese is Vice President of Employee Benefit Regulatory Affairs for CBIZ Benefits & Insurance Services, Inc., a division of CBIZ, Inc. She serves as in-house counsel, with particular emphasis on monitoring and interpreting state and federal employee benefits law. Ms. McLeese is based in the CBIZ Leawood, Kansas office.

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CBIZ
Health Reform Bulletin

Subject: Updated Summary of Benefits and Coverage (SBC) Guidance and New FAQs
Date: April 25, 2013

The Department of Labor's Employee Benefits Security Administration (EBSA), as well as the Departments of Health and Human Services and Treasury have jointly issued new Summary of Benefits and Coverage (SBC) FAQs along with an updated template and sample completed SBC.

As background, the ACA requires plans to provide an SBC (see prior Health Reform Bulletins: *ACA Updates: Summary of Benefits and Coverage*, 5/17/12; *Summary of Benefits and Coverage*, 3/21/12; and *ACA Updates-Final Rules: Summary of Benefits and Coverage*, 2/10/12).

The SBC form originally issued was only for use during the first year of compliance. The governing agencies have just released the updated SBC template and sample completed SBC that can be used for the second year of compliance. The second year of compliance is defined as coverage beginning on or after January 1, 2014 and before January 1, 2015.

The only substantive change to this form is that the SBC must include a statement that the plan does or does not meet minimum essential coverage (MEC) standards and that the plan does or does not meet the minimum value standard.

MEC generally includes coverage under:

- **Employer-sponsored group health plans**, whether insured or self-funded, and grandfathered plans, as well as COBRA coverage (if actually elected) and retiree coverage. It also includes group health coverage sponsored by non-profit and for-profit entities, and governmental entities, including local governments
- **Government-sponsored plans** such as Medicare, Medicaid, Children's Health Insurance Program (CHIP), TRICARE, and various Veteran's health programs
- **Individual health policies**, including a qualified health plan offered by an Exchange
- **Other similar types of comprehensive health coverage** recognized by HHS as minimum essential coverage

It should be noted that HIPAA-excepted coverage alone will not qualify as minimum essential coverage. For examples of HIPAA-excepted coverage, see Health Reform Bulletin *Individual Minimum Essential Coverage and Affordability Standard*, 02/06/13.

As a reminder, MEC is important in that it is the level of coverage that most individuals, legally present in the United States, must maintain in order to avoid the individual shared responsibility tax that will take effect January 1, 2014. It is important for large employers, in that it is the level of coverage the employer must offer to its full-time employees in order to avoid the risk of a 'no coverage' shared responsibility penalty.

Minimum value is the plan's or coverage's share of the total allowed costs of benefits provided under the plan or coverage, which may not be less than 60 percent of such costs.

The governing agencies state that a plan can continue to use the current SBC form as long as it is accompanied by a cover letter including language explaining the plan's compliance with the MEC standard and minimum value standards. Model language is as follows:

> **Does this Coverage Provide Minimum Essential Coverage?**
> The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy [does/does not] provide minimum essential coverage.**
>
> **Does this Coverage Meet the Minimum Value Standard?**
> In order for certain types of health coverage (for example, individually purchased insurance or job-based coverage) to qualify as minimum essential coverage, the plan must pay, on average, at least 60 percent of allowed charges for covered services. This is called the "minimum value standard." This health coverage [does/does not] meet the minimum value standard for the benefits it provides.

The FAQs affirm that the governing agencies will continue to honor a good faith compliance standard. What this means is, as long as a plan is making its best effort to comply with the SBC requirement, this will be given credence.

The FAQs also affirm that previously issued safe harbor and other good faith compliance standards remain in force. A couple of safe harbors that are of particular note include:

- The relief provided to expatriate plans (FAQs Part IX, Q13),
- Rules relating to carve-out plans (FAQs Part VIII, Q5),
- Rules relating to electronic distribution of SBCs (FAQs Part IX, Q1), and
- Relief from an issuer's obligation to provide an SBC for a plan component that it does not insure (FAQs Part IX, Q10).

In conclusion, plans should be prepared to use the new SBC form on January 1, 2014, or at minimum include the cover letter as described above.

About the Author: Karen R. McLeese is Vice President of Employee Benefit Regulatory Affairs for CBIZ Benefits & Insurance Services, Inc., a division of CBIZ, Inc. She serves as in-house counsel, with particular emphasis on monitoring and interpreting state and federal employee benefits law. Ms. McLeese is based in the CBIZ Leawood, Kansas office.

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CBIZ
Health Reform Bulletin

Subject: **Minimum Value and Affordability; Shortened Exchange Application**

Date: **May 7, 2013**

As the first week of May is upon us, so are additional regulations implementing the Affordable Care Act (ACA). The Internal Revenue Service has just issued proposed regulations offering guidance on minimum value and affordability. While these regulations are only proposed, they can be relied on until further guidance is issued.

As background, the ACA requires large employers - those employing 50 or more employees - to offer minimum essential coverage (MEC) that is both adequate and affordable, or risk a shared responsibility excise tax.

One of the burning questions has been what impact will certain employer plan design features, such as health reimbursement accounts and wellness incentives, play in the minimum value and affordability determinations? This guidance offers some insight into what the government is thinking.

MINIMUM VALUE

To meet minimum value, the plan covers at least 60% of the value of medical expenses. There are three methodologies to measure minimum value with a fourth methodology available for small employers. They are:

- A minimum value calculator;
- Minimum value safe harbor plan designs (see details below)
- A determination made by an actuary (must be a member of the American Academy of Actuaries); and
- For small employer plans: a plan that meets any of the metal tiers (below) will be deemed to meet minimum value.
    - Bronze (actuarial value 60%)
    - Silver (actuarial value 70%)
    - Gold (actuarial value 80%)
    - Platinum (actuarial value 90%)

The preamble to these proposed regulations suggests the following as potential safe harbor plan designs (assuming the plan includes the benefits described in the calculator referred to above):

- A plan with a $3,500 integrated medical and drug deductible, 80 percent plan cost-sharing, and a $6,000 maximum out-of-pocket limit for employee cost-sharing
- A plan with a $4,500 integrated medical and drug deductible, 70 percent plan cost-sharing, a $6,400 maximum out-of-pocket limit, and a $500 employer contribution to an HSA; and

- A plan with a $3,500 medical deductible, $0 drug deductible, 60 percent plan medical expense cost-sharing, 75 percent plan drug cost-sharing, a $6,400 maximum out-of-pocket limit, and drug co-pays of $10/$20/$50 for the first, second and third prescription drug tiers, with 75 percent coinsurance for specialty drugs.

The guidance provides that in determining minimum value, employer contributions to an HSA can be used. First year contributions to an integrated HRA can be used but only if HRA funds are available for cost–sharing such as deductibles, co-pays and the like, but not for premium. Wellness incentives, with the exception of tobacco incentives, cannot be factored in determining minimum value. For purposes of these regulations, an integrated HRA is expected to be defined as an HRA used in connection with a specific health plan and where participation in the HRA is contingent on participation in the health plan.

AFFORDABILITY

To mitigate the risk of a shared responsibility penalty, a plan must meet minimum value standards and must be affordable. To be affordable, the plan cannot cost an individual more than 9.5% of income. Three safe harbors are available to make this calculation, as follows:

- Box 1 of W-2
- Average wage method, or
- A federal poverty level method.

The regulations propose that affordability is determined without regard to wellness incentive with two exceptions. Any tobacco incentive can be taken into account in determining affordability. In other words, affordability is determined after applicability of the tobacco incentive without regard to whether the individual actually receives the tobacco incentive. Other wellness incentives **are not** taken into account in determining affordability except that for 2014 only, a wellness incentive in place as of May 3, 2013, can be taken into account. This is true for then existing employees as well as individuals who become newly eligible thereafter. Again this only applies for the first year (2014) of shared responsibility compliance.

The proposed regulations include a few other points of note. Generally, for the employer to avoid the risk of shared responsibility tax, the employer must simply offer adequate coverage at an affordable rate. As long as the employee is eligible for the coverage, the employee would be ineligible for government assistance.

The regulations clarify that in the case of an individual on COBRA, as long as the employee is no longer currently employed, the standard is raised to actual coverage and the same is true for retiree coverage. In other words, only if the inactive employee is actually covered by COBRA or retiree health coverage, will the individual be declined access to government assistance. Conversely, if the individual is actively working and entitled to COBRA, such as due to reduction in hours, the mere eligibility for COBRA would disqualify the person from premium assistance.

The regulations also caution that an employer cannot abate its shared responsibility risk by forcing an employee to participate in a health plan, and specifically, if the health plan does not meet adequacy and affordability standards. Forcing an employee onto a plan could also raise potential whistleblower challenges under the law.

SHORTENED MARKETPLACE/EXCHANGE APPLICATION

One of the premises behind the ACA is that an individual can use a single application to apply for coverage through the marketplace that will be used to determine available coverage options as well as, availability of the advanced tax credit and eligibility for Medicaid (see CBIZ Health Reform Bulletin, *90 Day Wait and Other Updates*, 3/26/13).

The 21 page application has been significantly shortened and divided into three segments:

- An application specifically for individuals seeking marketplace coverage that do not have access to employer-provided coverage;
- An application specific to individuals and families looking for options under the marketplace who do have access to employer-provided coverage; and
- An application for individuals seeking coverage in the marketplace but not seeking government assistance.

Of particular interest to employers is the Employer Coverage Tool, which is on page 10 of the family application. Employers will want to be prepared to provide information about coverage available including whether the plan meets ACA's minimum value and affordability standards. Note, the application measures affordability after any tobacco discount has been applied without regard to whether the individual actually receives the discount.

Presumably, there will be a way for the employer to reflect affordability, after other compliant wellness discounts as permitted, during this first year of compliance, as described above. The employer may also be asked to share any plan changes that will take effect in the next year. The application continues to need additional tweaking but certainly provides guidance about the direction the single source application is going.

About the Author: Karen R. McLeese is Vice President of Employee Benefit Regulatory Affairs for CBIZ Benefits & Insurance Services, Inc., a division of CBIZ, Inc. She serves as in-house counsel, with particular emphasis on monitoring and interpreting state and federal employee benefits law. Ms. McLeese is based in the CBIZ Leawood, Kansas office.

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CBIZ
Health Reform Bulletin

Subject: **Early Retiree Reinsurance Program**

Date: **May 9, 2013**

The Early Retiree Reinsurance Program (ERRP) was included as part of the Affordable Care Act. The program was intended to be a bridge to January 1, 2014, when the marketplace, previously known as exchanges, would be available.

The ERRP is quickly coming to a close, to that end the Centers for Medicare and Medicaid Services has issued a *Notice*, listing a couple of key dates that are important for plan sponsors who have participated in the ERRP program. Of particular note:

- The last day upon which a plan sponsor may submit an ERRP reimbursement request is July 31, 2013; and
- The last day upon which a plan sponsor may submit an ERRP reopening request is December 31, 2013

Plan sponsors in the ERRP will want to familiarize themselves with these dates.

These dates notwithstanding, it is very important to remember that the record keeping requirement of the ERRP remains in force. Generally, records must be maintained for six years. See prior Health Reform Bulletins:

- *ERRP Update – Program Closes* (12/12/11)
- *Increase in ERRP Cost Thresholds* (10/18/11)
- *ERRP Update* (4/4/11)
- *Early Retiree Reimbursement Program Updates* (10/5/10)
- *Update: Early Retiree Reinsurance Program* (9/1/10)
- *Early Retiree Reinsurance Program Application Process Opened* (6/29/10)
- *Early Retiree Subsidy – Initial Application Date is Approaching* (6/11/10)
- *Early Retiree Reinsurance Program* (5/5/10)

About the Author: Karen R. McLeese is Vice President of Employee Benefit Regulatory Affairs for CBIZ Benefits & Insurance Services, Inc., a division of CBIZ, Inc. She serves as in-house counsel, with particular emphasis on monitoring and interpreting state and federal employee benefits law. Ms. McLeese is based in the CBIZ Leawood, Kansas office.

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CBIZ
Health Reform Bulletin

Subject: **Notice to Employees of Coverage Options; Updated COBRA Model**

Date: **May 10, 2013**

One of the provisions of the Affordable Care Act (ACA) requires employers to give employees an explanation of the health plan options available under the Marketplace previously known as the exchange. This requirement was to commence March 1, 2013, but was delayed until future guidance is issued (see prior CBIZ Health Reform Bulletin, *Sub-Regulatory Guidance and FAQs Issued*, 1/25/13).

NOTICE OF COVERAGE OPTIONS

The Department of Labor has provided some temporary guidance in the form of a Technical Release 2013-02 and two model notices explaining Marketplace options that can be used until future guidance is issued, which is still expected in late summer or early fall. The requirement to provide the Marketplace notice generally **applies to all employers of any size**. It applies to private sector, for profit, and not-for-profit entities as well as to public sector entities.

The notice must be provided to all new hires. The temporary guidance says that as long as the notice is provided within 14 days of hire, it will be deemed timely. For all current employees, the notice must be provided before October 1, 2013. The model notice for use by employers who offer coverage can be found *here*. The model notice for employers who offer no coverage can be found *here*. It is notable that both notices require certain employer information (see Part B of each notice). One can assume this information is being collected so that the Marketplace can contact the employer.

The model notice to be used by employers who offer coverage includes an optional section requesting individualized information about the health plan. Employers will want to familiarize themselves with the information requested on the notice, particularly the individualized information, as it could create additional administrative burden for the employer.

In the affordability section, the notice affirms that affordability is determined assuming any tobacco incentive has been achieved. Presumably, employers who offer a wellness incentive for the first year of compliance can assume that this incentive has been granted too (see prior CBIZ Health Reform Bulletin, *Minimum Value and Affordability*, 5/9/13).

COBRA MODEL ELECTION

The Department of Labor has updated the COBRA model election to reflect options available through the Marketplace. As a reminder, COBRA requires that upon the occurrence of a qualifying event, a COBRA election notice must be sent. The revised model election notice can be found *here*.

Employers will want to review this model election notice and incorporate the requisite information: 1) reference to the Marketplace and available plans through the Marketplace and, 2) in 2014, no preexisting condition exclusions will be imposed.

This model election form can be used immediately.

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CBIZ
Health Reform Bulletin

Subject: **Final Rules Issued: 1) Incentives for Nondiscriminatory Wellness Programs in Group Health Plans** and **2) Small Business Health Options Program (SHOP)**
Date: June 3, 2013

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INCENTIVES FOR NONDISCRIMINATORY WELLNESS PROGRAMS IN GROUP HEALTH PLANS

Wellness strategy has, and continues to be, a centerpiece of health plan design. The Affordable Care Act (ACA) expands, in some ways, the incentive that can be used to drive wellness. The ACA's governing Agencies (HHS, DOL and IRS) issued final regulations governing wellness programs on June 3, 2013. These final regulations are quite similar to the proposed regulations issued in November, 2012 (see CBIZ Health Reform Bulletin, *Proposed Regulations: Wellness Programs, Essential Health Benefits and Rating Restrictions, Guaranteed Issue and Renewal Rules*, 11/28/12).

These final wellness rules are applicable to plan years beginning on or after January 1, 2014. The rules apply to both grandfathered and non-grandfathered group health plans, whether insured or self-funded.

In summary, a wellness program that is part of a health plan can be designed as a **participation-only program**, or as a **contingent program:**

A **participation-only program** is one based strictly on taking part in the program. Examples of such programs include:

- Cost or fees for a fitness center membership.

- A reward for participation in a diagnostic testing program, as long as the reward is not outcome-based.
- A program to encourage preventive care through waiver of deductible or co-pays such as prenatal care or well-baby visits. Note, however, non-grandfathered plans are required to provide certain preventive health services without the imposition of cost sharing.
- A program for reimbursement of a smoking cessation program, as long as it is not outcome-based.
- A reward for attending monthly no-cost health education seminars.
- A reward for completion of a health risk assessment (HRA) without further action (educational or otherwise) required by the employee regarding health issues identified as part of the HRA.

A participation-only program must be made available to all similarly situated individuals and the reward for participation is not limited in any way. Generally, there are very few restrictions on participation only programs.

A ***contingent program*** can take one of two forms: it can either be an *activity-only* program or an *outcome-based* program.

An **activity-only program** is one in which individuals are encouraged to participate in a specific activity that may preclude participation by certain individuals with health conditions such as severe asthma, pregnancy or recent surgery; in which case, a reasonable alternative would have to be made available, as more fully described below Examples of activity-only programs include a walking program, a diet program, or an exercise program.

An **outcome-based wellness program** requires achievement of an outcome based goal. Both types of contingent programs required compliance with five standards: they are:

1. The reward, taken together with all rewards from other wellness programs, cannot exceed 30% of the cost of single coverage; or, if the wellness program is made available to the family, then the cost of the relevant coverage (for example, full family, or individual + one). If the program relates to tobacco free standards, the incentive can be as much as 50 percent.
2. The program must be reasonably designed to promote health or prevent disease, and cannot be overly burdensome. The program cannot be designed in a way that would cause it to be suspect, or be a subterfuge to evade the purposes of the law.
3. The program must give individuals the ability to qualify for the program, at least once annually.
4. The program must be available to all individuals and offer **reasonable alternative** methods of compliance for those who cannot comply because of health reasons. The program may request proof of the inability to comply. Following are examples of reasonable alternative standards:
   - *Educational programs*. If a program requires completion of an educational program, the plan must make the educational program available instead of requiring an individual to find such a program unassisted, and cannot require an individual to pay for the cost of the program.
   - The *time commitment* must be reasonable. For example, requiring attendance nightly at a one-hour class would be unreasonable.
   - *Diet Programs*. If the reasonable alternative standard is a diet program, plans are not required to pay for the cost of food but must pay any membership or participation fee.
   - *Medically-inappropriate programs*. If an alternative is recommended by the employer's medical adviser, and if the individual's personal physician attests that the plan's recommendations are not medically appropriate for that individual, the plan must provide a reasonable alternative standard that accommodates the physician's recommendations of

medical appropriateness. Plans may impose standard cost sharing under the plan or coverage for medical items and services furnished based upon the physician's recommendations. Further, if reasonable under the circumstances, a plan may seek verification, such as a statement from an individual's personal physician, that a health factor makes it unreasonably difficult or medically inadvisable for the individual to satisfy the standards of an activity-only wellness program.

5. In any plan material that describes wellness programs, the availability of alternative standards must be described. The plan must disclose in all plan materials describing the terms of the program the availability of other means of qualifying for the reward or the possibility of waiver of the otherwise applicable standard (see below for model notice). If plan materials merely mention that a program is available, without describing its terms, then this disclosure is not required. Following is some model language that can be used to satisfy the notice requirement:

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

   The regulations provide additional sample language that could further describe aspects of the program, such as programs aimed at cholesterol reduction, fitness programs, and smoking cessation programs.

With regard to the availability of a reasonable alternative standard, for an activity-based program, a reasonable alternative must be made available if performing the activity is unreasonably difficult due to a medical condition, or is medically inadvisable.

The standard for an outcome-based wellness program is, according to these final regulations, somewhat broader. A *reasonable alternative* must be made available for all individuals who do not initially meet the outcome-based standard, not just for those for whom it is medically inadvisable.

Also emphasized in these regulations is the requirement that the full reward for participation in the wellness program must be available to those pursuing the reasonable alternative. This may mean that the reward be provided retroactively, i.e., the regulations affirm that the reward must be fully available within the plan year. If the reward affects health insurance premium, this can present challenges for compliance with IRC Section 125 cafeteria plans that will have to be addressed in the design of the wellness program. If there is a mid-year premium change, it is important that the cafeteria plan include language providing that if the cost of coverage changes, the salary reduction election can be automatically increased or decreased. The plan should go on to say that if the change in premium is significant that individuals can revoke and make a consistent new election. The law is less clear with regard to flexible medical spending account (FSA plan) incentives. Some wellness plan designs contemplate providing mid-year FSA contributions. It is not clear at this point that such contribution would be permissible. Hopefully, the IRS will provide guidance on this subject.

Integration of Wellness Rules with Other Laws

These regulations only address wellness programs and compliance with the HIPAA rules prohibiting discrimination based on health status, and the wellness rules contained in the ACA. These rules do not address potential discrimination issues that may arise under other laws, such as Title 7 of the Civil

Rights Act including, but not limited to, the *Americans with Disabilities Act* (ADA), the *Age Discrimination in Employment Act* (ADEA), and the impact of the *Genetic Information Nondiscrimination Act of 2008* (GINA) on wellness programs, particularly with regard to the use of health risk assessments.

On May 9, 2013, the Equal Employment Opportunity Commission (EEOC) hosted a meeting to gather information on how to ensure that wellness programs comply with various discrimination laws. One of the outstanding questions has been and remains, what constitutes "*voluntary*" collection of medical information? As background, the ADA permits the collection of medical information by a bona fide health plan as long as it is voluntary and not a subterfuge or a way to avoid the protections of the ADA. Until guidance is forthcoming, a good faith effort will have to be made to ensure that the wellness program does not run afoul of these rules.

Taxation of Wellness Plan Incentives

One of the linchpins of wellness programs relates to the taxation of wellness plan incentives. Following is a brief primer on this issue.

- If the incentive, in effect, is a health benefit, such as a premium discount, a contribution to a health reimbursement plan, the payment of a deductible or co-pay, among others, the incentive is tax-favored, as long as it complies with any applicable discrimination rules. Of particular note, health reimbursement arrangements are subject to discrimination rules, as are cafeteria plans, and certain of the component plans under a cafeteria plan. Therefore, any incentives offered through these types of plans should be monitored carefully.
- Any incentive that is cash, or cash-equivalent, such as a gift card, is fully taxable. There is no "*de minimis*" (minimal) exception to this requirement. According to informal, non-binding advice from the IRS, the employer is responsible for reporting the value of the cash or cash-equivalent on the individual's Form W-2, whether the employer pays the cash directly, or uses an intermediary to pay the cash.
- Generally, incentives, such as gym membership, are fully taxable, as well.
- Incentives such as T-shirts, coffee cups or other similar promotional-type products may fall within the IRC § 132 de minimis fringe benefit exception and may not be subject to tax. But, if the de minimis exception does not apply, the cost equivalent must be included in the individual's income.
- Employee discounts, generally, are not taxable.

Employers offering wellness incentives should discuss these matters with their tax advisers.

SMALL BUSINESS HEALTH OPTIONS PROGRAM (SHOP)

On May 31, 2013, the Agencies issued the pre-published version of final regulations relating to the Small Business Health Options Program (SHOP). In general, these final regulations affirm guidance previously issued (see CBIZ Health Reform Bulletin, *Overview of Final Exchange Regulations*, 3/28/12). Two modifications in the final rules to note are:

- **Special enrollment events**. Under the proposed SHOP regulations, there were separate triggering events giving rise to special enrollment periods applicable to SHOPs than as permitted through Exchanges or "marketplaces". The final SHOP regulations align the special enrollment triggering events for SHOPs to those that are currently available through the marketplaces. Thus, 30-day special enrollment periods are available through a SHOP when an individual acquires a new dependent through marriage, or birth or adoption of a child, or

loses minimum essential coverage due to certain events such as termination of employment. In addition, the final regulations provide for a 60-day special enrollment period through a SHOP when an individual becomes ineligible for Medicaid or the Children's Health Insurance Program (CHIP); or when he/she becomes eligible for premium assistance through Medicaid or CHIP.

- **Choice of QHP - Transitional Rule**. For plan years beginning on or after January 1, 2014 and prior to January 1, 2015, a SHOP has the option of allowing employers to offer a choice of qualified health plans (QHPs) at a single level of coverage to their qualified employees. A federally-facilitated SHOP is only required to offer employers a choice of one QHP from its available options. A state-based marketplace may likewise, for the first year of compliance, provide that employers select one QHP for their employees. Alternatively, a state-based marketplace could forge ahead and allow the small employer to choose a metal tier, making any of the plans in the metal tier available to the employer's employees.

About the Author: Karen R. McLeese is Vice President of Employee Benefit Regulatory Affairs for CBIZ Benefits & Insurance Services, Inc., a division of CBIZ, Inc. She serves as in-house counsel, with particular emphasis on monitoring and interpreting state and federal employee benefits law. Ms. McLeese is based in the CBIZ Leawood, Kansas office.

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CBIZ
Health Reform Bulletin

Subject: **Reporting and Paying PCOR Fees – Revised Form 720 Issued**
Date: June 4, 2013 (*Revised June 17, 2013 – See Addendum, below)*

One of the fees imposed on both insured and self-funded health plans by the Affordable Care Act is the Patient Centered Outcome Research (PCOR) fee. The purpose of this fee is to fund a Patient-Centered Outcome Research Trust Fund. This Trust Fund, in turn, supports a Patient-Centered Outcomes Research Institute to assist patients, clinicians, purchasers, and policymakers in making informed health decisions by advancing comparative clinical effectiveness research. This fee and types of plans subject to the fee are more fully described in the CBIZ Health Reform Bulletin, *Final Regulations Issued: Patient-Centered Outcomes Research Fees and Medical Device Tax* (12/11/12).

The form to be used for reporting and paying the fee is the second quarter IRS Form 720 filing. A revised Form 720 has been made available via the IRS website: http://www.irs.gov/pub/irs-pdf/f720.pdf.

For insured plans, the insurer is responsible for this reporting. A self-funded plan sponsor is responsible for its own reporting. The fees are based on the average number of lives covered under the policy or plan.

The first report is due July 31, 2013 for plan years ending between October 1, 2012 and December 31, 2012.

Part II of the instructions to the Form 720 (available in pdf version or html version) describe how covered lives are to be counted. Note in particular, the rules for applicable self-funded plans for the first year of compliance.

Addendum (June 17, 2013)
Since the issuance of this Bulletin on June 4, 2013, some important information applicable to self-funded plans has been issued. The IRS' Office of Chief Counsel recently issued Technical Advice Memorandum (TAM) AM2013-002. This TAM affirms that an employer who pays a PCOR fee can deduct this expense as a reasonable necessary business expense. It is important to note that all TAMs do not carry the force of law; however, they do provide guidance on how the IRS will administer a provision.

It is also very important to remember that 1) payment of the PCOR fees is a plan sponsor's responsibility; and 2) PCOR fees cannot be paid by plan assets (see PCOR discussion in this CBIZ Health Reform Bulletin, *Sub-Regulatory Guidance and FAQs Issued*, 1/25/13).

Subject: **1) Employer Shared Responsibility Penalty and Reporting Requirements Delayed**
2) Final Exchange Regulations, Individual Exemptions and Minimum Essential Coverage Clarifications
Date: July 3, 2013

EMPLOYER SHARED RESPONSIBILITY PENALTY AND REPORTING REQUIREMENTS DELAYED

Late in the day on July 2, 2013, the Assistant Secretary for Tax Policy at the U.S. Department of the Treasury posted on a blog that the Treasury Department intends to delay, for one year, the shared responsibility penalty that could be imposed on employers employing 50 or more employees if the employer does not offer adequate coverage at an affordable rate.

Also delayed is an employer and plan reporting requirement that was to have commenced in 2014. IRC Code Sections 6055 and 6056 require employers employing 50 or more employees sponsoring a self-funded or insured plan to file a reporting form reflecting certain information about the plan. To date, this form has not been developed. In conjunction with these reporting requirements, a benefit statement with information derived from the report would have to be provided to employees. Guidance on these matters is expected later this summer.

According to the blog, the Treasury Department reports it is delaying this requirement to provide more time to create a more efficient system. Because this reporting requirement is delayed, the government will not have the information it needs to impose the penalty; hence, the shared responsibility penalty is likewise being delayed.

Official guidance on this topic is to be issued in the next week or so; look for an update when this guidance is available.

In the meantime, employers are encouraged to continue to offer and even enhance access to coverage. For employer planning purposes, employers should know that all systems are "go", at least at the moment, for other requirements of the law including but not limited to the marketplace notice obligation (see CBIZ Health Reform Bulletin, *Notice to Employees of Coverage Options; Updated COBRA Model*, 5/10/13); and, the requirement for individuals to maintain MEC (see below for additional details). Because the individual shared responsibility requirement remains in effect, employees will still be eager to have information about available employer coverage.

In addition, all of the required health plan changes effective for plan years beginning on or after January 1, 2014 including but not limited to the maximum 90-day waiting period and ban on imposition of preexisting condition exclusion limitations remain in effect.

EXCHANGE FUNCTIONS, ELIGIBILITY FOR EXEMPTIONS AND MEC CLARIFICATIONS

Final regulations relating to *Exchange Functions: Eligibility for Exemptions and Miscellaneous Minimum Essential Coverage Provisions* were issued on July 1, 2013, together with an HHS Fact Sheet highlighting clarifications of these final regulations. Of particular note to employers, these regulations modify the definition of minimum essential coverage (MEC) and provide guidance on how a plan can become certified as a MEC plan (see below).

Individual Shared Responsibility Requirement – Eligibility for Exemptions

Beginning in 2014, all individuals residing in the U.S. must maintain a minimum level of coverage, or risk a shared responsibility payment. The IRS issued proposed regulations in January, 2013 that set forth the individuals exempt from maintaining MEC, as well as defining what types of coverage qualifies as MEC (see CBIZ Health Reform Bulletin, *Individual Minimum Essential Coverage and Affordability Standard*, 2/6/13).

One of the exemption categories for individuals is hardship. With regard to the hardship exemption, the final regulations and related HHS Guidance provide for additional exemptions in the following instances:

- Financial or domestic circumstances such that purchasing coverage would cause the individuals to experience a serious deprivation of food, shelter, clothing or other necessities. For example, exemptions would be available for the homeless, impending eviction, foreclosure or bankruptcy, or sudden property loss due to natural disasters such as fire or flood;
- Lack of affordable coverage available through the marketplace based on projected income;
- Ineligibility for Medicaid (in states that have not expanded Medicaid);
- Individuals determined eligible for self-only employer-sponsored coverage, but who cannot afford family coverage through the employer's plan; and
- Indian tribal members and their dependents eligible for services through an Indian health care provider.

Eligibility for Premium Assistance

To help individuals meet their shared responsibility requirement, government assistance is available to help them. On June 26, 2013, the IRS issued Notice 2013-41 addressing when an individual is deemed eligible for MEC and is not eligible for premium assistance or a cost share.

As background, an individual who is eligible for minimum essential coverage, including government plans, such as Medicare, Medicaid, the Children's Health Insurance Program (CHIP) or TRICARE, is ineligible to receive government assistance for purchasing coverage through the marketplace (previously known as the 'exchange'). Similar to the rule applicable to the employer shared responsibility requirement, an individual who is eligible for government coverage through such program such as Medicaid or CHIP, for example, will remain ineligible for premium assistance if his/her coverage under that Medicaid or CHIP program is lost due to failure to pay premium.

The Notice goes on to clarify that government-sponsored programs that require individuals to pay a certain premium for participation, such as TRICARE, or in the rare instance that an individual has to purchase Medicare Part A coverage, will only cause disqualification for premium assistance if the individual actually enrolls in that program.

Transition relief to individuals whose employers maintain non-calendar year plan years

IRS Notice 2013-42 provides for transition relief to individuals whose employers maintain non-calendar year plan years. Specifically, if an employer maintains a non-calendar year plan year, and if an individual does not enroll in the coverage during the 2013 enrollment season, the individual will not be subject to the shared responsibility penalty until the plan anniversary occurring in 2014.

In prior IRS guidance, transition relief was provided for non-calendar year cafeteria plans allowing a mid-year cafeteria plan change to accommodate compliance with the individual shared responsibility provisions applicable during 2014. A Section 125 plan is permitted but not required to avail itself to this transition relief. Plan sponsors may be less inclined to allow these mid-year changes since individuals will not be subject to the shared responsibility penalty until the plan anniversary occurring on or after January 1, 2014.

MINIMUM ESSENTIAL COVERAGE CLARIFICATIONS

For purposes of the individual shared responsibility requirement, MEC generally includes coverage under:

- Employer-sponsored group health plans, whether insured or self-funded, and grandfathered plans, as well as COBRA coverage (if actually elected) and retiree coverage. It also includes group health coverage sponsored by non-profit and for-profit entities, and governmental entities, including local governments. Plans excepted from HIPAA and limited scope benefit plans do not qualify as MEC.
- Government-sponsored plans such as Medicare, Medicaid, Children's Health Insurance Program (CHIP), TRICARE, and various Veteran's health programs
- Individual health policies, including a qualified health plan offered by an Exchange.
- Other similar types of comprehensive health coverage recognized by HHS as minimum essential coverage

The final regulations modify the MEC status of self-funded student health plans, AmeriCorp plans and state high risk pools. These types of plans only qualify as MEC in 2014; thereafter, the plan would have to file for MEC certification (see MEC Certification Process, below). Refugee Medical Assistance supported by the Administration for Children and Families and Medicare Advantage plans are also deemed as MEC.

MEC Certification Process

To be certified as minimum essential coverage, the plan sponsor would submit the following information to HHS:

1. Identity of the plan sponsor and appropriate contact persons;
2. Basic information about the plan, including:
    - Name of the organization sponsoring the plan;
    - Name and contact information of the individual authorized to make certification on behalf of the organization;
    - Number of enrollees;
    - Eligibility criteria;
    - Cost sharing requirements, including deductible and out-of- pocket maximum limit;
    - Description of essential health benefits coverage; and

3. Certification together with supporting documentation of compliance with the ACA requirements applicable to non-grandfathered plans in the individual market.

Once recognized as minimum essential coverage, a plan must provide notice to all enrollees of its minimum essential coverage status, and must comply with ACA's information reporting requirement.

About the Author: Karen R. McLeese is Vice President of Employee Benefit Regulatory Affairs for CBIZ Benefits & Insurance Services, Inc., a division of CBIZ, Inc. She serves as in-house counsel, with particular emphasis on monitoring and interpreting state and federal employee benefits law. Ms. McLeese is based in the CBIZ Leawood, Kansas office.

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Subject: **Women's Health Services Mandate Final Regulations – Exemption for Religious Employers and Non-Profit Religious Organizations**
Date: July 5, 2013

The Affordable Care Act requires non-grandfathered plans to cover in-network preventive services at no cost to the participant. In 2012, the preventive services specific to women was modified to include contraception and related services, applicable to all group health plans, excluding church plans. The narrow definition of "church plan" created much concern for certain types of organizations who are opposed to the mandate. In an effort to address these concerns, the governing agencies issued some transition relief for certain organizations with religious affiliations. Further, the government modified the definition of "church plan". On July 2, 2013, final regulations were issued as follows:

A church plan, defined as plan sponsored by a religious employer, is fully exempt from the mandate to cover contraceptive and related services. A ***religious employer*** is any organization that is organized and operates as a nonprofit entity, as defined in IRC Sections 6033(a)(3)(A)(i) or (iii) and includes churches, temples, other houses of worship and their affiliated organizations

An organization with religious affiliation is known as an "eligible organization". An ***eligible organization*** is defined as one that:

1. Opposes providing coverage for some or all of the contraceptive services required by the women's services mandate on account of religious objections;
2. Is organized and operates as a nonprofit entity;
3. Holds itself out as a religious organization; and
4. Self-certifies that it satisfies the above three criteria (as discussed below) for each plan year to which the accommodation is applicable.

While a plan sponsored by an eligible organization is not fully exempt from the mandate, these regulations make an accommodation such that the eligible organization is not required to arrange or pay for the objectionable benefit. This accommodation is likewise available to student health plans. But, its insurer or TPA of a self-funded plan must independently make the benefits available to plan participants. An eligible organization must certify to its insurer or TPA and attest to the following criteria:

1. The organization is organized and operates as a nonprofit entity;
2. From February 10, 2012 onward, the health plan established or maintained by the organization has consistently not provided all or some of the required contraceptive coverage because of the religious beliefs of the organization; and
3. Either the insurer or third-party administrator on behalf of a self-funded plan provides notification of the non-coverage to plan participants.

The self-certification must be executed by an authorized individual of the organization, and specify the types of contraceptive services that the organization does not wish to administer or fund. This certification need only be done once; though, if the employer changes the insurer or TPA, the certification must be provided to the new provider. The insurer or TPA must, in turn, notify plan participants about the availability of the contraceptive coverage. Below is the model language that can be used in the notice:

> *"Your employer has certified that your group health plan qualifies for an accommodation with respect to the federal requirement to cover all Food and Drug Administration-approved contraceptive services for women, as prescribed by a health care provider, without cost sharing. This means that your employer will not contract, arrange, pay, or refer for contraceptive coverage. Instead, [name of third party administrator/health insurance issuer] will provide or arrange separate payments for contraceptive services that you use, without cost sharing and at no other cost, for so long as you are enrolled in your group health plan. Your employer will not administer or fund these payments. If you have any questions about this notice, contact [contact information for third party administrator/health insurance issuer]."*

Effective Date

With the exception of the rules relating to the religious employer definition, these regulations apply to plan years beginning on or after January 1, 2014. The definition of religious employer applies to plan years beginning on or after August 1, 2013. The transitional relief issued in February, 2013 (see CBIZ Health Reform Bulletin, *Preventive Health Services for Women: Regulations Final – Limited Exception for Certain Church Plans*, 2/13/12) is extended for plan years beginning between August 1, 2013 and December 31, 2013.

Additional information relating to the final regulations:

- HHS Fact Sheet: Affordable Care Act Rules on Expanding Access to Preventive Services for Women
- HHS Fact Sheet: Women's Preventive Services Coverage and Non-Profit Religious Organizations
- Updated Guidance on the Temporary Enforcement Safe Harbor, issued June 28, 2013
- Certification Form for Eligible Organizations [word version or pdf version]

Background CBIZ Health Reform Bulletins:

- *Women's Preventive Services Update Impacting Religious Organizations* (2/6/13)
- *Preventive Health Services for Women: Regulations Final – Limited Exception for Certain Church Plans*, (2/13/12)
- *Preventive Care Coverage Expanded to include Women's Health Services*, (8/3/2011)

Applicability to For-Profit Employers with Religious Objections

These regulations provide no relief to for-profit entities with a religious objection to provide contraceptive services. To date, many court challenges have been brought. It is anticipated that this issue could reach the Supreme Court at some point. Two of the most recent court decisions are:

- **Hobby Lobby**. Recently, the 10th Circuit Court of Appeals returned a case brought by Hobby Lobby Stores, Inc, a for-profit employer, to the district court for consideration of granting an preliminary injunction on religious grounds to temporarily block the enforcement of the contraceptive coverage mandate (*Hobby Lobby Stores, Inc. v. Sebelius*, 2013 WL 3216103 (10th Cir. 2013); *Hobby Lobby Stores, Inc. v. Sebelius*, No.

CIV-12-1000-HE (W.D. Okla. 2013). The Court concluded that Hobby Lobby was entitled to bring claims under the Religious Freedom Restoration Act (RFRA), which provides that the government cannot substantially burden a person's exercise of religion. This decision has relieved Hobby Lobby of a significant $100 per day per person penalty imposed under IRC Section 4980D, which could have resulted in a total of $1.3 million per day/$475M per year penalty.

- **Beckwith**. The U. S. District Court, Middle District of Florida in Tampa has issued a preliminary injunction in the matter of Beckwith Electric Company (*Beckwith Electric Co., Inc. v. Sebelius*, Case No. 8:13-cv-0648-T-17MAP), enjoining the government from imposing the contraception mandate on a for-profit entity. The Court determined that the plaintiff met the requirements to be granted preliminary injunction, based on the premise that the mandate violates first amendment rights under the RFRA.

About the Author: Karen R. McLeese is Vice President of Employee Benefit Regulatory Affairs for CBIZ Benefits & Insurance Services, Inc., a division of CBIZ, Inc. She serves as in-house counsel, with particular emphasis on monitoring and interpreting state and federal employee benefits law. Ms. McLeese is based in the CBIZ Leawood, Kansas office.

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Subject: **IRS Guidance on Delay of Employer Shared Responsibility Reporting Requirements**
Date: July 10, 2013

Shortly before the July 4th holiday, the Treasury Department announced in a blog that certain reporting requirements will be delayed, and hence the imposition of the employer shared responsibility tax would be delayed until 2015 (see CBIZ Health Reform Bulletin, *Employer Shared Responsibility Reporting Requirements Delayed and Final Exchange Regulations*, 7/3/13). In the blog, the government has promised guidance; this has come in the form of IRS Notice 2013-45, issued on July 9, 2013.

As background, employers employing 50 or more full-time equivalent employees are required to offer their employees working 30 or more hours a week, health coverage that meets minimum value standards at an affordable rate, or risk an paying an excise tax. The excise tax would be triggered when an employee qualifies for government assistance to pay for health coverage purchased through the marketplace (exchange), and he/she had not been offered adequate coverage at an affordable rate by the employer (see CBIZ Health Reform Bulletin, *Shared Responsibility Guidance*, 1/9/13). Individuals potentially eligible for government assistance are those who fall between 100% and 400% of the federal poverty level.

The law includes two new reporting requirements that were to take effect in 2014. IRC Section 6055 imposes a reporting requirement upon insurers, self-funded health plans, and other entities providing minimum essential coverage. IRC Section 6056 imposes a reporting requirement upon large employers (those with 50 or more full-time employees) to disclose certain plan information for purposes of the shared responsibility excise tax. These reports have not been developed. The government has indicated that it wants to work with stakeholders in the development of these reporting requirements.

The government will use these reports to determine whether an employer might be subject to the excise tax. The government will review the information contained in these forms and compare it to individuals who have been granted premium assistance. The government would then provide this information to the reporting employer who would have an opportunity to respond, proving or disproving that the affected individual was offered adequate coverage at an affordable rate. Because these reports are not available yet, the government indicated that it will not be able to assess the excise tax for 2014.

The IRS guidance relating to this transition relief comes in four fairly simple question and answers, as follows:

1. ***When will the IRS publish rules regarding IRC Sections 6055 and 6056 Information Reporting and how will these provisions apply for 2014?***
   According to this Notice, the rules governing the IRC Sections 6055 and 6056 reports described above will be published later this summer. Employers and insurers are encouraged to voluntarily comply with the reporting requirements for the 2014 year, though, the reports will not be required until 2015. According to this Notice, the hope is that allowing adequate time to develop systems to ensure accurate reporting will, in the long term, facilitate a smooth transition.

2. ***What does the 2014 transition relief mean for IRC §6056 Information Reporting with regard to the Employer Shared Responsibility requirements that take effect in 2014?***
   The reporting form required by IRC Section 6056 is to be used by large employers to report information about the coverage it offers to employees. Because the reporting form is not available, employers are encouraged, again, to voluntarily comply with the reporting requirements in 2014 but the reports are not required until 2015.

3. ***Does this transition relief impact employees requesting premium assistance?***
   No; employees will still be able to request premium assistance through the marketplace (exchange). However, the employer may be asked to provide information about its plan coverage in that process. The single source application that will be used for purposes of applying for coverage through the marketplace, and determine eligibility for premium assistance, Medicaid, or other government assistance, includes an *Employer Tool* asking for information about the employer's plan. The employer will want to become familiar with this Tool (see *Appendix A* on pages 9-10 of the Marketplace Consumer Application); and in fact, the employer may want to pro-actively provide its employees with the information requested in the Tool.

4. ***Does this transition relief impact other aspects of ACA?***
   No. All other aspects of the ACA remain in effect, including the individual shared responsibility requirement.

WHAT SHOULD AN EMPLOYER DO?

At this point, all systems are 'GO' for all aspects of the ACA, with the exception of the IRC Sections 6055 and 6056 reporting requirements described above. And, there will be no risk of the employer shared responsibility tax penalties imposed for the 2014 year. Large employers (those employing 50 or more full-time employees) are encouraged to:

1. Develop systems to ensure smooth reporting as soon as guidance is issued; and
2. Continue offering and consider expanding access to their plans.

With regard to developing a reporting system, at minimum, the type of information that may be requested pursuant to IRC Section 6056 includes:

1. Name, date, and employer identification number of the employer.
2. Certification as to whether the employer offers to its full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan.

3. If the employer certifies that it offered its full-time employees (and their dependents) the opportunity to enroll:
    - The length of any waiting period;
    - The months during the calendar year for which coverage under the plan was available;
    - The monthly premium for the lowest cost option in each of the enrollment categories under the plan: and
    - The employer share of the total allowed costs of benefits provided under the plan.
4. The number of full-time employees for each month during the calendar year.
5. The name, address, and TIN of each full-time employee during the calendar year and the months during which such employee (and any dependents) were covered under any such health benefits plans.

The marketplaces (exchanges) are expected to be open for enrollment beginning October 1, 2013. Small employers will be able to buy coverage through the Small Business Health Options Program (SHOP) – see these CBIZ Health Reform Bulletins:

- *Small Business Health Options Program* (6/3/13)
- *Overview of Final Exchange Regulations* (3/28/12)

Group Health Plan Mandates

Under the ACA, the following requirements will be imposed on group health plans for plan years beginning on or after January 1, 2014:

- ❒ Applicable to all group health plans, including grandfathered and non-grandfathered plans:
    1. Ban on preexisting condition exclusion limitations on anyone;
    2. Extension of dependent coverage until age 26;
    3. Full implementation of ban on annual or lifetime limits for essential health services;
    4. Increased limit in outcome-based incentives/disincentives in wellness programs from 20 to 30%; or, up to 50% for tobacco free programs; and
    5. Ban on waiting periods exceeding 90 days.

- ❒ In addition, non-grandfathered health plans are subject to these ACA Provisions:
    1. Fair health insurance premiums;
    2. Guaranteed availability of coverage;
    3. Guaranteed renewability of coverage;
    4. Ban on discrimination against health care providers (“any willing provider” type laws);
    5. Inclusion of essential benefit coverage, providing a specified actuarial value, and cost-sharing limitations by insurers in small group and individual markets, and large group markets via State marketplaces. The cost-sharing limitations, specifically out-of-pocket limits, apply to both insured and self-funded plans offered through or outside marketplace; and
    6. Coverage for individuals participating in approved clinical trials

Additional ACA Requirements applicable to Group Health Plans

1. New Reporting Obligation*:* Notice of Marketplace (exchange) Coverage (10/1/13)

2. Fees and Taxes
    1. Patient-Centered Outcome Research Fee
    2. Transitional Reinsurance Fund (Premium Stabilization Program)

About the Author: Karen R. McLeese is Vice President of Employee Benefit Regulatory Affairs for CBIZ Benefits & Insurance Services, Inc., a division of CBIZ, Inc. She serves as in-house counsel, with particular emphasis on monitoring and interpreting state and federal employee benefits law. Ms. McLeese is based in the CBIZ Leawood, Kansas office.

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Subject: **October 1st Deadline Reminder: Notice to Employees of Marketplace Coverage Options**
Date: August 28, 2013

October 1st is fast approaching and that means the Affordable Care Act's Marketplace Notice must be distributed to employees (see CBIZ HRB, *Notice to Employees of Coverage Options; Updated COBRA Model*, 5/10/13).

As background, the Affordable Care Act (ACA) requires all employers to provide a notice of marketplace options to their employees explaining the health insurance marketplace (also known as "exchange"). Beginning October 1, 2013, each state will have a marketplace either established by the state itself, or through a federally-facilitated marketplace, or by a federal-state partnership marketplace through which individuals can buy health coverage. The Marketplace Notice is intended to explain important information about the pros and cons of buying coverage through the marketplace.

Who is required to provide the Marketplace Notice?
All employers subject to the Fair Labor Standards Act (FLSA) are required to provide the Marketplace Notice to their employees. The FLSA generally applies to virtually all employers employing at least one employee.

Who gets the Marketplace Notice?
All employees, including full-time and part-time employees, without regard to eligibility status for the health plan.

Who need not be given the Marketplace Notice?
The Marketplace Notice need not be provided to dependents of employees, former employees including retirees, or to former employees on COBRA continuation coverage. Note, though, an active employee on COBRA, for example due to a reduction in hours, would get the notice.

When must the Marketplace Notice be given?
- For current employees, the notice must be provided before October 1, 2013; AND
- All new hires hired on or after October 1, 2013 must be provided the Marketplace Notice timely, which means that, at least through 2014, within 14 days of hire.

What must the Marketplace Notice say?
The DOL's Employee Benefit Security Administration provides two model Marketplace Notices that contain required information that must be communicated to employees. One model notice is to be completed by employers offering coverage, and the other for employers who do not

offer coverage. Both model notices can be viewed and/or downloaded from the DOL's website and are available in both English and Spanish:

- The model notice for use by employers **who offer coverage** to some or all of their employees:
  - English (available in pdf format or word format)
  - Spanish (available in pdf format only)

- The model notice for employers who **do not offer health coverage:**
  - English (available in pdf format or word format)
  - Spanish (available in pdf format only)

What information must be included in the Marketplace Notice?
The required elements of a Marketplace Notice for employers **who offer health coverage** include a general overview of the insurance marketplaces (Part A), and Part B that provides information specifically relating to the employer plan, including:

1. Employer's name, contact information and EIN;
2. Whether health coverage is offered to all or some of the employer's employees and their dependents;
3. Whether coverage meets the minimum value and affordability standards; and
4. Optional language (page 3) derived from the Marketplace Employer Coverage Tool that intended to assist employees to understand their coverage options.

Elements of a Marketplace Notice for employers **who do not offer health coverage** include similar Part A language relating to the marketplace overview, and Part B that provides contact information about the employer, together with a statement that there is no employer plan available for which the individual is eligible.

The appropriate Marketplace Notice can be tailored to the employer as long as the minimum elements contained in the model notices are communicated.

Why is it important to explain whether the health plan meets minimum value and is affordable?
Providing information as to whether a health plan meets minimum value and affordability is important because it is determinative of whether an employee could be eligible for government assistance, such as a premium tax credit, for coverage purchased through the marketplace.

Generally, individuals are eligible for government assistance when their income falls between 100% and 400% of the federal poverty level, and they are ineligible for minimum value coverage that is affordable. In addition, an individual is ineligible for government assistance if the individual is actually covered by a health plan, whether or not that plan meets minimum value or affordability. This clarification might be a good addition to the language contained in the Marketplace Notice for employers who offer coverage, or included in a cover letter or memorandum provided with the model Notice.

How can the Marketplace Notice be delivered to employees?
The Marketplace Notices must be in writing in a manner calculated to be understood by the average employee.

- Paper versions of the notice can sent to employees by first class mail; or,

- The Notice can be provided electronically, as long as the DOL's electronic disclosures rules are followed, i.e., employees must have regular employment-based access to the employer's computer system. It is important to note that simply posting the notice to an employer's intranet and providing a link to it would not satisfy delivery of receiving the notice. For employers sending the notice as an e-mail attachment, it is recommended to confirm receipt of the message and notice by initiating a delivery and/or read receipt, or other tracking mechanism, to the e-mail message.

Does the COBRA election form need to be revised to reflect ACA changes?

For an employer plan subject to federal COBRA, there is no mandate at this time to modify its COBRA election form. However, due to the advent of the marketplace, the elimination of preexisting condition exclusion limitations applicable to plan anniversaries beginning on or after January 1, 2014, and the expiration of certain COBRA penalties, the DOL has provided a new model COBRA election form containing these changes. An employer may wish to begin using this modified COBRA election form in late 2013; or, coincident with the employer's plan anniversary occurring in 2014.

The revised model COBRA election form is available in both English and Spanish. The DOL also provides a red-lined version to indicate the particular changes made to the model election form language.

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CBIZ
Health Reform Bulletin

Subject: **Guidance and Updates: 1) Distribution of Marketplace Notice; 2) 90-day Waiting Period; 3) Individual Shared Responsibility; 4) Employer Appeals in Marketplace Eligibility Determinations; 5) Small Business Tax Credit; 6) Preventive Care – Health Saving Accounts; and 7) Internal Claims, Appeals and External Review: Providing Culturally and Linguistically Appropriate Notices**

Date: September 11, 2013

As October 1st fast approaches, the government is busy issuing a plethora of guidance. October 1st is an important date in that it is the date the marketplace, sometimes referred to exchange, is open for business. What this means is that individuals and small businesses can begin to enroll in health coverage through these newly implemented vehicles. Coverage purchased through these marketplaces will become effective January 1, 2014, at the earliest.

DISTRIBUTION OF MARKETPLACE NOTICE TO EMPLOYEES

One of the most immediate matters for employers to attend to is distribution of the market place notice (see CBIZ HRB *October 1st Deadline Reminder: Notice to Employees of Marketplace Coverage Options*, 8/28/13). The DOL's Employee Benefit Security Administration has just issued a new set of Frequently Asked Questions relevant to this notice.

Specifically, this sub-regulatory guidance affirms that a third party can distribute the marketplace notice on behalf of the employer. This might make sense, for example, for a multi-employer plan to distribute the notice to individuals covered by the multi-employer plan. If an employer's employees participate in a multi-employer plan, a notice distributed by the multi-employer plan would satisfy the employer's obligation. However, it is very important for the employer to remember that it must provide the notice to all of its other employees who do not receive the notice from the multi-employer plan.

Another example might be a third party administrator distributing the notice to all individuals covered by the plan it administers. Again, the employer must remember that the marketplace notice must be provided to all employees; therefore, the employer would be obligated in this situation to distribute the notice to those who do not receive it from a third party.

90-DAY WAITING PERIOD

On the first plan anniversary occurring on or after January 1, 2014, the maximum waiting period that can be imposed by any plan is 90 days (see CBIZ HRBs *90 Day Wait and Other Updates* (3/26/13) and *Guidance Issued Relating to 90-day Waiting Period and Defining Full-time Employee* (9/4/12)).

A newly issued FAQ affirms that substantive eligibility provisions that are not directed at avoiding the 90-day restriction are permissible. The example used in the FAQ is a multi-employer plan that defines eligibility based on hours worked in a quarter for one or more employers. Based on these

hours worked, the individual would qualify for coverage for the subsequent quarter. This FAQ affirms that this type of eligibility provision is permissible.

INDIVIDUAL SHARED RESPONSIBILITY – FINAL REGULATIONS

The ACA imposes an individual shared responsibility requirement. This requirement mandates that beginning January 1, 2014, virtually all individuals residing in the U.S. must maintain a minimum level of coverage, or risk a shared responsibility payment (see CBIZ HRB, *Individual Minimum Essential Coverage*, 2/6/13).

On August 30, 2013, the IRS and Treasury Department issued final regulations, together with a Fact Sheet, relating to the individual shared responsibility requirement. Following are highlights of these regulations.

- ***Employer Coverage Qualifies as MEC***. While these regulations do not have significant importance for employers, they do affirm that generally employer health coverage, whether insured or self-funded, will constitute minimum essential coverage (MEC). Similarly, COBRA and retiree coverage qualifies as MEC as long as the individual is actually covered.

- ***Third Party Coverage***. Of great interest to employers who use third party coverage, the preamble to the regulations affirms that third party coverage, such as coverage through a professional employer organization (PEO), a leasing company, or by a multi-employer plan, qualifies as MEC. The preamble does go to great lengths to affirm that this in no way implicates who the employer is. In other words, the employer-employee relationship is governed by existing law and contractual relationship, and is not impacted by this determination.

- ***Liability for Dependent Coverage***. These regulations require the individual to maintain coverage for him/herself and his/her dependents. For purposes of these regulations, dependents are those as defined by IRC Section 152, including the taxpayer's biological child, step child, adopted child or foster child, up to age 26, as well as a dependent who meets the definition of qualifying child or qualifying relative of the taxpayer. The individual would be liable for the shared responsibility payment attributable to the dependent's lack of coverage regardless of whether the taxpayer claims the individual as a dependent on a Federal income tax return for the taxable year.

- ***Transition Relief***. There is transitional relief for 2014 for individuals whose employers maintain non-calendar year plan years (see the Transition Relief discussion in the CBIZ HRB, *Employer Shared Responsibility Reporting Requirements Delayed and Final Exchange Regulations*, 7/3/13). If the individual is eligible for an employer plan for which the anniversary is different from the calendar year, the individual will not be subject to individual shared responsibility requirement until the plan anniversary occurring on or after January 1, 2014.

EMPLOYER APPEALS IN MARKETPLACE ELIGIBILITY DETERMINATIONS

On August 28, 2013, the HHS" Center for Consumer Information & Insurance Oversight issued final rules, together with a Fact Sheet, relating to exchange (marketplace) program standards. Of particular note, these rules address how individuals and employers can appeal eligibility decisions rendered by the marketplaces, including determinations rendered through the small business health options program (SHOP). This would include instances in which an individual's eligibility for premium tax credits or cost-sharing reductions is denied, or a determination that an employer's plan does not provide minimum essential coverage that meets both minimum value and affordability standards.

SMALL BUSINESS TAX CREDIT (SBTC) UPDATES

The Affordable Care Act includes a small employer health insurance tax credit that has been in effect for several years now (see CBIZ HRB *Additional Guidelines to the Small Business Tax Credit* (12/22/10) and *The Small Business Health Care Tax Credit* (5/20/10)). On August 26, 2013, the IRS issued proposed regulations relating to this tax credit.

Following are highlight of these proposed regulations. These changes begin January 1, 2014.

- ***Eligible Employers***. Employers entitled to the credit remain the same. To be eligible, the employer must employ fewer than 25 full-time equivalent employees whose average annual wages are less than $50,000 (adjusted for inflation beginning in 2014). In addition, the small employer must cover at least 50% of the cost of single (not family) health care coverage for each employee.

- ***Qualifying Coverage***. The credit is only available for qualified health plan (QHP) coverage purchased through the Small Business Health Options Program (SHOP) and is only available for 2 consecutive years. The small employer does not relinquish its right to the credit by not taking it immediately. In other words, the employer could decide to claim the credit in 2017 and 2018, even though it may have qualified for the credit earlier.

- ***Amount of Credit***. For tax years beginning in 2014 and beyond, the maximum credit will increase from 35% to 50% of premiums paid by small business employer, and from 25% to 35% paid by small tax-exempt employers.

- ***Uniform Contributions***. To be eligible for the credit the employer must make a uniform contribution toward health coverage. The regulations give several examples of how to determine a uniform percentage:

  Example1. An eligible small employer (Employer) offers a QHP on a SHOP Exchange, Plan A, which uses composite billing. The premiums for Plan A are $5,000 per year for self-only coverage, and $10 ,000 for family coverage. Employees can elect self-only or family coverage under Plan A. Employer pays $3,000 (60% of the premium) toward self-only coverage under Plan A and $6,000 (60% of the premium) toward family coverage under Plan A. In this example, the Employer's contributions of 60% of the premium for each tier of coverage satisfy the uniform percentage requirement.

  Example 2. Same scenario as Example 1, except that Employer pays $3,000 (60% of the premium) for each employee electing self-only coverage under Plan A and pays $3,000 (30% of the premium) for each employee electing family coverage under Plan A. In this example, the Employer's contributions of 60% of the premium toward self-only coverage and the same dollar amount toward the premium for family coverage satisfy the uniform percentage requirement, even though the percentage is not the same.

- ***Transition Relief.*** If a small employer health plan year is different from a taxable year, the employer would be able to take the full 50% credit in 2014 even if it does not offer QHP coverage though a SHOP until its plan anniversary occurring in 2014, as long as:
  1. As of August 26, 2013, the small employer offers coverage in a plan year that begins on a date other than the first day of its taxable year;

2. The employer offers coverage during the period before the first day of the plan year beginning in 2014 that would have qualified the employer for the credit under the rules otherwise applicable to the period before January 1, 2014; and
3. The employer begins offering coverage through a SHOP as of the first day of its plan year that begins in 2014.

Additional information relating to the SBTC, including a tax credit estimator, FAQs, and forms for claiming the credit can be found on the IRS' dedicated webpage.

PREVENTIVE CARE – HEALTH SAVING ACCOUNTS

On September 9, 2013, the IRS issued Notice 2013-57 affirming that a qualified high deductible health plan (HDHP) used in conjunction with a health savings account (HSA) remains HSA-qualified despite providing first dollar coverage for preventive services mandated by ACA. As background, an HSA must be paired with a qualified HDHP. The HDHP can only reimburse expenses after a certain minimum statutory deductible has been satisfied. The ACA requires that non-grandfathered health plans cover preventive services without any cost-sharing, including the imposition of a deductible. This ruling affirms that the preventive services mandated by the ACA can be covered by the qualified HDHP used in conjunction with an HSA without requiring satisfaction of a deductible.

INTERNAL CLAIMS, APPEALS AND EXTERNAL REVIEW: UPDATE ON PROVIDING CULTURALLY AND LINGUISTICALLY APPROPRIATE NOTICES

The ACA requires that documents provided to individuals in a claim denial and external review process be provided in a culturally and linguistically appropriate manner, i.e., in the appropriate language of the claimant (see CBIZ HRB, *Modifications to Claims and Appeals, and External Review Processes*, 7/11/11). The determination of what language to provide information to claimants is based on the number of non-English speakers residing in a particular geographic area. The threshold percentage for group health plans requires language appropriate notices when at least 10% of a county's population speaks a particular non-English language and who do not speak English "very well". The HHS' Center for Consumer Information & Insurance Oversight has recently issued updated step-by-step instructions for calculating the 10% threshold in order to provide the appropriate documents in the appropriate languages.

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CBIZ
Health Reform Bulletin

Subject: **Information Reporting by Employers on Health Coverage and Reporting of Minimum Essential Coverage**
Date: September 18, 2013

The Affordable Care Act includes many reporting and disclosure requirements. Among these are two Internal Revenue Code Section reporting requirements found in IRC Sections 6055 *and 6056. These Code Sections require plans and employers to provide information to the* government about the plan and who is covered by the plan. In addition, these Code Sections require benefit statements to be provided to the insureds, similarly advising them about the nature of the coverage. The purpose of these Code Sections is to provide information both to the government and to the insureds that will assist in assessing employer shared responsibility, as well as individual shared responsibility and entitlement to premium assistance in the form of a tax credit.

Because the actual reports had not been finalized, the IRS announced a delay of these reporting requirements until 2015 (see CBIZ HRBs, *IRS Guidance on Delay of Employer Shared Responsibility Reporting Requirements* (7/10/13) and *Employer Shared Responsibility Reporting Requirements Delayed and Final Exchange Regulations* (7/3/13)).

On September 9, 2013, the IRS and Treasury issued proposed regulations, flushing out details of the Sections 6055 and 6056 reporting requirements. At this point, these regulations are proposed only, and there is nothing specific for employers and health plans to do other than be aware of the types of obligations that are in the offing.

IRC SECTION 6055 REPORTING

The type of information required to be reported to the IRS on the proposed Form 1095-B, for Code Section 6055 purposes, includes the following information for each calendar year:

1. Name, address, and EIN for the person required to file the return;
2. Name, address, and TIN, or date of birth of the responsible individual;
3. Name and TIN, or date of birth of each individual covered under the policy or program; and
4. For each covered individual, the months for which the individual was enrolled in coverage and entitled to receive benefits.

In addition, information returns reporting minimum essential coverage provided to an individual under an insured group health plan must report:

1. Name, address, and EIN of the employer sponsoring the plan;
2. Whether the coverage is a qualified health plan enrolled in through the Small Business Health Options Program (SHOP) and the SHOP's unique identifier; and
3. Other information specified in forms, instructions, or published guidance.

Timing of filing. The report is required to be filed with the IRS no later than February 28th of each year (or March 31st of each year, if filed electronically), reflecting information for the previous calendar year.

Benefit Statements to Employees
Employers submitting a return, pursuant to Section 6055, must furnish the same information to all individuals named in the return, together with the contact phone number of the individual filing the return and the policy number. This can be accomplished by providing a copy of the Form 1095-B, or similar substitute statement as prescribed by the IRS. These benefit statements must be provided annually by January 31st and are based on prior calendar plan year information. These statements may be provided electronically, as long as the electronic distribution standards contained in the regulations are followed.

IRC SECTION 6056 REPORTING
Section 6056 requires employers to report to the IRS information about their compliance with the employer shared responsibility provisions including the type of health care coverage they offer to their employees. In addition, employers are required to furnish related benefit statements to employees to assist them in determining whether they can claim a premium tax credit on their tax return.

The IRS Form 1095-C (employee statement) or a Form 1094-C (transmittal) are the proposed designated forms to be used for Section 6056 reporting. At minimum, following is information that will be requested on the form:

1. The employer's name, address, EIN;
2. Name and phone number of the employer's contact person;
3. Identification of the calendar year for which the information is reported;
4. Certification as to whether the employer offered to its full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage under its group health plan by calendar month;
5. The months during the calendar year for which coverage under the plan was available;
6. Each full-time employee's share of the lowest cost monthly premium (self-only) for coverage providing minimum value offered to that full-time employee under the employer-sponsored plan, by calendar month;
7. The number of full-time employees for each month during the calendar year; and
8. The name, address, and taxpayer identification number of each full-time employee during the calendar year and the months, if any, during which the employee was covered under the plan.

Timing of filing. The report is required to be filed with the IRS no later than February 28th of each year (or March 31st of each year if filed electronically), reflecting information for the previous calendar year.

Benefit Statements to Employees
Full-time employees must be furnished with a written statement derived from information contained in the employer's report. This can be accomplished by providing a copy of the Form 1095-C, or similar substitute statement as prescribed by the IRS. These benefits statements must be provided annually by January 31st and are based on prior calendar plan year information. These statements may be provided electronically, as long as the electronic distribution standards contained in the regulations are followed.

Effective Date. Written comments on these proposed regulations must be received by November 8, 2013. These regulations are proposed to apply for calendar years beginning after December 31, 2014.

Simplified Reporting. The preamble to both sets of the regulations contemplates trying to simplify some of the reporting requirements. A self-funded employer, for example, at this point is subject to at least 5 health coverage reporting obligations including the Section 6055 report to the IRS, a Section 6055 report to the employees, a Section 6056 report to the IRS, a Section 6056 report to the employees, and a Form W-2 reporting of health coverage (which became effective for the 2012 tax year). Hopefully, the final regulations will allow some streamlining of these reporting requirements. We will monitor the situation and update you as regulations and reporting forms are finalized.

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CBIZ
Health Reform Bulletin

Subject: **Impact of ACA on HRAs, Health Care FSAs, and Other Employer Health Care Arrangements**
Date: September 20, 2013

The Affordable Care Act (ACA) has raised many questions with regard to account-based plans, such as Flexible Spending Accounts (FSAs) and Health Reimbursement Arrangements (HRAs). Specifically are these types of account-based plans obligated to comply with the market provisions of the ACA, such as the requirement to cover preventive services without cost share and the prohibition against annual limits. The imposition of these types of provisions, of course, is contrary to the nature of account-based plans.

On September 13, 2013, The Department of Labor (DOL) issued Technical Release No. 2013-03 and the IRS issued Notice 2013-54 addressing some of these issues.

Without getting into all of the details of these rules, the following is an overview of these releases. In a nutshell, the technical releases affirm prior guidance (see CBIZ HRB *Sub-Regulatory Guidance and FAQs Issued*, 1/25/13), that an HRA cannot be used to purchase individual coverage through the marketplace. In fact, no form of pre-tax contribution, whether through an HRA, FSA, or other premium payment, can be used to purchase individual coverage.

An HRA can, on the other hand, be integrated with a group plan and if the HRA is properly integrated in either two methodologies described below, the HRA itself will not be required to comply with market reforms. The two types of integration are known as ***minimum value integration*** and ***no minimum value integration***.

In both methodologies, the HRA can only be available to individuals actually covered by an ACA compliant plan. For both methodologies, the ACA compliant plan can be that of the employer sponsoring the HRA (the individual's employer) or it can be a plan offered by another employer, such as a spouse's employer. Also for both methodologies, the individual must be given the opportunity, at least annually, to permanently waive participation in the HRA. Presumably, the reason for this requirement is to allow the individual to decline the coverage and presumably become eligible for premium assistance through the marketplace.

In the no minimum value integration, the HRA is limited to reimbursing co-pays, co-insurance, deductibles, and premiums of the ACA compliant plan with which the HRA is integrated. In addition, the HRA may reimburse medical expenses that do not qualify as essential health benefits.

In the minimum value integration, the ACA compliant plan with which the HRA is integrated must meet minimum value (MV) standard. Minimum value means that the plan covers at least 60% of

the cost of medical services. Unlike the no minimum value HRA, it can reimburse any medical expense permitted by IRC §213(d).

Retiree Only HRAs

This guidance affirms previously issued regulations that a retiree-only HRA, i.e. an HRA that only covers retirees who do not have current employment status, is exempt from the market provisions of the ACA. Further, the guidance affirms that the HRA qualifies as minimum essential coverage. A retiree covered by this type of HRA would be prohibited from receiving premium assistance through the marketplace since the HRA qualifies as minimum essential coverage.

Excepted FSAs

This guidance affirms that an excepted FSA is not subject to the market reform provisions of the ACA. To be an excepted FSA, the FSA must:

- Only reimburse dental or vision expenses;
- Cover fewer than two participants who are active employees; or
- Meet the maximum benefit test. What this means is that the maximum benefit available cannot exceed two times the salary reduction election; or, the salary reduction election plus $500, whichever is greater. In addition, the FSA must meet an availability test. What this means is that the participants in the FSA must also be eligible for a health plan that is subject to HIPAA.

An FSA that is not excepted is, in fact, subject to the market provisions of the ACA.

Additional §125 Issues

Generally, the ACA prohibits the use of pre-tax dollars through an IRC §125 plan to buy individual policies through the marketplace. Some states, such as Massachusetts, have a law allowing pre-tax contributions to be used for the purchase of coverage through a marketplace. This guidance affirms that these pre-tax contributions can continue until the plan anniversary occurring on or after January 1, 2014, at which time this practice will no longer be allowed.

Finally, this guidance addresses employee assistance programs, affirming that an employee assistance program will not constitute minimum essential coverage as long as it does not provide significant medical benefits. Future guidance defining what constitutes significant medical benefits is anticipated.

What should an employer do?

- If applicable, cease reimbursing individual policies on a tax-favored basis.
- If you have or intend to have an HRA, make sure it is integrated as described above. Specifically, make certain it is only available to individuals actually enrolled in ACA compliant coverage.
- Amend the HRA to include an opt-out provision.

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CBIZ
Health Reform Bulletin

Subject: **Small Business Health Options Program (SHOP) Updates**
Date: October 31, 2013

One of the components of the Affordable Care Act is the Small Business Health Options Program (SHOP). The SHOP is the marketplace, sometimes referred to as "exchange", specific to small employers.

STATUS OF MARKETPLACE ESTABLISHMENT

To date, 26 states are utilizing a federally-facilitated marketplace/exchange (FFE), 17 states plus the District of Columbia have established their own marketplace/exchange, and 7 states are operating a federal/state partnership marketplace, as follows.

States Utilizing Federally-Facilitated Marketplace			
Alabama	Louisiana	North Carolina	Tennessee
Alaska	Maine	North Dakota	Texas
Arizona	Mississippi	Ohio	Virginia
Florida	Missouri	Oklahoma	Wisconsin
Georgia	Montana	Pennsylvania	Wyoming
Indiana	Nebraska	South Carolina	
Kansas	New Jersey	South Dakota	

State-Run Marketplace			
California	Idaho	Nevada	Utah*
Colorado	Kentucky	New Mexico	Vermont
Connecticut	Maryland	New York	Washington
District of Columbia	Massachusetts	Oregon	
Hawaii	Minnesota	Rhode Island	

**In Utah, the state operates the SHOP; individuals utilize the FFE for selecting coverage.*

State/Federal Partnership Marketplace			
Arkansas	Illinois	Michigan	West Virginia
Delaware	Iowa	New Hampshire	

Recently, the Centers for Medicare and Medicaid Services (CMS) issued policy and guidance regulating the management and operations of SHOPs specifically as it relates to type of coverage offered, employer applications, enrollment procedures, enrollment timeframes, minimum participation standards, and calculation of employer and employee premiums and contributions. Following are highlights of this guidance. This review relates primarily to the federal SHOP; a state-SHOP may have additional requirements.

COVERAGE AND ENROLLMENT

An employer eligible for the SHOP must meet 3 criteria:

1. It must be 'small employer', defined as an employer employing between 1 and 100 employees. Employer size is determined based on the prior calendar year; both full-time employees and full-time equivalent employees are counted. (For 2014 and 2015, a state may define small employer as one employing 1 to 50 employees. States may open their marketplaces to large employers in 2017);
2. The coverage must be offered to all full-time employees, defined as individuals working 30 or more hours per week; and
3. The employer's principal office must be within the SHOP's geographic area.

In order to enroll in coverage through a SHOP, employers and employees are required to complete applications to determine their eligibility for coverage. The SHOP is based on an employee choice model pursuant to which the employer will select a metal tier of coverage and the employees choose any plan within that tier; in some instances, the employee may even be able to move up a tier. The metal tiers are categorized based on the level of benefit coverage, i.e., Bronze (covers 60% of total average costs of care), Silver (70%), Gold (80%) and Platinum (90%).

In 2014, employers utilizing a federally-facilitated SHOP (FF-SHOP) can only choose one qualified health plan (QHP) at a single metal tier of coverage for their employees. A state can choose to make the full metal tier available, or limit it to one plan like the FF-SHOPs. Beginning in 2015, all SHOPs are required to offer all plans within a single metal tier of coverage.

Once an employer enrolls through a SHOP and employees elect the employer's offer of coverage, the SHOP then provides enrollment information to the relevant QHP issuer (insurer).

INITIAL AND ANNUAL OPEN ENROLLMENT PERIODS AND COVERAGE

Initial open enrollment in the FF-SHOP began October 1, 2013. The effective date of coverage is based upon the date selected by the employer as part of the application and enrollment process, as follows:

Plan Selection Date	*Effective Date of Coverage*
10/1/13 through 12/15/13	1/1/14
Between the 1st and 15th day of the month	1st day of the following month
Between the 16th and last day of the month	1st day of the second following month

Employer plans are issued on a 12-month basis. Open enrollment and renewal periods will occur on a rolling basis throughout the year. Employers will receive renewal notices from the FF-SHOP at least three months prior to the end of the plan year and have 30 days to respond to the renewal offer. If the employer opts to renew the coverage, then the SHOP will then notify employees about their coverage options for the subsequent year.

Employees have up to 30 days to either accept or waive coverage, as well as add dependents or make changes to their QHP coverage during this open enrollment period. Both the employer's plan offerings and employee coverage decisions must be submitted to the SHOP by the 15th of the month prior to the end of the employer's plan year in order to be timely effective for the beginning of the following plan year.

Delay in On-line Enrollment Process. In late September, HHS announced a delay in the availability of electronic enrollment in a SHOP November, 2013. Updates since have moved the electronic enrollment availability to the end of November, at the earliest. According to the news release, as long as employers and employees complete the enrollment process by December 15, 2013, coverage will begin January 1, 2014.

SPECIAL ENROLLMENT PERIODS

A SHOP must provide for a 30-day special enrollment period during which qualified individuals may enroll in QHPs or change QHPs upon the occurrence of certain life events. These events are:

- Addition of a dependent as a result of marriage, birth, adoption, or placement for foster care;
- The covered employee or dependent loses minimum essential coverage due to job loss or loss of QHP certification;
- The employee moves to a new state and gains access to employer health coverage;
- An employee's enrollment or non-enrollment in a plan is the result of the error, misrepresentation, or inaction by the Marketplace or by HHS; or
- Violation of a contract provision as proven by the covered employee.

The affected employee must notify the SHOP of a life event that triggers a special enrollment period within 30 days of the event. An employee who becomes eligible or loses eligibility for Medicaid or the Children's Health Insurance Program (CHIP) would have 60 days from the date of the event to notify the SHOP. If the employee fails to timely notify the SHOP of the event, then he/she would have to wait until their next annual enrollment period to make a change.

MINIMUM PARTICIPATION RULES

A SHOP can impose a 70% participation requirement unless a state requires a higher standard. States that currently require employers to meet a minimum 75% participation rate are Arkansas, Iowa, New Hampshire, New Jersey, South Dakota and Texas.

For participation purposes, all employees, including full-time, part-time employees, COBRA continuees, retirees participating in the employer plan, and business owners, as well as those buying individual coverage are included in the calculation. Employees covered by another employer group health plan, or by a government program such as Medicare, Medicaid or TRICARE, need not be counted.

The minimum participation rate is calculated only upon initial enrollment and renewal. Mid-year fluctuations in a group's participation rate will generally not affect eligibility for coverage. However, if a group falls below the minimum participation standard at renewal, then coverage would likely not be renewed. In this instance, an employer could re-apply for coverage at another time during the year when it could meet the minimum participation standard.

PREMIUMS AND CONTRIBUTIONS

For purposes of determining premium, the SHOP will offer the employer a choice between a composite rating formula, or an age-rating formula, unless a state specifies the rating methodology. Premiums for QHP coverage offered through a FF-SHOP are calculated based on the employer's selected QHP and the number of employees who accept the offer of coverage. The total group premium is determined by adding the per-premium for each participant and beneficiary covered under the plan, adjusted by the applicable geographic rating are, based on the employer's principal place of business.

Once the premiums are totaled, the amount is then divided by the number of employees electing coverage to get the average employee contribution rate. The employer would then apply the same percentage of its contribution for employee-only coverage, with the employee paying the balance, subject to any applicable tobacco surcharge. This same procedure in determining premium calculations and employer and employee contribution rates applies if the employer also selects dependent coverage and/or dental coverage, in addition to the medical coverage.

> *Example*. If the youngest employee enrolling has a premium of $100 and the oldest employee enrolling has a premium of $120, the average premium for everyone would be $110. If the employer decides to contribute 80% (or $88) towards the premium payments, each employee would pay $22. If an employee adds 2 dependents to the coverage plan, an additional premium amount will be added for the employee based on the ages of the dependents. The employer's contribution of 80% (or $88) for its employees will remain the same.

The employer's contribution percentage toward premium cannot vary based on work status of employee, i.e., the employer contribution percentage must be the same for all of its full-time and part-time employees, and cannot vary based on employee classes.

Part of the SHOP application includes an employee worksheet for estimating premiums and determining coverage. Because an employer may not know whether any of its employees or their dependents would participate in the employer's plan selection, CMS encourages employers to collect the relevant information from its workforce prior to making application for SHOP coverage. The more accurate the information provided by the employer would likely result in a more precise estimate of premium.

It is important to note that generally, coverage bought through the marketplace cannot be purchased with salary reduction dollars via IRC Section 125 (cafeteria) plan. The only exception to this is coverage purchased through the SHOP.

WAITING PERIODS

Beginning January 1, 2014, the ACA mandates that waiting periods can be no longer than 90 days. During the initial application process through a SHOP, an employer can select its new hire waiting period from a choice of zero days, up to 60 days. The 60-day waiting period option is the maximum selection to ensure that coverage becomes effectuated by the maximum allowable period of 90 days.

NOTIFYING EMPLOYEES ABOUT SHOP COVERAGE

Once the employer completes its application for coverage through the SHOP, selects the coverage, determines its contribution toward coverage and submits a roster of its employees, the SHOP will then send an e-mail to all employees identified on the roster about the availability of the employer coverage. The e-mail will include each employee's unique access code and a link to the SHOP website for purposes of completing the employee application. Employers should ensure that the information provided in the employee roster is accurate as they are ultimately liable for ensuring their employees are notified of available health coverage through the SHOP. Presumably, this obligation is in addition to the Marketplace notice required to be provided by all employers; though, no additional guidance has been issued on this point.

INTERPLAY WITH SMALL BUSINESS TAX CREDIT

The small business tax credit (SBTC) has been available to certain eligible employers for several years now. Beginning in 2014, only QHP coverage purchased through the SHOP is available for the SBTC, and only for a 2-consecutive year period. To be eligible, the employer must employ fewer than 25 full-time equivalent employees whose average annual wages are less than $50,000 (adjusted for inflation beginning in 2014). In addition, the small employer must cover at least 50% of the cost of single (not family) health care coverage for each employee. In addition, the employer must make a uniform contribution toward health coverage. For tax years beginning in 2014 and beyond, the maximum credit increases to 50% of premiums paid by small business employer (35% for small tax-exempt employers).

Additional Information about SHOPs:

- SHOP Marketplace (HealthCare.gov portal)
- *Infographic: Five Steps for Employers to Apply for Coverage in the SHOP Marketplace*

Background CBIZ Health Reform Bulletins relating to SHOPs:

- Small Business Health Options Program (6/3/13)
- Overview of Final Exchange Regulations (3/28/12)

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CBIZ
Health Reform Bulletin

Subject: **Year-end Wrap Up**
Date: December 2, 2013

As 2013 draws to a close, the "to-do" list for compliance with the Affordable Care Act (ACA) remains long. The law has, and continues to, evolve.

EMPLOYER SHARED RESPONSIBILITY REQUIREMENT

The employer shared responsibility component of the law, which requires employers employing 50 or more full-time plus full-time equivalent employees to either offer adequate health coverage at an affordable rate to those employees working 30 or more hours per week or risk a penalty, has, in effect, been delayed until 2015. This enforcement delay is due, in large part, to the delay of the reporting requirement that would have been used to manage the shared responsibility requirement (see CBIZ Health Reform Bulletins, *Information Reporting by Employers on Health Coverage and Reporting of Minimum Essential Coverage* (9/18/13) and *IRS Guidance on Delay of Employer Shared Responsibility Reporting Requirements* (7/10/13)). At this point in time, it is prudent to assume that the employer shared responsibility requirement will take effect January 1, 2015.

This delay notwithstanding, an employer who will or may become subject to the employer shared responsibility requirement will want to assess its workforce with particular attention to variable hour employees. A *variable employee* is one for whom it cannot be reasonably determined at the time of hiring whether the individual will be regularly scheduled to work at least 30 hours per week. Examples of individuals who would likely fall into the variable employee category include, among others, substitute teachers and construction workers.

Generally, an individual's status as a full-time employee, i.e., working 30 or more hours per week, is determined on a month-by-month basis. This creates much complexity for employers as it relates to variable hour employees. The regulations would allow an employer to use a look-back period, known as a *measurement period*, to determine an individual's hours worked, based on this determination; at which point, the individual would be deemed full-time for a subsequent period, known as the *stability period*. For more details about these rules, see the CBIZ Health Reform Bulletin, *A Primer on ACA's Variable Employee Rules* (11/5/12). It is important to remember that this safe harbor is only available for variable hour employees, including seasonal employees. This methodology cannot be used for individuals who are clearly full-time. We anticipate getting further guidance on these matters in the relatively near future. In the meantime, it is prudent to begin gathering data if it is anticipated that this type of safe harbor will be used.

2014 MARKET REFORMS

Notwithstanding the employer-shared responsibility requirement delay, certain ACA market reforms take effect on plan anniversaries on or after January 1, 2014.

All group health plans, including grandfathered and non-grandfathered health plans, are subject to the following provisions:

- Ban on preexisting condition exclusions imposed on anyone;
- Full implementation of ban on annual limits on the dollar value of essential health benefits (EHB) (the prohibition of lifetime limits on EHBs has been in effect for several years);
- Extension of dependent coverage until age 26;
- Increased limit in outcome-based incentives/disincentives permitted in wellness programs from 20 to 30%; or, up to 50% for tobacco-free programs; and
- Ban on waiting periods exceeding 90 days.

In addition to the list of ACA provisions above, non-grandfathered health plans are subject to these ACA provisions in 2014:

- Fair health insurance premiums;
- Guaranteed availability of coverage;
- Guaranteed renewability of coverage;
- Ban on discrimination against health care providers ("any willing provider" type laws);
- Coverage for individuals participating in approved clinical trials;
- Inclusion of essential benefit coverage by insurers in the small group and individual markets; and
- Cost-sharing limitations. Following are the deductible and out-of-pocket limits that can be imposed by plans:
    - Deductible (only applicable to small insured plans offered in/outside Marketplace)
        - $2,000 for single coverage
        - $4,000 for coverage for more than one
    - Out-of-pocket (applicable to insured plans offered via the Marketplace, and insured and self-funded plans offered outside Marketplace)
        - $6,350 for single coverage
        - $12,700 for coverage for more than one

FIRST DOLLAR COVERAGE FOR PREVENTIVE HEALTH SERVICES: CONTRACEPTIVE COVERAGE MANDATE

ACA requires first dollar coverage for certain preventive health services in plans, such as screenings, preliminary testing and counseling. These services were expanded to include women's health preventive services including all FDA-approved contraceptive services beginning August 1, 2012. Church plans, defined as plans sponsored by a religious employer, are fully exempt from the mandate to cover contraceptive and related services.

Final regulations issued in June, 2013 provide for an accommodation for non-exempt, non-profit religious organizations that object to including contraceptive coverage on religious grounds (see CBIZ Health Reform Bulletin, *Women's Health Services Mandate Final Regulations – Exemption for Religious Employers and Non-Profit Religious Organizations*, 7/5/13).

Under this accommodation, a plan sponsored by an eligible organization is not required to arrange or pay for the objectionable benefit as long as it meets certain criteria. However, its insurer or third party administrator will have to include contraceptive coverage in the plan beginning January 1, 2014. Several lawsuits initiated by religious organizations objecting to inclusion of this coverage continue to wind their way through the courts. It is likely that these challenges will reach the Supreme Court.

With regard to for-profit entities objecting to the contraceptive coverage mandate, the Supreme Court has agreed to address the Freedom of Religion issue as it relates to the ACA's contraceptive coverage mandate. Specifically, the Supreme Court will review the issue of whether a corporation should be treated like an individual with regard to the First Amendment rights to Freedom of Religion, and the rights under the Religious Freedom Restoration Act (RFRA). The Supreme Court is expected to hear the case in March of 2014, with its decision expected in June 2014.

ONLINE SHOP ENROLLMENT DELAYED

The ACA provides small employers, currently those with fewer than 50 employees, the opportunity to purchase coverage through the Small Business Health Options Program (SHOP). On November 27, 2013, the HHS issued guidance and FAQs stating that employers wishing to purchase coverage through the SHOP should do so through a qualified agent or broker rather than through the on-line portal for this first year of compliance. The primary reason for purchasing coverage through the SHOP in 2014 is that it is the only way to obtain the small business tax credit, available only to employers employing 25 or fewer employees and who meet other criteria. The guidance also provides that for coverage to be effective by January 1, 2014, the coverage is to be bound by December 15, 2013 (or, December 23, 2014 for federal exchanges).

INDIVIDUAL SHARED RESPONSIBILITY REQUIREMENT

The individual shared responsibility requirement mandates that beginning January 1, 2014, virtually all individuals residing in the U.S. must maintain a minimum level of coverage, or risk a shared responsibility payment (see CBIZ HRBs, *Guidance and Updates* (9/11/13) and *Individual Minimum Essential Coverage*, 2/6/13)).

Individuals seeking health coverage can enroll through the HealthCare.gov website. For coverage to be effective on January 1, 2014, individuals must enroll by December 23, 2013. There will be no risk of penalty if individuals enroll through the Marketplace by March 31, 2014.

If the individual is eligible for an employer plan for which the anniversary is different from the calendar year, the individual will not be subject to individual shared responsibility requirement until the plan anniversary occurring on or after January 1, 2014 (see *Transition Relief* in the CBIZ HRB, *Guidance and Updates* (9/11/13).

PROPOSED BENEFIT AND PAYMENT PARAMETERS IN 2015

On December 2, 2013, the Department of Health and Human Services published proposed benefit and payment regulations addressing several issues applicable to the 2015 benefit year. Following are some of the proposals contained in the regulations:

- ***Transitional Reinsurance Fee.*** The goal of a transitional reinsurance program is to stabilize premiums in the individual market due to anticipated immediate enrollment of higher risk individuals. The reinsurance money would be used to offset the expenses of

the newly eligible individuals. For 2014, the contribution rate is $5.25 per covered life per month, or approximately $63, annually. The proposed annual reinsurance contribution rate to be collected in 2015 is $44 per enrollee.

In addition, HHS proposes to divide the payment of fees into two installments beginning in 2015: one in January and one in December.

Virtually, all-sized health plans, whether insured or self-funded are subject to the fees. However, according to the proposed regulations, a self-funded, self-administered plan where no third party administrator or other third party is used to administer the plan could be exempt from the fees in the 2015 and 2016 benefit years.

- ***2015 Open Enrollment Period.*** For benefit years beginning on January 1, 2015, the annual open enrollment period would begin November 15, 2014 and extend through January 15, 2015.

- ***Proposed 2015 Cost Sharing and Deductible Limits*.** In 2015, the maximum annual limitation on cost sharing would be $6,750 for self-only coverage and $13,500 for other than self-only coverage. In the small group market, for calendar year 2015, the maximum annual limitation on deductibles would be $2,150 for self-only coverage and $4,300 for other than self-only coverage.

HEALTH INSURANCE PROVIDER FEES

Beginning January 1, 2014, the ACA imposes an annual fee upon "covered entities" such as insurers who engage in providing health insurance for U. S. health risks. The assessed fees are apportioned amongst all applicable covered entities (insurers) based on a ratio of net premiums for insuring U. S. risks during the preceding calendar year as compared to the aggregate net premiums for that same year. The fee is assessed when net premiums covering US risks exceed $25 million for the previous year.

A few weeks ago, the IRS issued guidance addressing these fees and related reporting requirements in the form of final regulations, IRS Notice 2013-76 and IRS Revenue Ruling 2013-27.

For purposes of the fees, covered entities include:

- State-licensed health insurance companies;
- Federal or state-licensed HMOs;
- Entities providing health insurance under Medicare Advantage, Medicare Part D, or Medicaid; and
- Self-funded multiple employer welfare arrangements (MEWA).

Plans not subject to these fees include those sponsored by non-profit entities, such as VEBAs. Although employers who sponsor self-funded plans are exempt from these fees, there may be potential impact on stop-loss coverage by affected insurers.

The types of affected insurance coverage provided by covered entities not only include health insurance, but also on limited-scope dental and vision insurance, as well as, retiree-only insurance. Employee assistance programs and wellness programs are not considered health

insurance for purposes of this fee unless they provide significant benefits in the nature of medical care or treatment.

Although employers are not subject to these fees, the covered entity/insurer may pass along some of these costs to employer/policyholders. In this event, the IRS considers the fee to be part of the insurer's cost of doing business; and does not permit any exemption or exclusion from gross income it pays to offset the fees.

Covered entities are required to report their net premiums written during the prior year by filing the Form 8963 with the IRS by April 15th of the year in which the fee is due (by May 1st for the initial 2014 filing report).

YEAR-END REMINDERS

FORM W-2 REMINDER - AGGREGATE COST OF HEALTH COVERAGE

The Form W-2 must include the aggregate cost of health coverage for employers who issue 250 or more W-2's for the 2013 year. For details about this mandatory reporting, see these CBIZ Health Reform Bulletins, *Reminder: Fast Approaching Form W-2 Reporting Requirement* and *Additional IRS Guidance on W-2 Reporting Requirement*. The aggregate cost information is to be reported in Box 12, using Code DD.

SUMMARY OF BENEFITS AND COVERAGE

Under ACA, all group health plans, including grandfathered plans, whether insured or self-funded, are required to provide a Summary of Benefits and Coverage (SBC) to plan participants within certain timeframes:

1. Upon application;
2. By the first day of coverage;
3. Within 90 days of enrollment be special enrollees;
4. Upon contract renewal; and
5. Upon request.

For coverage beginning January 1, 2014 and before January 1, 2015, an SBC must include a statement about whether the plan does or does not meet minimum essential coverage standards and minimum value standard.

MARKETPLACE NOTICE OBLIGATION

All employers subject to Fair Labor Standards Act were to provide the initial notice of marketplace options to all employees by October 1, 2013. In addition, there is an on-going obligation to provide the Notice to all new hires within 14 days of hire. The p*urpose of the Notice* is to explain important information about the pros and cons of buying coverage through the marketplace. The DOL provides model notices that can be used by employers who offer health coverage to some or all employees, and for those who do not offer coverage.

PATIENT-CENTERED OUTCOMES RESEARCH INSTITUTE FEE

One of the ACA fees imposed on both insured and self-funded health plans is the Patient Centered Outcome Research (PCOR) fee. The purpose of this fee is to fund a Patient-Centered Outcome Research Trust Fund. This Trust Fund, in turn, supports a Patient-Centered Outcomes Research Institute to assist patients, clinicians, purchasers, and policymakers in making informed health decisions by advancing comparative clinical effectiveness research.

This fee and types of plans subject to the fee are more fully described in the CBIZ Health Reform Bulletins, *Reporting and Paying PCOR Fees – Revised Form 720 Issued* (6/4/13) and *Final Regulations Issued: Patient-Centered Outcomes Research Fees* (12/11/12).

The fee, required to be reported annually to the IRS on the second quarter Form 720 and paid by its due date, July 31, is based on the average number of lives covered under the policy or plan. For policy and plan years ending after Sept. 30, 2012, and before Oct. 1, 2013, the applicable dollar amount is $1. For policy and plan years ending after Sept. 30, 2013, and before Oct.1, 2014, the applicable dollar amount is $2. For additional information about the PCOR fee, see IRS webpage, questions and answers and chart of plans subject to the fees.

About the Author: Karen R. McLeese is Vice President of Employee Benefit Regulatory Affairs for CBIZ Benefits & Insurance Services, Inc., a division of CBIZ, Inc. She serves as in-house counsel, with particular emphasis on monitoring and interpreting state and federal employee benefits law. Ms. McLeese is based in the CBIZ Leawood, Kansas office.

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CBIZ
Health Reform Bulletin

Subject: **Excepted Benefit Proposed Regulations**
Date: January 6, 2013

One of the many challenges presented by the Affordable Care Act (ACA) relates to what are known as "excepted benefits". *Excepted benefits* are exempt from some, but not all laws impacting employee benefits including but not limited to the HIPAA portability rules, as well as the market provisions of the ACA. On December 24, 2013, the ACA's governing agencies (DOL, IRS and HHS) issued proposed regulations addressing certain of these excepted benefits; specifically, limited-scope dental and vision benefits and employee assistance programs (EAPs). In addition, the regulations propose a new type of excepted benefit known as a "limited wraparound benefit".

LIMITED-SCOPE DENTAL AND VISION BENEFITS

As background, a limited scope dental or vision benefit is excepted if coverage is provided under a separate and independent policy; or, if it is not a separate and independent policy, for example, in the case of a self-funded situation, the dental or vision plan is not integral with the health plan. What this means is that the participants must have the right to elect or decline the dental or vision coverage; and if elected, there must be a separate cost for the coverage. These regulations propose to eliminate the separate cost requirement. Thus, a limited scope dental or vision plan, including a self-funded plan, can be excepted without obligating the plan to charge a separate premium for the benefit.

EMPLOYEE ASSISTANCE PROGRAMS (EAP)

Generally, an EAP that provides significant coverage in the form of medical benefits is subject to the ACA. Guidance to date provides that as long as the medical care provided by the EAP is not significant, the EAP would be considered excepted. These regulations propose that in 2015 and beyond, four conditions must be met for the exception to apply:

1. The EAP cannot provide significant medical care.
2. The benefits under the EAP cannot be coordinated with another health benefit plan. Specifically, health coverage cannot be contingent upon first accessing coverage under the EAP, and the EAP benefit cannot be contingent on participating in the health plan.
3. The EAP cannot be financed by another group health plan.
4. There cannot be any cost-sharing imposed by the EAP.

LIMITED WRAPAROUND COVERAGE

The regulations propose a third type of excepted benefit known as a limited "wraparound" benefit. Relevant to employers subject to ACA's shared responsibility requirement, the wraparound coverage would be available to individuals for whom the employer coverage is deemed unaffordable. Important to this wraparound coverage is that the employer must offer coverage that meets both minimum value (pays at least 60% of total allowed cost of benefits under the plan) and is affordable (the employee's contribution does not exceed 9.5% of his/her household income) for the majority of its employees.

The premise behind the wraparound coverage is that if the employer coverage is unaffordable to certain employees, the employee could forego the employer coverage and obtain individual coverage together with the wraparound coverage. The employer would, of course, risk an employer shared responsibility penalty for failure to offer adequate coverage at an affordable rate. Therefore, whether this wraparound concept will be attractive to employers remains to be seen.

Requirements of Wraparound Coverage

According to the proposed regulations, wraparound coverage would be deemed an excepted benefit if all of the following criteria are met:

1. The wraparound coverage must be coordinated with a non-grandfathered individual policy. The individual policy cannot be excepted coverage.
2. The wraparound coverage must cover non-essential health benefits, or reimburse the cost of care provided by out-of-network health care providers, or both. And, such coverage can cover cost-sharing under the individual policy; though, the coverage of cost sharing cannot be the only benefit that the wraparound policy provides.
3. The plan sponsor offering such wraparound coverage must sponsor another group health plan that meets the minimum value standard and the affordability standard for a majority of its employees. Only individuals eligible for this primary plan may be eligible for the wraparound coverage.
4. The cost of the wraparound coverage can be no greater than 15%, including both the employer and employee share, of the cost of the primary coverage.
5. The wraparound coverage cannot discriminate as to eligibility, benefits, or premiums based on health status; nor can it discriminate as to salary.

EFFECTIVE DATE

Comments on these proposed regulations must be submitted by February 24, 2014. Employers can rely on these proposed regulations for purposes of limited scope dental and vision plans, and for EAPs. If final guidance is more restrictive, its effect will be prospective. Time will tell whether and how the rules surrounding the wraparound benefit proposal plays out. This wraparound concept is not available until regulations become final; at the earliest, this would be 2015.

About the Author: Karen R. McLeese is Vice President of Employee Benefit Regulatory Affairs for CBIZ Benefits & Insurance Services, Inc., a division of CBIZ, Inc. She serves as in-house counsel, with particular emphasis on monitoring and interpreting state and federal employee benefits law. Ms. McLeese is based in the CBIZ Leawood, Kansas office.

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CBIZ
Health Reform Bulletin

Subject: **Implementation Guidance FAQs**
Date: January 13, 2014

The ACA's governing agencies (Labor, HHS and IRS) have issued their 18th set of implementation FAQs, further defining certain aspects of the Affordable Care Act, as well as how the law coordinates with the *Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008* (MHPAEA). Following are highlights of this guidance.

WOMEN'S PREVENTIVE HEALTH SERVICES EXPANDED

The ACA requires individual and group health plans to provide coverage for certain preventive services without imposing any cost-sharing requirements (co-payment, co-insurance, or deductible), when such services are delivered by in-network providers. These rules apply to both non-grandfathered individual and group health plans, including both insured and self-funded plans; the rules do not apply to grandfathered plans.

The types of preventive services to be covered are those recommended by several agencies, including the United States Preventive Services Task Force. Last fall, this Task Force expanded its recommended guidelines relating to women's health services to include coverage for certain medications for women who have a high risk for developing breast cancer. As such, women's health preventive services must now include coverage for these risk-reducing medications without cost share where applicable as part of a medical management regime.

This will take effect for plan years beginning on or after September 24, 2014 (January 1, 2015 for calendar year plans).

COST SHARING REQUIREMENT

These FAQs affirm that for plan years beginning on or after January 1, 2015, the out of pocket limit on essential health benefits must be satisfied, even if the plan uses different service providers. These FAQs do state that a plan may apply unique limits to certain benefits as long as in the aggregate, the out of pocket limit is satisfied. For 2014, the out-of-pocket limit (applicable to insured plans offered via the Marketplace, and insured and self-funded plans offered outside the Marketplace) is $6,350 for single coverage; $12,700 for coverage for more than one. The FAQs affirm previous guidance stating that out of pocket limits only apply to in-network benefits. A plan can, but is not required to impose the out of pocket limit on other network benefits.

EXPATRIATE PLANS

These FAQs affirm previous guidance relating to insured plans covering ex-patriots living outside the United States. In a nutshell, for plans ending prior to December 31, 2015, expatriate plans are exempt from certain ACA provisions, including many of the market-type reforms, such as the dependent age restriction, prohibition of imposing annual and lifetime limits and preexisting condition exclusions, prohibition of plan rescission, coverage for preventive services, as well as certain reporting and disclosure obligations. For this exemption to apply, the plan must have been in

compliance with the other benefit-related federal laws enacted prior to the ACA, such as ERISA and HIPAA. This exemption only applies to insured group health plans covering primary insureds and their covered dependents who live outside the United States for at least 6 months of the year. Further, the FAQs affirm that coverage provided under an insured expatriate health plan is considered to meet the minimum essential coverage requirement.

WELLNESS PROGRAMS

- ***Tobacco surcharges***. Under an outcome-based wellness program, also known as a health-contingent wellness program, offered in connection with a group health plan, the maximum financial incentive offered to participants is 30% of the cost of coverage; or, up to 50% if the program relates to tobacco free standards. These FAQs affirm that as long as an individual is given an opportunity to achieve the reward at least once per year, the individual would not have to be given the reward at another time during the plan year, even if the conditions for receiving the reward are satisfied.

- ***Reasonable Alternative***. If a participant's health care provider states that an outcome-based program is not advised for him/her, and recommends an activity-only program, the FAQs affirm that the participant should be permitted to explore any available alternative options for achieving the goal that is appropriate for him/her.

  Notice of Availability of Reasonable Alternative Options. A plan is required to include a notice of available alternative options in its plan materials of how to qualify for a reward if an alternative option is recommended by his/her health care provider, or is otherwise available through the wellness program. This FAQ affirms that the language of the model notice (below) can be modified as long as the substance of it is included. Following is some model language that can be used to satisfy the notice requirement:

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

FIXED INDEMNITY PLANS

Generally, a fixed indemnity plan is only deemed to be an excepted benefit, i.e., not subject to the ACA's market reform provisions, if it reimburses a fixed dollar amount per day (or per other period) of hospitalization or illness, regardless of the amount of expenses incurred. Typically, these types of policies are provided under separate contract and are not coordinated with a group health plan.

According to these FAQs, the HHS is proposing to make modifications to individual fixed indemnity policy design such that benefits would not be paid solely on a per-period basis to qualify as an excepted benefit. As such, the policy would have to meet the following criteria:

1. It is sold only to individuals who have other health coverage that is minimum essential coverage;
2. There is no coordination between the provision of benefits and an exclusion of benefits under any other health coverage;

3. The benefits are paid in a fixed dollar amount regardless of the amount of expenses incurred and without regard to the amount of benefits provided with respect to an event or service under any other health coverage; and
4. A notice is displayed prominently in the plan materials informing policyholders that the coverage does not meet the definition of minimum essential coverage and will not satisfy the individual responsibility requirements of the ACA.

COORDINATION OF ACA AND MENTAL HEALTH PARITY LAWS

FAQ 12 affirms that individual health insurance policies, both grandfathered and non-grandfathered, that provide mental health benefits, as well as non-grandfathered small group health insured plans are subject to the federal mental health parity laws (the *Mental Health Parity Act* (MHPA), as amended by the *Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008* (MHPAEA)). These types of policies and plans become subject to the mental health parity laws for plan years beginning on or after July 1, 2014 (January 1, 2015 for calendar year plans). In effect, this leaves only small grandfathered group health insured plans exempt from the mental health parity laws. As a reminder, the federal mental health parity laws have applied to large group health plans (plans covering 50 or more employees) since its inception.

About the Author: Karen R. McLeese is Vice President of Employee Benefit Regulatory Affairs for CBIZ Benefits & Insurance Services, Inc., a division of CBIZ, Inc. She serves as in-house counsel, with particular emphasis on monitoring and interpreting state and federal employee benefits law. Ms. McLeese is based in the CBIZ Leawood, Kansas office.

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CBIZ
Health Reform Bulletin

Subject: **Certification of Compliance with Electronic Transaction Requirements**
Date: January 23, 2014

On January 2, 2014, HHS published proposed regulations relating to certification of compliance with the electronic transaction requirements of the Affordable Care Act (ACA). These regulations are only proposed at this point. Nevertheless, it is a good time to review certain requirements imposed on health plans; these rules are particularly significant to self-funded health plans.

Generally, a plan sponsor contracts with a business associate, such as a third party administrator (TPA) to handle its claim process. Therefore, most of the compliance described below will be accomplished by the TPA. The plan sponsor will want to ensure that its business associate agreement clearly requires the TPA to be compliant with the electronic transaction and operating rules required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) administrative simplification rules, and subsequent laws including the Health Information Technology for Economic and Clinical Health Act (HITECH) and the ACA.

As background, the administrative simplification standards required under the *Health Insurance Portability and Accountability Act of 1996* (HIPAA) include three components: health care privacy rules, security of health data rules, and the electronic data interchange (EDI) rules. The EDI rules govern electronic transactions between health plans, providers, and health care clearinghouses. Examples of administrative and financial health care transaction standards include:

- Health claims and equivalent encounter information;
- Enrollment and disenrollment in a health plan;
- Eligibility for a health plan;
- Health care payment and remittance advice;
- Health plan premium payments;
- Health claim status;
- Referral certification and authorization; and
- Coordination of benefits.

The ACA modifies certain aspects of EDI rules, now known as the electronic transaction rules. These rules require the "controlling health plan" to obtain a unique health plan identifier (HPID). A *controlling health plan* (CHP) is a health plan that controls its own business activities, actions and policies; or is controlled by an entity that is not a health plan. A CHP may control the business activities, actions and policies of one or more "subhealth plans" ("SHP"). A SHP is a health plan whose business activities, actions or policies are controlled by a CHP. Certainly, more clarity surrounding these definitions would be useful. In the meantime, it can be assumed that a single employer self-funded plan would be considered a CHP.

A CHP or SHP obtains a health plan identifier (HPID) by an on-line application process through the CMS Enterprise Portal (https://portal.cms.gov/). Steps in the application process include:

1. A registration process with the CMS portal to obtain a user ID and password. The type of information required for registration includes:
    - Company information (company name, Federal Employer Identification Number and domiciliary address);
    - Authorizing official information (name, title, phone number and e-mail address); and
    - The health plan's NAIC number or Payer ID used in standard transactions.
2. Determination and designation of the user's role for purposes of managing and accessing company information.
3. Selection of the particular application type as a CHP or SHP.
4. Review and submission of the application.

Once the application has been submitted, the entity's authorized official will be notified of the pending application. If the application is approved, the entity's authorized official will be notified by e-mail of its assigned HPID number.

Large health plans must obtain an HPID by November 5, 2014; by November 5, 2015 for small plans (those annual receipts of $5 million or less). The use of an HPID for all plans must begin by November 7, 2016.

Once the CHP or SHP obtains a HPID, it must certify that it is in compliance with certain standards for electronic transactions, as well as certain operating procedures. The regulations specifically require certification for compliance with applicable standards and operating rules for:

- Eligibility for a health plan transactions;
- Health care claim status transactions; and
- Health care electronic funds transfers (EFT) and remittance advice transactions.

Certification can be accomplished in one of two ways:

1. Obtain a certification seal for Phase III CAQH CORE Operating Rules by the Council for Affordable Quality Healthcare's Committee on Operating Rules for Information Exchange (CAQH CORE); or
2. A HIPAA Credential. In order to receive a HIPAA Credential, a CHP must sign an attestation that states that the CHP has successfully tested with at least three trading partners that collectively conduct at least 30% of the CHP's transactions with providers (among other requirements).

The certification schedule is as follows:

- A CHP that obtained a HPID (pursuant to the HIPAA rules) prior to January 1, 2015 would be required to certify its compliance with its data and information systems by December 31, 2015.
- A CHP that obtains a HPID on or after January 1, 2015 is required to certify compliance by January 1, 2016.

This proposed rule also establishes penalty fees for CHPs that do not comply with the certification of compliance requirements.

NEXT STEPS

- ❑ Insured health plans are generally not directly impacted by these rules as the insurer is responsible for the electronic transactions, including certification of compliance and obtaining a unique health plan identifier.
- ❑ A self-funded plan should:
  - ◆ Ensure its business associate agreement requires the TPA to comply with electronic transaction rules; and
  - ◆ Work with the TPA to ensure compliance with the certification responsibilities as they become required.
- ❑ Apply for a unique health plan identifier. Consult with the TPA for any assistance it can provide in obtaining the HPID well before the compliance date.

About the Author: Karen R. McLeese is Vice President of Employee Benefit Regulatory Affairs for CBIZ Benefits & Insurance Services, Inc., a division of CBIZ, Inc. She serves as in-house counsel, with particular emphasis on monitoring and interpreting state and federal employee benefits law. Ms. McLeese is based in the CBIZ Leawood, Kansas office.

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CBIZ
Health Reform Bulletin

Subject: **Final Rules Addressing the Employer Shared Responsibility Requirement**
Date: February 12, 2014

One of the centerpieces of the Affordable Care Act (ACA) is the so-called employer shared responsibility requirement. This requirement, which was to take effect on January 1, 2014, and was subsequently delayed until 2015, is the subject of final regulations issued today.

As background, the employer shared responsibility requirement applies to employers employing 50 or more employees. It requires affected employers to offer a certain standard of health coverage to their employees working 30 or more hours per week, or risk one of two penalties (see CBIZ *Health Reform Bulletins*, *Shared Responsibility Guidance* (1/9/13) and *Employer Shared Responsibility Reporting Requirements Delayed*, 7/3/13).

The final regulations do not change the requirement that employers offer coverage or risk a penalty; however, they do provide a limited reprieve for certain employers. It should be noted that for purposes of determining employer size in the first year of compliance, affected employers can use any consecutive 6-month period occurring in the preceding calendar year.

Employers employing between 50 and 99 full-time (plus full-time equivalent) employees in 2014 will not be subject to the employer shared responsibility requirement, generally, until their plan anniversary occurring in 2016, as long as the employer does not materially reduce the health benefits offered as of February 9, 2014. To maintain its level of benefits, the employer must continue its contribution toward single coverage (the employer contribution must be maintained at least 95% of its level as of that date) and the employer must continue to maintain the class of employees and dependents to whom coverage is offered. The employer will be required to certify that it has maintained this status on a form yet to be provided.

Employers employing 100 or more employees are subject to the employer shared responsibility requirement, effective January 1, 2015. Though, if an employer maintains a non-calendar year plan year as of December 27, 2012 and has not changed the plan year since that date, the employer, generally, will become subject to the requirement on its plan anniversary occurring on or after January 1, 2015.

These regulations do provide that while an employer generally must offer minimum essential coverage to at least 95% of its full-time employees in order to avoid the IRC §4980H(a) penalty (the $2,000 penalty), the 95% requirement is reduced to 70% through the end of the 2015 plan year. Furthermore, for the 2015 plan year, should the employer not offer minimum essential coverage to at least 70% of its full-time employees and at least one of those employees obtains cost-sharing or premium credit through the marketplace, the penalty is calculated by taking the total employee count, minus the first 80 employees, times $2000. The above notwithstanding, it is important to remember that the IRC §4980H(b) penalty (the $3,000 penalty) may still be imposed if a full-time employee qualifies for premium assistance when purchasing coverage through the marketplace.

Full-time Employee Definition

The final regulations include rules similar to the proposed regulations. They allow a month-by-month determination of full-time employee status. As an alternative, for individuals for whom it is not clear at the time of hire whether they will be full-time, i.e., working 30 or more hours per week, the rules permit the use of a measurement/stability period.

The final regulations also address issues relating to non-traditional work situations. As a general statement, the rules require a reasonable allocation of time to be granted for work performed. A few examples are:

- *On-call employees*. A reasonable method must be used to credit time that an employee is obligated to be "on call".
- *Adjunct faculty*. For adjunct faculty members, a reasonable amount of time must be allocated for time worked. The regulations include a safe harbor of sorts that requires 75 minutes per hour of class time allocated to preparation. In addition, time must be counted if the individual is required to attend a faculty meeting.
- *Airline personnel*. For employees such as airline pilots who are subject to layovers, a reasonable amount of time, such as 8 hours in a day, must be granted for layover time.
- *Bona fide volunteers*. The regulations verify that volunteers, both government volunteers such as emergency responders and firefighters and the like, as well as volunteers for not for profit entities, need not be counted as employees for purposes of the shared responsibility requirement.
- *Members of a religious order* who have taken a vow of poverty need not be counted as employees for performing duties for the religious entity.
- *Seasonal employee.* The final regulations provide that a seasonal employee who generally works less than six months per year and generally works at the same time each year, such as a ski instructor in the winter or life guard in the summer, is not deemed to be a full-time employee for penalty purposes.

There is much more to these final rules than is included here. Over the weeks to come, we will analyze specific parts of the regulations and provide summaries on unique aspects of the regulations such as matters relating to school employees, matters relating to breaks in service, and matters relating to change in status. These are just a few of the individualized summaries that you can expect.

Additional Treasury Department and IRS information relating to final regulations:

- Fact Sheet
- Questions and Answers

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CBIZ
Health Reform Bulletin

Subject: **Final Rules – 90-Day Waiting Period**
Date: February 24, 2014

The Affordable Care Act (ACA) requires all health plans to comply with a waiting period that is no longer than 90 calendar days, effective for plan years beginning on or after January 1, 2014. Today, final regulations defining this requirement have been issued by the ACA's governing agencies (IRS/DOL/HHS). This provision applies to virtually all types of plans, including insured and self-funded plans, whether grandfathered or not, and without regard to plan size.

90-DAY WAITING PERIODS

In large part, the final regulations followed previously issued guidance. In summary, the regulations affirm that the maximum waiting period that can be imposed by plans is 90 calendar days. If the 91st day falls on a weekend, and if coverage cannot commence that day, the applicability date cannot be carried forward to the next business day. If coverage can only commence on a business day, it would have to begin on the last business day prior to the expiration of the 90-day waiting period.

The regulations affirm that the 90-day waiting period is a one-time occurrence and cannot be imposed over and over again unless the individual's employment terminates and the individual is re-hired. However, the regulations underscore that an individual cannot be terminated and re-hired as a way to avoid the requirement.

Effective date. These final regulations apply to group health plans for plan years beginning on or after January 1, 2015. For plan years beginning in 2014, plans must comply with either the proposed rules or the final rules.

Background CBIZ Health Reform Bulletins – 90-day waiting period:

- *ACA Updates: 90-Day Waiting Period Limitation* (2/10/12)
- *Guidance Issued Relating to 90-day Waiting Period and Defining Full-time Employee* (9/4/12)
- *90 Day Wait and Other Updates* (3/26/13)
- *See 90-day Waiting Period in Guidance and Updates* (9/11/13)

ORIENTATION PERIOD

The ACA governing agencies also released today a proposed regulation relating to orientation periods. This regulation would allow the imposition of a one-month orientation period prior to the start of a waiting period. The orientation period would be a time of assessment to determine whether an individual has the requisite qualifications, licensure, or other standard to perform the job. The regulations propose that the way to calculate the one-month orientation period is to add one calendar month and subtract one calendar day; after which time, the maximum 90-day waiting period would have to commence. The preamble to the regulation indicates that orientation periods are only used infrequently.

Effective date. Comments on the proposed regulation must be received by April 25, 2014. This provision may be relied upon at least through the end of 2014.

CONFORMING CHANGES TO HIPAA RULES

Effective for all individual and group health plans, both grandfathered and non-grandfathered plans, whose plan anniversary occurs on or after January 1, 2014, no preexisting condition exclusion can be imposed on anyone. The final regulations issued today include additional examples on what constitutes a preexisting condition, all of which are impermissible.

Because of this ACA provision, several conforming changes were required to be made to the following HIPAA portability rules:

- Late and special enrollment periods;
- HMO affiliation periods; and
- Prohibiting discrimination against participants and beneficiaries based on a health factor.

Effective date. These changes to the HIPAA portability rules apply to group health plans for plan years beginning on or after April 25, 2014. Until these amendments to the existing HIPAA rules regulations become applicable, plans are required to continue to comply with the existing rules, as applicable.

Certificates of Creditable Coverage. Beginning January 1, 2015, plans of all sizes, insured or self-funded, and grandfathered or not, are no longer required to provide a Certificate of Creditable Coverage. This should come as a ray of sunshine amidst all of the increased burden placed on HR departments as a result of ACA.

WHAT SHOULD AN EMPLOYER DO?

Review your health plan. Make certain it is or will be compliant with the waiting period restriction by the first plan year beginning on or after January 1, 2014. Note: the consequence of failing to comply with this requirement is significant-- $100 per employee/per day of noncompliance. The minimum excise tax for a compliance failure is $2,500, up to $15,000 if the violations are determined to be more than '*de minimis'*. The maximum excise tax for unintentional failures for a single employer plan is the lesser of 10% of the amount paid during the preceding tax year by the employer for the group health plan, or $500,000. However, no maximum cap applies if the failure to comply is intentional.

Also note, some state insurance laws, California, for example, have more restrictive waiting periods. If a health plan is insured, it must comply with the relevant state's insurance law.

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Subject: **Exploring the Final Employer Shared Responsibility Regulations**
Date: March 10, 2014

Introduction

As follow-up to our earlier Health Reform Bulletin (see *Final Rules Addressing the Employer Shared Responsibility Requirement*, 2/12/14), below is a further analysis of certain aspects of the final employer shared responsibility regulations issued on February 12, 2014.

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EMPLOYERS SUBJECT TO THE ACA'S SHARED RESPONSIBILITY REQUIREMENT

Employer Defined. The shared responsibility rules apply to all public and private 'large employers' employing an average of at least 50 full-time employees ("FTE"), including full-time equivalent employees ("FTEE") on business days during the preceding calendar year. Affected large employers include those organized as for-profit entities, non-profit entities including churches, as well as federal, state and local government entities.

Applicability of the control group rules. All employees of a controlled group of entities under IRC Sections 414(b) or (c), or an affiliated service group under IRC Sections 414(m) or (o) are taken into account in determining whether the members of the controlled group or affiliated service group together are an applicable large employer. It should be noted, however, that any penalty imposed against entities of a control group or affiliated service group are applied separately to the individual entity. It should also be noted that the term 'employer' includes a predecessor employer and a successor employer.

Determining applicable status. An employer determines if it is subject to the shared responsibility requirement for a current year by counting the number of its FTEs (those working 30 or more hours per week) together with its FTEEs (those working less than 30 hours per week; for example, two individuals each working on average 15 hours per week equate to one FTEE) employed during the prior calendar year.

Step 1. For each month of the prior year, the employer counts the:

- ❑ Number of FTEs; ***plus***
- ❑ Number of FTEEs (determined by adding up the hours worked by FTEEs for the month, not exceeding 120 hours per employee, and then dividing by 120).

Step 2. Add the resulting totals from Step 1 for each month in the prior year and divide by 12 to obtain the prior year average.

- ❑ If the result of this calculation is less than 50, the employer would not be deemed to be an applicable large employer for the current calendar year.
- ❑ If the result of this calculation is 50 or more, the employer would be deemed an applicable large employer for the current calendar year, unless a seasonal worker exception applies.

Seasonal worker exception. For purposes of counting employees, the regulations provide an exception for employers employing seasonal workers. An example of a seasonal worker is a retail worker employed exclusively during holiday seasons. If an employer's workforce exceeds 50 FTEs for 120 days or fewer during a calendar year, and the employees in excess of 50 who were employed during that period were seasonal workers, the employer would not be considered an applicable large employer.

TRANSITION RELIEF RULES

First year transition relief. For purposes of determining applicable status for the first year of implementation, an employer can determine whether it is an applicable large employer for 2015 by calculating the number of its employees employed on business days in any consecutive six-month period in 2014, as chosen by the employer.

New employer. If an employer did not exist in prior calendar year, and if it can be reasonably anticipated that the employer will employ 50 or more employees, then the shared responsibility requirements will apply.

Employers employing between 50 and 99 FTEs (plus FTEEs) in 2014 will not be subject to the employer shared responsibility requirement, generally, until their plan anniversary occurring in 2016, as long as the employer does not materially reduce the health benefits offered as of February 9, 2014. Further, the employer cannot change the plan year after February 9, 2014. To maintain its level of benefits, the employer must continue its contribution toward single coverage (the employer contribution must be maintained at least 95% of its level as of that date), and the employer must continue to maintain the class and workforce size of its employees and dependents to whom coverage is offered. The employer will be required to certify that it has maintained this status on a form yet to be provided.

Employers employing 100 or more employees are subject to the employer shared responsibility requirement, effective January 1, 2015.

Transition Relief for Non-Calendar Year Plan Years. The final regulations retain the non-calendar year plan year transition rules (see 'Effective Date' discussion in the CBIZ Health Reform Bulletin, *Shared Responsibility Guidance*, 1/9/13) replacing relevant dates to correspond to the 2015 plan year. It is important to note that this transition relief is only available if the non-calendar year plan year has not been changed since December 27, 2012. Also note, the final regulations add an

additional way to comply which we will call the 'full-time employee percentage transition method". According to this method, compliance with the employer shared responsibility provisions will apply on the plan anniversary occurring in 2015 as long as during the 12-month period ending on February 9, 2014, the plan either covered at least one-third of all full-time employees, or was offered to at least one-half of all full-time employees.

These regulations do provide that while an employer generally must offer minimum essential coverage to at least 95% of its FTEs in order to avoid the IRC §4980H(a) penalty (the $2,000 penalty), the 95% requirement is reduced to 70% through the end of the 2015 plan year (see CBIZ *Health Reform Bulletins*, *Shared Responsibility Guidance* (1/9/13) and *Employer Shared Responsibility Reporting Requirements Delayed*, 7/3/13). Furthermore, for the 2015 plan year, should the employer not offer minimum essential coverage to at least 70% of its FTEs and at least one of those employees obtains cost-sharing or premium credit through the marketplace, the penalty is calculated by taking the total employee count, minus the first 80 FTEs (for 2015 plan year only; the first 30 FTEs for years thereafter), multiplied by 1/12 of $2,000.

Even if the 70% threshold is met for the 2015 plan year, it is important to remember that the IRC §4980H(b) penalty (the $3,000 penalty) may still be imposed if an FTE qualifies for premium assistance when purchasing coverage through the marketplace. The amount of the penalty for the month is equal to the number of FTEs who receive a premium tax credit for that month multiplied by 1/12 of $3,000.

Next Steps

- ❑ Monitor the size of your workforce. This is especially important for employers whose workforce size hovers around the threshold for being subject to the law.

WHO IS AN EMPLOYEE AND HOW IS AN EMPLOYEE CLASSIFIED FOR ACA'S EMPLOYER SHARED RESPONSIBILITY REQUIREMENT?

Generally, for the employer shared responsibility provisions, an employee is full-time if the employee works, on average, 30 or more hours per week. In many situations, an employee's status is not clear. To this end, the recently issued final regulations provide two methods: a *monthly method* and a *look-back method* that can be used for determining full-time status as it relates to the potential assessment of an employer shared responsibility penalty. The monthly method looks at hours worked in a month to determine full-time status for that month. The look-back method uses a look-back period, known as a measurement period, to assess hours worked. Based on hours worked during the look-back (measurement) period, an individual's status as full-time or not full-time is set for an entire stability period. Following are some definitions that are important for this analysis.

Definitions

An ***administrative period*** refers to an optional period selected by the employer of up to 90 days beginning immediately following the end of a measurement period and ending immediately before the start of the associated stability period. The term also includes the period between a new employee's start date and the beginning of the initial measurement period, if the initial measurement period does not begin on the employee's start date.

Employee is defined as a common-law employee. The term *does not* include:

- A leased employee;
- A sole proprietor, a partner in a partnership, or a two-percent S corporation shareholder; or
- Real estate agents and direct sellers ("IRC Section 3508 employees").

A ***full-time employee*** is defined as one who works for an employer an average of at least 30 hours per week. An employee who works 130 hours of service in a calendar month is deemed to meet the monthly equivalent of the 30 hours of service per week standard, as long as this equivalency rule is applied consistently.

Hour of service means each hour for which an employee is paid for the performance of duties for the employer. The term also includes each hour for which an employee is paid for a period of time during which no duties are performed, such as vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty or leave of absence.

An ***initial measurement period*** is a period of 3 to 12 consecutive months, measured forward from the date of hire. Or, the initial measurement period can run from the first of the month or first payroll period following the date of hire.

An ***initial stability period*** is a period of time in which the individual is deemed full-time, or not full-time, based on hours worked during the initial measurement period; it must be the same duration as the standard measurement period. If, based on hours worked during the initial measurement period, the individual is deemed not full-time, then the corresponding stability period must end at the commencement of the standard stability period that is coincident with the first standard measurement period occurring after the individual's date of hire.

A ***part-time employee*** means a new employee who is reasonably expected to be employed on average less than 30 hours of service per week during the initial measurement period, based on the facts and circumstances at the employee's start date.

A ***seasonal employee*** is an individual who, on an annual basis, works 6 months or less and is generally employed at the same time each year, such as a ski instructor or a summer lifeguard.

A ***standard measurement period*** is a period of time defined by the employer equaling 3 to 12 consecutive months which is used to measure hours worked for variable employees. The standard measurement period is the same for all individuals in a class of employees. Different standard measurement periods can be used for different classifications of employees; though, the only classifications allowed are:

- Collectively bargained employees and non-collectively bargained employees;
- Each group of collectively bargained employees covered by a separate collective bargaining agreement;
- Salaried employees and hourly employees; and
- Employees whose primary places of employment are in different states.

A ***standard stability period*** is a period of time for which a variable employee is deemed to be full-time or not full-time, based on hours worked during a standard measurement period of more than 6 calendar months, or the length of the standard measurement period.

A ***variable employee*** is one whose work schedule varies, such that it is not known at the point of hire whether the individual will, on average, work 30 or more hours per week. The term variable employee includes *seasonal employees.* An ***on-going variable employee*** is one who has worked a full standard measurement period.

Calculating hours of service

For purposes of determining the number of hours of service an employee works, actual working hours are counted, plus hours in which an employee is paid but does not work, such as vacation, holiday, sick leave, disability leave, layoff, military duty or other paid leave of absence, are also counted. In addition, under the look-back method (see below) certain unpaid hours of service, such as FMLA leave, USERRA leave and jury duty, are counted.

The final regulations clarify that *hours of service* does not include services:

- Performed by government volunteers such as emergency responders and firefighters, as well as volunteers for not for profit entities;
- Performed by members of a religious order who have taken a vow of poverty;
- Received as part of a work-study program, or
- Received as compensation for services performed outside the United States. Note, only hours of service in the 50 states and the District of Columbia are counted. Hours of service outside the U.S., including the U.S. territories, are not counted.

With regard to unique workforces, the final regulations clarify the calculation of hours of services for:

- *On-call employees*. A reasonable method must be used to credit time that an employee is obligated to be "on call".
- *Adjunct faculty.* For adjunct faculty members, a reasonable amount of time must be allocated for time worked. The regulations provide a safe harbor of sorts that require 75 minutes per hour of class time allocated to preparation, or the use of any other reasonable method for calculating hours of service. In addition, other obligatory time required of the individual, such as required office hours, must be counted.
- *Airline personnel.* For employees such as airline pilots who are subject to layovers, a reasonable amount of time, such as 8 hours in a day, must be granted for layover time.

Determining Full-time Employee Status

For purposes of determining full time employee status for employer shared responsibility purposes, a monthly determination can be used. Alternatively, a look-back methodology can be used.

The ***monthly methodology*** looks at hours worked in a month and based on those hours worked, an individual's status is determined. If an individual is hired as a full-time employee (as defined above) and as long as that individual is offered health coverage that meets minimum value and is affordable by the first of the fourth month following the date of hire, then the employer would not be at risk of a shared responsibility penalty for that individual, even for the first 3 months. Note, however, that the maximum waiting period that can be imposed is 90 calendar days (see CBIZ Health Reform Bulletin, *Final Rules – 90-Day Waiting Period*, 2/24/14). The monthly methodology determination is really only practical for individuals who consistently work 30 or more hours per week; or, those who consistently work fewer than 30 hours per week. It is an impractical methodology when applied to individuals whose hours vary in that an individual's hours would not be known until the end of the month, at which time it would be too late to offer health coverage for that month. For this reason, the use of a look-back method is allowed.

A ***look-back method*** is based on the premise that hours worked are calculated during a measurement period. Based on those hours worked, an individual is deemed full-time or not full-time. The initial look-back method runs from the individual's date of hire or shortly thereafter. An employer is allowed to use, for example, the first of the month following the date of hire. The advantage to this methodology is that the employer would only have up to 12 initial measurement periods to monitor in any 12-month period. The initial measurement period can run 3 to 12 months, and may be followed by an administrative period. The combined measurement and administrative periods cannot exceed 13 months, plus a fraction of a month, measured from the date of hire.

To move from initial employee status to on-going employee status, the individual must be measured as an on-going employee beginning with the first standard measurement period that occurs after the date of hire. For this purpose, an *on-going employee* is an employee who has been employed for at least one standard measurement period.

Examples. See *Illustrative Examples* on pages 11 to 13. For Examples 1 through 5 below, assume the following parameters:

- Standard stability period: January 1 through December 31
- Standard measurement period: November 1 through October 31of previous year
- Administrative period: November 1 through December 31

Example 1. John is an on-going employee. During a standard measurement period of November 1, 2015 to October 31, 2016, John, on average, works at least 30 hours per week. Thus, John is deemed a full-time employee for the standard stability period for the 2017 calendar year.

Example 2. Joe is hired on May 1. He is determined to be a variable hour employee. An initial 12-month measurement period running from May 1 to April 30 is used to determine his status. The initial measurement period is followed by a one-month administrative period, May 1 through May 31. Joe is deemed to be full-time based on hours worked during the initial measurement period. Joe's initial stability period runs from June 1 through May 31. Coincident with the initial measurement period, Joe is measured during the first standard measurement period that arises after his date of hire. Joe is deemed full-time based on hours worked during the standard measurement period. Thus, Joe is deemed full-time during the standard stability period, a portion of which, January through May coincides with his initial stability period. In addition to being deemed full-time during the initial stability period, Joe is deemed full-time for the balance of the standard stability period, June 1 through December 31.

TRANSITION RELIEF. The final regulations allow an employer to use a 6-month measurement period during 2014 to correspond with a 12-month stability period in 2015. To use this transition relief, the 6-month measurement period must be a consecutive 6-month period beginning no later than July 1, 2014 and can be paired with up to a 90-day administrative period.

Example. Assume Old Company employs 200 employees, 80 of whom are variable hour employees. Assume Old Company sponsors a health plan with a calendar year plan year. For the first year of compliance (which is 2015 for Old Company), Old Company can use a measurement period of 6 consecutive months (May 1, 2014 through October 31, 2014) with no more than 90 day administrative period of November 1, 2014 through December 31, 2014. Old Company measures the 80 variable hour employees to determine whether on average they work 30 or more hours per week during the transitional measurement period. Based on this determination, individuals will be deemed full-time or not full-time for the standard stability period.

What happens if an employee has no hours of service?

If an employee has no hours of service for more than 13 consecutive weeks, and if the individual returns to work, the individual can be treated as a new hire. *[Note, for school employees, the applicable break in service period is 26 consecutive weeks].* Conversely, if the individual returns to work in less than 14 consecutive weeks, then the individual must be returned to the status that he/she had prior to the break in service.

> **Example 3.** During standard measurement period, Joe worked an average of 30 or more hours per week. Joe is deemed to be a full-time employee during stability period. Joe does not perform any hour of service and is not paid between April 1 through July 8 (total of 14 weeks). None of this time qualifies as a special unpaid leave of absence. Joe is re-hired on Nov 1. Because Joe has incurred a 13-consecutive week or greater period of break in service, Joe can be considered a new hire, qualifying for a new initial measurement period.
>
> **Example 4.** Assume the same facts as above, except Joe returns to work on May 27 (8 weeks measured from April 1 through May 27). Joe is deemed full-time in accordance with his pre-break status since the break in service is shorter than 13 weeks.

What if an individual's status changes during a measurement period?

If an individual is a variable hour employee and is in an initial measurement period, and if that individual's status changes to full-time, then the individual must be treated as a full-time employee by the first of the 4th month from the date of change in status.

> **Example 5.** Joe is hired on July 1 as a variable hour employee. His initial measurement period runs from July 1 through June 30. On January 15 (during the initial measurement period), Joe is moved to a new position. The new position qualifies as a full-time position. On May 1, Joe must be treated as a full-time employee.

The final regulations include several complex rules relating to change in status for on-going employees. Put very simply, if a look-back period is used, the individual's status of deemed full-time or not full-time is maintained for the entire stability period. If the monthly measurement method is being used, and if an individual's work classification changes from part-time to full-time or vice versa, then the employer would not risk a shared responsibility penalty as long as an offer of coverage is made by the first day of the fourth month following the change in employment status.

Next Steps

- ❑ Determine which employees are full-time (30+ hours per week or 130 hours per month).
- ❑ Determine which employees are part-time (<30 hours per week or 130 per month).
- ❑ Determine which employees are variable or seasonal.
- ❑ Review health plan eligibility provisions and modify if necessary to reflect intended eligibility standards.
- ❑ Decide whether to take advantage of a look-back (measurement) and stability period.
  - ➢ If using a measurement/stability period:
    - ◆ Define it for new employees (initial) and define it for on-going employees (standard).
    - ◆ Add to new hire practice, a determination of whether the individual is full-time, part-time, variable or seasonal.
    - ◆ Track hours of service: Identify full-time, part-time, variable or seasonal individuals.

- Track hours of service for all employees.
- If variable or seasonal, track hours worked during measurement period.

➢ If you're not using a measurement/stability period, analyze status each month.

WHAT IS AN "OFFER OF COVERAGE" FOR ACA SHARED RESPONSIBILITY PURPOSES?

An offer of coverage is an offer of minimum essential coverage ("MEC"). Generally, MEC includes the type of coverage available under most insured and self-funded employer-sponsored group health plans, without regard to grandfathered status. In order to avoid all shared responsibility penalties, the coverage offered must meet an affordability standard and a minimum value standard.

Affordability Standard. Coverage under an employer-sponsored plan is deemed affordable to a particular employee if the employee's required contribution to the plan does not exceed 9.5% of the employee's household income for the taxable year, based on the cost of single coverage in the employer's least expensive plan. Under multi-employer plans, the employee contribution cannot exceed 9.5% of wages reported to the multi-employer plan.

With some clarifications, the final regulations retain the three safe harbors for purposes of determining affordability; they are:

1. A ***Form W-2 determination*** in which the employer's lowest cost self-only coverage providing minimum value does not exceed 9.5% of the employee's Form W-2 wages (Box 1) for the calendar year.
2. A ***rate of pay method*** in which the minimum value cannot exceed 9.5% of an amount equal to 130 hours, multiplied by the employee's hourly rate of pay as of the first day of the coverage period. For salaried employees, the monthly salary is used instead of the 130 hour standard. The final regulations permit an employer to apply this method to hourly employees if they experience a reduction in pay during the year. The rate of pay method cannot be used for commissioned sales people.
3. A ***Federal poverty line (FPL) standard*** in which cost of single coverage does not exceed 9.5% of the individual federal poverty line rate for the applicable calendar year, divided by 12. The final regulations permit an employer to use the poverty guidelines in effect six months prior to the beginning of the plan year.

An employer can use one of the optional safe harbors above for its entire employee population. In the alternative, the employer can apply one of these safe harbors to a specific category of employees, such as a particular job category or by compensation status (hourly vs. salaried), as long as the method is uniformly and consistently used for all employees in the particular category.

Minimum Value Standard. Coverage is deemed to meet the minimum value standard if it covers a minimum of 60% of the total allowed cost of benefits expected to be incurred under the plan. For purposes of determining whether an employer's group health plan provides a minimum value of benefits, the plan can utilize a minimum value calculator, a designed-based safe harbor checklist established by HHS/IRS, or the plan can seek an appropriate actuarial certification.

How often must coverage be offered?
MEC must be offered at least once per year. These regulations clarify that the offering of coverage is deemed satisfied if individuals have an opportunity to change their elections at least once per year.

When does an offer of coverage by a third party qualify as an offer of coverage by an employer?
If an employer contributes to a multi-employer or single employer Taft-Hartley plan or a multiple employer welfare arrangement, it is deemed to be an offer of coverage by the employer.

If an employer contracts with a professional employer organization (PEO) or other staffing type arrangement and if the employer is deemed to be the co-employer, then the employer's obligation of offer coverage will be satisfied through/by coverage through the PEO only if there is an additional charge to the employer for each participant who elects coverage.

Who must be offered health coverage?
MEC must be offered to employees working 30 or more hours per week (employees plus dependents beginning in 2015 and beyond) or risk becoming subject to the 'no coverage' penalty. It should be noted that for these purposes, *dependent* includes the employee's son or daughter through the end of the month of their 26th birthday. Dependent does not include a step-child or foster child nor the spouse of an employee. Children who are not U.S. citizens, with exception of certain adopted children, need not be offered coverage for shared responsibility purposes; with the exception of children from contiguous countries.

Employees of a Control Group. If an employee works for more than one entity in a control group or commonly controlled group of businesses, the employer for whom the individual works the most hours is deemed to be the employer for shared responsibility purposes. If the individual works the same number of hours for each entity, the entities can decide who will be the 'employer' for shared responsibility purposes.

Next Steps

- ❑ Assess the health coverage offering
  - ➢ Make certain full time employees, those working 30 or more hours per week, are given an effective opportunity to accept or decline MEC at least once per year.
  - ➢ Make certain the offer is available to the dependent children of the employee through the end of the month of the dependent's 26th birthday. If coverage is not currently available to dependent children, work toward this goal.
- ❑ Define methodology for determining affordability: Form W-2 method, the rate of pay method or the Federal poverty line (FPL) standard.
- ❑ Know your risk. How many full-time employees are offered MEC? Is it affordable? To avoid a penalty risk, offer adequate coverage at an affordable rate. It is the offer, not the take-up rate, which matters.

ACA'S EMPLOYER SHARED RESPONSIBILITY PROVISIONS UNIQUE TO EDUCATIONAL ORGANIZATIONS
Educational organizations employing 50 or more employees are subject to the employer shared responsibility requirements of the ACA in the same manner as all other employers. However, there are some provisions unique to educational organizations that are hi-lighted below.

Periodic Breaks during Academic Year. Frequently, the academic year runs on a nine or ten-month schedule, rather than a 12-month schedule. Further, the academic year often includes

periodic breaks of a few weeks, such as a winter break. The final regulations relating to the employer shared responsibility requirement provide that these breaks cannot be used to negatively impact hours worked by employees of the educational system. In summary, break time must be disregarded in calculating hours. Alternatively, hours during the break, not to exceed 501 hours, must be attributed to the overall time worked by the educational employee.

Calculating hours of service. As a general statement, a reasonable allocation of time must be granted for work performed. The final rules make the following clarifications in calculating hours of service by educational organizations:

- Hours of service does not include services received by *students on a federal work-study program*. Note, though, that other student worker hours, such as internships or externships, are counted.
- *Adjunct faculty.* For adjunct faculty members, a reasonable amount of time must be allocated for time worked. The regulations provide a safe harbor of sorts that require 75 minutes per hour of class time allocated to preparation, or the use of any other reasonable method for calculating hours of service. In addition, other obligatory time required of the individual, such as required office hours, must be counted.
- *Volunteers*. Hours of service offered by volunteers of educational organizations are not counted. Many schools may use volunteers for coaching, athletics or leading other extracurricular activities. These hours need not be counted even if the volunteer is reimbursed for expenses or paid a '*de minimis'* stipend. Schools with positions that are or may be volunteer positions should work with their legal counsel to ensure that the position's status meets all of the requirements of a volunteer position. The regulations are not clear on how to handle dual role individuals; for example, an individual who is a teacher but also volunteers time as an extracurricular coach.

Break in service rules. The regulations retain the break in service rules set forth in the proposed regulations. Specifically, an individual would have to have at least a 26-week period during which no hour of service is credited before the individual could be treated as a new employee for ACA purposes.

Next Steps for Educational Organizations

- ❑ Identify the various types of employees employed by the educational organization, including but not limited to:
  - ➢ Full-time employees;
  - ➢ Variable hour employees;
  - ➢ Seasonal employees;
  - ➢ Part-time employees; and
  - ➢ Volunteers
- ❑ Develop a system to track hours worked. Determine whether a look-back period or a monthly measurement period will be used for a particular class of employees.

The information contained herein is not intended to be legal, accounting, or other professional advice, nor are these comments directed to specific situations. The information contained herein is provided as general guidance and may be affected by changes in law or regulation. The information contained herein is not intended to replace or substitute for accounting or other professional advice. Attorneys or tax advisors must be consulted for assistance in specific situations. This information is provided as-is, with no warranties of any kind. CBIZ shall not be liable for any damages whatsoever in connection with its use and assumes no obligation to inform the reader of any changes in laws or other factors that could affect the information contained herein. As required by U.S. Treasury rules, we inform you that, unless expressly stated otherwise, any U.S. federal tax advice contained herein is not intended or written to be used, and cannot be used, by any person for the purpose of avoiding any penalties that may be imposed by the Internal Revenue Service.

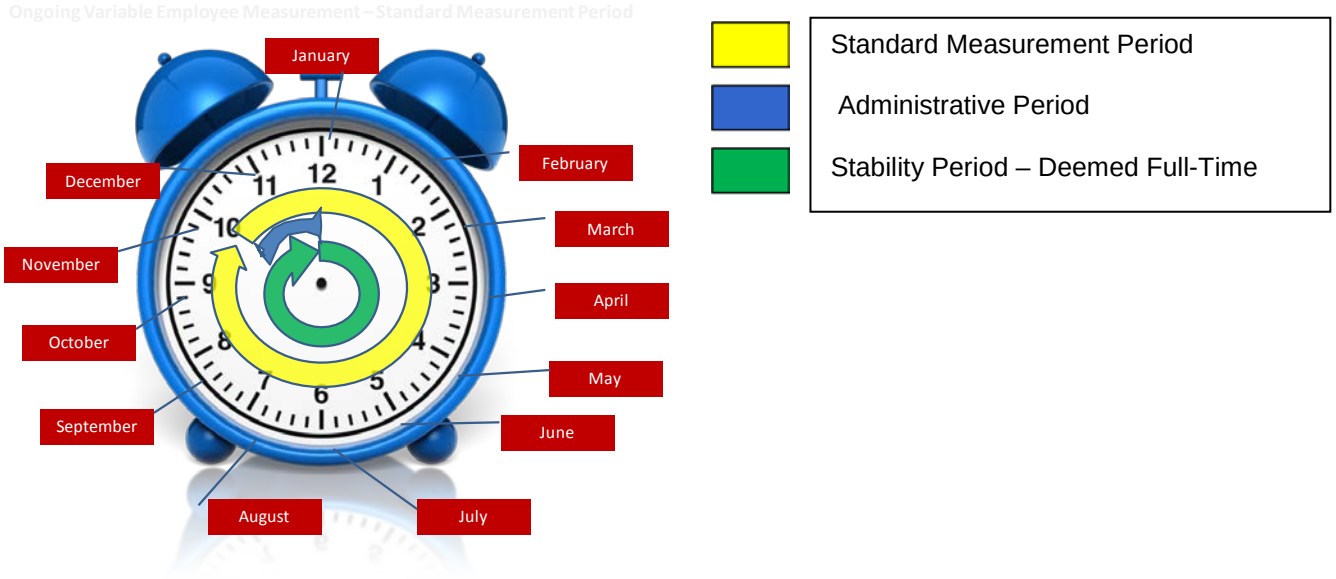
ILLUSTRATIVE EXAMPLES

The following depictions illustrate the examples (repeated here below) provided on pages 6 and 7 of this Health Reform Bulletin

Examples. For Examples 1 through 5 below, assume the following parameters:

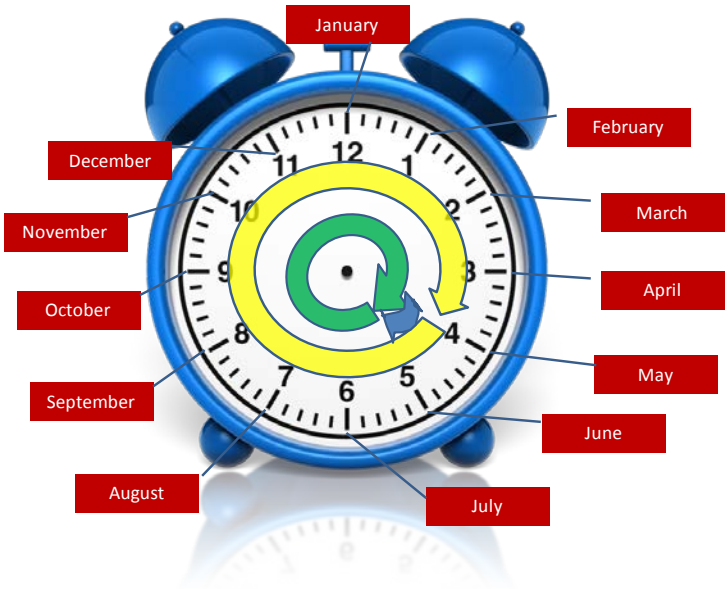
- Standard stability period: January 1 through December 31
- Standard measurement period: November 1 through October 31 of previous year
- Administrative period: November 1 through December 31

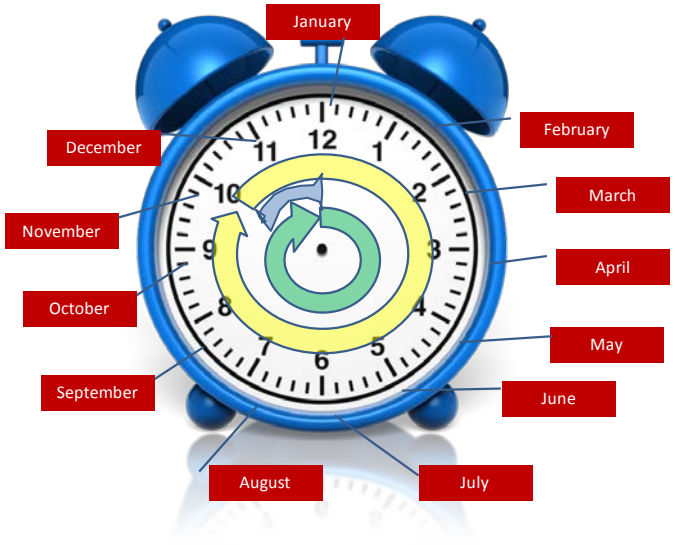
Example 1. John is an on-going employee. During a standard measurement period of November 1, 2015 to October 31, 2016, John, on average, works at least 30 hours per week. Thus, John is deemed a full-time employee for the standard stability period for the 2017 calendar year.



Example 2. Joe is hired on May 1. He is determined to be a variable hour employee. An initial 12-month measurement period running from May 1 to April 30 is used to determine his status. The initial measurement period is followed by a one-month administrative period, May 1 through May 31. Joe is deemed to be full-time based on hours worked during the initial measurement period. Joe's initial stability period runs from June 1 through May 31. Coincident with the initial measurement period, Joe is measured during the first standard measurement period that arises after his date of hire. Joe is deemed full-time based on hours worked during the standard measurement period. Thus, Joe is deemed full-time during the standard stability period, a portion of which, January through May coincides with his initial stability period. In addition to being deemed full-time during the initial stability period, Joe is deemed full-time for the balance of the standard stability period, June 1 through December 31.

Initial Measurement Period For Variable New Hire *Coincides With* Standard Measurement Period For Ongoing Variable Employee





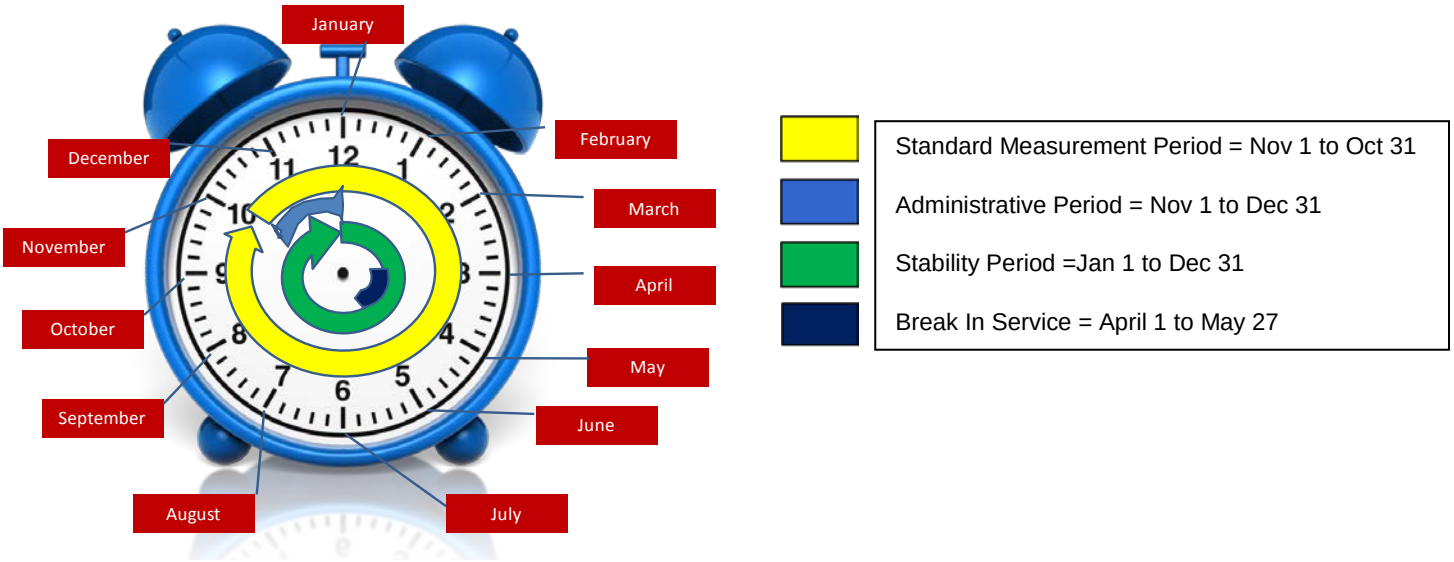
	Initial Measurement Period = May 1 to April 30th
	Administrative Period = May 1 to May 31
	Stability Period =June 1 to May 31

	Standard Measurement Period = Nov 1 to Oct 31
	Administrative Period = Nov 1 to Dec 31
	Stability Period =Jan 1 to Dec 31

Example 3. During standard measurement period, Joe worked an average of 30 or more hours per week. Joe is deemed to be a full-time employee during stability period. Joe does not perform any hour of service, and is not paid between April 1 through July 8 (total of 14 weeks). None of this time qualifies as a special unpaid leave of absence. Joe is re-hired on Nov 1. Because Joe has incurred a 13-consecutive week or greater period of break in service, Joe can be considered a new hire, qualifying for a new initial measurement period.

	Standard Measurement Period = Nov 1 to Oct 31
	Administrative Period = Nov 1 to Dec 31
	Stability Period =Jan 1 to Dec 31
	Break In Service = Apr 1 to Jul 8
	Initial Measurement Period – New Hire Nov 1 to Oct 31

Example 4. Assume the same facts as above, except Joe returns to work on May 27 (8 weeks measured from April 1 through May 27). Joe is deemed full-time in accordance with his pre-break status since the break in service is shorter than 13 weeks.



CBIZ
Health Reform Bulletin

Subject: **1) IRS Final Rules – IRC Sections 6055 and 6056 and 2) HHS Benefit and Payment Parameters for 2015**
Date: March 14, 2014

IRS Final Rules – IRC Sections 6055 and 6056

The Affordable Care Act (ACA) imposes some new annual reporting requirements, the specific objective of which is to inform the IRS and individuals about who has access to minimum essential coverage (MEC), and when an employer shared responsibility assessment might be owed. In addition, these requirements are intended to facilitate the determination about who is eligible for premium assistance.

As background, individuals who fall below 400% of the federal poverty level (FPL) and do not have access to MEC that meets the minimum value and affordability standards may be entitled to premium assistance in the form of an advance tax credit available only for purchase of coverage through the marketplace. To help the IRS know who is offered MEC, IRC Section 6055 requires insurers, self-funded plans and other providers of MEC to report certain information to the IRS. Of particular interest to employers is the newly added IRC Section 6056 reporting requirement. This requirement obligates employers subject to the employer shared responsibility rules of the ACA, specifically employers employing 50 or more employees (known as "applicable large employer" or "ALE"), to report certain information annually to the IRS, as well as provide related benefit statements to employees.

The IRS issued proposed regulations on these reporting requirements six months ago (see CBIZ Health Reform Bulletin, *Information Reporting by Employers on Health Coverage and Reporting of Minimum Essential Coverage*, 9/18/13).

Final IRS regulations on both IRC Sections 6055 and 6056 reporting were published on March 10, 2014, together with a Fact Sheet. These regulations are effective March 10, 2014 and apply to calendar years beginning after December 31, 2014.

IRC Section 6056 Reporting

Section 6056 requires employers to report to the IRS information about their compliance with the employer shared responsibility provisions, including the type of health care coverage they offer to their employees. In addition, employers are required to furnish related benefit statements to employees to assist them in determining whether they can claim a premium tax credit on their tax return.

The IRS Form 1095-C (employee statement) and a Form 1094-C (transmittal) are the proposed designated forms to be used for Section 6056 reporting. The type of information to be reported includes:

1. Name, address and employer ID of the ALE;
2. Name and telephone number of a contact for ALE;

3. The calendar year for which the report is filed. Note, the reports are based on calendar years, not plan years;
4. Reporting on a calendar month basis of the following:
    - Certification as to whether the ALE's full-time employees and their dependents, including spouses, are given an opportunity to enroll in MEC,
    - The number of FTEs employed by ALE,
    - The months for which MEC was offered, and
    - The employee's share of the monthly premium for single health coverage that meets minimum value;
5. The name, address and taxpayer ID number for each full-time employee offered coverage.

It is important to note that to avoid the risk of an IRC Section 4980H penalty (the employer shared responsibility penalty), the ALE is obligated to offer MEC to the employee and dependents (biological and adopted children only) through the month of their 26th birthday. This notwithstanding, the Section 6056 reporting requirement obligates the employer to report on whether coverage is offered to spouses.

Alternative Reporting Methods

The final regulations provide for two alternative reporting methodologies for satisfying the IRC Section 6056 reporting in 2015. They are:

1. **Certification of Qualifying Offer**. In this method, the ALE certifies on the Form 1095-C (or other IRS designated form) that it made a qualifying offer of MEC to its full-time employees and their spouses and dependents for all months during the year at a cost under 9.5% of the single federal poverty line (approx $1,100 for 2015). Either a copy of the form filed with the IRS or similar document would then be used to satisfy the related benefit statement disclosure to participants.
2. **Option to report without separate identification of full-time employees**. If the ALE offers MEC that meets the affordability standard to at least 98% of its employees and their dependents, the ALE is not required to separately identify its full-time employees or report the total number of its full-time employees on the Section 6056 return for the reporting year.

Timing of filing. The report is required to be filed with the IRS no later than February 28th of each year (or March 31st of each year if filed electronically), reflecting information for the previous calendar year.

Benefit Statements to Employees

Full-time employees must be furnished with a written statement derived from information contained in the employer's report. This can be accomplished by providing a copy of the Form 1095-C or other IRS designated form. The statement would include the employee's name and address, his/her Social Security number, and a code indicating that an offer of coverage for all 12 months of calendar year or the specific months for which coverage is offered has, in fact, been made. These benefits statements must be provided annually by January 31st and are based on prior calendar plan year information.

Manner of Distribution. These benefit statements may be provided in paper or electronically. The paper version is required to be mailed to the full-time employee's last known permanent address or, if no permanent address is known, to the employee's temporary address. These

statements may be provided electronically or by posting to a website, as long as the electronic distribution standards contained in the regulations are followed.

IRC Section 6055 Reporting

Insurers, self-funded plans and other providers of MEC are required to report certain information to the IRS, known as IRC Section 6055 Reporting. The type of information required to be reported to the IRS on the Form 1095-B (or other IRS designated form) includes the following information for each calendar year:

1. Name, address, and EIN for the person required to file the return;
2. Name, address, and TIN, or date of birth of each individual covered under the policy or program; and
3. For each covered individual, the months for which the individual was enrolled in coverage and entitled to receive benefits.

In addition, information returns reporting MEC provided to an individual under an insured group health plan must report:

- Name, address, and EIN of the employer sponsoring the plan; and
- Whether the coverage is a qualified health plan enrolled in through the Small Business Health Options Program (SHOP) and the SHOP's unique identifier.

Timing of filing. The report is required to be filed with the IRS no later than February 28th of each year (or March 31st of each year, if filed electronically), reflecting information for the previous calendar year.

Benefit Statements to Employees

Employers submitting a Section 6055 return must furnish the same information to all individuals named in the return, together with the contact phone number of the individual filing the return and the policy number. This can be accomplished by providing a copy of the Form 1095-B, or similar substitute statement as prescribed by the IRS. These benefit statements must be provided annually by January 31st and are based on prior calendar plan year information. These statements may be provided electronically, as long as the electronic distribution standards contained in the regulations are followed.

Combined 6055/6056 Streamline Reporting

The final regulations provide a combined streamline reporting process, particularly for ALEs offering self-funded plans that would be subject to both Code Sections 6055 and 6056 requirements. While the IRS has not formally released the designated forms for accomplishing these reporting requirements yet, the final regulations indicated that an ALE sponsor of a self-insured plan who is subject to both IRC Sections 6055 and 6056 reporting requirements would complete both sections of IRS Form 1095-C. An ALE sponsoring an insured plan will also utilize the Form 1095-C, but need only complete the relevant information required by Section 6056 since it is the insurer who files information to satisfy its Section 6055 obligation.

Next Steps

While employers are encouraged to file the Section 6056 report for the 2014 calendar year, it is not obligatory until the 2015 calendar year, due in the first quarter of 2016. Employers should begin thinking about how to design a system that captures the relevant data. The IRS reporting forms referred to in this document have not been issued yet; they are expected to be available in the near future.

If an employer is interested in the alternative reporting process, the employer should work toward ensuring that affordability standard it uses is the single federal poverty line limit; or, it offers coverage to at least 98% of its full-time employees.

HHS BENEFIT AND PAYMENT PARAMETERS FOR 2015

The Department of Health and Human Services (HHS) issued its *2015 Benefit and Payment Parameters* on March 11, 2014. These uniform standards are intended for health insurers and the marketplace to ensure health coverage options for consumers, as well as provide planning guidance for insurers and employers. Following are highlights of these standards:

2015 Cost-sharing Limitations. Following are the deductible and out-of-pocket limits that can be imposed by plans:

- Deductible (only applicable to small insured plans offered in/outside Marketplace)
  - $2,050 for single coverage
  - $4,100 for coverage for more than one
- Out-of-pocket (applicable to insured plans offered via the Marketplace, and insured and self-funded plans offered outside Marketplace)
  - $6,600 for single coverage
  - $13,200 for coverage for more than one

Transitional Reinsurance Fee. The goal of a transitional reinsurance program is to stabilize premiums in the individual market due to anticipated immediate enrollment of higher risk individuals. The reinsurance money would be used to offset the expenses of the newly eligible individuals. For 2014, the contribution rate is $5.25 per covered life per month, or approximately $63, annually. The annual reinsurance contribution rate to be collected in 2015 is $44 per enrollee. Virtually, all-sized health plans, whether insured or self-funded are subject to the fees. Self-funded, self-administered plans are exempt from the transition reinsurance fee for the 2015 and 2016 reporting year. This is expected to have very limited application in that most self-funded plans engage the services of a third party administrator.

Federal Exchange User Fees. To support the functions of federally-facilitated marketplaces (FF-marketplace), participating insurers offering a plan through a FF-marketplace are required to remit a user fee to HHS each month. In 2015, the federal user fee remains at 3.5% of premium revenue of insurers who participate in the FF-marketplace.

Open Enrollment Period for 2015. The annual open enrollment period for the 2015 benefit year through the Marketplace is November 15, 2014 through February 15, 2015.

About the Author: Karen R. McLeese is Vice President of Employee Benefit Regulatory Affairs for CBIZ Benefits & Insurance Services, Inc., a division of CBIZ, Inc. She serves as in-house counsel, with particular emphasis on monitoring and interpreting state and federal employee benefits law. Ms. McLeese is based in the CBIZ Leawood, Kansas office.

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CBIZ
Health Reform Bulletin

Subject: **Elimination of Deductible Limits in Small Employer Sponsored Plans**
Date: April 4, 2014

On April 1, 2014, President Obama signed H.R. 4302, *Protecting Access to Medicare* Act *of 2014* (Public Law No 113-93). Part of this so-called "doc-fix" law that temporarily adjusts the formula used to determine Medicare reimbursement payments to doctors includes a provision (Section 213) that repeals the ACA's deductible restriction imposed on small employer plans, retroactive to the ACA's enactment (March 23, 2010). What this means is that small employer plans will no longer be subject to the $2,000 single/$4,000 family deductible restriction.

These types of plans will continue to be subject to the out-of-pocket restrictions. For 2014, the annual out-of-pocket limits applicable to both insured and self-funded plans offered through and outside the Marketplace are $6,350 for single coverage and $12,700 for coverage for more than one. In 2015, the maximum annual limitation on cost sharing is $6,600 for self-only coverage; $13,200 for other than self-only coverage (see the *Cost Sharing Limitation* discussion in the *HHS Benefit and Payment Parameters for 2015* section of this CBIZ Health Reform Bulletin).

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CBIZ
Health Reform Bulletin

Subject: **Implementation Guidance**
Date: May 7, 2014

In recent days, the government agencies responsible for administering the Affordable Care Act (ACA) have issued a number of pieces of guidance and tools to assist in the further implementation of the law.

CHOICE OF MARKETPLACE COVERAGE OR COBRA CONTINUATION COVERAGE

In response to opportunities available through the Marketplace, both the Departments of Health and Human Services (HHS) and Labor (DOL) announced, on May 2, 2014, issuance of revised model COBRA forms and a revised CHIP premium assistance notice, as well a special enrollment opportunity for individuals on COBRA.

Revised Model COBRA and CHIP Forms

Generally, the revised COBRA and CHIP notices explain, in greater detail, the availability of coverage through the marketplace and potential availability of premium assistance.

Of particular note, the COBRA election notice describes a 60-day enrollment window for choosing marketplace coverage, measured from the date of employment termination. If an individual does not take advantage of the 60-day window, then the next enrollment opportunity for marketplace coverage would be during the annual open marketplace enrollment period.

Once COBRA coverage terminates, the COBRA continuee would be eligible to enroll in the marketplace through a special enrollment period, even if the marketplace open enrollment period has ended. COBRA continuees are also permitted a special enrollment period in which to switch to marketplace coverage if they incur another qualifying event such as marriage or birth of a child. Individuals signing up for marketplace coverage rather than COBRA coverage cannot switch to COBRA under any circumstances.

The notice also explains how an individual could enroll in another group health plan, such as through a spouse's group health coverage as long as the individual requests enrollment within 30 days of the loss of coverage. If the individual elects COBRA rather than enrolling in the other coverage, he/she will have another opportunity to enroll within 30 days of losing COBRA coverage.

The revised notice also includes factors for weighing the options in coverage such as premium provider networks, drug formularies, severance payments, service areas and other cost-sharing considerations.

While it is not mandatory to use these revised model notices, if they are used in good faith, it will be deemed compliance with the notice requirement. All three revised model notices are available via the DOL's website (http://www.dol.gov/ebsa/):

- Updated COBRA Model General Notice
- Updated COBRA Model Election Notice
- Updated CHIP Model Notice for Employers Regarding Premium Assistance Opportunities

Special Enrollment Opportunity for Individuals on COBRA

HHS appears to be concerned that individuals currently on COBRA may not have understood their rights to enroll in the marketplace. Therefore, a special enrollment opportunity has been made available to individuals currently on COBRA continuation coverage to switch to marketplace coverage. This special enrollment 60-day window expires on July 1, 2014. To take advantage of this special enrollment opportunity, HHS suggests COBRA continuees contact the Marketplace call center (1-800- 318-2596) to activate the special enrollment period and to inform the call center that they are calling about their COBRA benefits and the marketplace. Once determined eligible for the special enrollment period, these individuals can then view all available plans and continue the enrollment process either via phone or by creating an account on healthcare.gov website. It should be noted that this special enrollment opportunity applies for purposes of the federal marketplace. It is not fully clear whether it would apply to state-run marketplaces.

IMPLEMENTATION FAQS

The 19th set of implementation FAQs address the revised COBRA notices, as above, as well as clarifies certain matters relating to cost sharing requirements, preventive services, excepted FSA plan status and summaries of benefits and coverage.

Cost-Sharing Matters

For plan years beginning in 2014, the ACA imposes cost-share restrictions on essential health benefits provided by non-grandfathered group health plans. Specifically, the out-of-pocket limits are, for 2014, the same as the out-of-pocket limits applicable to high deductible health plan (HDHP) coverage used in conjunction with a health savings account (HSA). For 2014, the annual out-of-pocket limits applicable to both insured and self-funded plans offered through and outside the Marketplace are $6,350 for single coverage and $12,700 for coverage for more than one. In 2015, the out-of-pocket limits will be tied to a premium adjustment percentage, calculated according to Health and Human Services (HHS) guidelines. HHS has proposed the annual limitation on out-of-pocket costs for 2015 would be $6,600 for self-only coverage and $13,200 for family coverage. These limits are slightly different than those allowed by HDHP coverage tied to an HSA.

As a reminder, a law enacted last month repealed the ACA's deductible restriction imposed on small employer plans retroactive to the ACA's enactment (see CBIZ Health Reform Bulletin, *Elimination of Deductible Limits in Small Employer Sponsored Plans*, 4/4/14).

The FAQs address how plans calculate out-of-pocket limits to particular issues; specifically:

- *Balanced billing*. A network-based health plan can count out-of-pocket spending for non-network items or services toward the annual out-of-pocket maximum, as long as it uses a reasonable method for doing so.

- *Generic vs. Brand Name Drugs*. As part of an essential health benefit package, if a plan covers generic drugs with a separate option to obtain a brand-named drug by paying a higher cost-share, the difference in plan cost between the generic and brand name drug does not have to be counted toward the annual out-of-pocket maximum.

Preventive Services

Under ACA, group health plans must provide coverage for certain preventive health services, as well as recommended evidence-based items or services, without imposing any cost sharing requirements when the services are delivered by in-network providers. The FAQ clarifies that if a recommendation or guideline fails to specify the frequency, method, treatment, or setting for the provision of that service, then the plan can use reasonable medical management techniques to determine any such coverage limitations.

With regard to preventive coverage for tobacco cessation, the DOL would consider the following services to meet the preventive service standards of tobacco use counseling and intervention:

1. Screening for tobacco use; and,
2. For those using tobacco products, at least two tobacco cessation attempts per year. A "cessation attempt" means four tobacco cessation counseling sessions (minimum 10 minute duration) plus a 90-day trial of prescribed FDA-approved tobacco cessation medications.

FSA Plans with carry-forward feature retain excepted status

Certain salary reduction flexible medical spending account (FSA) plans are excepted (exempt) from the ACA, as well as the HIPAA portability rules, as long as the FSA plan:

- Only reimburses dental or vision expenses;
- Covers fewer than two participants who are active employees; or
- Meets a maximum benefit test, i.e., the maximum benefit available cannot exceed two times the salary reduction election; or, the salary reduction election plus $500, whichever is greater. In addition, the FSA must meet an availability test, i.e., participants in the FSA must also be eligible for a health plan that is subject to ACA and HIPAA.

In October, 2013, the Internal Revenue Service issued guidance modifying the use-it or lose-it rule applicable to FSA plans to allow up to $500 of unused dollars to be carried forward and used in the next plan year (see *IRS Guidance Modifies the Use-it or Lose-it Rule and Permits a Status Change Event for Marketplace Enrollment*, *Benefit Beat*, 11/5/13).

The DOL confirms in its FAQ that if an excepted FSA plan adopted a $500 carry-forward feature, it would not impact its status as an excepted plan.

Summary of Benefit and Coverage

About a year ago, the DOL and HHS released an updated Summary of Benefits and Coverage (SBC) template to be used for the second year of compliance, defined as coverage beginning on or after January 1, 2014 and before January 1, 2015 (see *Updated Summary of Benefits and Coverage (SBC) Guidance and New FAQs*, 4/25/13). The newly released FAQ states that until future guidance is issued, plans can continue to use these 'second year applicability' templates and uniform glossary to meet their compliance obligations.

In addition, good faith compliance with all SBC requirements remains in effect, even though they were only supposed to be in effect for a certain period of time.

NEW SHOP TOOLS TO ASSIST SMALL BUSINESSES

The Small Business Health Options Program (SHOP) Marketplace tailors to those employers with 50 or fewer full-time equivalent employees (FTEs). The Healthcare.gov website has two new tools to assist small employers in providing an estimate of their potential tax credit for providing health coverage to their employees, as well as a tool to assist in calculating whether the employer meets the employee threshold criteria to participate in the SHOP. Following are links to these tools:

- **SHOP Tax Credit Estimator**: https://www.healthcare.gov/small-business-tax-credit-calculator/. Also note that the IRS continues to have its tax credit calculator available as well: http://www.taxpayeradvocate.irs.gov/calculator/SBHCTC.htm

- **SHOP Full-Time Equivalent Calculator:** https://www.healthcare.gov/fte-calculator/

MARKETPLACE REPORTING OBLIGATIONS – ADVANCED TAX CREDITS

The IRS issued regulations addressing reporting and disclosure obligations of marketplaces relating to individuals receiving advance tax credits toward payment of their health coverage.

In a nutshell, a marketplace is required to report to the IRS on a monthly and annual basis, information relating to individuals who enroll in qualified health plans through the marketplace, including premium amounts and advanced tax credit payments paid for coverage under the particular plan. In addition, a marketplace is required to provide an annual statement to these enrolled individuals containing the same type of information for purposes of satisfying their own tax filing obligations. A marketplace can use the Form 1095–A (or other IRS-designated form) as the disclosure statement, and must furnish the statement on or before January 31st of the year following the calendar year of coverage.

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CBIZ

Health Reform Bulletin

Subject: **Reminder: PCOR Fees and Transitional Reinsurance Fees**
Date: June 18, 2014

July 31st is fast approaching which means it is time to begin thinking about the Patient-Centered Outcomes Research (PCOR) fee. And, we are almost halfway through 2014, which means the first transitional reinsurance fee will soon be due. Following is a summary of these two fees imposed by the Affordable Care Act. Please refer our prior CBIZ Health Reform Bulletins listed below for additional background information.

PROVISION	PATIENT-CENTERED OUTCOME RESEARCH FEE	TRANSITIONAL REINSURANCE FUND (PREMIUM STABILIZATION PROGRAM)
PLAN APPLICABILITY	❒ Insurers of all-sized fully-insured plans ❒ All-sized employers of self-funded plans *Also applies to:* ◆ Retiree-only plans ◆ COBRA and state continuation coverage ◆ Non-integrated health reimbursement arrangements (HRA) (generally, not permissible in 2014 and beyond unless it is excepted) ◆ Integrated HRA (Note: an HRA integrated with insured plan would pay the fee; an HRA integrated with self-funded plan does not) ◆ Medical flexible spending accounts (FSA) subject to HIPAA	❑ Insurers of all-sized fully-insured plans ❑ All-sized employers of self-funded plans *Also applies to:* ◆ Post-employment plans that are primary to Medicare, such as early retiree plans ◆ COBRA continuation coverage

PROVISION	PATIENT-CENTERED OUTCOME RESEARCH FEE	TRANSITIONAL REINSURANCE FUND (PREMIUM STABILIZATION PROGRAM)
PLAN APPLICABILITY, *con't*	Plans *not subject* to the fees include: ◆ HIPAA-excepted benefit plans such as limited scope dental and vision plans ◆ FSAs excepted from HIPAA ◆ Employee assistance programs, disease management programs, and wellness programs if the program does not provide significant benefits in the nature of medical care or treatment ◆ Expatriate group health plans primarily covering employees who work and reside outside the U.S. (however, foreign nationals working in the US *are* counted in the calculation of the fee)	Plans *not subject* to fees include: ◆ HIPAA-excepted benefit plans such as limited scope dental and vision plans ◆ HRAs integrated with comprehensive insured or self-funded group coverage ◆ Flexible medical spending account plans (FSA) ◆ Health savings accounts (HSA) except an HDHP used in conjunction with HSA is considered major medical insurance and thus, subject to reinsurance contributions ◆ Employee assistance plans, disease management programs, and wellness programs if the program does not provide significant benefits in the nature of medical care or treatment. ◆ Post-employment plans where Medicare is primary to group plan. ◆ Stand-alone prescription drug plans ◆ TRICARE or other military benefit plans ◆ Certain Indian Tribal benefit programs ◆ Certain expatriate plans
AMOUNT OF FEE	◆ $1 per covered life for plan years ending prior to October 1, 2013 ◆ $2.00 per covered life (indexed) for plan years thereafter.	◆ For 2014: $5.25 per covered life per month based on calendar year ◆ For 2015: $3.66 per covered life per month based on calendar year
INSURED PLANS: METHODS FOR DETERMINING COVERED LIVES	Actual count, Snapshot, Member months, or State form methods	Actual count, Snapshot, Member months, or State form methods

PROVISION	PATIENT-CENTERED OUTCOME RESEARCH FEE	TRANSITIONAL REINSURANCE FUND (PREMIUM STABILIZATION PROGRAM)
SELF-FUNDED PLANS: METHODS FOR DETERMINING COVERED LIVES	Actual count, Snapshot, or Form 5500 methods	Actual count, Snapshot, or Form 5500 methods
ENTITY PAYING FEE	❑ By insurer of fully insured plan ❑ By plan sponsor of self-funded plan	❑ By insurer of fully insured plan ❑ By plan sponsor of self-funded plan
REPORTING AND PAYING THE FEE	PCOR fees paid once a year in connection with IRS Form 720, *Quarterly Federal Excise Tax Return:* ◆ For insured plans, Form 720 due by July 31st following the close of the plan year. ◆ For self-funded plans, Form 720 due by July 31st of the calendar year following the plan year end.	◆ Submit annual enrollment count (based on first 9 months of year) to HHS by November 15th of each year on form available via www.pay.gov. Reporting form will auto-calculate contribution amounts and allow payments to be made. ◆ Contributions paid in two installments: 1st installment due within 30 days of invoice reflects actual reinsurance contribution (plus HHS's administrative costs); 2nd installment will be invoiced in 4th quarter following the year of submission and reflects amounts allocated to U.S. Treasury.
FEES PAID FROM PLAN ASSETS?	No	Yes
APPLICABILITY PERIOD	Plan years ending after 9/30/12 *No fee assessed for plan years ending after 9/30/19 (for calendar year plans, this means the 2018 plan year)*	Calendar years 2014 to 2016

PROVISION	PATIENT-CENTERED OUTCOME RESEARCH FEE	TRANSITIONAL REINSURANCE FUND (PREMIUM STABILIZATION PROGRAM)
ADDITIONAL INFORMATION AND RESOURCES	❑ IRS webpage on Patient-Centered Outcomes Research Institute Fee ◆ IRS chart on types of coverage subject to the PCORI Fee ◆ IRS Questions and Answers ❑ CBIZ Health Reform Bulletins ◆ *Year-end Wrap Up (12/21/11)* ◆ *Fees on Health Insurance Policies & Self-Insured Plans: Patient-Centered Outcome Research Trust Fund (4/18/12)* ◆ *Final Regulations Issued: Patient-Centered Outcomes Research Fees and Medical Device Tax (12/11/12)* ◆ *Chart of Health Plan Fees and Taxes (12/18/12)* ◆ *See Patient-Centered Outcomes Research Fee in Sub-Regulatory Guidance and FAQs Issued (1/25/13)* ◆ *Reporting and Paying PCOR Fees: Revised Form 720 Issued (6/4/13)* ◆ *Year-end Wrap Up (12/23/13)*	❑ CMS Questions and Answers ◆ Reinsurance Fee Process (5/22/14) ◆ Reinsurance Enrollment Count (11/8/13) ❑ CBIZ Health Reform Bulletins ◆ *Premium Stabilization Program Proposals and 2) Chart of Health Plan Fees and Taxes (12/18/12)* ◆ *Implementation Guidance (3/12/13)* ◆ *See 'Transitional Reinsurance Fee' in 'Proposed Benefit and Payment Parameters in 2015' in Year-end Wrap Up (12/23/13)* ◆ *HHS Benefit and Payment Parameters for 2015 (3/14/14)*

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CBIZ
Health Reform Bulletin

Subject: **Final Rules Address Orientation Period**
Date: June 26, 2014

The Affordable Care Act (ACA) requires all health plans to comply with a waiting period that is no longer than 90 calendar days, effective for plan years beginning on or after January 1, 2014. The ACA's governing agencies (IRS, Labor and HHS) issued final regulations addressing the 90-day waiting period restriction earlier this year, together with a proposed regulation relating to orientation periods (see CBIZ HRB, *Final Rules – 90-Day Waiting Period*, 2/24/14).

On June 25, 2014, the agencies published final rules implementing orientation periods. As with the proposed rule, the final rules permit the imposition of a one-month orientation period prior to the beginning of a waiting period. The orientation period is a time of assessment to determine whether an individual has the requisite qualifications, licensure, or other standards to perform the job.

The one-month orientation period is measured forward from the employee's date of hire by adding one calendar month and subtracting one calendar day; after which time, the maximum 90-day waiting period would commence. For example, if an eligible employee's start date is May 3rd, the orientation period would end on June 2nd. Similarly, if an eligible employee's start date is October 1st, then the last day of the orientation period would be October 31st.

Applicability date. The final orientation period rules become applicable to both insured and self-funded group health plans for plan years beginning on or after January 1, 2015. In the meantime, the proposed regulations, which mirror the final regulations, can be relied upon.

NEXT STEPS

- ❑ If an orientation period is to be implemented, make certain the insurance contract, health plan, reinsurance contract or any other governing document accurately reflect the terms of the orientation period.

- ❑ Make certain the orientation period is used for its intended purpose, i.e., to meet requisite qualifications, licensure, or other standards to perform the job, and not used as a subterfuge to delay the waiting period.

- ❑ It is important to note that an orientation period followed by a 90-day waiting period could put an employer at risk for the ACA's shared responsibility penalty under IRC Section 4980H(a) or (b). As a reminder, employers employing 50 or more employees are subject to the employer shared responsibility requirement and could be at risk for a penalty if adequate and affordable coverage is not offered by the first day of the 4th month following the date of hire.

Example: XYZ Company is subject to the ACA's employer shared responsibility requirement. XYZ Company hires Joe as a full-time employee on January 6th. A one-month orientation period followed by a 90-day waiting period is imposed, making Joe's coverage date May 6th (give or take a day, depending on leap year status). While this timeframe satisfies the waiting period requirements, it puts XYZ Company at risk for the shared responsibility penalty since coverage was not offered by May 1st (the first day of the 4th month following the hire date).

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CBIZ
Health Reform Bulletin

Subject: **Preventive Services – Contraceptive Mandate**
Date: July 2, 2014

On June 30, 2014, the Supreme Court in a 5-4 decision ruled that closely held corporations are not obligated to cover the contraceptive benefit mandated by the Affordable Care Act (ACA), if they object to doing so on religious grounds. In a nutshell, the Court ruled in *Burwell v. Hobby Lobby et al.* [No. 13-354 (U.S. June 30, 2014)] that a closely held corporation is protected by the Religious Freedom and Restoration Act (RFRA).

The RFRA, enacted in 1993, is a federal law intended to prevent laws that would substantially burden a person's free exercise of their religion. According to the Opinion:

> *"RFRA prohibits the "Government [from] substantially burden[ing] a person's exercise of religion even if the burden results from a rule of general applicability" unless the Government "demonstrates that application of the burden to the person—(1) is in furtherance of a compelling governmental interest; and (2) is the least restrictive means of furthering that compelling governmental interest." 42 U. S. C. §§2000bb–1(a), (b) (emphasis added)."*

The ACA requires non-grandfathered plans to cover preventive services at no cost to the plan participant and included among these preventive services are certain women's health services some of which relate to contraception. For purposes of determining applicability of the mandate, entities can be divided into three and possibly now, four classifications:

1. **Churches**. Religious organizations, specifically churches and religious orders, are expressly exempt, i.e., plans sponsored by these entities are not obligated to cover contraceptive services.

2. **Eligible Organizations**. Non-profit entities with a religious affiliation, known as "eligible organizations" are not entitled to the full exemption, but are entitled to certify their religious objection and thus be exempt from providing the coverage. In this instance, individuals obtain the services directly from an insurer or third party administrator. Several of these eligible organizations are objecting to having this degree of association with the contraceptive mandate, and it is expected that the Supreme Court will take this up next term.

3. **For-Profit Entities**. The ACA does not provide an exemption from the contraceptive mandate for private sector entities, including for-profit entities. Upon review of this issue, the Supreme Court determined that "*the contraceptive mandate, as applied to closely held corporations, violates RFRA*." This means that a closely held for-profit corporation is not obligated to cover the contraceptive products or services to which the entity objects.

> A closely held corporation is defined in several ways. The term generally refers to a small privately held for-profit corporation consisting of few shareholders, typically family members or other close associates. For federal tax law purposes, the IRS refers to a closely held corporation as one in which over 50% of the value of its outstanding stock is owned (directly or indirectly) by 5 or fewer individuals at any time during the last half of the tax year; and is not a personal service corporation. For corporation formation purposes, a state may have a similar definition.

This Opinion does not address corporations that are publicly traded, arguably making this group a fourth category which today, is obligated to comply fully with the mandate.

NEXT STEPS

First and most important, the provisions of the ACA remain in full force and effect and all steps toward compliance should continue to be followed. This ruling relates only to the contraceptive mandate and it applies only to closely held corporations with a religious objection to some or all of the required services.

It is likely that matters will continue to evolve as it relates to the contraception requirement. Lawsuits challenging this same issue brought by eligible organizations will continue to wind their way through the courts.

It is likely that the Health and Human Services will issue additional regulations establishing a process by which a closely held corporation with a religious objection to forego some or all of the contraception requirements. The regulations are likely to provide a methodology whereby employees of objecting corporations can obtain these services. This process will likely mirror that which is available to eligible organizations described above.

About the Author: Karen R. McLeese is Vice President of Employee Benefit Regulatory Affairs for CBIZ Benefits & Insurance Services, Inc., a division of CBIZ, Inc. She serves as in-house counsel, with particular emphasis on monitoring and interpreting state and federal employee benefits law. Ms. McLeese is based in the CBIZ Leawood, Kansas office.

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CBIZ
Health Reform Bulletin

Subject: **Small Business Tax Credit – Final Regulations**
Date: August 5, 2014

On June 30, 2014, the Internal Revenue Service issued final regulations relating to the small business tax credit ("SBTC"). As background, small businesses and tax-exempt employers that provide health care coverage to their employees under a qualified health care arrangement are entitled to a tax credit.

The final regulations adopt most of the subject matter addressed in the proposed regulations and prior issued guidance (see "*Small Business Tax Credit (SBTC) Updates*" in the CBIZ Health Reform Bulletin, *Guidance and Updates*, 9/11/13). Primarily, the final regulations address changes to the SBTC applicable in 2014 and beyond. Following are highlights of these final rules.

Eligible Employers. Employers entitled to the credit remain the same. To be eligible, the employer must employ fewer than 25 full-time equivalent employees whose average annual wages are less than $50,000 (indexed; $50,800 for 2014). Employers employing 10 or fewer full-time equivalent employees whose average annual wages are less than $25,000 (indexed; $25,400 for 2014) also qualify for the SBTC. In addition, the small employer must cover at least 50% of the cost of single (not family) health care coverage for each employee.

Qualifying Coverage. The credit is only available for qualified health plan (QHP) coverage purchased through the Small Business Health Options Program (SHOP) and is only available for 2 consecutive year period. The final regulations provide that a stand-alone dental plan offered through the SHOP is available for credit.

Amount of Credit. For tax years beginning in 2014 and beyond, the maximum credit is 50% of premiums paid by small business employer; 35% for premiums paid by small tax-exempt employers. The SBTC is limited to the average premium in the rating area in which the employee enrolls.

Uniform Contribution Requirement. To be eligible to take the SBTC, the employer must make a uniform contribution toward health coverage. The final regulations make certain clarifications relating to the uniform contribution requirement, as follows.

- **Composite Billing and List Billing.** The final regulations adopt the definitions of "composite billing" and "list billing" as used in prior guidance.

  Composite billing refers to a billing system where the insurer charges a uniform premium for each employee or charges a single aggregate premium for a group of covered employees, the total of which is divided by the number of employees to determine the uniform billing. Under this method, if an employer offers one QHP with

one level of employee-only coverage, the uniform percentage requirement is met if the employer pays at least 50% of premium for employee-only coverage for each enrolled employee. The final regulations also provide a calculation method to satisfy the uniform premium requirement where different tiers of coverage are available at different premium cost.

List billing refers to a system wherein the insurer lists a separate premium for each employee based on age or other factors. Under this method where an employer offers employee-only coverage, the uniform percentage requirement can be met in one of two ways; either:

- The employer pays up to 50% of premium per employee, or
- The employer utilizes an "employer-computed composite rate". In this method, if an employee contribution is required for employee-only coverage, each enrolled employee would pay no more than 50% of the composite rate for such coverage.

These rules also address variances in calculating uniform percentage contributions when both a composite and list billing applies, when the coverage is tiered and when multiple QHPs are involved.

- ❑ The final regulations affirm that employer contributions to a health reimbursement arrangement (HRA), a health flexible spending arrangement (FSA plan) or a health savings account (HSA) are not taken into account for purposes of determining premium payments by the employer when calculating the credit.

- ❑ An employer need not offer SHOP **dependent coverage** but if it does, the premium paid for the SHOP dependent coverage is counted in determining the amount of the SBTC. SHOP dependent coverage is available to domestic partners, civil union partners, and their dependents. An employer's contribution, or lack thereof, will not jeopardize the employer's uniform percentage standard.

- ❑ **Tobacco Surcharge**. A tobacco surcharge imposed by a QHP that the employer pays is not included in premium for purposes of satisfying the uniform premium requirement nor does it count as premium payment for purposes of claiming the credit.

- ❑ **Wellness programs**. Any additional employer contribution attributable to an employee's participation in a wellness program is not counted in the uniform percentage calculation. This is true whether the difference is due to a discount for participation or a surcharge for non-participation in the wellness program. The employer contribution for non-participating employees must be at least 50% of the premium (including any premium surcharge for nonparticipation). However, for purposes of computing the credit, the employer contributions are taken into account, including those contributions attributable to an employee's participation in a wellness program.

Claiming the Credit. Beginning in 2014, an employer may claim the credit for two consecutive taxable years, beginning with the first tax year in or after 2014 in which the employer attaches Form 8941, *Credit for Small Employer Health Insurance Premiums*, to its income tax return. A tax-exempt employer would attach the Form 8941 to its Form 990-T, *Exempt Organization Business Income Tax Return*.

On July 25, 2014, the IRS issued a draft Form 8941 to be used to claim the credit in 2014. This version of the form includes some statutory changes applicable to the 2014 tax year. It is important to note that this version is only a draft and subject to change.

Transition rules. The final regulations affirm the proposed transition relief rules for obtaining the credit in instances in which the employer's plan year differs from the tax year (see Transition Relief in the prior CBIZ Health Reform Bulletin).

Effective date. The final regulations are effective June 30, 2014. However, employers may rely on the proposed regulations for taxable years beginning after 2013 and before 2015.

Additional IRS Information and Resources:

- IRS webpage: Small Business Health Care Tax Credit for Small Employers
- Questions and Answers
- SBTC Estimator (calculator)

About the Author: Karen R. McLeese is Vice President of Employee Benefit Regulatory Affairs for CBIZ Benefits & Insurance Services, Inc., a division of CBIZ, Inc. She serves as in-house counsel, with particular emphasis on monitoring and interpreting state and federal employee benefits law. Ms. McLeese is based in the CBIZ Leawood, Kansas office.

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CBIZ
Health Reform Bulletin

Subject: **Implementation Updates: 1) IRS Releases Draft Section 6055 and 6056 Reporting Forms; 2) 2015 Affordability Standards for Minimum Essential Coverage; and 3) Disclosure Requirement for Reduction or Elimination in Preventive Services**
Date: August 5, 2014

IRS Releases Draft Section 6055 and 6056 Reporting Forms

The Affordable Care Act (ACA) imposes new reporting requirements on health insurers, as well as on certain employers. These reporting requirements are imposed by IRC Sections 6055 and 6056 (see CBIZ Health Reform Bulletin, *IRS Final Rules – IRC Sections 6055 and 6056*, 3/14/14). These reporting requirements are for the purpose of helping the government discern who might be entitled to premium assistance, as well as discern what employers might be subject to the employer shared responsibility excise tax. This bulletin will focus primarily on the employer's reporting obligation.

The first report will be required for the 2015 calendar year, due in 2016. There is a report due to participants which must be provided by January 31st of each year; the first report would be due January 31, 2016. The report to the government will be due by February 28th of each year if filed by paper; by March 31st if filed electronically.

The IRS released the following draft reporting forms on July 24, 2014:

- Form 1094-B *Transmittal of Health Coverage Information Returns*
- Form 1095-B *Health Coverage*
- Form 1094-C *Transmittal of Employer-Provided Health Insurance Offer and Coverage Information Returns*
- Form 1095-C *Employer-Provided Health Insurance Offer and Coverage*

It is important to note that these are draft forms only and are subject to change. It expected that the related draft instructions to these forms will be issued sometime this month, and the final instructions and forms will be issued thereafter.

Generally, the C series of these forms will be used by employers subject to the shared responsibility requirement, i.e., those employing 50 or more employees. The Form 1095-C is the statement to be provided to each plan participant. The Form 1094-C is the transmittal form used to submit the Form 1095-C to the government.

In addition, self-funded plans will complete certain parts of these forms to reflect whether the coverage qualifies as minimum essential coverage (MEC). Generally, insurers will complete the B series, Form 1094-B being the transmittal form and the Form 1095-B being the statement to insured indicating whether the coverage provided qualifies as MEC.

Our CBIZ Employee Services will be hosting another webinar on October 21st, *Report Overload! Are You Meeting Your Requirements?* Hopefully, the final forms and instructions will be available by then and we'll include a discussion of the new forms at that time.

In the meantime, particularly for employers subject to the ACA's shared responsibility requirement, organizations will want to take a look at the draft forms and begin developing a system to collect the requisite information. In particular, note that Social Security numbers will need to be provided. If the employer does not have the Social Security number for individuals for whom reporting is required, they will want develop a system to collect them. If the employer cannot obtain a Social Security number, the individual's date of birth could be used.

Basically, the forms require the employers to report on whether health coverage was offered for each month of the year and if coverage was not offered, then the employer would be required to provide the reason for not offering coverage, such as in the instance where the employer was not in business during the reporting timeframe, an employee works part-time or an employee was in a waiting period.

As a reminder, employers subject to the shared responsibility requirement will be obligated to prepare the forms for the 2015 calendar year, even if the risk of an excise tax is delayed due to one of the transition rules (see "Transition Relief Rules" in the CBIZ HRB, *Exploring the Final Employer Shared Responsibility Regulations*, 3/10/14)

Again, these are draft forms only. As soon as the final forms and instructions are available, we will provide more detail.

2015 AFFORDABILITY STANDARDS FOR MINIMUM ESSENTIAL COVERAGE

In Revenue Procedure 2014-37, the IRS released the 2015 contribution percentages for purposes of determining affordable minimum essential coverage standards under the shared responsibility requirement, as follows:

- ***Employer Shared Responsibility Requirement***. Employers subject to the ACA's shared responsibility requirement must offer minimum essential coverage (MEC) that meets an affordability standard and a minimum value standard or risk a penalty. Generally, MEC includes the type of coverage available under most insured and self-funded employer-sponsored group health plans, without regard to grandfathered status. MEC is deemed affordable to a particular employee if the employee's required contribution to the plan does not exceed 9.5% (9.56% in 2015) of the employee's household income for the taxable year, based on the cost of single coverage in the employer's least expensive plan.

- ***Individual Shared Responsibility.*** Beginning this year, all U. S. residents must maintain MEC or risk a shared responsibility penalty. There are currently 9 categories of individuals exempt from the requirement to maintain MEC. Specifically, an individual who cannot afford coverage because the premium cost exceeds 8% (8.05% for 2015) of his/her household income would be exempt from the individual mandate.

  In addition, this Revenue Procedure includes a revised "Applicable Percentage Table" for purposes of calculating an individual's premium tax credit for tax years beginning in 2015.

In related guidance (Rev. Proc..2014-46), the IRS released the 2014 monthly national average premium for qualified health plans that is used in determining the maximum individual shared responsibility penalty. For 2014, the potential penalty for failure to maintain MEC is the greater of $95 per adult and $47.50 per child (up to $285 for a family); or 1.0% of family income. The total amount of penalty is capped based on the average cost under a bronze level plan offered through the marketplace. For 2014, the monthly average bronze level plan premium is $204 per individual; $1,020 for a family with five or more members.

DISCLOSURE REQUIREMENT FOR REDUCTION OR ELIMINATION IN PREVENTIVE SERVICES

In response to the Supreme Court's decision in the Hobby Lobby case (see CBIZ HRB, *Preventive Services - Contraceptive Mandate*, 7/2/14), the Department of Labor's Employee Benefit Security Administration issued an FAQ reminding plan sponsors about the requirements to comply with certain ERISA disclosure requirements.

Specifically, if a closely held corporation is eligible to claim the religious objection to providing contraceptive coverage to its employees under a group health plan, and if it wishes to remove these benefits from the plan, this would be a material reduction in benefits requiring a modification to the summary plan description. This change in benefits can be provided to plan participants in the form of a summary of material modification (SMM).

The SMM must be provided to participants as soon as possible, but in no event later than 60 days from the date the plan sponsor adopts the change.

About the Author: Karen R. McLeese is Vice President of Employee Benefit Regulatory Affairs for CBIZ Benefits & Insurance Services, Inc., a division of CBIZ, Inc. She serves as in-house counsel, with particular emphasis on monitoring and interpreting state and federal employee benefits law. Ms. McLeese is based in the CBIZ Leawood, Kansas office.

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CBIZ
Health Reform Bulletin

Subject**: Implementation Update: Women's Preventive Health Services**
Date: August 28, 2014

The women's health services component of the Affordable Care Act's (ACA) preventive services mandate continues to evolve. As background, the ACA requires non-grandfathered plans to provide specified preventive services at no cost to plan participants. These preventive services require coverage of certain women's health services including contraceptive coverage.

The requirement to cover contraceptive services has been challenged by many organizations. Two of these challenges have reached the Supreme Court:

- *Burwell v. Hobby Lobby et al.* [No. 13-354 (U.S. June 30, 2014)] wherein the Court held that a closely held corporation is protected by the Religious Freedom and Restoration Act; and thus not obligated to cover the contraceptive benefit mandated by the ACA (see CBIZ Health Reform Bulletin, *Preventive Services - Contraceptive Mandate*, 7/2/14).

- *Wheaton College v. Burwell* [134 S. Ct. 2806 (2014)] wherein a religiously affiliated college sought an injunction to relieve it from the obligation of filing an exemption to the contraceptive mandate by way of the EBSA Form 700. As background, regulations issued in July 2013 provided for an accommodation for certain eligible organizations such that they would not be required to arrange or pay for the objectionable benefit by filing a self-certification Form 700 (see *Women's Health Services Mandate Final Regulations – Exemption for Religious Employers and Non-Profit Religious Organizations*, 7/5/13). In this methodology, the insurer or third party administrator (TPA) of a self-funded plan would then independently make the benefits available to plan participants. Wheaton College found the process of filing the Form 700 to be objectionable.

In response to these challenges, the Departments of Health and Human Services, Labor and Treasury (governing agencies) issued interim final and proposed regulations in an effort to ensure that women have access to the services prescribed by the law in a manner that is palatable to the challenging organizations.

The interim final rules continue to sanction the self-certification methodology but also provide an alternative process of compliance pursuant to which the eligible organization can notify HHS in writing of its objections. HHS provides a model notice that can be used for this purpose. The type of information to provide in the notice includes:

- Name, contact information and type of the organization;
- Service provider information include plan name, contact information, category (insurer or TPA) and plan type (church or student plan); and

- A description of the contraceptive services or subset of services to which the eligible organization objects.

Once HHS receives the notification, it will then notify the insurer or TPA associated with the notification who would make the objectionable services available to plan participants. The insurer or TPA would be reimbursed the costs of services from the fees paid by insurers to participate in the federal marketplace.

Effective Date
The interim final regulations are effective on August 27, 2014. Comments on these rules may be submitted to the Agencies by October 27, 2014.

As a result of the *Hobby Lobby* decision referenced above, the ACA's governing agencies issued proposed regulations which would amend the definition of eligible organization to include a closely held for-profit entity whose shareholders have sincerely held religious beliefs in contravention of some or all of the contraceptive services. HHS is seeking comments on whether the definition of closely held corporation would be based on the number of shareholders or concentration of ownership. The closely held organization would pursue the certification method described above. It is important to note that this definition would not extend to a publicly traded corporation.

Effective Date
Comments on the proposed rules must be received by October 21, 2014.

About the Author: Karen R. McLeese is Vice President of Employee Benefit Regulatory Affairs for CBIZ Benefits & Insurance Services, Inc., a division of CBIZ, Inc. She serves as in-house counsel, with particular emphasis on monitoring and interpreting state and federal employee benefits law. Ms. McLeese is based in the CBIZ Leawood, Kansas office.

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CBIZ
Health Reform Bulletin

Subject**: IRS Releases Draft Instructions for ACA Shared Responsibility Reporting**
Date: September 15, 2014

On August 28, 2014, the Internal Revenue Service (IRS) issued draft instructions for the annual reporting that will be required by employers subject to the Affordable Care Act's shared responsibility requirements, as well as by plans providing minimum essential coverage (MEC). These forms are the 1094 and 1095 B-series for reporting MEC, and the 1094 and 1095-C series for reporting employer provided coverage required specifically by employers subject to shared responsibility. These draft forms were issued in late July (see CBIZ Health Reform Bulletin, *IRS Releases Draft Section 6055 and 6056 Reporting Forms*); below are links to the recently issued draft instructions that pertain to the forms:

- Instructions for Forms 1094-B and 1095-B
- Instructions for Forms 1094-C and 1095-C

It is important to note that these instructions and forms are drafts only and subject to change.

For purposes of both sets of forms, the Form 1094 is the transmittal form submitted to the IRS; the Form 1095 is the benefit statement provided to plan participants. There are some simplified reporting methods that can be used in certain circumstances. These will be discussed in our upcoming webinar mentioned below.

The **B Series** of these forms is used to report MEC and is prepared by the insurer for insured plans, and by the plan sponsor of a self-funded plan (a self-funded plan sponsor subject to shared responsibility can accomplish this obligation by completing Part III of the Form 1095-C). This report advises the IRS about whether the individual was covered by MEC. This requirement applies without regard to plan size.

The **C Series** of these forms is applicable only to employers subject to shared responsibility. It is used by the IRS to determine who is entitled to premium assistance, as well as determine whether an employer subject to shared responsibility might be at risk for an IRC §4980H(a) no-coverage tax, or an IRC §4980H(b) inadequate or unaffordable tax. The instructions provide fairly explicit information about how to complete the transmittal Form 1094-C and the benefit statement (Form 1095-C) with regard to the 'who' (employee, spouse, dependent), the 'what' (MEC, minimum value) and 'how much' (is it affordable?) conditions of the coverage being offered.

In a nutshell, the reporting requires for each month of the calendar year, a representation of who is a full-time employee, whether that full-time employee, his/her spouse or his/her children were offered coverage, whether that coverage met minimum value, and whether it was affordable. And for each month for which coverage was not offered, a representation as to why the coverage was not offered; for example, for reasons such as the individual was not

employed during that month, the individual was not full-time, or the individual was in a limited non-assessment period, such as a waiting period or an initial measurement period

Further, the reporting rules require the use of employee's social security number (SSN); and for employers required to complete Part III of the Form 1095-C, the SSNs of the dependents must also be collected which might create an additional burden on employers.

The applicable employer would be required to file Forms 1094-C and 1095-C with the IRS and to furnish a copy of Form 1095-C to the employee. Below is a quick snapshot of the type of information required for these forms.

Form 1094-C

- Part I of the form requests identifying information about the "applicable large employer" such as name, EIN, address and contact information of the person submitting the form.

- Part II requests further details relating to whether the reporting employer is part of an aggregated group, the number of 1095-C forms filed by the reporting entity, and indication of the applicable type(s) of coverage utilized by the employer in its offer of health coverage to its full-time employees.

- Part III is set up in a chart format. Here a reporting entity would complete a month by month tally of whether an employer offered MEC to 95% of its full-time employees and their dependents, the number of full-time and non-full-time employees employed for each month, the number of months the reporting employer was part of an aggregated group if applicable, and whether the employer certifies eligibility for transition relief available for employers employing between 50-99 employees, or 100 or more employees. It is important to note that all covered lives must be reported, whether full-time or not.

Form 1095-C

The Form 1095-C is used to report information to the IRS about each employee and for determining eligibility for premium tax credits. It is also provided to each employee included in the report.

- Part I requests the name, social security number and mailing address for each employee as well as identifying information about the "applicable large employer" such as name, EIN, address and contact information of the person submitting the form.

- Part II requires an indicator code to be entered on a per month basis of the type of coverage offered to the employee. For example, Code 1A would designate a qualifying offer of MEC providing minimum value offered to full-time employees and their dependents with the employee contribution for self-only coverage not to exceed 9.5% of household income. Then, the employer would enter the employee's share of the lowest cost monthly premium for self-only minimum value coverage. Depending on the indicator code entered, a reporting entity would then indicate by using another series of codes whether any of the IRC 4980H safe harbor codes need be used. For example, a Code 2A would designate an employee who is not full-time. A Code 2F would designate that a W-2 safe harbor is used as it relates to affordability.

- ❑ Part III, Covered Lives, need only be completed if an employer sponsors a self-insured plan in which the employee enrolled, regardless of whether the employee works full-time.

Due Date. The instructions make clear that the reporting is required to begin in 2015. Employers may, but are not required to, report for the 2014 tax year. Note, even if an employer chooses to report for the 2014 tax year, no penalty will be assessed as the shared responsibility requirement will not take effect until 2015.

Upcoming CBIZ Webinar. Please join us for an upcoming CBIZ Employee Services webinar, "*Report Overload! Are You Meeting Your Requirements?"* scheduled for Tuesday, October 21, 2014 where these forms will be discussed in greater detail. Click **here** for additional information about this webinar and/or to register to attend the webinar.

Additional information about these reporting requirements is available from IRS website:

- Questions and Answers on Reporting of Offers of Health Insurance Coverage by Employers (Section 6056)
- Questions and Answers on Information Reporting by Health Coverage Providers (Section 6055)

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Health Reform Bulletin

Subject: **IRS Pronouncements: 1) Cafeteria Plan Status Change Events, 2) Employment Status Change Proposals to Employer Shared Responsibility Rules, 3) Increase in PCOR Fees; and Final Excepted Benefit Regulations**
Date: October 6, 2014

The Internal Revenue Service recently released three pronouncements relating to the Affordable Care Act (ACA). In addition, final regulations have been issued relating to certain excepted benefits.

NEW CAFETERIA PLAN STATUS CHANGE EVENTS

Generally, a cafeteria plan election is binding for a 12-month period. A cafeteria plan election can only be changed if certain status change events occur and only as long as the cafeteria plan document allows for the relevant status change event and only as long as the change being made is consistent with that status change. The newly released guidance, IRS Notice 2014-55, provides for two new cafeteria plan status change events.

Thus far, the ACA marketplace open enrollment period has not been a status change event. This creates challenges for non-calendar year cafeteria plans. The IRS guidance indicates that the cafeteria plan regulations will be amended to allow a status change event both for the marketplace open enrollment time, as well as for the marketplace special enrollment events that permit enrollment upon certain events such as moving to a new state, a change in income or family events such as marriage or birth of a child.

Further, this Notice provides that a cafeteria plan can include, as a status change event, a reduction in hours to less than 30 hours per week, even if that does not cause a loss of eligibility under the health plan. Without this permissible status change event, an individual would be ineligible to make a change because it would not meet the consistency rule.

Effective date. This guidance can be relied upon prior to the regulations being amended.

Amending the Cafeteria Plan Document. If an employer wants to add these status change events to its Section 125 cafeteria plan, then the cafeteria plan document must be amended to adopt the changes. The amendment would need to be adopted before the last day of the plan year in which the elections are allowed and can be made effective retroactively to the beginning of the plan year. A plan can be amended to adopt the new election changes for the 2014 cafeteria plan year as long as the amendment is made before the last day of the 2015 plan year. However, no elections to revoke coverage are allowed to be made on a retroactive basis. In addition, once the cafeteria plan is amended, then plan participants must be notified of the changes.

EMPLOYER SHARED RESPONSIBILITY – CHANGE IN EMPLOYMENT STATUS PROPOSALS

IRS Notice 2014-49 provides additional guidance on changes in employment status, particularly relevant as it relates to the ACA employer shared responsibility requirement and use of measurement periods.

As a reminder, for purposes of the employer shared responsibility provisions, an employee is deemed full-time if the employee works, on average, 30 or more hours per week. In many situations, an employee's status upon hire is not clear. To this end, the regulations provide two methods: a monthly method and a look-back method that can be used for determining full-time status as it relates to the potential assessment of an employer shared responsibility penalty (see CBIZ Health Reform Bulletin, *Exploring the Final Employer Shared Responsibility Regulations* (3/10/14).

The monthly method looks at hours worked in a month to determine full-time status for that month. The look-back method uses a look-back period, known as a measurement period, to assess hours worked. Based on hours worked during the look-back (measurement) period, an individual's status as full-time, or not full-time, is set for an entire stability period.

One of the challenges exists when the measurement standard changes. This can occur in several ways; for example, where one moves from a monthly method to a look-back method or vice versa. This Notice provides additional guidance specifically as it relates to, for example, the types of measurement period that is used for a class of employees. For example, if an employer uses a 12-month look-back period for its employees covered by collective bargaining agreement (CBA) and a 6-month look-back period for its hourly employees, and if the employer wants to move the hourly measurement methodology to mirror the CBA methodology, this Notice provides guidance on how to accomplish this (see Example 7 in the *CBIZ Examples of Change in Measurement Period from Monthly to Look-back and Vice Versa*).

Corporate Transactions. In the event of a business acquisition, the government continues to look at ways to best accommodate business transactions. Until future guidance is issued, at least through the end of 2016, in the event of a business reorganization, an employer can use the methodologies described in the Notice.

Effective date. The information contained in the Notice can be relied upon until future guidance is provided.

PCOR FEE – ADJUSTED AMOUNT

IRS Notice 2014-56 relates to the Patient Centered Outcomes Research (PCOR) fee. The PCOR fee was $1 for the first year; $2 for the second year; and, is tied to inflation thereafter. This guidance indicates that the PCOR fee will be $2.08 for plan years ending between October 1, 2014 and October 1, 2015.

EXCEPTED BENEFITS – FINAL REGULATIONS

On October 1, 2014, the three ACA governing agencies (HHS, IRS and DOL) issued final regulations relating to certain excepted benefit plans; specifically, limited scope dental and vision plans, and employee assistance programs. Generally, these types of excepted benefit plans are exempt from many aspects of the ACA, as well as HIPAA.

The final regulations generally adopt the requirements of the proposed regulations issued in December, 2013 (see CBIZ HRB, *Excepted Benefit Proposed Regulations*, 1/6/14), with a few clarifications as follows.

Insured limited-scope dental benefits, limited-scope vision benefits, or long-term care benefits are excepted from the ACA (and HIPAA) if the benefits are provided under a separate policy, certificate, or contract, or are otherwise not an integral part of a group health plan which means:

1. Participants can decline and/or opt out of the coverage regardless of whether a participant contribution is required for the coverage; and
2. The claims for benefits are administered under a separate contract from the claims administered by the group plan.

To be "*limited scope*", the plan must specifically, and only provide benefits for, in the case of dental plans, issues relating to the function and structure of the mouth, and for vision coverage, issues relating to the function and structure of the eye.

Generally, an employee assistance program (EAP) would be subject to the ACA if it provides *significant* medical care. The regulations indicate that short-term limited counseling would not be considered significant medical care whereas long-term services. such as disease management. would be. As a side note, this appears to be a bit in contravention of the standard used for COBRA purposes. Hopefully, clarifying guidance will be issued at some point.

An EAP would be exempt from the ACA if:

1. The program does not provide significant medical care benefits; and
2. The benefits under the EAP are not coordinated with benefits under another group health plan. This means that:
   - Participants in the other group health plan are not required to use and exhaust benefits under the EAP as a gatekeeper before an individual is eligible for benefits under the other group health plan;
   - Participant eligibility for benefits under the EAP cannot be dependent upon participation in another group health plan;
   - No employee premiums or contributions are required as a condition of participation in the EAP; and
   - There is no cost share requirement by the EAP.

The proposed regulations suggested a third type of excepted benefit known as a limited "wraparound" benefit. The premise behind the wraparound coverage is that if the employer coverage is unaffordable to certain employees, the employee could forego the employer coverage and obtain individual coverage together with the wraparound coverage. These final regulations do not further address this concept but it is indicated that future guidance will.

Effective date. The final regulations apply to group health plan years beginning on or after January 1, 2015. Until then, either the proposed or final regulations may be relied upon.

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CBIZ
Health Reform Bulletin

Subject: **Completing the Transition Reinsurance Fee Form**
Date: October 28, 2014 (revised November 21, 2014)

On October 24, 2014, the CMS Center for Consumer Information and Insurance Oversight (CCIIO) released the official form, together with a user manual, for submitting enrollment counts and setting up payment for the transitional reinsurance fee.

As background, the Affordable Care Act (ACA) imposes a transitional reinsurance fee, the goal of which is to help stabilize premiums in the individual market due to enrollment of higher risk individuals in the marketplace beginning in 2014. All insurers and plan sponsors of self-funded plans are required to contribute to this reinsurance fund over a three year period from 2014 through 2016.

The entities responsible for submitting the relevant information and paying the fees are insurers of fully insured plans and plan sponsors of self-funded plans (though, third party administrators can facilitate the process on behalf of plan sponsors), referred to as "reporting entities". The reporting and payment of fees is based on the type of plan issued by the insurer or plan sponsor. Virtually all-sized health plans, such as major medical plans and high deductible health plans used in conjunction with a health savings account (HSA), are subject to these fees. This includes plans sponsored by single employers, as well as multiple employer plans and multi-employer plans. Post-employment plans that are primary to Medicare, such as early retiree plans and COBRA continuation coverage are also subject to the fee. Plans *not subject* to fees include:

- HIPAA-excepted benefit plans such as limited scope dental and vision plans;
- Health reimbursement arrangements integrated with comprehensive insured or self-funded group coverage;
- Flexible medical spending account plans;
- HSA investment accounts;
- Employee assistance plans, disease management programs, and wellness programs if the program does not provide significant benefits in the nature of medical care or treatment;
- Stand-alone prescription drug plans;
- TRICARE or other military benefit plans;
- Certain Indian tribal benefit programs; and
- Certain expatriate plans.

Steps in Completing the Form

The reporting form, known as the "*ACA Transitional Reinsurance Program Annual Enrollment Contributions Submission Form*" and payment process is accomplished through the Pay.gov website (https://www.pay.gov). According to CCIIO's companion User Manual, following are steps to follow for in the contribution submission process.

Prior to registering in the Pay.gov website, reporting entities should review the actual form and instructions. Information that should be prepared prior to registration includes the collection of data, a calculation of the entity's annual enrollment count, and preparation of supporting documentation (see Section 4.2 of the Manual, *Collection of Required Information for Filing*).

Step 1. Register with Pay.gov (https://www.pay.gov/) Entities that do not already have an account with pay.gov must register and create an account for purposes of completing the contribution form, uploading support documentation and providing payment information (see Section 5 of the Manual for registration tips). The registration information used to create user profile and pre-populate certain information on the form.

Step 2. Complete the "*ACA Transitional Reinsurance Program Annual Enrollment Contributions Submission Form*". Section 6 of the manual provides the details about the required information to complete this form including the reporting entity's contact information, selection of the type of payment and benefit year, uploading support documentation of the entity's gross annual enrollment count, and scheduling the contribution payment.

Step 3. Upload Supporting Documentation. The form requires detailed information about the reporting entity's enrollment count in a specific format (refer to *Appendix D, Supporting Documentation* on pages 51-56 of the Manual for required elements and format specifications). Below is a snapshot of the methodologies that can be used to count covered lives by type of reporting entity:

Methodology for Counting Covered Lives	Insured Group Health Plan	Self-Funded Group Health Plan
Actual Count Add the total number of covered individuals on each day of the first 9 months of the benefit year and divide that total by the number of days in the first 9 months	✓	✓
Snapshot Count Add the total number of covered individuals on any date during the same corresponding month in each of the first three quarters of the benefit year, and divide that total by the number of dates on which a count was made.	✓	✓
Snapshot Factor Add total number of covered lives of reinsurance contribution enrollees on any date during same corresponding month in each of the first three quarters of the calendar year, i.e., March, June and September, and dividing that total by the number of dates on which a count was made.		✓
Member Months or State Form Multiply the average number of all policies offered by the insurer in effect for the first 9 months of the benefit year by the ratio of covered individuals per policy in effect. The calculation is derived by data the insurer annually files with its relevant state licensure department, such as a state insurance department.	✓	
Form 5500 Based on average number of covered participants at the beginning and end of the plan year, as reported on the relevant Form 5500 for the applicable plan year		✓

Step 4 – Enter payment information. Information provided by the reporting entity by this point of the form will result in an automatic calculation of the fees due. The reporting entity then needs to schedule its payment, and provide electronic banking transaction information to pay the fees (see section 6.7 and 6.8 of the Manual). Reporting entities can set up to pay the fee in one or two installments. The first collection deadline is January 15, 2015; the second collection deadline is November 15, 2015. Or, the entity can choose to pay both installments at once by January 15, 2015.

KEY DEADLINES FOR 2014 BENEFIT PLAN YEAR REPORTING	
Dec. 5, 2014*	Submit Annual Enrollment Count and Schedule Contribution Payment Date(s)
Jan. 15, 2015	Remit first (or combined) Contribution Amount: $52.50 per covered life**
Nov. 15, 2015	Remit second Contribution Amount: $10.50 per covered life**

**The initial Nov.15, 2014 deadline had been extended to Nov. 17, 2014. However, on Nov.15, 2014, CMS further extended the deadline to Dec. 5, 2014.*
***For purposes of 2015 benefit year reporting, the first or combined contribution rate reduces from $52.50 to $33 per covered life; the second contribution amount increases from $10.50 to $11 per covered life.*

Resources for Additional Information

- *ACA Transitional Reinsurance Program Annual Enrollment Contributions Submission Form*
- ACA Transitional Reinsurance Program Annual Enrollment and Contributions Submission Form Manual
- Pay.gov: https://pay.gov/
- Registration for Technical Assistance Portal (REGTAP): https://www.regtap.info/
- CCIIO's Transitional Reinsurance Program – Reinsurance Contributions webpage

Background CBIZ Health Reform Bulletins

- *PCOR Fees and Transitional Reinsurance Fees* (6/18/14)
- *HHS Benefit and Payment Parameters for 2015* (3/14/14)
- *See 'Transitional Reinsurance Fee' in 'Proposed Benefit and Payment Parameters in 2015' in Year-end Wrap Up* (12/23/13)
- *Implementation Guidance* (3/12/13)
- *Premium Stabilization Program Proposals and 2) Chart of Health Plan Fees and Taxes* (12/18/12)

About the Author: Karen R. McLeese is Vice President of Employee Benefit Regulatory Affairs for CBIZ Benefits & Insurance Services, Inc., a division of CBIZ, Inc. She serves as in-house counsel, with particular emphasis on monitoring and interpreting state and federal employee benefits law. Ms. McLeese is based in the CBIZ Leawood, Kansas office.

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CBIZ
Health Reform Bulletin

Subject**: Year-End Wrap-Up**
Date: December 11, 2014

As 2014 draws to a close, a new Congress and continued court challenges should not deter efforts needed now to ensure compliance with the Affordable Care Act (ACA) as we know it. While we know not what the new Congress will do, you can be sure that many aspects of the ACA will be considered. In addition, the Supreme Court has agreed to review the *King v. Burwell* case on the issue of whether the premium tax credit, available to individuals whose household income falls below 400% of the federal poverty level, is obtainable in both the federal and state marketplaces. The hearing of this case is expected to be held in early March, 2015. Again, we know not how the Supreme Court will rule.

In this interim, following are some recent updates and reminders relating to ACA compliance.

RECENT ACA GUIDANCE

Health plans that fail to cover hospital or physician services ("skinny plans") fail to meet minimum value standard

On November 4, 2014, the Departments of Health and Human Services and Treasury issued guidance (IRS Notice 2014-69) clarifying that so-called "skinny plans" that fail to provide coverage for hospital services and/or physician services will not qualify as a minimum value plan.

As a reminder, minimum value (MV) means that the plan covers at least 60% of the cost of medical services. It is necessary that a plan meet minimum value in order to avoid the IRC Section 4980H(b) penalty. The Notice goes on to state that an individual's eligibility for premium assistance will not be jeopardized if the only coverage offered fails to meet MV standards. Because these products have been promoted, the Notice provides that any products in place prior to November 4, 2014 will be honored through the end of the plan year. However, any new plan implemented will put the employer at risk for a shared responsibility penalty.

Further, this Notice provides that any communication suggesting that this type of coverage would disqualify an individual from premium assistance must be proactively corrected, i.e., the summary of benefits and coverage or other plan communications must accurately reflect that a plan which fails to meet minimum value will not disqualify the individual from receiving premium assistance.

Employer Premium Payment Arrangements for Individual Coverage

On November 6, 2014, the Department of Labor's Employee Benefit Security Administration released its 22nd set of implementation FAQs addressing several scenarios in which cash is offered by an employer, either to incent individuals to choose individual coverage over group

coverage, or to otherwise attempt to satisfy the employer's shared responsibility obligation. Once again, the door is being closed and locked on these types of arrangements.

As background, in September 2013, the government issued guidance prohibiting the use of tax-favored money for individual premium, whether purchased through the marketplace or outside the marketplace (see CBIZ Health Reform Bulletin, *Impact of ACA on HRAs, Health Care FSAs, and Other Employer Health Care Arrangements*, 9/20/13). The guidance affirmed that no form of pre-tax contribution, whether through a health reimbursement arrangement, flexible medical spending account or other premium payment plan could be used to purchase individual coverage.

Then, on May 13, 2014, the IRS again came out with guidance, in an FAQ format, cautioning employers about the risk of violating the reimbursement of individual premium rules.

In the newest FAQs, the DOL goes even further, clarifying that whether the cash is offered on a pre-tax or after-tax basis makes no difference. If it is used to pay individual premium, it makes the individual policy an employer-sponsored plan subject to all of the requirements of the Affordable Care Act. Since these products do not necessarily comply with all requirements, it puts the employer at risk for a $100 per day/per participant penalty for failure to offer a compliant plan.

In the second FAQ, the DOL addressed whether an employer could offer a high claimant cash as an incentive to decline the employer-sponsored coverage. Once again, the answer is "No". As an aside, not only is the answer "No" from an ACA perspective, but would likely be "No" from an Americans with Disabilities Act's perspective as well.

In the third FAQ, the government says, "No", once again to a scenario whereby an IRC Section 105 plan is set up to which the employer contributes and the individual purchases coverage.

INDIVIDUAL SHARED RESPONSIBILITY MANDATE

As a reminder, individuals must maintain a minimum level of coverage or be subject to a tax. The potential fees imposed on individuals for failing to maintain health coverage increases in 2015 to the greater of 2% of yearly household income; or, $325 per person ($162.50 per child under 18).

Determining Affordability of Coverage

There are certain exemptions to the requirement to maintain minimum essential coverage (see CBIZ Health Reform Bulletin, *Individual Minimum Essential Coverage*, 2/6/13). One of these exemptions occurs if the cost to the individual to purchase coverage exceeds 8% (8.05% for 2015) of household earnings (the government is proposing to increase the required contribution percentage to 8.13% of household income beginning in 2016). This affordability standard is distinct from the employer's shared responsibility affordability standard and distinct from the affordability standard for being entitled to premium assistance.

On November 26, 2014, the IRS issued final regulations relating to minimum essential coverage (MEC) and hardship exemptions for purposes of the individual shared responsibility mandate. Specifically, these regulations address the effects of employer contributions to a cafeteria plan or health reimbursement arrangement (HRA), and wellness program incentives for affordability purposes. It remains to be seen whether these standards will be included in the premium tax credit affordability regulations.

- **Cafeteria Plan Contributions**
  For purposes of determining affordability of coverage, amounts made available for the current plan year under a cafeteria plan will not be included in the employee's cost if the amount:
  1. Cannot be taken as a taxable benefit, such as cash;
  2. Is only used to pay for MEC; and
  3. Is only used to pay for medical care, as defined in IRC Section 213(d).

- **Employer Contributions to HRAs**
  Amounts newly made available for the current plan year under an HRA that an employee may use to pay premiums, or may use to pay cost-sharing or benefits not covered by the primary plan in addition to premiums, are counted toward the employee's required contribution if the HRA is integrated with the employer-sponsored group health plan.

- **Wellness Program Incentives**
  For purposes of determining affordability, the final regulations clarify that wellness incentives, such as a discount or rebate, or imposition of a surcharge, unrelated to tobacco use are treated as unearned; while wellness incentives related to tobacco use are treated as earned. However, if there is an incentive for completing a program unrelated to tobacco use and a separate incentive for completing a program related to tobacco use, then the incentive related to tobacco use may be treated as earned.

Premium Tax Credit

The following contribution percentages will be used to determine whether an individual is eligible for affordable employer-sponsored MEC in tax years beginning in 2015 and 2016:

Household income percentage of Federal poverty line	Initial percentage *2015*	Final percentage *2015*	Initial percentage *2016*	Final percentage *2016*
Under 133%	2.01%	2.01%	2.03%	2.03%
Between 133% and 150%	3.02%	4.02%	3.05%	4.07%
Between 150% and 200%	4.02%	6.34%	4.07%	6.41%
Between 200% and 250%	6.34%	8.10%	6.41%	8.18%
Between 250% and 300%	8.10%	9.56%	8.18%	9.66%
Between 300% and 400%	9.56%	9.56%	9.66%	9.66%

ACA Provisions Effective in 2015

Cost-share limits

The 2015 out-of-pocket limits applicable to insured plans offered via the Marketplace, and insured and self-funded plans offered outside Marketplace are:

- $6,600 for single coverage
- $13,200 for coverage for more than one

As a reminder, the 2015 out of pocket limits applicable to high deductible health plans used in conjunction with a health savings account are $6,450 for individual; $12,900 for family.

Employer Shared Responsibility Requirement

- **Employers employing 100+ Employees** could be subject to excise tax penalties under IRC Section 4980H(a) and (b) beginning 2015. The penalty tax is based on number of employees employed in 2014; and, whether adequate affordable coverage is offered in 2015.
- **Employers employing between 50 to 99 Employees** in 2014 would not be subject to the employer shared responsibility requirement, generally, until their plan anniversary occurring in 2016, as long as:
    1. There has been no change in the plan year since February 9, 2014;
    2. The employer maintains its workforce size and average hours worked; and
    3. The employer maintains previously offered health coverage. This means that:
        - The health coverage offered and the group to whom it is offered has not materially eliminated or reduced; and
        - The employer contribution toward such coverage is maintained at the same or greater contribution level, or does not fall below 95% of the dollar amount contributed toward single coverage prior to February 9, 2014.
- **Employers employing fewer than 50 employees in 2014** *are not* subject to the employer shared responsibility requirement. These employers have the option to apply and purchase coverage through the Small Health Options Program (SHOP).
- **For employers employing fewer than 25 employees,** the IRS' Small Business Tax Credit is available for a two-consecutive year period. The credit only applies to SHOP coverage. For purposes of this credit, an eligible employer is one who employs fewer than 25 full-time employees whose average annual wages is less than $50,800 (indexed for 2015). Those employers employing fewer than 10 full-time employees whose average annual wage is less than $25,800 are also eligible for the credit. The maximum credit is 50% of premiums paid by employer (35% for premiums paid by small tax-exempt employer).

Required Reporting and Disclosure

The ACA imposes new reporting requirements; these are found in IRC Sections 6055 and 6056. Section 6055 reporting relates to who qualifies for minimum essential coverage (MEC). Section 6056 reporting relating to the employer shared responsibility requirement will assist the government in determining which employers might be subject to a shared responsibility risk, as well assist in determining whether individual taxpayers are entitled to premium assistance.

The forms for both of these reporting requirements are the Form 1094 transmittal and Form 1095 benefit statement. IRC Section 6055 reporting is accomplished on the B series of the form; the employer shared responsibility reporting is accomplished on the C series. A self-funded employer subject to shared responsibility can satisfy both its IRC Sections 6055 and 6056 reporting obligations by completing all parts of the Form 1095-C

The first reports will be required for the 2015 calendar year, due in 2016. The benefit statements must be provided to individuals listed in the reporting forms by January 31st of each year; the first report is due January 31, 2016. The report to the government will be due by February 28th of each year if filed by paper; by March 31st if filed electronically.

Thus far, the IRS has only issued draft versions of the forms and instructions; the final version of these forms is expected in the near future.

To assist our clients with these reporting requirements, CBIZ will be making an ACA Reporting Tool & Technology Platform available in 2015 to accommodate the collection, processing, and ongoing record-keeping of the required data. Ask your CBIZ representative for information about the **CBIZ ACA CheckPoint** tool.

Background CBIZ Health Reform Bulletins on these reporting requirements:

- *IRS Releases Draft Instructions for ACA Shared Responsibility Reporting* (9/15/14)
- *IRS Releases Draft Section 6055 and 6056 Reporting Forms* (8/5/14)
- *IRS Final Rules – IRC Sections 6055 and 6056* (3/14/14)
- *Information Reporting by Employers on Health Coverage and Reporting of Minimum Essential Coverage* (9/18/13)

Affordability Standard – Employer-Sponsored Coverage

Under an employer-sponsored plan, coverage is deemed affordable to a particular employee if his/her required contribution to the plan does not exceed 9.5% (indexed for 2014) of the employee's household income for the taxable year, based on the cost of single coverage in the employer's least expensive plan. The household income threshold percentage increases to 9.56% for 2015; it is proposed to increase to 9.66% for 2016. The employer shared responsibility regulations provide three safe harbors that can be used by employers to determine affordability (see Affordability Standard in the CBIZ Health Reform Bulletin, *Exploring the Final Employer Shared Responsibility Regulations*, 3/10/14). Note, at this point, the safe harbors continue to be based on 9.5% household income standard.

PROPOSED BENEFIT AND PAYMENT PARAMETERS FOR 2016

On November 26, 2014, the Center for Medicare and Medicaid Services (CMS) published proposed benefit and payment regulations addressing several issues applicable to the 2016 benefit year. Following are some of the proposals contained in the regulations:

- ***Transitional Reinsurance Fee***. The goal of a transitional reinsurance program is to stabilize premiums in the individual market to offset the expenses of the eligible individuals enrolling in the Marketplace. For 2014, the contribution rate is $63 per covered life, $44 per covered life in 2015. The proposed amount for 2016 drops to $27 per covered life.
- ***Annual Open Enrollment Period.*** For the 2016 plan year, the annual open enrollment period for obtaining coverage through the Marketplace will run from October 1, 2015 through December 15, 2015. CMS proposes to maintain the October 1st through December 15th enrollment period applicable in years thereafter.
- ***Cost Sharing Limits***. In 2016, the proposed maximum annual limitation on cost sharing will be $6,850 for self-only coverage; $13,700 for other than self-only coverage. CMS clarified that the annual cost-share limitation applies for the plan year and not the calendar year for non-calendar year plan. In addition, insurers can, but are not required to, count out-of-network cost share amounts against the annual limit.
- ***Federal Exchange User Fees***. Insurers participating in the federal marketplace are subject to a user fee to help pay for the operational expenses of the Marketplace. For 2014 and 2015, the user fee rate is 3.5% of the monthly premium charged by the insurer. Based on CMS' enrollment and premium projections, the 3.5% user fee in 2016 is proposed to remain the same.

NEXT STEPS

- ❑ Employers subject to ACA shared responsibility requirement (50+ employees):
  - Assess your shared responsibility risk.
  - Amend health plan and cafeteria plan eligibility provisions (if necessary). Be aware of two new status change events that were authorized for cafeteria plans specifically allowing a change in election due to a Marketplace open or special enrollment period and the other relating to a reduction in hours to less than 30 hours a week (see *New Cafeteria Plan Status Change Events* in the CBIZ Health Reform Bulletin, *IRS Pronouncements*, 10/6/14). If a cafeteria plan intends to permit these status change events, make certain the plan is amended by the end of the 2015 plan year.
  - Measure all employees using monthly or look-back standard.
  - Establish a process to collect Social Security Numbers for employees (if insured); for employees and dependents (if self-funded).
  - Ensure that the monthly data required for the IRC Sections 6055 and 6056 reporting obligations is captured beginning January 1, 2015.

- ❑ Employers sponsoring plans of any size should review the terms and conditions of their plans, especially the eligibility provisions to ensure that they accurately meet the employer's intent. Of particular note, the definition of spouse should be reviewed as should employee eligibility. Also note, the cafeteria plan status changes as described above are available to employer-sponsored cafeteria plans of any size.

- ❑ If your group health plan is self-funded, the deadline for submitting the transitional reinsurance form together with annual enrollment count and payment scheduled had been extended to December 5, 2014.

YEAR-END REMINDERS

- ❑ ***Form W-2 Reminder - Aggregate Cost of Health Coverage***
  The Form W-2 must include the aggregate cost of health coverage. The aggregate cost information is to be reported in Box 12, using Code DD. For details about this mandatory reporting, see these CBIZ Health Reform Bulletins, *Reminder: Fast Approaching Form W-2 Reporting Requirement* and *Additional IRS Guidance on W-2 Reporting Requirement*.

- ❑ ***Summary of Benefits and Coverage***
  Under ACA, all group health plans, including grandfathered plans, whether insured or self-funded, are required to provide a Summary of Benefits and Coverage (SBC) to plan participants within certain timeframes:
  1. Upon application;
  2. By the first day of coverage;
  3. Within 90 days of enrollment be special enrollees;
  4. Upon contract renewal; and
  5. Upon request.

- ***Marketplace Notice Obligation***
  All employers subject to Fair Labor Standards Act were to provide the initial notice of marketplace options to all employees by October 1, 2013. In addition, there is an on-going obligation to provide the Notice to all new hires within 14 days of hire. The purpose of the Notice is to explain important information about the pros and cons of buying coverage through the marketplace. The DOL provides model notices (in both English and Spanish) that can be used by employers who offer health coverage to some or all employees, and for those who do not offer coverage.

- ***Patient-Centered Outcomes Research Institute Fee***
  The Patient Centered Outcome Research (PCOR) fee is required to be reported annually to the IRS on the second quarter Form 720 and paid by its due date, July 31, is based on the average number of lives covered under the policy or plan. The fee was $1 for the first year; $2 for the second year. The fee increases to $2.08 for plan years ending between October 1, 2014 and October 1, 2015. For additional information about the PCOR fee, see IRS webpage, questions and answers and chart of plans subject to the fees.

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CBIZ
Health Reform Bulletin

Subject: **1) Expatriate Plans exempt from ACA; 2) Proposed SBC Changes; 3) Updated County Chart for Use in Language-specific Plan Communications; 4) Excepted Wrap-around Coverage; and 5) Taxpayer Assistance for Individuals**
Date: January 8, 2015

EXPATRIATE PLANS EXEMPT FROM ACA

On December 16, 2014, President Obama signed into law, the *Expatriate Health Coverage Clarification Act of 2014*, as part of the *Consolidated and Further Continuing Appropriations Act 2015* (H.R. 83; now Public Law 113-235). This law makes expatriate health plans exempt from certain Affordable Care Act (ACA) mandates applicable to group health plans; and apply to both insured and self-funded expatriate plans issued or renewed on or after July 1, 2015. Guidance issued last year by the Department of Labor provided transitional relief for certain insured expatriate plans for purposes of ACA compliance (see CBIZ Health Reform Bulletin, *Applicability of ACA to Expatriate Group Health Coverage*, 3/12/13).

The new law clarifies that in order for the exemption to apply, the expatriate plan must meet certain criteria as to eligibility including dependent coverage, the types of covered benefits and services, and the ability to meet the minimum essential coverage standards. Specifically, a 'qualified expatriate plan' must meet all of the following criteria:

1. The individuals enrolled in the plan must be qualified expatriates. *Qualified expatriates* include:
    - Individuals on a temporary transfer or work assignment in the U.S. as required by their employer and who require access to health insurance in multiple countries;
    - Individuals working outside the U.S. for a minimum of 180 days in a consecutive 12 month period in which the plan year overlaps; and
    - Non-profit groups (charitable workers) who travel or re-locate globally and who require access to health insurance in multiple countries.

    Individuals who are not U. S. nationals and reside in the country of which they are citizens would not be eligible to participate in the plan;
2. Substantially all of the benefits provided under the plan or coverage are not HIPAA-excepted benefit plans such as limited benefit plans or limited scope dental and vision plans provided under separate policy or contract, or non-coordinated benefits;
3. The plan covers certain inpatient hospital services, outpatient facility services, physician services, and emergency services, depending on the nature of the covered individuals. For example, medical services must be available to employees who require access to such services in multiple countries;
4. The benefits provided under the expatriate health plan satisfy the minimum essential coverage standard;
5. If the plan or coverage provides dependent coverage of children, it must make such dependent coverage available for adult children until age 26;

6. The plan's insurer or administrator is licensed to sell insurance in more than two countries and offers reimbursement for items or services under the plan in the local currency in eight or more countries, as well as maintain call centers and claim processing centers in those countries; and
7. The plan or coverage, and the plan sponsor or insurer has been in compliance with the federal laws governing plan compliance prior to the enactment of ACA, such as federal mental health parity provisions, the ERISA claims and appeal procedures, the HIPAA non-discrimination provisions, and any reporting and disclosure obligations under ERISA.

A plan that meets the qualification requirements above would be exempt from most of the ACA mandates including many of the insurance market reforms, as well as exempt from the Patient Centered Outcome Research fees, reinsurance contributions and the annual health insurer provider fees. While these plans may be exempt from certain ACA mandates, expatriate plans remain subject to the IRC Section 4980I "Cadillac" tax. Further, these plans qualify as MEC for purposes of IRC Section 6055 and 6056 reporting purposes. With regard to the Section 6056 benefit statement disclosures, these can be provided electronically to covered individuals unless the individual explicitly refuses electronic distribution.

Proposed Changes for Summary of Benefits and Coverage

On December 22, 2014, the ACA's governing agencies (HHS, IRS and DOL) released proposed changes to the Summary of Benefits and Coverage (SBC) template and related documents. In the proposed template, the agencies removed some obsolete language, clarified certain text relating to continuation of coverage, minimum essential coverage, and minimum value, and make changes to the overall SBC format. In addition, these regulations would add a third cost example relating to coverage for a simple fracture treated in an emergency room.

The proposed SBC template, together with instructions and related glossary are available for viewing on both the DOL and HHS websites:

- Summary of Benefits and Coverage (SBC) Template | MS Word Format
- Instructions for Completing the SBC - Group Health Plan Coverage
- Uniform Glossary of Coverage and Medical Terms

Comments on these regulations are due by March 2, 2015. If finalized, changes to the SBC content and related materials would apply on the first day of the first open enrollment period beginning on or after September 1, 2015. For individuals enrolling outside the open enrollment period, the content changes would apply on the first day of the first plan year beginning on or after September 1, 2015.

Use of Specific Language in Plan Communications - Updated County Chart

As a reminder, the ACA requires certain plan communications to be provided to individuals in a culturally and linguistically appropriate manner. This means that individuals residing in a particular county where 10% or more of its population are literate in a non-English language must be provided the SBC and glossary in the appropriate non-English language. This rule is similar to the language requirements applicable to internal claims and appeals and external review disclosures. The CMS' Center for Consumer Information & Insurance Oversight annually updates the list of counties in which language translations would be appropriate, based on geographic population shifts as reported by the Census Bureau. The updated data county chart is available **here**.

PROPOSED AMENDMENTS TO WRAPAROUND COVERAGE

On December 23, 2014, the ACA's governing agencies published another round of proposed regulations relating to excepted benefits as it would apply to wraparound coverage. As background, certain excepted benefit plans are generally exempt from both HIPAA, as well as the ACA (see CBIZ Health Reform Bulletin, *Excepted Benefit Proposed Regulations*, 1/6/14).

These regulations propose a pilot project that would begin at the end of 2017 and run for three years. It would allow wrap-around coverage in two very specific circumstances: one could be made available to part-time employees as long as the employer offers adequate and affordable coverage to at least 95% of its full-time employees; the second relates to coverage offered through the multi-state marketplace plans. In both instances, several other criteria must be met. Comments on these proposed regulations are due by January 22, 2015.

TAXPAYER ASSISTANCE FOR INDIVIDUALS

As a reminder, the ACA requires virtually all individuals lawfully present in the United States to maintain minimum essential coverage (MEC) or pay a tax. To this end, the IRS has several documents available to assist individual taxpayers. While this isn't specifically relevant to employers, it might be useful to know what individual taxpayers are required to have in order to prove MEC, obtain an exemption, or pay a tax.

- *Health Care Law: What's New for Individuals & Families* (Publication 5187)
- *Facts about making a shared responsibility payment* (Publication 5185) English | Spanish
- *Facts about Health Coverage Exemptions* (Publication 5172) English | Spanish. This Fact Sheet discusses the Form 8965 that is used to report a coverage exemption granted by the Marketplace and filed with the taxpayer's federal income tax return.
- *Facts about the Individual Shared Responsibility Provision* (Publication 5156) English | Spanish
- *Affordable Care Act & Taxes - At a Glance*
- Questions and Answers on the Individual Shared Responsibility Provision
- Chart for determining whether an individual has MEC
- Information and FAQs about the Premium Tax Credit
- *Reporting and Calculating the Payment*

Individuals obtaining coverage through the Marketplace and seeking a premium tax credit could expect to receive the Form 1095-A by January 31, 2015. This form is furnished to individuals by the Marketplace to allow them to claim the premium tax credit, and to reconcile the credit on their returns with advance payments of the premium tax credit. If an individual fails to receive the Form 1095-A, the IRS provides contact information for all Marketplaces to assist them in requesting the form.

About the Author: Karen R. McLeese is Vice President of Employee Benefit Regulatory Affairs for CBIZ Benefits & Insurance Services, Inc., a division of CBIZ, Inc. She serves as in-house counsel, with particular emphasis on monitoring and interpreting state and federal employee benefits law. Ms. McLeese is based in the CBIZ Leawood, Kansas office.

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CBIZ
Health Reform Bulletin

Subject: **1) Finalized ACA Reporting Forms and 2) Employer Appeals to Marketplace Determinations**
Date: February 16, 2015

FINALIZED VERSIONS OF ACA REPORTING FORM 1094 AND 1095 SERIES

In recent days, the Internal Revenue Service (IRS) has issued a number of forms and compliance tools to assist employers subject to the Affordable Care Act's shared responsibility requirements to comply with the law. Of particular note, the finalized version of the forms used to satisfy the IRC Section 6056 and 6055 reporting requirements, together with the related instructions, have been issued.

Note, these are the forms for the *voluntary* reporting which can be done (but is not required) for the 2014 calendar year. The forms to be used for the *mandatory* reporting for the 2015 calendar year, which will be due in early 2016, will be issued later this year. Presumably, they will be quite similar to the forms just issued.

These forms, in large part, follow the draft forms and instructions issued in late July and August, 2014, respectively (see CBIZ Health Reform Bulletins, *IRS Releases Draft Instructions for ACA Shared Responsibility Reporting* and *IRS Releases Draft Section 6055 and 6056 Reporting Forms*).

Employer Health Insurance Reporting Requirement (IRC §6056)

The IRC Section 6056 reporting requirement is generally accomplished on the Form 1094-C (transmittal) and Form 1095-C (benefit statement) and is used for two purposes. First, it is used to help the IRS determine whether the employer might be at risk for an employer shared responsibility excise tax. Secondly, the forms are used to help the IRS to determine whether an individual is properly entitled to the premium tax credit. Both forms are filed by an employer subject to the ACA's shared responsibility requirements.

- ❑ Instructions for Forms 1094-C and 1095-C (PDF or HTML):
  - Form 1094-C, *Transmittal of Employer-Provided Health Insurance Offer and Coverage Information Returns*
  - Form 1095-C, *Employer-Provided Health Insurance Offer and Coverage*

Health Insurance Coverage Reporting by Insurers and Sponsors of Self-funded Plans (IRC§6055)

The IRC Section 6055 reporting requirement is used to verify that an individual has been covered by minimum essential coverage. Generally, it is accomplished by the insurer for an insured plan. An employer/plan sponsor of a self-funded plan subject to the IRC Section 6056 requirements described above can satisfy both Section 6055 and 6056 reporting obligations by completing Part III of the Form 1095-C, rather than using the B series of the forms.

- Instructions for Forms 1094-B and 1095-B (PDF or HTML)
  - Form 1094-B, *Transmittal of Health Coverage Information Returns*
  - Form 1095-B, *Health Coverage*

In addition, the IRS released a revised Publication 5196**,** *Affordable Care Act: Reporting Requirements for Applicable Large Employers*. This brochure provides a snapshot of the types of information that an employer subject to the ACA's shared responsibility requirements would need in order to prepare and complete the reporting forms.

EMPLOYER APPEALS TO MARKETPLACE DETERMINATIONS

Employers may be receiving notification from a Marketplace indicating that one (or more) of their employees applied for Marketplace coverage and was deemed to be eligible for a premium tax credit. The notice may go on to say that the employee's eligibility for the tax credit is based on a determination that the employer failed to offer affordable minimum essential coverage that meets the minimum value standard, and thus the employer could be subject to the IRC Section 4980H tax penalty.

An employer will have two opportunities to appeal a claim that an individual is not offered adequate and affordable health coverage:

- **Appeals to HHS**. The first is one that would be triggered upon receiving a notice to that effect issued by a Marketplace. The notification letter may say that the individual has been granted the advanced premium tax credit, based on information the individual provided, stating that employer coverage was not offered. This does not cause the employer to become subject to the excise tax. Nevertheless, the employer can appeal it. The primary advantage to correcting the determination early is that it may relieve the employee from having to pay back an improperly received credit. The HHS regulations provide for an employer appeal process contained in 45 CFR 155.555. There is no standard format for an appeal to HHS. In general, the appeal request should be in writing and submitted within the timeframe indicated in the letter. The type of information to include in the appeal should 1) clearly identify the parties and reference the notice received and, 2) provide the basis for the appeal, i.e., explain when and what coverage was offered and to whom.

- **Appeals to IRS**. The second opportunity that an employer will get to explain its situation will come from the IRS. It will come after the individual's tax filing due date and after the employer has filed its IRC Section 6056 filing (which is accomplished on the Forms 1094 and 1095-C, as above). It is based on this information that a potential excise tax would be assessed and the employer would certainly want to respond to that appeal. This information would come sometime in 2016 for instances occurring in 2015. Also see this FAQ from IRS below:

  > ***27. How will an employer know that it owes an Employer Shared Responsibility payment?***
  > *The IRS will adopt procedures that ensure employers receive certification that one or more employees have received a premium tax credit. The IRS will contact employers to inform them of their potential liability and provide them an opportunity to respond before any liability is assessed or notice and demand for payment is made. The contact for a given calendar year will not occur until after the due date for employees to file individual tax returns for that year claiming*

premium tax credits and after the due date for applicable large employers to file the information returns identifying their full-time employees and describing the coverage that was offered (if any).

Also noteworthy is a new IRS webpage entitled, "Types of Employer Payments and How They Are Calculated". The information contained in this webpage is worthwhile reading for employers who want to understand how the ACA shared responsibility penalty process might work.

CONCLUSION

In summary, an employer should make certain that it has the systems in place to capture the data required for these reports. It will be to the employer's advantage not only to ensure that any penalties for failure to complete and submit these tax forms be avoided, but also to be able quickly and accurately respond to an IRS inquiry should the need arise.

As a reminder, CBIZ recently launched its CBIZ ACA CheckPoint tool. CBIZ ACA Checkpoint provides employers with the tools to determine whether they are an applicable large employer, track and manage employee measurement periods (initial, standard, stability and administrative), and aid in complying with ACA's employer shared responsibility reporting requirements. To view a short video demonstration of CBIZ ACA CheckPoint, click here. For more information, contact your local CBIZ consultant.

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CBIZ
Health Reform Bulletin

Subject: **1) HHS Benefit and Payment Parameters for 2016; and 2) Preview of Cadillac Tax Implementation**
Date: March 3, 2015

HHS Benefit and Payment Parameters for 2016

On February 27, 2015, the Department of Health and Human Services (HHS) published final rules, together with a Fact Sheet, relating to Benefit and Payment Parameters for 2016. These uniform standards are intended for health insurers and the marketplace to ensure health coverage options for consumers, as well as provide planning guidance for insurers and employers. Following are certain highlights of these rules that may be of interest to employers.

Cost-sharing Requirements

The Affordable Care Act imposes certain cost-sharing restrictions, such as deductible and out-of-pocket limits on health plans. These annual out of pocket limits apply to insured plans offered through the marketplace, and insured and self-funded plans offered outside marketplace. Below are cost sharing limitations for 2014 through 2016:

	Self-only Coverage	Other than Self-only Coverage
2014	$6,350	$12,700
2015	$6,600	$13,200
2016	$6,850	$13,700

HHS Inflationary Percentage for 2016

The Affordable Care Act directs the Secretary of HHS to determine an annual premium adjustment percentage that is used to set the rate of increase for three parameters detailed in the law:

1. The maximum annual limitation on **cost sharing** (as above);
2. The required contribution percentage by individuals for minimum essential health coverage for purposes of determining eligibility for a **hardship exemption under the individual shared responsibility requirement** (IRC Section 5000A). One of these exemptions occurs if the cost to the individual to purchase coverage exceeds 8% (8.05% for 2015) of household earnings. In 2016, the required contribution percentage increases to 8.1% of household earnings for purposes of exemption from the individual shared responsibility requirement. This affordability standard is distinct from the employer's shared responsibility affordability standard and distinct from the affordability standard for being entitled to premium assistance.
3. The **assessable payment amounts under IRC Section 4980H(a) (the $2,000 excise tax penalty) and IRC Section 4980H(b) (the $3,000 excise tax penalty) relating to employer shared responsibility**. This percentage is calculated based on the projections of average per enrollee employer-sponsored insurance premiums from the National Health Expenditures Accounts that is calculated by the CMS Office of the Actuary. For 2015, the percentage is 4.213431463%. In 2016, the inflationary

adjustment jumps to 8.316047520%. What this means is that the potential penalty assessment pursuant to IRC Section 4980H(a) would increase from $2,080 in 2015 to $2,160 in 2016. The IRC Section 4980H(b) penalty would increase from $3,120 in 2015 to $3,240 in 2016.

Transitional Reinsurance Fee. The goal of a transitional reinsurance program is to stabilize premiums in the individual market to offset the expenses of the eligible individuals enrolling in the marketplace. For 2014, the contribution rate was $63 per covered life, $44 per covered life in 2015; the amount for 2016 drops to $27 per covered life.

Annual Open Enrollment Period. For the 2016 plan year, the annual open enrollment period for obtaining coverage through the marketplace or the Small Health Options Program (SHOP) will run from November 1, 2015 through January 31, 2016.

Federal Exchange User Fees. Insurers participating in the federal marketplace are subject to a user fee to help pay for the operational expenses of the marketplace. For 2014 and 2015, the user fee rate is 3.5% of the monthly premium charged by the insurer. Based on CMS' enrollment and premium projections, the 3.5% user fee in 2016 remains the same.

Minimum Value Standard

These regulations affirm the November, 2014 guidance that in order to meet the minimum value (MV) standard, a plan must not only meet 60% medical expense reimbursement standard but also a benefit package standard pursuant to which the plan must cover hospitalization and physician services. This provision generally applies immediately to all employer-sponsored group plans, except for plans entered into November 4, 2014 with plan years beginning by March 1, 2015.

Health Plan Design

While these regulations primarily relate to plans offered through the marketplace, the above-referenced provisions are important for employers to understand. In addition, the regulations address some issues, while directed at qualified health plans offered through the marketplace, that are important conceptually for employers to be aware of. The regulations intend to ensure that individuals have fair access to health services.

In particular the rules finalize several standards relating to the 10 essential health benefits (EHB) to be included in base benchmark plan, including habilitative services, coverage of pediatric services, and prescription drug coverage.

- In particular, the rules provide for a uniform definition of habilitative services for purposes of differentiating these types of services with rehabilitative services. Further, plans required to provide EHB cannot impose limits on coverage of habilitative services that are less favorable than those limits imposed on coverage of rehabilitative services.
- The regulations address drug formularies with regard to the "exception process" pursuant to which a covered individual or his/her physician can request approval for clinically appropriate drugs not covered by the plan. This process must also include an expedited review process based on exigent circumstances such as when the individual has a serious health condition that may seriously jeopardize his/her life, health, or ability to regain maximum function, or the individual is undergoing a current course of treatment using a non-formulary drug. In addition, if a plan denies the exception request for the non-formulary drug, the plan must have a process for the individual or

his/her physician to request an independent review organization to review the exception request and the plan's denial of coverage.

The regulations caution against any plan design that expressly or implicitly discriminates against individuals by, for example, pushing high claimants into more expensive plans.

The regulations also address network and provider adequacy and reserve the right to provide future guidance on these matters. The take-away from all of this is that the government intends health plans to provide adequate services to individuals.

PREVIEW OF CADILLAC TAX IMPLEMENTATION

On February 23, 2015, the Internal Revenue Service issued the first in what it anticipates being a series of notices relating to the Affordable Care Act's IRC Section 4980I ("Cadillac" tax) provision. This guidance (IRS Notice 2015-16) is not law or regulation. What the government appears to be doing is issuing a series of notices to try to get a sense of how regulations should be written. After information is gathered, proposed regulations will be issued, presumably with a comment period, followed by final regulations. The IRS Notice addresses three subjects: applicable coverage, cost of coverage and annual statutory limits.

Beginning in 2018, the Cadillac tax imposes a 40% excise tax on the amount paid for high cost employer-sponsored health coverage that exceeds certain threshold limits. The type of coverage subject to the Cadillac tax would generally include all health coverage, whether insured or self-funded; but would generally not include excepted benefits. According to this Notice, applicable coverage would include employer contributions and salary contributions to flexible medical spending accounts, health savings accounts and medical savings accounts; but would not include after-tax contributions to such plans. Coverage would include on-site medical clinics; but the government is considering excluding on-site clinics that provide limited services such as de minimis medical care and occupational injury only.

As for the cost of coverage, it is anticipated that the COBRA methodology would be used to calculate the cost of coverage. The Notice (sort of) implies that the government might be finally looking at getting us rules on how to calculate COBRA premium using the past service and actuarial methods.

Finally, the Notice addresses the statutory limits. The annual statutory limit to which the Cadillac tax would be imposed is individual coverage exceeding $10,200, or $27,500 for family coverage. However, these numbers are only placeholders, as there would be various calculations that could increase these annual figures. Specifically, in 2018, the first year the tax would be imposed, a health cost adjustment percentage would be applied to the baseline dollar limit. In 2019 and beyond, a cost of living adjustment would be imposed.

Much could happen over the years before this provision takes effect. Again, this Notice is only an initial foray into how regulations might finally look.

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CBIZ
Health Reform Bulletin

Subject: **Refunds for Incorrect Calculations of Transitional Reinsurance Fees**
Date: April 17, 2015

The CMS' Center for Consumer Information and Insurance Oversight (CCIIO) has provided guidance on obtaining a refund if the transitional reinsurance fee was calculated improperly.

As background, the Affordable Care Act (ACA) imposes a transitional reinsurance fee, the goal of which is to help stabilize premiums in the individual market due to enrollment of higher risk individuals in the marketplace. All insurers and plan sponsors of self-funded plans ("contributing entities") are required to contribute to this reinsurance fund over a three year period from 2014 through 2016.

For the 2014 benefit year, contributing entities were required to submit their annual enrollment count and schedule their resulting contributions on a self-reporting form via www.pay.gov by December 5, 2014. The reporting form auto-calculated the annual contribution amount based on the enrollment count submitted by the contributing entity. The contribution amount of $63 per covered life was due on January 15, 2015. Or, if the entity elected to pay the fee in two installments, the first contribution amount of $52.50 per covered life was due on January 15, 2015; the second contribution amount of $10.50 per covered life is due November 15, 2015. (For the 2015 benefit year, the annual reinsurance contribution rate to be collected is $44 per covered life; further reducing to $27 per covered life in 2016. For self-reporting purposes for the 2015 and 2016 benefit years, presumably the reports will be due by November 15th of the respective reporting year.)

If a contributing entity discovers an error in its annual enrollment count submitted on the 2014 reporting form, it can request a refund from CMS. The refund request must be accomplished by April 30, 2015, or 90 days from the date the entity submitted its form, whichever is later. For the 2015 and 2016 benefit years, refund requests based on enrollment count errors must be submitted within 90 days of the date the form was submitted.

Refund requests and other inquiries relating to the transition reinsurance contribution process should be sent to reinsurancecontributions@cms.hhs.gov.

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CBIZ
Health Reform Bulletin

Subject: **Coverage for Preventive Services**
Date: May 20, 2015

On May 11, 2015, the Departments of Health and Human Services, Labor and Treasury released another set of FAQs relating to coverage of preventive services. As background, the Affordable Care Act (ACA) requires non-grandfathered plans in the individual and group markets to provide specified preventive services at no cost to plan participants.

- **Contraceptive coverage.** Of particular note, the FAQ clarifies the requirement to cover contraceptive services, probably in large part in response to plans interpreting this requirement more narrowly than the law intends. This guidance affirms that individual and group health plans, whether insured or self-funded, must cover at least one form of contraception in each of the methods, as approved by the Food and Drug Administration (FDA). These FDA-approved methods* are:

Surgical Sterilization Implant for Women	Patch
Implantable Rod	Vaginal Contraceptive Ring
IUD Copper	Diaphragm with Spermicide
IUD w/ Progestin	Sponge with Spermicide
Injection	Cervical Cap with Spermicide
Oral Contraceptives(Combined Pill) “The Pill”	Female Condom
Oral Contraceptives (Progestin only) “The MiniPill”	Spermicide
Oral Contraceptives Extended/Continuous Use “The Pill”	Emergency contraception

**While the FDA-approved methods additionally list sterilization surgery for men and male condoms, the ACA does not require these services to be covered.*

The guidance further clarifies that contraceptive coverage must also include clinical services, including patient education and counseling, needed for the particular contraceptive method.

Within each method, a plan may utilize reasonable medical management techniques. If it does, it must defer to the recommendations of a health care provider. Further, the plan must have an exception process that is readily available and prompt.

According to this guidance, the government recognizes that plans may not have understood the need to comply in this manner. Therefore, enforcement will begin to apply in the first plan or policy year occurring 60 days following publication of the FAQ (July 10, 2015).

- **Breast cancer screening.** One of the recommended guidelines for appropriate cancer screenings relates to testing for potentially harmful mutations in breast cancer susceptibility genes (BRCA 1 or BRCA 2). The guidance clarifies that coverage for such screenings, together with genetic counseling, must be provided even in asymptomatic women when recommended by their attending physician.

- **Well-woman Preventive Care for Dependents**. The guidance clarifies that plans covering dependents must also cover recommended well-woman preventive services for dependent children when determined to be age and developmentally-appropriate for the dependent by the attending provider.

- **Colonoscopy coverage**. Plans cannot impose cost sharing relating to anesthesia services used in connection with a colonoscopy if the attending provider determines that anesthesia would be medically appropriate for the individual.

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CBIZ
Health Reform Bulletin

Subject: **1) Final Summary of Benefits and Coverage Rules; 2) IRS releases draft 2015 reporting forms; and 3) Revised External Review Process**
Date: June 19, 2015

FINAL SUMMARY OF BENEFITS AND COVERAGE RULES

The Affordable Care Act (ACA) requires individual and group health plans, including grandfathered plans, to provide a written summary of benefits and coverage (SBC) explaining certain aspects of health benefit coverage.

Six months ago, the ACA's tri-governing agencies (Departments of Labor, Health and Human Services and Treasury) released some proposed changes to SBCs (see *Proposed SBC Changes* in CBIZ Health Reform Bulletin 105, 1/8/15). On June 15, 2015, the agencies published final regulations. The final rules generally adopt most of the proposed changes and focus more on distribution methods and timelines. Following are some of the clarifications and highlights of the final rules.

- **Who provides the SBC?** Generally, for insured plans, SBCs are provided by insurer and plan administrator; this is a joint obligation. The final regulations affirm that compliance by one entity is deemed compliance by the other. If the insurer is providing the SBC, then the plan administrator does have an obligation to monitor compliance. For self-funded plans, the plan administrator (generally, the plan sponsor unless the plan indicates otherwise) is responsible for issuing SBCs. In addition, insurers and group health plans must make a uniform glossary of insurance terms available upon request by participants.

- **SBC content**. With regard information required to be contained in an SBC, the Departments of Labor and Health and Human Services have model SBC templates, instructions and related material available on their websites. The model SBC template includes the required elements and content. It should be noted that the DOL's website has two sets of model SBC forms posted – one set applies to SBCs issued before January 1, 2017, and another set contains proposed SBCs for use on or after January 1, 2017. However, caution should be exercised in using the proposed SBC templates because the regulations indicate that the tri-agencies will collaborate with the National Association of Insurance Commissioners (NAIC) to finalize a new SBC template, which should be available later this year. The finalized SBC template would then be used on the first day of the first plan year that begins on or after January 1, 2017.

  The SBC must also include a statement about whether a plan meets minimum essential coverage standards and the minimum value standard. If an SBC does not contain this language, the final regulations clarify that this information must be included in the cover letter that is distributed to participants along with the SBC.

- **Timeframes for providing SBC**. There are five instances in which SBCs must be provided: upon application, by the first day of coverage, within 90 days of enrollment for special enrollees, upon contract renewal, and upon request. The final regulations clarify that:
  - If an insurer provides the SBC prior to application for coverage, it would not be required to provide another SBC at the time application is made unless there is a change in the SBC content provided in the pre-application version.
  - In the event that a plan sponsor is negotiating coverage terms following application, an updated SBC reflecting those finalized coverage terms need not be provided until the first day of coverage, unless otherwise requested.

- **Website access to underlying plan or policy**. The final regulations require website posting of the actual underlying insurance policy. For insured group plans, the insurer is required to post the policy's certificate of coverage on its website for on-line access by the plan sponsor, as well as by participants and beneficiaries.

- **Enforcement**. A group health plan that willfully fails to provide the SBC to a participant or beneficiary could be subject to a fine up to $1,000 for each such failure.

Effective date. The final regulations become effective August 17, 2015. The changes made in the final regulations, such as timing of SBC distribution and website access to underlying policies, become applicable on the first day of the first plan year beginning on or after September 1, 2015 (January 1, 2016 for calendar year plan).

DRAFT 2015 VERSIONS OF ACA REPORTING FORM 1094 AND 1095 SERIES

The Internal Revenue Service (IRS) has released draft 2015 editions of the Form 1094 and 1095 series. These forms are used to satisfy the IRC Section 6056 and 6055 reporting requirements. Once the forms and related instructions are finalized by the IRS, presumably later this year, the 2015 forms will be used for the mandatory reporting for the 2015 calendar year, due in early 2016.

As background, employers subject to the employer shared responsibility requirement (those employing 50 or more full-time employees) are required to file an annual report to the IRS for purposes of determining individuals entitled to premium assistance, as well as determine whether an employer might be at risk for an IRC §4980H(a) no-coverage tax, or an IRC §4980H(b) inadequate or unaffordable tax. Each applicable large employer must file the Form 1094-C (transmittal form) and Form 1095-C annually with the IRS, as well as provide the related Form 1095-C benefit statements to employees listed in the Form 1094-C.

Insurers, self-funded plans and other providers of minimum essential coverage (MEC) are also required to file an annual report to the IRS for purposes of reporting individuals covered by MEC. This requirement applies without regard to plan size. Insurers, self-funded plans and other providers of minimum essential coverage (MEC) file Form 1094-B and Form 1095-B to the IRS.

A self-funded plan sponsor subject to employer shared responsibility requirements can accomplish its MEC reporting obligation by completing Form 1094-C and Parts I, II and III of Form 1095-C. Self-funded plans that are not subject to shared responsibility requirements complete their obligation on the Form 1094-B and 1095-B.

Following are the draft 2015 forms released by the IRS:

- Form 1094-B *Transmittal of Health Coverage information Returns*
- Form 1095-B *Health Coverage*
- Form 1094-C *Transmittal of Employer-Provided Health Insurance Offer and Coverage Information Returns*
- Form 1095-C *Employer-Provided Health Insurance Offer and Coverage*

The 2015 draft forms, in large part, follow the 2014 versions. Following are changes to note in the 2015 edition of the Form 1095-C:

- The 2015 draft Form 1095-C adds a new field, titled "Plan Start Month". This new field is optional for 2015. Filers can choose to add this field and provide plan year information to add this field and enter "00", or, at their option, leave this new field out (thus using 2014 format). For 2016 and beyond, this field will be required.
- The 2015 form also includes a continuation sheet that filers use if they need to report coverage for more than six individuals.
- For 2015, the indicator codes in Part II, Line 14 "Offer of Coverage" (as outlined in the 2014 instructions) will remain unchanged from the 2014 codes.
- Beginning in 2016 and beyond, filers will need to include two additional codes, if applicable. These new indicator codes will indicate to the IRS and to full-time employees that the employer's offer to the spouse is a conditional offer.

Until final forms and instructions are issued, employers are still in a bit of a waiting game but steps should be taken now to ensure the ability to report in early 2016.

Background CBIZ Health Reform Bulletins

- HRB 106: *Finalized ACA Reporting Forms* (2/16/15)
- HRB 92: *IRS Final Rules – IRC Sections 6055 and 6056* (3/14/14)

REVISED EXTERNAL REVIEW PROCEDURES

The ACA requires individual and non-grandfathered group health plans, whether insured or self-funded, to provide for an internal claim and appeal process, as well as an external review process for coverage determinations and claims. These rules added an external review requirement for ERISA plans and extended the claims, appeals and external review requirements to plans exempt from ERISA such as state and local government plans and church plans.

With regard to the external review process, an individual who has received an adverse determination relating to his/her coverage or claim has the right to appeal to an independent third party. Many states have an external appeals process in place. In the event that a state does not require plans to follow an external review process, the federal external review procedure would be followed. The federal procedures also govern self-funded plans exempt from state law and subject to ERISA.

On June 15, 2015, the HHS' Center for Consumer Information and Insurance Oversight (CCIIO) released an updated process for plans, including non-grandfathered group health plans and non-federal self-funded state and local government plans that elect the federal external review process. Previously, plans were required to make the election via an HHS e-mail address. Plans electing to utilize the federally-administered external review process must now do so by way of the Health Insurance Oversight System (HIOS), a web-based CMS portal. The guidance

sets forth the steps for electing the federal external review process depending upon whether the entity is a new or existing HIOS user.

About the Author: Karen R. McLeese is Vice President of Employee Benefit Regulatory Affairs for CBIZ Benefits & Insurance Services, Inc., a division of CBIZ, Inc. She serves as in-house counsel, with particular emphasis on monitoring and interpreting state and federal employee benefits law. Ms. McLeese is based in the CBIZ Kansas City office.

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CBIZ
Health Reform Bulletin

Subject: **Supreme Court Opinion – *King v. Burwell***
Date: June 25, 2015

Today, the Supreme Court issued its opinion in the *King v. Burwell* case. In summary, it is business as usual for the Affordable Care Act. The Supreme Court opined in a 6-3 decision that the IRC Section 36B premium assistance tax credit is available both in marketplaces established by the state and by the federal government.

As background, the law includes a premium tax credit to assist certain lower income individuals whose household earnings fall between 100 and 400% of federal poverty level to purchase health coverage. The statute as written arguably limits the tax credit to individuals who buy coverage through a state run marketplace. At current count, the marketplaces in roughly two-thirds of the states are run by the federal government, leaving one-third of the states running their own marketplaces.

Chief Justice writing the majority opinion states that while the law may not be a model of 'construction', it is the obligation of the courts to interpret the law to assist with the overall statutory intent. Without getting into too much detail about the overall implications of this opinion from a jurisprudent perspective, the Court set out three primary pillars of the ACA as follows:

1. The guaranteed access to health coverage and community rating;
2. The individual requirements to obtain health coverage; and
3. The availability of premium assistance in the form of a tax credit for certain individuals.

According to the majority opinion, it is not the intent of the law to limit or remove one of these essential pillars; thus, it must have been the intent of the Congress to make the tax credit available whether the marketplace established in a state is accomplished by the state or by the federal government.

Dissenting opinion argues to the contrary, but for ACA compliance purposes, as stated above, it is business as usual. For employers subject to the employer shared responsibility aspect of the law, this means continue all efforts toward compliance.

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CBIZ
Health Reform Bulletin

Subject: **1) Interim Guidance on Expatriate Health Coverage; 2) Updates on Section 6055/6056 Reporting; 3) Final rules - preventive services; and 4) PCOR Fees and Transitional Reinsurance Fee Reminders**

Date: July 13, 2015

INTERIM GUIDANCE ON EXPATRIATE HEALTH COVERAGE

The IRS recently issued guidance (IRS Notice 2015-43) relating to employer-sponsored expatriate health coverage. As background, expatriate health plans issued or renewed on or after July 1, 2015 would be exempt from certain ACA provisions as long as certain criteria are met (see CBIZ HRB, *Expatriate Plans Exempt from ACA*, 1/8/15). However, the ACA governing agencies have determined that employers and plan sponsors may need additional time and guidance to modify their current arrangements to comply with the law. Thus, until further guidance is issued, employers and plan sponsors are encouraged to use a reasonable good faith interpretation of criteria issued to date as they bring the plans into compliance.

While certain ACA mandates may not apply, it should be noted that special rules apply to expatriate health coverage with regard to the Patient-Centered Outcomes Research (PCOR) fee (see *Plan Applicability* in the chart on page 3) and to the annual fees paid by insurers. In addition, the Section 6055 and 6056 reporting obligations due in early 2016 remain applicable to plans providing expatriate health coverage.

UPDATES ON SECTION 6055/6056 REPORTING

- ***Increase in Tax Information Reporting Penalties***. The Internal Revenue Service can assess penalties when certain tax information is not provided on a timely basis. Specifically, penalties may be assessed for failure to file information returns or provide payee statements, such as the Form W-2 and Form 1099, and notably, the newly imposed Affordable Care Act's Forms 1094 and 1095, or related payee statements. On June 29, 2015, President Obama signed the *Trade Preferences Extension Act of 2015* (Public Law No. 114-27). This new law increases these penalties, as follows:
  - The penalty for failure to file an information return increases from $100 to $250 for each return for which such failure occurs. The total penalty imposed for all failures during a calendar year increases from $1.5 million to $3 million.
  - The penalty for failure to provide a correct payee statement increases from $100 to $250 for each statement with respect to which such failure occurs, with the total penalty for a calendar year not to exceed $1.5 million.
  - Special rules apply that increase the per-statement and total penalties if there is intentional disregard of the requirement to furnish a payee statement.

  These increased penalties become effective January 1, 2016, meaning for returns due in early 2016 for the 2015 tax year.

- ***E-filing Reports.*** As the IRS gears up in preparation for processing the Forms 1094 and 1095 filed electronically, employers and plan sponsors who plan to e-file their own reports are encouraged to review their dedicated web page, Affordable Care Act Information Returns (AIR) Program. The IRS has several publications relating to the steps involved in the e-file process, such as registration, applying for an AIR Transmitter Control Code, uploading data files, testing process and related guidance.

FINAL RULES: PREVENTIVE SERVICES

On July 10, 2015, the tri-governing ACA agencies (Departments of Labor, Treasury and Health and Human Services) released final rules relating to preventive services. Generally, these rules reiterate prior guidance with regard to coverage for preventive services without major changes.

With regard to contraceptive coverage, these rules finalize the interim rules issued last year (see CBIZ HRB, *Implementation Update: Women's Preventive Services*, 8/28/14). Of particular note, eligible organizations with a religious objection for providing contraceptive services can either self-certify on a form provided by HHS or Form 700 from the Department of Labor. Closely held for-profit entities whose shareholders have sincerely held religious beliefs in contravention of some or all of the contraceptive services may pursue the same self-certification process. The final regulations also clarify the definition of a closely held for profit entity as one that is not publicly traded, and has an ownership structure under which over 50% of the organization's ownership interest is owned by five or fewer individuals, or an entity with a substantially similar ownership structure.

Effective date. These rules are scheduled to be published on July 14, 2015 and become effective September 12, 2015.

PCOR FEES AND TRANSITIONAL REINSURANCE FEE REMINDER

July 31st is fast approaching which means it is time to begin thinking about the Patient-Centered Outcomes Research (PCOR) fee. And, we are almost halfway through 2015, which means the transitional reinsurance fee will soon be due. Below on pages 3 to 5 is a chart summary of these two fees imposed by the Affordable Care Act. Please refer to our prior CBIZ Health Reform Bulletins listed on page 5 for additional background information.

PROVISION	PATIENT-CENTERED OUTCOME RESEARCH FEE	TRANSITIONAL REINSURANCE FEE (PREMIUM STABILIZATION PROGRAM)
PLAN APPLICABILITY	❒ Insurers of all-sized fully-insured plans ❒ All-sized employers of self-funded plans *Also applies to:* ◆ Retiree-only plans ◆ COBRA and state continuation coverage ◆ Non-integrated health reimbursement arrangements (HRA) (generally, not permissible in 2014 and beyond unless it is excepted) ◆ Integrated HRA (Note: an HRA integrated with insured plan would pay the fee; an HRA integrated with self-funded plan does not) ◆ Medical flexible spending accounts (FSA) subject to HIPAA Plans *not subject* to the fees include: ◆ HIPAA-excepted benefit plans such as limited scope dental and vision plans ◆ FSAs excepted from HIPAA ◆ Employee assistance programs, disease management programs, and wellness programs if the program does not provide significant benefits in the nature of medical care or treatment ◆ Expatriate group health plans primarily covering employees who work and reside outside the U.S.; or cover foreign nationals working in the U.S. for specific and temporary purpose, or who work less than six months of the plan year, or cover certain non-profit groups (charitable workers) who travel or re-locate globally for at least 6 months of the plan year ◆ Stop loss and indemnity reinsurance policies	❑ Insurers of all-sized fully-insured plans ❑ All-sized employers of self-funded plans *Also applies to:* ◆ Post-employment plans that are primary to Medicare, such as early retiree plans ◆ COBRA continuation coverage Plans *not subject* to fees include: ◆ HIPAA-excepted benefit plans such as limited scope dental and vision plans ◆ HRAs integrated with comprehensive insured or self-funded group coverage ◆ Flexible medical spending account plans (FSA) ◆ Health savings accounts (HSA) except an HDHP used in conjunction with HSA is considered major medical insurance and thus, subject to reinsurance contributions ◆ Employee assistance plans, disease management programs, and wellness programs if the program does not provide significant benefits in the nature of medical care or treatment. ◆ Post-employment plans where Medicare is primary to group plan. ◆ Stand-alone prescription drug plans ◆ TRICARE or other military benefit plans ◆ Certain Indian Tribal benefit programs ◆ Certain expatriate plans

PROVISION	PATIENT-CENTERED OUTCOME RESEARCH FEE	TRANSITIONAL REINSURANCE FEE (PREMIUM STABILIZATION PROGRAM)
AMOUNT OF FEE	◆ For policy and plan years ending after 9/30/12 and before 10/1/13, the applicable dollar amount is $1 per covered life. ◆ For policy and plan years ending after 9/30/13 and before 10/1/14, the applicable dollar amount is $2 per covered life. ◆ For policy and plan years ending after 9/30/14 and before 10/1/15, the applicable dollar amount is $2.08 per covered life.	◆ For 2014: $5.25 per covered life per month based on calendar year ◆ For 2015: $3.66 per covered life per month based on calendar year ◆ For 2016: $27 per covered life
INSURED PLANS: METHODS FOR DETERMINING COVERED LIVES	Actual count, Snapshot, Member months, or State form methods	Actual count, Snapshot count, Member months or State form methods
SELF-FUNDED PLANS: METHODS FOR DETERMINING COVERED LIVES	Actual count, Snapshot, or Form 5500 methods	Actual count, Snapshot count, Snapshot factor, or Form 5500 methods
ENTITY PAYING FEE	❑ By insurer of fully insured plan ❑ By plan sponsor of self-funded plan	❑ By insurer of fully insured plan ❑ By plan sponsor of self-funded plan
REPORTING AND PAYING THE FEE	PCOR fees paid once a year in connection with IRS Form 720, *Quarterly Federal Excise Tax Return:* ◆ For insured plans, Form 720 due by July 31st following the close of the plan year. ◆ For self-funded plans, Form 720 due by July 31st of the calendar year following the plan year end.	◆ Submit annual enrollment count (based on first 9 months of year) to HHS by November 15th of each year on the "*ACA Transitional Reinsurance Program Annual Enrollment Contributions Submission Form"* available via www.pay.gov. ◆ The reporting form will auto-calculate contribution amounts and allow payments to be made in one or two installments.
FEES PAID FROM PLAN ASSETS?	No	Yes
APPLICABILITY PERIOD	Plan years ending after 9/30/12 *No fee assessed for plan years ending after 9/30/19 (for calendar year plans, this means the 2018 plan year)*	Calendar years 2014 to 2016

PROVISION	PATIENT-CENTERED OUTCOME RESEARCH FEE	TRANSITIONAL REINSURANCE FEE (PREMIUM STABILIZATION PROGRAM)
ADDITIONAL INFORMATION AND RESOURCES	❑ **IRS webpage:** ***Patient-Centered Outcomes Research Institute Fee*** ◆ IRS chart on types of coverage subject to the PCORI Fee ◆ IRS Questions and Answers ❑ **CBIZ Health Reform Bulletins** ◆ *Year-end Wrap Up (12/21/11)* ◆ *Fees on Health Insurance Policies & Self-Insured Plans: Patient-Centered Outcome Research Trust Fund (4/18/12)* ◆ *Final Regulations Issued: Patient-Centered Outcomes Research Fees and Medical Device Tax (12/11/12)* ◆ *Chart of Health Plan Fees and Taxes (12/18/12)* ◆ *See Patient-Centered Outcomes Research Fee in Sub-Regulatory Guidance and FAQs Issued (1/25/13)* ◆ *Reporting and Paying PCOR Fees: Revised Form 720 Issued (6/4/13)* ◆ *Year-end Wrap Up (12/23/13)* ◆ *PCOR Fees and Transitional Reinsurance Fees (6/18/14)* ◆ *Year-end Wrap Up (12/11/14)*	❑ **CCIIO's webpage**: ***Transitional Reinsurance Program – Reinsurance Contributions*** ❑ **CBIZ Health Reform Bulletins** ◆ *Premium Stabilization Program Proposals and 2) Chart of Health Plan Fees and Taxes (12/18/12)* ◆ *Implementation Guidance (3/12/13)* ◆ *See 'Transitional Reinsurance Fee' in 'Proposed Benefit and Payment Parameters in 2015' in Year-end Wrap Up (12/23/13)* ◆ *HHS Benefit and Payment Parameters for 2015 (3/14/14)* ◆ *PCOR Fees and Transitional Reinsurance Fees (6/18/14)* ◆ *Completing the Transitional Reinsurance Fee Form (10/28/14)* ◆ *Proposed Benefit and Payment Parameters for 2016 in Year-end Wrap Up (12/11/14)* ◆ *Transitional Reinsurance Fee Refund Requests (4/17/15)*

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CBIZ
Health Reform Bulletin

Subject: **1) Additional IRS Approaches to Cadillac Tax; 2) Transitional Reinsurance Fee Process for 2015 Benefit Year; 3) State Innovation Waivers; and 4) Applicability of ACA's Employer Shared Responsibility Provisions to Veterans and Native American Tribes**

Date: August 5, 2015

ADDITIONAL IRS APPROACHES TO CADILLAC TAX

As most are aware, the ACA includes a provision, known as the Cadillac tax, that will impose a nondeductible excise tax on health plans that exceed certain limits. This provision of the law takes effect in 2018. Thus far, no guidance has been issued on the Cadillac tax. However, on February 23, 2015, the IRS issued Notice 2015-16 in which the government began contemplating how it intends to frame the law (see CBIZ HRB 107, *Preview of Cadillac Tax Implementation*, 3/5/15)

On July 30, 2015, the IRS released a second pronouncement (IRS Notice 2015-52) which like the first, does not carry the weight of the law or regulation, but rather is an effort to test the waters to see how the law should be formulated. The new guidance expands the discussion with regard to identifying taxpayers liable for the excise tax, employer aggregation, allocation of the tax, payment of the applicable tax and determining the cost of applicable coverage.

For an insured group health plan, the insurer would be liable for the tax. If the health coverage is used in conjunction with a health savings account (HSA) or an Archer MSA, the employer is liable for the tax applicable to the particular investment account. For all other applicable coverage, the entity who administers the plan benefits would be the payer. This means for self-funded group health plans, generally, it would be the plan sponsor unless the plan is administered by a third party administrator or claims payer. From this Notice, it appears that the government is contemplating who should be responsible – the day-to-day claims payer or the entity who is ultimately responsible.

With regard to aggregation of employers for purposes of determining the tax, the control group rules apply, i.e., all employers § 414(b), (c), (m), or (o) are treated as a single employer. The government is recognizing the challenges that may arise relating to control groups and is considering ways to handle this.

For purposes of determining the cost of coverage for a taxable period, the IRS indicates that the tax due will be based on the calendar year, without regard to plan year. The government is recognizing the challenges that may exist relating to the potential timeframe discrepancies and is looking at ways to handle this. The cost of coverage can be adjusted for age and gender characteristics. According to this Notice, the government is considering a "snap shot day", which could be the first day of the plan year to make this calculation. This date would be different from the tax year/calendar year over which the tax would be assessed.

With regard to account-based plans such as HSAs, Archer MSAs, flexible medical spending account (FSA) plans and health reimbursement arrangements (HRAs), the IRS is working on how to balance the impact of the tax on these types of account based plans. They are considering an approach under which contributions to account-based plans would be allocated on a pro-rata basis over the period to which the contribution relates (generally, the plan year), regardless of the timing of the contributions during the period. Specific to account-based plans, such as FSA plans that allow a carry forward, consideration is begin given on how to avoid double counting.

For reporting the excess amounts and paying the tax, the IRS is contemplating using the Form 720, *Quarterly Federal Excise Tax Return* (which is also used to pay the Patient Centered Outcome Research Institute fees).

Comments on these proposals must be submitted to the IRS by October 1, 2015.

TRANSITIONAL REINSURANCE FEE PROCESS FOR 2015 BENEFIT YEAR

In preparation for reporting and paying the transitional reinsurance fees for the 2015 benefit year, the Centers for Medicare and Medicaid services released an overview of the process and procedures.

As background, the ACA imposes a transitional reinsurance fee, the goal of which is to help stabilize premiums in the individual market due to enrollment of higher risk individuals in the marketplace beginning in 2014. All insurers and plan sponsors of self-funded plans are required to contribute to this reinsurance fund over a three year period from 2014 through 2016.

The entities responsible for submitting the relevant information and paying the fees are insurers of fully insured plans and plan sponsors of self-funded plans (though, third party administrators (TPA) can facilitate the process on behalf of plan sponsors), referred to as “reporting entities”. However, certain self-funded, self-administered plans who do not use a TPA may be exempt from making contributions in 2015 and 2016.

The reporting and payment of fees is based on the type of plan issued by the insurer or plan sponsor. Virtually all-sized health plans, such as major medical plans and high deductible health plans used in conjunction with a health savings account (HSA), are subject to these fees.

The steps for counting covered lives, completing the *ACA Transitional Reinsurance Program Annual Enrollment Contributions Submission Form*, uploading the supporting documentation and paying the fee via pay.gov website are the same as required last year (see CBIZ HRB, Completing the Transitional Reinsurance Fee Form, 11/21/14). However, the supporting documentation is only required for *2015 ACA Transitional Reinsurance Program Annual Enrollment and Contributions Submission Form* submissions with four or more contributing entities.

The contribution rate for the 2015 benefit year 2015 is $44 per covered life. Contributions can be made in one payment of $44 per covered life (combined collection); or, made in two-part payment of $33 per covered life (first collection) and $11 per covered life (second collection).

Deadlines

- If making one payment of the fee, the *2015 ACA Transitional Reinsurance Program Annual Enrollment Contributions Submission Form* must be submitted by November 16, 2015; the full fee must be paid by January 15, 2016.
- If opting to make two payments, the *Form* must be filed by November 16, 2015; the first part of the two payments must be paid by January 15, 2016; the second payment is due by November 15, 2016.

CMS will again be hosting training webinars to assist entities in the process and procedures. Reporting entities are encouraged to register for these trainings through REGTAP (https://www.REGTAP.info).

STATE INNOVATION WAIVERS

The Affordable Care Act includes a provision that takes effect in 2017 which would allow a state to apply for an innovation waiver; pursuant to which the state could be relieved from certain aspects of the ACA. As long as a state could prove that the primary goals of the ACA could be achieved under its plan and such plan would provide adequate coverage to a comparable number of people in an economically efficient manner, then certain ACA provisions would be waived such as the requirements to:

- Establish qualified health plans;
- Provide consumer choices and insurance competition through the marketplaces; and
- Provide for premium tax credits and cost-sharing reductions for plans offered within the marketplaces.

In addition, a state may be able to design a program that would allow it to forego the individual and employer shared responsibility provisions.

To apply for an innovation waiver, the state completes an application and submits it for review by the Secretary of Health and Human Services. The CMS' Center for Consumer Information & Insurance Oversight issued a Fact Sheet highlighting the application process together with FAQs primarily directed at states that might be interested in seeking an innovation waiver. If a state files for an innovation waiver, there will be a comment period before it is approved. No innovation waiver will be granted with an effective date prior to January 1, 2017.

APPLICABILITY OF ACA'S EMPLOYER SHARED RESPONSIBILITY PROVISIONS

Veterans

On July 31, 2015, President Obama signed the *Surface Transportation and Veterans Health Care Choice Improvement Act of 2015* (H.R. 3236; now Public Law 114-41). This law provides that for purposes of determining whether an employer is an applicable large employer with regard to employee enrollment in minimum essential health coverage under an eligible employer sponsored plan, individuals covered for medical care under TRICARE or the Veterans Administration are *not* counted. This provision applies retroactively for months beginning January 1, 2014.

Native American Tribes

A recent lawsuit challenged the applicability of the ACA's employer shared responsibility mandate to a Native American tribe. Currently, members of a federally-recognized Indian tribe or those eligible for services through the Indian Health Services are exempt from the ACA's individual shared responsibility mandate, i.e., they are not required to pay a fee for not maintaining health

coverage. However, there is no similar exemption under the employer shared responsibility mandate for Native American Tribes or Tribal employers.

In the case of *Northern Arapaho Tribe v. Burwell* (Case No. 14-CV-247 SWS, D. Wyo. July 2, 2015), the Tribe sought to be exempt from the ACA's employer shared responsibility mandate. The Tribe employs over 900 individuals to work on its reservation in operating a casino, convenience store, gas station, and grocery store. The Tribe had intended to provide subsidies to its employees for them to purchase health coverage through the Wyoming marketplace rather than provide employee health coverage. The U.S. District Court of Wyoming ruled that if the Tribe provides subsides to its employees for purchasing health coverage through the marketplace, it was acting in the role of an employer and thus, would not be exempt from the employer shared responsibility requirement.

On a related note, Senator Steve Daines (R-MT) and Representative Ryan Zinke (R-MT) introduced legislation, *The Tribal Employment and Jobs Protection Act* (S.1771/H.R. 3080) on July 15, 2015; which, if enacted, would exempt Native American tribes and tribal employers from the ACA's employer shared responsibility provisions.

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CBIZ
Health Reform Bulletin

Subject: **IRS Issues Draft Forms and Instructions for 2016 Reporting**
Date: August 17, 2015

On August 6, 2015, the Internal Revenue Service (IRS) issued draft 2015 Forms and Instructions for the annual reporting that will be required in 2016 by employers subject to the Affordable Care Act's shared responsibility requirements, as well as by plans providing minimum essential coverage (MEC):

- Instructions for Forms 1094-B and 1095-B
- Form 1095-B, Health Coverage
- Instructions for Forms 1094-C and 1095-C
- Form 1095-C, Employer-Provided Health Insurance Offer and Coverage

These forms are used to satisfy the IRC Section 6056 and 6055 reporting requirements. The Form 1094-B and 1095 B-series is used for reporting MEC; and the Form 1094 and 1095-C series is used for reporting employer provided coverage by employers subject to the ACA's shared responsibility requirement.

It is important to note that these instructions and forms are drafts only and subject to change.

HIGHLIGHTS FROM DRAFT INSTRUCTIONS APPLICABLE TO **BOTH** B AND C SERIES OF THE FORMS 1094 AND 1095:

- **Due Date**. For forms filed in 2016 reporting coverage provided in calendar year 2015, the Forms 1094 and 1095 of the B and C series are required to be filed with the IRS by February 29, 2016; or March 31, 2016, if filing electronically.

  Electronic filing. Reporting entities required to file 250 or more information returns must file the forms electronically (eFile). The 250-or-more requirement applies separately to each type of form. For example, if an entity is filing 500 Forms 1095-B and 100 Forms 1095-C, then it must file the Forms 1095-B electronically, but is not required to e-file the Forms 1095-C. While the IRS encourages entities to file electronically even if there are less than 250 returns, entities can apply for a hardship waiver from the electronic filing requirement. To receive a waiver, entities must file a Form 8508, *Request for Waiver From Filing Information Returns Electronically* with the IRS at least 45 days prior to the due date of the returns.

  For entities that eFile the forms, the IRS has developed a guide (Pub. 5165, *Guide for Electronically Filing Affordable Care Act (ACA) Information Returns (AIR) for Software Developers and Transmitters*) of the various procedures, transmission formats, business rules and validation process for eFiled returns through the IRS' AIR system.

- **Extension of time to file**. An automatic 30-day extension of time to file the B or C series of forms is available by completing Form 8809, *Application for Extension of Time to File*

Information Returns. The Form 8809 may be submitted on paper or through the FIRE System either as a fill-in form or an electronic file. No signature or explanation is required for the extension. However, the Form 8809 must be filed with IRS by the due date of the return in order to get the 30-day extension. It should be noted that proposed regulations issued by the IRS earlier this week would disallow the automatic 30-day extension.

- **Substitute returns**. Entities not using the designated IRS forms may be able to use a substitute form, as long as the form meets the IRS required criteria. See IRS *Publication 5223, General Rules & Specifications for Substitute Affordable Care Act Forms 1094-B, 1095-B, 1094-C, and 1095-C and Certain Other Information* for specifications for private printing of substitute information returns.

- **Correcting forms**. The Instructions provide information about how to make corrections on forms that have already been submitted to the IRS, as well as information about how to provide corrected forms that have already been furnished to individuals.

- **Consent to furnish statement electronically.** The IRS requires entities to obtain an affirmative consent when furnishing a statement electronically to individuals. The consent must relate specifically to the relevant Form 1095-B or 1095-C. The individual may consent on paper or electronically, such as by e-mail. If consenting by paper, the individual must confirm the consent electronically. A statement may be furnished electronically by e-mail or by informing the individual about how to access the statement on the reporting entity's website. In addition, the instructions outline the steps to be taken if an extension of time is needed for purposes of furnishing statements to individuals.

- **Penalties for failure to file.** The instructions reiterate the potential increased penalties for failure to comply with reporting requirements (see *Increase in Tax Information Reporting Penalties* from CBIZ HRB 112, *Updates on Section 6055/6056 Reporting*, 7/13/2015. Given the increase in these penalties, it is very important that a good faith effort be made to comply with these reporting obligations.

  Penalty Relief. For 2015 reporting, the IRS indicates that it won't impose penalties on filers for reporting incorrect or incomplete information, including TINs or dates of birth, if the reporting entity can show that it has a made good faith effort to comply with the information reporting requirements for coverage in 2015.

- **Record retention**. Copies of information returns filed with the IRS, or the ability to reconstruct the data, must be kept for at least 3 years, measured from the due date of the returns.

FOLLOWING ARE SOME OF THE SPECIFIC CHANGES TO FORMS 1094 and 1095-B:

- **Supplemental coverage**. Entities filing the B series are not required to report supplemental coverage for purposes of MEC reporting. This would include coverage that supplements a government sponsored program such as Medicare or TRICARE; or, coverage provided to an individual in one or more plans provided by the same plan sponsor, i.e., the plan sponsor is required to report only one type of MEC. According to the instructions, coverage is not deemed to be provided by the same plan sponsor if they aren't reported by the same reporting entity. Thus, an insured group health plan and a self-insured health reimbursement arrangement covering the employees of the same employer aren't considered supplemental.

This might be particularly relevant when an employer offers a retiree-only health reimbursement arrangement.

- In Part II of Form 1095, lines 10–15 request employer information, such the name, EIN, and mailing address for the employer sponsoring the coverage. If the employer is a member of a controlled group, information for the specific controlled group member that is the covered employee's employer is entered in these lines. The instructions clarify that if the coverage is provided through an association or a Multiple Employer Welfare Arrangement, information for the participating employer of the covered employee must be provided. Part II of the form need not be completed if the coverage is provided through a multiemployer.

- Part IV of the Form requires information about the covered individuals, such as name, SSN or date of birth, and series of check boxes in indicate the months that an individual was covered under the plan. The draft instructions clarify that if an individual wasn't covered for all months, the applicable box(es) for the months in which the individual was covered for at least one day must be checked. In addition, if there are more than six covered individuals to report, then this information for the additional covered individuals must be provided on Part IV, Continuation Sheet.

FOLLOWING ARE SOME OF THE SPECIFIC CHANGES TO FORMS 1094 AND 1095-C:

- **Form Revisions:**
  - For 2015, the Form 1094-C was revised to move line 19 (*Is this the Authoritative Transmittal for this ALE Member?*) into Part I of the form and to allow for an entry in the "All 12 Months field" in Part III, Line 23, column (b) Full-Time Employee Count for an applicable large employer member.
  - **Plan Start Month**. Part II of the Form 1095-C includes a box to place a 2-digit indicator code for purposes of identifying the calendar month of the beginning plan year in which the employee is offered coverage. This box is optional for 2015 form but may be made mandatory in future years.

- **Breaks in service**. An employee on unpaid leave during the break in service is treated as an employee for reporting purposes during the break in service; while a former employee whose employment had been terminated during the break in service would not be treated as an employee for reporting purposes.

- **Minimum value**. A plan provides minimum value if the plan pays at least 60% of the costs of benefits and provides substantial coverage of inpatient hospitalization services and physician services. An offer of coverage under a plan that fails to provide substantial coverage of inpatient hospitalization and physician services should be reported on Form 1095-C as not providing minimum value, even if an employer qualifies for the IRC Section 4980H transition rule.

- **Indicator codes for Employee Offer and Coverage**. In Line 14, a series of codes are used to indicate the type of coverage offered to employees and their dependents. The draft instructions clarify explanations of some of these codes:
  - An offer of coverage is treated as made to an employee's dependents only if the offer of coverage is made to an unlimited number of dependents regardless of the actual number of dependents, if any, an employee has during any particular calendar month.
  - An offer of COBRA continuation coverage that is made to a former employee upon termination of employment is reported as an offer of coverage using the appropriate

indicator code on line 14 only if the former employee enrolls in the coverage. If the former employee does not enroll in the coverage (even if a spouse or dependent of the former employee independently enrolls in the coverage), code 1H (No offer of coverage) should be entered for any month for which the offer of COBRA continuation coverage applies. An offer of COBRA continuation coverage that is made to an active employee (for instance, an offer of COBRA continuation coverage that is made due to a reduction in the employee's hours that resulted in the employee no longer being eligible for coverage under a plan) is reported in the same manner and using the same code as an offer of that type of coverage to any other active employee.

- **Calculating employee's share of premium.** Line 15 requires the dollar amount of an employee's share of the lowest cost monthly premium for self-only minimum value coverage. For purposes of determining the monthly employee contribution, an employer can divide the total employee share of the premium for the plan year by the number of months in the plan year to determine the monthly employee contribution for the plan year. This monthly employee contribution would then be reported for any months of that plan year that fall in the 2015 calendar year.

- In the case of a **multi-employer plan**, each employer contributing on behalf of an individual participating in a multi-employer plan is responsible for reporting. An employer can satisfy its shared responsibility obligation by contributing to the multi-employer plan, but it remains responsible for tracking the individuals and making certain that the reporting obligation is accomplished. The employer should make certain it can obtain from the multiemployer plan, information such as who participated and that the plan meets minimum value and affordability. An employer can satisfy its obligation by completing Line 14, using code 1H and in Line 16, Code 2E.

In several places throughout the draft instructions, the IRS provides tips and examples; for instance, in the qualifying offer discussion, the IRS provides alternative methods of reporting. These tips and examples should prove to be useful for filers.

As soon as the instructions are finalized, we will provide additional information. In the meantime, employers and other responsible entities should familiarize themselves with these forms and instructions to ensure being prepared for the filings due in 2016.

As a reminder, the CBIZ ACA CheckPoint provides employers with the tools to determine whether they are an applicable large employer, track and manage employee measurement periods, and aid in complying with ACA's employer shared responsibility reporting requirements. To view a short video demonstration of CBIZ ACA CheckPoint, click HERE. CBIZ is also hosting a webinar on August 20th entitled, *CBIZ ACA CheckPoint: Is This Your Solution for Employee Measurement, Tracking and Reporting for 2015? Time is running out!* Click HERE to register for this webinar. Please note new implementation requests for CBIZ ACA CheckPoint will only be taken until October 1, 2015 to ensure adequate time for implementation. For more information about CBIZ ACA Checkpoint, contact your local CBIZ consultant.

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CBIZ
Health Reform Bulletin

Subject: **1) New Law Amends Definition of Small Employer; 2) Finalized ACA Reporting Forms - 1094 and 1095 Series; 3) Employer Notices of Marketplace Determinations; 4) Cost Sharing and Out-of-Pocket Limits; 5) Adjusted PCORI Fee; 6) Determining Minimum Value Standard of Health Coverage; and 7) Nondiscrimination in Health Plans, Programs and Activities**

Date: October 12, 2015

NEW LAW AMENDS DEFINITION OF SMALL EMPLOYER

On October 7, 2015, President Obama signed H.R.1624, *Protecting Affordable Coverage for Employees Act* ("PACE"). This law allows a state to define *small employer* for purposes of health insurance as an employer employing between 1 and 50 employees in the previous calendar year; and at least one employee on the first day of the corresponding plan year. Most states currently define small employer in this manner.

The Affordable Care Act, prior to enactment of PACE, would have changed the definition of small employer, effective January 1, 2016, to an employer employing between 1 and 100 employees. According to this new law, a state may, but is not obligated, to use the 100 or fewer definition. For example, California, Colorado, District of Columbia, North Carolina, New York and Virginia have modified the definition of small employer to mean one who employs fewer than 100 employees. These states, of course, would have the legislative right to change the definition back to 1 to 50 employees. Presumably, states that have not yet expanded their small employer definition would retain the 50 or fewer employee definition.

What does this mean?

Small employer plans, according to the ACA, are subject to certain requirements that large employer plans are not subject to; notably, the rate setting issue based on age, geographic location, family composition and tobacco use. Further, only insured small employer plans are required to include all essential health benefits (EHBs) as defined by the state (note, large employer plans, including self-funded plans, are not required to include all EHBs; but to the extent that a plan does include an EHB, the EHBs are subject to restrictions such as no annual or lifetime limits and cost-sharing restrictions). Retaining the 50 or fewer employee definition will limit the number of employers impacted by these provisions.

As true with any new law, there will surely be some issues to be resolved, not the least of which is renewals already in process based on an expanded definition of small employer.

FINALIZED 2015 ACA REPORTING FORMS 1094 AND 1095 SERIES

The Affordable Care Act (ACA) imposes two new Internal Revenue Code sections. One requires reporting of minimum essential coverage (MEC); the other requires employers subject to the employer shared responsibility provisions to report on offers of coverage. This reporting is

required beginning January 1, 2015, with the first reports due in 2016. The IRS has recently released the finalized 2015 forms and instructions to be used for the reports:

Health Insurance Coverage Reporting by Insurers and Sponsors of Self-funded Plans (IRC§ 6055)

- Instructions for 2015 Forms 1094-B and 1095-B (PDF or HTML)
- Form 1094-B, *Transmittal of Health Coverage Information Returns*
- Form 1095-B, *Health Coverage*

Employer Health Insurance Reporting Requirement (IRC § 6056)

- Instructions for 2015 Forms 1094-C and 1095-C (PDF or HTML)
- Form 1094-C, *Transmittal of Employer-Provided Health Insurance Offer and Coverage Information Returns*
- Form 1095-C, *Employer-Provided Health Insurance Offer and Coverage*

In addition, the IRS has updated two of their webpages to provide further information and assistance to employers required to file the requisite forms:

- ACA Information Center for Applicable Large Employers (ALEs)
- Information Reporting by Applicable Large Employers

These finalized 2015 forms are substantially similar to the draft forms and instructions issued a few months ago (see CBIZ *Health Reform Bulletin*, *Draft 2015 versions of ACA Reporting Form 1094 and 1095 Series*, 6/22/15). A few notable modifications and clarifications to the 2015 Forms and Instructions are as follows:

- ***Coverage in more than one type of comprehensive health coverage, whether insured or self-funded.*** The instructions to the B series provides that if an employer sponsors a major medical plan and a health reimbursement arrangement (HRA), the employer need not file for the HRA. Conversely, if the employer has an employee covered by a non-excepted HRA and that employee is covered by, for example, a spouse's employer plan, the employer sponsoring the HRA would have to file (an *excepted HRA* is one covering, for example, dental-only or vision-only services). Generally, reporting is required for a retiree-only HRA because these HRAs are generally not integrated with health coverage. This exception is likewise reflected in the finalized instructions to Part III of the Form 1095-C, applicable to MEC reporting for self-funded plans.

  With regard to the C series:

  - **Reporting COBRA Coverage**. In Lines 14 to 16, the employer reports on offers of coverage, affordability and any applicable safe harbor codes. Of particular note, certain codes are used in Line 14 to specify the type of coverage offered and in Line 16 to specify any safe harbor codes that may apply, such as the employee is no longer employed or not a full-time employee. In a significant reversal from the draft to finalized forms that should come as welcome news for employers, an offer of COBRA continuation coverage to a terminated employee need not be reported. Rather, an employer can use Code 1H (No offer of coverage) on Line 14 and Code 2A (Employee not employed during the month) in Line 16, whether the individual elects or declines COBRA. Note, this is only applicable in the event of a terminated employee. Special rules apply to active employees electing COBRA, such as due to reduction in hours, as well as to dependents electing COBRA. Also note, if the plan is self-funded and the individual is covered through COBRA, then Part III MEC reporting must still be completed.

- **Determining Applicable Codes**
  The instructions relating to Line 14, Employee Offer and Coverage and Line 16 relating to Code Series 2 where applicable, provide important guidance on determining which indicator code to select if more than one code applies.

- **Multiemployer plans:**
  - For reporting offers of coverage for 2015, an employer relying on the multiemployer arrangement interim guidance would enter code 1H on line 14 for any month for which the employer enters code 2E on line 16. These codes indicate that the employer was required to contribute to a multiemployer plan on behalf of the employee for that month and therefore is eligible for multiemployer interim rule relief.
  - An employer is deemed to offer health coverage to an employee if it, or another employer in the Aggregated ALE Group, or a third party such as a multiemployer or single employer Taft-Hartley plan, a multiple employer welfare arrangement or a staffing firm offers health coverage on behalf of the employer.

- **Counting Employees**
  - For purposes of counting employees to determine applicable large employer (ALE) status, the final forms affirm that employees who have coverage under TRICARE or through the Veterans Administration are not counted (see *Applicability of ACA's Employer Shared Responsibility Provisions - Veterans* from CBIZ HRB 113, 8/5/15).
  - Employers must choose to use one of the following days of the month to determine the number of employees per month and must use that day for all months of the year:
    1. The first day of each month;
    2. The last day of each month;
    3. The first day of the first payroll period that starts during each month; or
    4. The last day of the first payroll period that starts during each month.

    The final instructions provide for an additional measurement period wherein the count can be determined from the 12th day of each month.

EMPLOYER NOTICES OF MARKETPLACE DETERMINATIONS

Employers subject to the ACA's' employer shared responsibility requirements will only be at risk for an excise tax if one or more of its full-time employees, defined as an individual working 30 or more hours per week, qualifies for premium assistance. These individuals are known as credit employees. To qualify for premium assistance or cost sharing, the individual must fall between 100-400% of the federal poverty level. There must have been no offer of adequate or affordable coverage by the employer. The individual is disqualified from being a credit employee if he/she enrolls in health coverage of any nature offered by the employer. If an individual is granted premium assistance or a cost-share, and is later found to be ineligible, the individual would be required to refund the advanced payment.

To facilitate this process, the federal marketplace can issue a notice to the employer advising that one of its employees have been granted premium assistance, giving the employer an opportunity to appeal this determination (also see *Employer Appeals to Marketplace*, CBIZ *Health Reform Bulletin*, 2/16/15). Presumably the purpose of the notice is to mitigate incorrect advanced payment of cost share or premium assistance.

In no way does this marketplace notice impose a tax upon the employer. The employer would only be subject to an excise tax after it has received a notice from the IRS and after it has had an opportunity to appeal. The IRS notice would be generated after the individual has filed his/her tax return and after the employer has filed its Form 1094-C and 1095-C.

During 2015, very few marketplaces actually issued notices. The CMS' Center for Consumer Information and Insurance Oversight recently issued a set of FAQs indicating that in 2016, it will begin issuing more employer notices. These will generally come from the federal marketplace and states that are using the federal platform. State-based marketplaces may, at their discretion, also issue notices.

According to these FAQs, the first batch of notices will come after the 2016 open enrollment period that will end January 31, 2016. The notices will be sent to the employer's address that is provided by the individual seeking coverage through the marketplace. Employers will be able to respond to the notices within 90 days, either affirming the individual has coverage or was offered coverage by the employer.

COST SHARING AND OUT-OF-POCKET LIMITS

The Affordable Care Act imposes certain cost-share restrictions on essential health benefits (EHB) provided under non-grandfathered group health plans, including non-grandfathered self-insured and large group health plans. For 2015, the annual out-of-pocket limit is $6,600 for self-only coverage and $13,200 for other than self-only coverage. In 2016, the out-of-pocket limit increases to $6,850 for self-only coverage; $13,700 for other than self-only coverage.

The Departments of Labor, Treasury and Health and Human Services recently released an implementation FAQ relating to cost sharing matters. The FAQ clarifies that for plan years beginning January 1, 2016, an individual cannot be subject to more than the individual statutory out-of-pocket limit on EHBs, even if the individual is covered by a family plan. Following is an example of how this cost sharing mechanism applies:

> *Example.* Assume a family of four individuals is enrolled in family coverage under a group health plan in 2016 with an aggregate annual limitation on cost sharing for all four enrollees of $13,000. Individual #1 incurs claims associated with $10,000 in cost sharing; and individuals #2, #3, and #4 each incur claims associated with $3,000 in cost sharing.
>
> In this example, because the self-only maximum annual limitation on cost sharing ($6,850 in 2016) applies to each individual, the cost sharing for individual #1 for 2016 is limited to $6,850, and the plan is required to bear the difference between the $10,000 in cost sharing for individual #1 and the maximum annual limitation for that individual, or $3,150. With respect to cost sharing incurred by all four individuals under the plan, the aggregate $15,850 ($6,850 + $3,000 + $3,000 + $3,000) in cost sharing that would otherwise be incurred by the four individuals together is limited to $13,000 (the annual aggregate limitation under the plan); thus, the plan must bear the difference between the $15,850 and the $13,000 annual limitation, or $2,850.

According to guidance, a plan can have two separate cost sharing limits for different benefits, such as one for the comprehensive medical plan and one for prescription drug plan. In this event, the combined cost share cannot exceed the overall limit.

ADJUSTED PATIENT-CENTERED OUTCOMES RESEARCH FEE

The Affordable Care Act imposes a Patient Centered Outcome Research (PCOR) fee which may be adjusted annually. For policy and plan years ending between October 1, 2015 and October 1, 2016, the fee will increase to $2.17, according to IRS Notice 2015-60. As background, the PCOR fee is assessed on the average number of lives covered under the policy or plan. The fee is required to be reported annually to the IRS on the second quarter Form 720 and paid by its due date, July 31st.

For additional information about the PCOR fee, see IRS webpage, questions and answers and chart of plans subject to the fees.

DETERMINING MINIMUM VALUE STANDARD OF HEALTH COVERAGE

The IRS has recently proposed a regulation to align with prior guidance relating to determining minimum value of health coverage. This standard is used for purposes of the ACA's employer shared responsibility provisions that require employer-sponsored plans to cover at least 60% of the total allowed costs of benefits provided under the plan, including substantial coverage of inpatient hospitalization and physician services. The minimum value standard also applies for purposes of determining eligibility for the premium tax credit.

NONDISCRIMINATION IN HEALTH PLANS, PROGRAMS AND ACTIVITIES

Section 1557 of the Affordable Care Act provides for open access to health coverage, programs and activities by all individuals. In other words, individuals cannot be discriminated or prohibited from participating in health related programs or denied health coverage on the basis of race, color, national origin, sex, age, or disability. To this end, the Department of Health and Human Services issued proposed regulations, together with a Fact Sheet and FAQs, that set forth the standards to be used by federally-sponsored health programs and activities to ensure that individuals are not denied access to these services. In addition, these regulations prohibit discrimination by health insurers, including plans issued through the marketplace and certain plans administered by employers receiving federal assistance, on the basis of race, color, national origin, disability, age, sex, gender identity or sexual orientation. Comments on these regulations must be submitted by November 9, 2015.

ABOUT THE AUTHOR: Karen R. McLeese is Vice President of Employee Benefit Regulatory Affairs for CBIZ Benefits & Insurance Services, Inc., a division of CBIZ, Inc. She serves as in-house counsel, with particular emphasis on monitoring and interpreting state and federal employee benefits law.
Ms. McLeese is based in the CBIZ Kansas City office.

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CBIZ
Health Reform Bulletin

Subject: Year-End Wrap Up
Date: December 29, 2015

The government is winding up 2015 and ringing in 2016 with a bang.

In a late breaking and most welcome development, the IRS has delayed the new Affordable Care Act's reporting and disclosure obligation, as follows.

- The 2015 Forms 1095-B and 1095-C benefit statements which were to be provided to affected individuals by February 1, 2016 now must be provided no later than March 31, 2016.
- The 2015 Forms 1094-B and 1095-B, and the 2015 Forms 1094-C and 1095-C reports must be submitted to the IRS no later than May 31, 2016 (or electronically, by June 30, 2016).

No additional requests for extensions will be granted. The IRS is encouraging employers to comply earlier, if possible; however, this automatic extension should come as welcome news for employers struggling to comply. Also see *Reporting and Disclosure* in the *Year End Reminders* below for additional information.

On December 18, 2015, President Obama signed the *Consolidated Appropriations Act, 2016* and the *Protecting Americans from Tax Hikes (PATH) Act of 2015* (H. R. 2029; now Public Law No. 114-113). These laws amend several provisions of the Affordable Care Act, as well as make changes in several benefit-related provisions. Of particular note, these laws:

- Extend, for two years, the imposition of the so-called Cadillac tax. The tax would be imposed on the cost of health coverage that exceeds certain thresholds. It was to take effect in 2018; the new law delays the effective date until 2020; and changes the status of the tax from an excise tax to a deductible tax.
- Place a one year moratorium for the 2017 tax year on the annual fee required to be paid by 'covered entities' (insurers) who engage in providing health insurance for U.S. health risks.
- Place a two-year moratorium on the medical device excise tax for 2016 and 2017.

In addition, the Internal Revenue Service issued guidance (Notice 2015-87) relating to Affordable Care Act (ACA) implementation on a potpourri of topics, as follows:

❑ EMPLOYER SHARED RESPONSIBILITY PROVISIONS

- **Affordability Standard**. For purposes of determining affordability, coverage under an employer-sponsored plan is deemed affordable if the employee's required contribution to

the plan does not exceed 9.5% of the employee's household income for the taxable year, based on the cost of single coverage in the employer's least expensive plan. According to the IRS guidance, this 9.5% safe harbor is now tied to inflation. Thus, for plan years beginning in 2015, the household income threshold percentage will increase to 9.56%. For plan years beginning in 2016, the threshold percentage will increase to 9.66%.

- **Increase in Excise Tax Penalties.** This guidance affirms the projected increases in the amount of penalties for purposes of calculating the 'no coverage' excise tax (IRC§ 4980H(a)) and the 'inadequate or unaffordable' excise tax (IRC §4980H(b)) for 2015 and 2016 (see chart below). These are the excise taxes that could apply if an applicable large employer (ALE) is found not to have offered health coverage to a full-time employee.

'NO COVERAGE' EXCISE TAX IRC § 4980H(a)		'INADEQUATE OR UNAFFORDABLE' EXCISE TAX IRC § 4980H(b)	
2015	$2,080	2015	$3,120
2016	$2,160	2016	$3,240
2017	$2,260 *(projected)*	2017	$3,390 *(projected)*

- **Determining Cost of Coverage**
  For purposes of determining affordability applicable to employers subject to the shared responsibility rules, this guidance addresses several scenarios as it relates to determining an employee's cost of coverage. In a nutshell:
  - An employee's cost is reduced by any newly available integrated health reimbursement arrangement (HRA) funds that can be used for premium or other plan expenses.
  - *Flex credits* available to an individual, either for the purchase of other benefits or taken in cash, do not impact the employee's cost of coverage.
  - *Cash-out option*. In this situation, an employee would receive an amount of cash as a result of foregoing employer contribution to health coverage. This guidance states that the government will be issuing regulations that would require the cash-out amount to be added to the employee's cost of coverage. An example might be is where an employee's health coverage costs $100, and if the employee declines health coverage, the employee would receive $100 in cash. In this example, the actual employee's cost of coverage would be $200. Until these regulations are issued, the government indicates that it will not enforce this method of determining affordability for plans in place prior to December 16, 2015.
  - In *determining hours worked*, all paid time is counted, including vacation, sick leave and other paid time. A question has arisen about third party paid time. This guidance affirms that as long as the employment relationship exists, third party paid time, such as short term or long term disability, does count. However, state temporary disability and state workers compensation are not counted.

❑ INDIVIDUAL PREMIUM AND HRAS

The government has said repeatedly that an employer cannot directly or indirectly contribute to individual premium. This guidance affirms previously issued guidance relating to health reimbursement arrangements (HRAs), as well as makes the following clarifications:

- HRAs for active employees must be integrated with comprehensive health coverage. This guidance clarifies that to be integrated, and if the HRA covers dependents, the dependents must be covered by the plan to which the HRA is integrated.
- An HRA that covers retiree-only individuals need not be integrated with a comprehensive plan. Further, HRA funds can be used to pay for excepted benefits, such as a dental-only plan, without violating the prohibition against premium payment plans.

MARKET REFORM: FINAL RULES

On November 18, 2015, the Affordable Care Act's tri-governing agencies (Departments of Health and Human Services, Labor and Treasury) released final rules relating to market reforms. These final rules incorporate the previously issued interim final rules and sub-regulatory guidance issued to date. While these rules do not break new ground, they do provide some clarifications, as follows:

- ***Grandfathered Health Plan Coverage.*** Grandfathered group health plans (those in existence since the ACA's enactment date, March 23, 2010) are exempt from certain ACA market reforms such as the patient protection provisions and providing coverage of preventive health services, immunizations, and screenings without any cost sharing (see the chart of the types of mandates applicable to grandfathered plans). As long as the plan is not significantly changed from that date forward, it can retain grandfathered status. Of particular note, these regulations affirm that a statement of grandfathered status must be included in plan communications; however, these statements need only be included in general plan communications provided to plan participants such as a summary plan description and not, for example, in an explanation of benefits (EOB).

- ***Essential Health Benefits.*** Beginning in 2014, the ACA requires non-grandfathered plans in the individual and small group markets issued both in and outside of the marketplace to cover essential health benefits (EHBs). Self-insured group health plans, health insurance coverage offered in the large group market, and grandfathered health plans are not required to cover EHBs. However, to the extent that self-funded plans and large insured plans offered outside the marketplace offer EHBs, these essential benefits cannot be subject to annual and lifetime limits, whether provided in-network or out of network. According to the final regulations, a plan can elect to use a benchmark plan for purposes of determining whether a particular benefit is an EHB. A plan can use any of the 51 state-based benchmark plans, or the Federal Employee Health Benefit Plan-based benchmark plan, to make its EHB determination. Additional information about the various EHB based benchmarking plan designs can be accessed on the CMS' Center for Consumer Information & Insurance Oversight website.

- ***Preexisting Condition Exclusions.*** The regulations affirm that while a plan cannot impose preexisting condition exclusion, it can have a benefit exclusion. However, the plan cannot impose an exclusion on benefits that it would otherwise cover.

- ***Coverage of Dependent Child to Age 26***. The regulations affirm that an HMO cannot exclude coverage for a dependent child simply because the child moves outside the service area, such as when a child goes to college.

- ***Rescission of coverage***. The regulations clarify that a rescission is a retroactive termination of coverage and can only be imposed due to fraud or misrepresentation. A prospective termination of coverage does not constitute a rescission.

- ***Designation of Primary Care Provider***. The regulations affirm that each covered life has the right to designate his/her primary care provider.

- ***Integrated health plans***. The regulations affirm previously issued guidance relating to health reimbursement arrangements (HRAs) and integrated health plans. For an employer employing fewer than 20 employees, and therefore not subject to the Medicare secondary payor (MSP) rules, the HRA can be coordinated with Medicare. This is not permissible for employers subject to the MSP rules.

Effective Date. The final market reform regulations become effective on January 19, 2016 and apply to group health plans beginning on the first day of the first plan year beginning on or after January 1, 2017.

PENALTIES FOR FAILURE TO COMPLY WITH ACA MARKET REFORMS

As a reminder, group health plans that fail to comply with certain federal laws, including violations relating to the ACA's market reform provisions could trigger the imposition of an excise tax, in accordance with IRC Section 4980D. The amount of the penalty is $100 per employee/per day of noncompliance. Employer/plan sponsors, insurers and third party administrators who are liable for the excise taxes are required to self-report ACA violations on the IRS Form 8928.

ACA PROVISIONS EFFECTIVE IN 2016

COST SHARE LIMITS

The Affordable Care Act imposes certain cost-share restrictions on essential health benefits provided under non-grandfathered group health plans, including non-grandfathered self-insured and large group health plans. In 2016, the out-of-pocket limit increases to $6,850 for self-only coverage; $13,700 for other than self-only coverage. For plan years beginning January 1, 2016, an individual cannot be subject to more than the individual statutory out-of-pocket limit on essential health benefits, even if the individual is covered by a family plan. The Centers for Medicare and Medicaid Services are proposing to increase these limits in 2017 to $7,150 for self-only coverage; $14,300 for other than self-only coverage. As a reminder, the 2016 out-of-pocket limits applicable to high deductible health plans used in conjunction with health savings accounts are $6,550 for individual coverage; $13,100 for family coverage.

INDIVIDUAL SHARED RESPONSIBILITY REQUIREMENT

- For 2015, the applicable fee for individuals who failed to maintain health insurance and did not qualify for an exemption is the greater of $325 or 2% of annual household income. In 2016, the fee increases to $695 per person or 2.5% of income, whichever is higher. The fee is calculated based on the number of months the individual, his/her spouse or tax dependents went without qualifying minimum essential coverage.

- The annual open enrollment period for 2016 coverage via HealthCare.gov closes on January 31, 2016. Unless a special enrollment event occurs, individuals who fail to enroll by that date would have to wait for the next annual enrollment opportunity (November 1, 2016 through January 31, 2017).

YEAR-END REMINDERS

❑ EMPLOYER SHARED RESPONSIBILITY REQUIREMENT

- **Applicability**. For purposes of the ACA's employer shared responsibility requirement and reporting and disclosure requirements, applicable large employer (ALE) status is determined each calendar year, based on the average size of the employer's workforce during the prior year. Thus, if you averaged at least 50 full-time employees, including full-time equivalent employees, during 2014, you are most likely an ALE for 2015 and are subject to the reporting and disclosure requirements due in early 2016.

- **Required Reporting and Disclosure.** The ACA imposes two Internal Revenue Code sections. One requires reporting of minimum essential coverage (MEC); the other requires employers subject to the employer shared responsibility provisions to report on offers of coverage. The forms for both of these reporting requirements are the Form 1094 transmittal and Form 1095 benefit statement. IRC Section 6055 reporting is accomplished on the B series of the form; the employer shared responsibility reporting is accomplished on the C series. A self-funded employer subject to shared responsibility can satisfy both its IRC Sections 6055 and 6056 reporting obligations by completing all parts of the Form 1095-C.

  Deadlines for Filing and Distributing Forms 1094 and 1095
  As mentioned above, the IRS has delayed the filing and distribution due dates applicable to the 2015 Forms, as follows.

  Filing Forms with IRS. The 2015 Forms 1094-B and 1095-B, and the 2015 Forms 1094-C and 1095-C reports must be submitted to the IRS no later than May 31, 2016 (or June 30, 2016, if filing electronically). Thereafter (beginning with the 2016 reporting forms), the due date for filing the Forms 1094 and 1095 is February 28th of each year (or by March 31st of each year, if filing electronically), or by next business day.

  Employers issuing 250+ forms must file the reports electronically (efile) with the IRS. If you are required to efile the Forms 1094 and 1095, you should review IRS Publication 5165, *Guide for Electronically Filing Affordable Care Act (ACA) Information Returns.* This guide provides specific details on the procedures, transmission formats, business rules and validation procedures for returns that must be transmitted in 2016.

  Furnish 2015 Form 1095 to Individuals. Individuals listed in the 2015 Forms 1094 and 1095 must be furnished copy of the relevant Form 1095 by March 31, 2016. Thereafter (beginning with the 2016 forms), individuals must receive a copy of the relevant Form 1095 by January 31st each year, or by next business day.

  Methods for Furnishing the Form 1095. The employer can provide a paper copy of the Form 1095 by hand, or send by mail, unless the recipient affirmatively consents to receive the Form 1095 in electronic format.

  To provide the statements electronically, the employer must first obtain affirmative consent from the individual to receive it electronically. The consent can be provided to the individual by paper, or electronically such as by email.

Once affirmative consent is obtained, the Form 1095 can be provided to the individual either electronically by email, or by informing individuals how to access the Form 1095 on the employer's website, if applicable. If posting on the employer's website, the employer is then required to notify the recipient that the Form 1095 is available on its website; this notice of website availability can be provided to recipients by mail, by email, or in person. The website availability notice must provide instructions on how to access and print the Form. If providing this notice by email, the phrase, "IMPORTANT TAX RETURN DOCUMENT AVAILABLE" must appear in all caps in the email subject line.

- **FORM W-2 REMINDER - AGGREGATE COST OF HEALTH COVERAGE**

  The Form W-2 must include the aggregate cost of health coverage. The aggregate cost information is to be reported in Box 12, using Code DD. For details about this mandatory reporting, see these CBIZ Health Reform Bulletins, *Reminder: Fast Approaching Form W-2 Reporting Requirement* and *Additional IRS Guidance on W-2 Reporting Requirement*.

TAX INFORMATION REPORTING PENALTIES

As a reminder, the IRS can assess penalties when certain tax information is not provided on a timely basis. Specifically, penalties may be assessed for failure to file information returns or provide payee statements, such as the Forms 1094 and 1095, as well as the Form W-2. Beginning in 2016, the penalty for failure to file an information return is $250 for each return for which such failure occurs, with the total penalty for all failures during a calendar year capped at $3 million. The penalty for failure to provide a correct payee statement is $250 for each statement with respect to which such failure occurs, with the total penalty for a calendar year not to exceed $1.5 million. Special rules apply that increase the per-statement and total penalties if there is intentional disregard of the requirement to furnish a payee statement.

- **SUMMARY OF BENEFITS AND COVERAGE**

  Under ACA, all group health plans, including grandfathered plans, whether insured or self-funded, are required to provide a Summary of Benefits and Coverage (SBC) to plan participants within certain timeframes:

  1. Upon application;
  2. By the first day of coverage;
  3. Within 90 days of enrollment be special enrollees;
  4. Upon contract renewal; and
  5. Upon request.

- **MARKETPLACE NOTICE OBLIGATION**

  All employers subject to Fair Labor Standards Act have an on-going obligation to provide the Notice of Marketplace Options to all new hires within 14 days of hire. The purpose of the Notice is to explain important information about the pros and cons of buying coverage through the marketplace. The DOL provides model notices (in both English and Spanish) that can be used by employers who offer health coverage to some or all employees, and for those who do not offer coverage.

- **PATIENT-CENTERED OUTCOMES RESEARCH INSTITUTE FEE**
  The Patient Centered Outcome Research (PCOR) fee is required to be reported annually to the IRS on the second quarter Form 720 and paid by its due date, July 31, is based on the average number of lives covered under the policy or plan. For plan years ending between October 1, 2014 and October 1, 2015, the fee was $2.08. The fee increases to $2.17 for policy and plan years ending between October 1, 2015 and October 1, 2016. For additional information about the PCOR fee, see IRS webpage, questions and answers and chart of plans subject to the fees.

- **TRANSITIONAL REINSURANCE FEE**
  The ACA imposes a transitional reinsurance fee, the goal of which is to help stabilize premiums in the individual market due to enrollment of higher risk individuals in the marketplace. All insurers and plan sponsors of self-funded plans are required to contribute to this reinsurance fund over a three year period from 2014 through 2016. The contribution rate for the 2015 benefit year is $44 per covered life; in 2016, this amount drops to $27 per covered life.

ABOUT THE AUTHOR: Karen R. McLeese is Vice President of Employee Benefit Regulatory Affairs for CBIZ Benefits & Insurance Services, Inc., a division of CBIZ, Inc. She serves as in-house counsel, with particular emphasis on monitoring and interpreting state and federal employee benefits law.
Ms. McLeese is based in the CBIZ Kansas City office.

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Health Reform Bulletin

CBIZ

Subject: 1) Correcting Forms 1094-C and 1095-C; 2) Required Contributions – Indexed Adjustments for Minimum Essential Coverage; 3) Revised SBC Templates and 4) Update on Employer Appeals to Marketplace Determinations

Date: April 18, 2016

Correcting Forms 1094-C and 1095-C

March 31st has come and gone and there are surely lingering questions about how to correct the newly required IRS reports. As background, Internal Revenue Code (IRC) Section 6055 requires insurers, self-funded plans and other providers of minimum essential coverage (MEC) to report certain information to the Internal Revenue Service (IRS). IRC Section 6056 obligates employers subject to the employer shared responsibility rules of the ACA, specifically employers employing 50 or more employees (known as "applicable large employer" or "ALE"), to report certain information annually to the IRS, as well as provide related benefit statements to employees.

This article will focus on the IRC Section 6056 obligation which is accomplished on the Form 1095-C benefit statement and Form 1094-C transmittal document. The Form 1095-C must be provided to each employee who was a full-time employee for at least one month in 2015. Generally, the first reports are due in 2016 for reporting information on the 2015 calendar year. The Form 1095-C must be provided to individuals by January 31st and transmitted to the IRS by February 28th (or March 31st if filing electronically). However, for this reporting year only, the filing dates were extended:

- The 2015 Form 1095-C must be provided to individuals by March 31, 2016;
- The 2015 Forms 1094-C and 1095-C must be submitted to the IRS no later than May 31, 2016 (or by June 30, 2016, if filed electronically).

There are penalties for not complying with the filing requirements (see *Updates on Section 6055/6056 Reporting - Increase in Tax Information Reporting Penalties*, 7/13/15). There are also potential penalties for providing incorrect or incomplete tax forms to the IRS, as well as to individuals. The IRS indicated that penalties could be abated as long as a good faith effort is made to provide the corrected information and as long as it is provided timely. Accordingly, for example, if the Form 1095-C was not furnished to individuals by March 31, 2016, then the potential penalty for failure to provide the form would be reduced from $250 to $50 if there is a reasonable cause for the delay in furnishing the form.

Similarly, because the IRS extended the due dates of the 2015 forms, the deadlines for correcting and furnishing the forms were likewise extended. If reporting failures are corrected within 30 days of the due date, the penalty would be reduced to $50. The penalties are also reduced if corrections are made after 30-day deadline and prior to October 1, 2016 for forms furnished to individuals, or by November 1, 2016 for forms filed with the IRS.

Process for Correcting Returns

According to the Form 1094/1095 instructions, any mistakes to the information contained in the forms must be corrected as soon as possible following discovery of the error. The instructions provide examples of errors and the processes for correcting the forms, depending on whether the forms have been submitted to the IRS and/or furnished to individuals.

I. **Steps to correct errors on original Form 1095-C that has not been filed with IRS but furnished to individuals**

As long as the Form 1095-C has not been transmitted to the IRS, then once the correction is made to the Form, write the words, "Corrected Form" at the top of the corrected Form 1095-C and send the corrected Form to the affected individual.

II. **Steps to correct errors on the original Form 1095-C that has been filed with the IRS and furnished to Employee**

1. Prepare a new Form 1095-C;
2. Enter an "X" in the "CORRECTED" box at the top of the Form 1095-C;
3. Submit corrected Form 1095-C with a Form 1094-C transmittal to the IRS (however, do not check the 'corrected' box on the Form 1094-C); and
4. Furnish a corrected Form 1095-C to the employee.

This process applies if any of the following information is incorrect on the originally filed form:

- Name, SSN, Employer EIN
- Offer of Coverage
- Premium Amount
- Safe Harbor and Other Relief Codes
- Covered Individuals Information

III. **Steps to correct errors on the original Form 1094-C that has been filed with IRS:**

1. Prepare a new authoritative Form 1094-C;
2. Enter an "X" in the "CORRECTED" box at the top of the form; and
3. Submit the standalone corrected transmittal with the corrected information.

Do not re-submit the Form(s) 1095-C if the correction only relates to Form 1094-C. This process applies when any of the following information is incorrect on the originally filed form:

- ALE Member or Designated Government Entity (Name and/or EIN)
- Total Number of Forms 1095-C filed by and/or on behalf of ALE Member
- Aggregated Group Membership
- Certifications of Eligibility
- Minimum Essential Coverage Indicator
- Full-Time Employee Count for ALE Member
- Aggregated Group Indicator
- Section 4980H Transition Relief Indicator

Note: If both the Form(s) 1094-C and 1095-C must be corrected, follow both processes described above in sections II and III for correcting forms that have already been filed.

Correcting Electronically Filed Forms. For issues specific to electronically filed forms, ALEs should refer to the correction process contained in Section 7 of IRS Publication 5165, *Guide for Electronically Filing Affordable Care Act (ACA) Information Returns for Software Developers and Transmitters*.

Required Contributions - Indexed Adjustments for Minimum Essential Coverage

IRS Revenue Procedure 2016-24 provides indexed adjustments in required contributions relating to minimum essential coverage beginning in 2017, as follows:

- **Premium Assistance Affordability Standard**. For purposes of determining premium assistance affordability, coverage is deemed affordable if the employee's required contribution does not exceed 9.5% of the employee's household income for the taxable year. For plan years beginning in 2016, the threshold percentage is 9.66%; for plan years beginning in 2017, the threshold percentage will increase to 9.69%. According to Notice 2015-87 released last year, the IRS and Treasury Department anticipate amending the employer shared responsibility regulation to provide that the employer affordability safe harbor is adjusted in the same manner as the premium assistance affordability standard. The employer safe harbor should likewise be 9.69% for 2017.

- **Hardship Exemption.** The required contribution percentage by individuals for MEC for purposes of determining eligibility for a hardship exemption under the individual shared responsibility requirement (IRC Section 5000A). One of these exemptions occurs if the cost to the individual to purchase coverage exceeds a certain percentage of household earnings. For 2016, the required contribution percentage is 8.1% of household earnings for purposes of exemption from the individual shared responsibility requirement. In 2017, the percentage increases to 8.16%. This affordability standard is distinct from the employer's shared responsibility affordability standard and distinct from the affordability standard for being entitled to premium assistance.

- **Premium Tax Credit.** The following contribution percentages are used to determine whether an individual is eligible for affordable employer-sponsored MEC for the 2016 and 2017 tax years:

Household income percentage of Federal poverty line	Initial percentage *2016*	Final percentage *2016*	Initial percentage *2017*	Final percentage *2017*
Under 133%	2.03%	2.03%	2.04%	2.04%
Between 133% and 150%	3.05%	4.07%	3.06%	4.08%
Between 150% and 200%	4.07%	6.41%	4.08%	6.43%
Between 200% and 250%	6.41%	8.18%	6.43%	8.21%
Between 250% and 300%	8.18%	9.66%	8.21%	9.69%
Between 300% and 400%	9.66%	9.66%	9.69%	9.69%

Revised Summary of Benefits and Coverage (SBC) Templates

The Affordable Care Act (ACA) requires individual and group health plans to provide participants with a written summary of benefits and coverage (SBC) of the plan. Both the Departments of Labor and HHS provide model SBC templates, a uniform glossary and related materials that can be used by plan sponsors and insurers.

On April 7, 2016, these agencies released updated versions of these documents. The revised SBC template is to be used beginning on the first day of the first open enrollment period that begins on or after April 1, 2017 relating to coverage for plan years beginning on or after that date. For plans and insurers that do not use an annual open enrollment period, the revised SBC template is to be used beginning on the first day of the first plan year that begins on or after April 1, 2017.

Both sets of model SBC templates, instructions and related materials to be used for current applicable coverage, as well as the revised template to be used on or after April 1, 2017, can be obtained from the DOL and HHS websites. Along with making the SBC simpler and shorter, some of other the changes in the revised version include:

- A discussion of deductibles and out-of-pocket amounts that individuals may incur based upon their selection of participating vs. non-network providers
- Modification of language relating to continuation of coverage, grievance and appeals, and whether the plan provides minimum essential coverage and meets the minimum value standards
- The current template contains two coverage examples – one relating to maternity expenses and the other relating to on-going management of diabetes. The newer template contains a third coverage example involving a simple fracture to show how a plan would handle an in-network emergency room situation.

Employer Appeals - Marketplace Decisions

As follow-up to a prior article, employers may begin receiving letters from the federal marketplace or a state marketplace relating to whether any of their employees are eligible to receive premium assistance (see *Employer Notices of Marketplace Determinations*, *CBIZ Health Reform Bulletin*, 10/12/15). Part of the ACA is the ability to get assistance in the form of a tax credit for the purchase of health coverage. Individuals eligible to receive the assistance are those who fall between 100 and 400% of federal poverty level and who do not have access to employer provided coverage.

These marketplace determinations are particularly important to employers subject to the ACA's employer shared responsibility requirements. These employers could be at risk for an excise tax penalty if one or more of their full-time employees who work 30 or more hours per week qualify for premium assistance. If the marketplace determines that an employee is not being offered affordable coverage that meets minimum value, it will then notify the employer of this determination. If the employer disagrees with the marketplace determination, it then has 90 days from the date of the marketplace determination to file an appeal. The appeal can be accomplished either by completing an on-line appeal form, or by sending a letter to HHS by US Mail. Information about submitting an appeal can be found on the HHS website.

It is important to note that in no way does this marketplace determination impose a tax upon the employer. The employer would only be subject to an excise tax after it has received a notice from the IRS and after it has had an opportunity to appeal. The IRS notice would be generated after the individual has filed his/her tax return and after the employer has filed its Form 1094-C and 1095-C. These employer tax filings occur in the year following the year for which the premium assistance is being considered. Responding to the marketplace determination could allay future inquiries from the IRS, assuming the individual was offered coverage.

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Health Reform Bulletin

CBIZ

Subject: 1) ACA Reporting and Fee Reminders: Section 6055/6056, PCORI Fees and Transitional Reinsurance Fees; 2) Final HHS Rules address Nondiscrimination in Health Plans; and 3) Update on Women's Preventive Health Services

Date: May 31, 2016

ACA Reporting and Fee Reminders

- **Section 6055/6056 Reporting**

  The due date for electronically submitting the Affordable Care Act's (ACA) required reports to the IRS is fast approaching. All 2015 Forms 1094-B and 1095-B, and the 2015 Forms 1094-C and 1095-C reports must be submitted electronically by June 30, 2016. The paper versions of these reports must have been filed with the IRS by May 31, 2016. In addition, individuals must have been given the relevant 2015 Form 1095-B and/or 1095-C benefit statements by March 31, 2016.

  As background, the ACA imposes two Internal Revenue Code sections. One requires reporting of minimum essential coverage; the other requires employers subject to the employer shared responsibility provisions to report on offers of coverage. The forms for both of these reporting requirements are the Form 1094 transmittal and Form 1095 benefit statement. IRC Section 6055 reporting is accomplished on the B series of the form; the employer shared responsibility reporting is accomplished on the C series. A self-funded employer subject to shared responsibility can satisfy both its IRC Sections 6055 and 6056 reporting obligations by completing all parts of the Form 1095-C.

  Any errors to the information contained in the forms that have already been submitted to the IRS must be corrected as soon as possible following discovery of the error. The Form 1094/1095 instructions provide the process for correcting the forms, depending on whether the forms have been submitted to the IRS and/or furnished to individuals.

  The IRS' *ACA Information Center for Applicable Large Employers* webpage provides information, forms, as well as helpful tools and videos to assist entities in completing their reporting obligations.

- **PCORI Annual Fees**

  July 31st is fast approaching and it's time to begin planning payment of the ACA's Patient-Centered Outcomes Research (PCOR) fee. Virtually, all health plans, whether insured or self-funded are subject to these fees. The PCOR fee is assessed on the average number of lives covered under the policy or plan. For policy and plan years ending between October 1, 2015 and October 1, 2016, the fee is $2.17 per covered life.

The fee is to be paid once a year in connection with IRS Form 720, *Quarterly Federal Excise Tax Return*. For insured plans, the Form 720 is due by July 31st following the close of the policy year. For self-funded plans, the Form 720 is due by July 31st of the calendar year following the plan year end.

For additional information about the PCOR fee, see the IRS' webpage, questions and answers and chart of plans subject to the fees.

- **Transitional Reinsurance Fee**
  This will be the last year for collection of the transitional reinsurance fee. As background, the ACA imposes the transitional reinsurance fee, the goal of which is to help stabilize premiums in the individual market due to enrollment of higher risk individuals in the marketplace. All insurers and plan sponsors of self-funded plans are required to contribute to this reinsurance fund over a three year period from 2014 through 2016. The contribution rate for the 2016 benefit year is $27 per covered life. The annual enrollment count (based on first 9 months of year) must be submitted to HHS by November 15, 2016 on the "*ACA Transitional Reinsurance Program Annual Enrollment Contributions Submission Form*" available via www.pay.gov. The reporting form will auto-calculate contribution amounts and allow payments to be made in one or two installments.

Final HHS Rules Address Nondiscrimination in Health Plans

On May 18, 2016, the Department of Health and Human Services (HHS) released final rules relating to nondiscrimination in health plans, programs and activities pursuant to Section 1557 of the Affordable Care Act. In general, these rules mirror the proposed regulations released last fall, with a few clarifications.

As background, Section 1557 of the ACA provides for open access to health coverage, programs and activities by all individuals. In other words, individuals cannot be discriminated against or prohibited from participating in health related programs or denied health coverage on the basis of race, color, national origin, sex, age, or disability. With regard to sex discrimination, the final rules clarify that individuals cannot be denied or provided limited coverage for health services based on transgender matters.

Generally, these rules impact insurers who operate within or outside the federal and state marketplaces, including the Small Business Health Option Program (SHOP), both in the individual and group marketplaces who receive federally funding. The rules also apply to third-party administrators (TPAs) who administer employer group health plans. These rules do not apply directly to most employers. However, an employer subject to Title VI of the Civil Rights Act of 1964 (race, color, national origin), Title IX of the Education Amendments of 1972 (sex), the Age Discrimination Act of 1975 (age), or Section 504 of the Rehabilitation Act of 1973 (disability) must ensure that any act it takes including the design of its employee benefit plan is not discriminatory.

In addition, the final rules formally adopt the principle that affected entities must take steps to provide reasonable access for individuals with limited English proficiency, such offering a qualified interpreter if needed in order to ensure individuals understand their rights. The rules also provide a process for individuals to seek remedies for alleged discriminatory actions. Part of this process entails an initial review of the complaint by HHS to determine whether the alleged discriminatory decision or action rests with the employer or TPA.

The final rules become effective July 18, 2016. However, to allow insurers and group health plans to make the changes required by these rules, such as modify covered benefits, benefits limitations or restrictions, or cost-sharing mechanisms, such as coinsurance, copayments, and deductibles, the final rules become applicable on the first day of the first plan year beginning on or after January 1, 2017.

Additional information about Section 1557, including FAQs can be obtained from the HHS' Office of Civil Rights website.

Update on Women's Preventive Health Services

On May 16, 2016, the Supreme Court rendered its opinion in *Zubik v Burwell*, the combined case challenges to ACA's contraceptive mandate for entities with religious opposition to providing contraceptive services. The Justices remanded these cases back to relevant courts of appeals that had previously rejected these challenges. These courts must now determine an approach going forward to accommodate the exercise of religious freedom while ensuring that women with access to health coverage receive full and equal health services, including contraceptive coverage.

About the Author: Karen R. McLeese is Vice President of Regulatory Affairs for CBIZ Benefits & Insurance Services, Inc., a division of CBIZ, Inc. She serves as in-house counsel, with particular emphasis on monitoring and interpreting state and federal employee benefits law.
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Subject: Best Practices for Employer Responses to Marketplace Notices
Date: July 11, 2016

Many employers may be receiving marketplace notices indicating that certain of their employees have been granted premium assistance. Rumor has it that a big batch of these notices was sent out in late June. What should employers do in response to these notices?

As background, individuals whose household income falls between 100 and 400% of federal poverty level and who are not offered adequate affordable coverage by their employer, or who have not enrolled in minimum essential coverage, may be entitled to premium assistance for the purchase of health coverage. If an individual is granted premium assistance and if the individual provides the marketplace with his/her employer's contact information, then the marketplace may notify the employer of the employee's receipt of premium assistance. This notice then provides an opportunity for the employer to appeal the marketplace decision. For additional background information about these marketplace notices, see CBIZ Health Reform Bulletin 117, *Employer Appeals - Marketplace Decisions* (4/18/16) and HRB 115, *Employer Notices of Marketplace Determinations* (10/12/15).

These marketplace notices may be sent to employers of any size, not just those employers subject to the ACA's employer shared responsibility provisions. It is very important to note that this marketplace notice is **not** a tax assessment – only the Internal Revenue Service can assess the tax owed, if applicable. An employer subject to the ACA's employer shared responsibility provisions may be assessed an excise tax (pursuant to IRC §4980H(a) or (b)) if it fails to offer adequate and affordable health coverage to its full-time employees. However, no excise tax would be imposed if an individual enrolls in minimum essential coverage without regard to whether it is affordable.

The employer owes no tax unless and until the IRS contacts the employer. The IRS would contact the employer after the employer has filed its Forms 1095-Cs with the IRS, and the individual taxpayer has filed his/her tax return in the year following the year in question. Conversely, the marketplace notice is issued at the time the individual is granted premium assistance.

How to Appeal a Marketplace Decision

Employers can appeal a marketplace determination by completing an "**Employer Appeal Request Form**", or by mailing a letter to the Department of Health and Human Services (HHS) that contains the information requested in this Form. The *Employer Appeal Request Form* can only be used to appeal a marketplace notice received from the federally-facilitated health insurance marketplace (healthcare.gov), or a state-based Marketplace operating in California, Maryland, Colorado, Massachusetts, District of Columbia, New York, Kentucky, or Vermont. Other state-based marketplaces may have their own notices and processes they utilize for notifying employers of the right to appeal a marketplace decision. With regard to an appeal relating to a Small Business Health Options Program (SHOP) eligibility decision, visit this website for more information: https://www.healthcare.gov/small-businesses/choose-and-enroll/appeal-a-shop-decision/.

The *Employer Appeal Request Form*, or letter to HHS, must be submitted within 90 days from the date of the Marketplace notice. The completed form and copies of any supporting documents must be mailed to:

Health Insurance Marketplace
Dept. of Health and Human Services
465 Industrial Blvd.
London, KY 40750-0061

In the alternative, the Form or letter, together with supporting documentation, may be faxed to a secure fax line: 1-877-369-0129.

Additional information about employer appeals to Marketplace decisions is available at this website: https://www.healthcare.gov/marketplace-appeals/employer-appeals/.

Best Practices for Employers

Following are some best practice steps that employers can take in light of these marketplace notices when appealing a marketplace decision:

- ❑ Maintain accurate records of all employees and their status as full-time or part-time.
- ❑ Maintain records of offers of health coverage to your employees, including records of health coverage declination.
- ❑ Notify internal staff, such as your HR department or affiliate offices, to watch for receipt of a marketplace notice. Educate your staff on the importance of notifying a central source, such as HR department, in the event of receiving a marketplace notice.
- ❑ Remember the marketplace notice will reflect the individual's current year status.
- ❑ If the employer is subject to the ACA's employer shared responsibility provisions (one who employs 50 or more employees) and receives a marketplace notice, review the notice and determine:
    1. The employment status of the individual. For example, was the individual a full-time employee or part-time employee at the time in question; or, was the individual not an employee;
    2. Whether the individual was offered adequate and affordable coverage or enrolled in minimum essential coverage of any kind; and
    3. Whether the individual was in a limited non-assessment period such as a waiting period or an initial measurement period.

  If the individual was a full-time employee at the time referenced in the marketplace notice and if an offer of adequate affordable coverage was made, or if the individual was enrolled in minimum essential coverage of any kind, the employer might want to respond to the marketplace notice. In all other instances, the employer would not want to appeal if the individual is properly entitled to premium assistance.
- ❑ Be aware of the timeframe for making the appeal. The *Employer Appeal Request Form* or letter to HHS, together with supporting documents, must be mailed or faxed within 90 days from the date of the marketplace notice (see address and fax number above).
- ❑ Maintain confidentiality. It is very important that any sensitive information contained in the notice be similarly protected in the employer's appeal. The marketplace notice should be reviewed carefully and only the types of identifying information contained in the notice, such as truncated social security numbers, should be used in the appeal.

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Subject: 1) Proposed Regulations: Expatriate Health Plans, Excepted Benefit Plans, Essential Health Benefits relating to Lifetime and Annual Limits, and Individual Shared Responsibility Requirements; 2) IRS Releases Draft 2016 Forms 1094/1095

Date: July 13, 2016

The tri-governing agencies (Departments of Labor, Health and Human Services and Treasury) of the Affordable Care Act (ACA) released **proposed reliant regulations** on June 10, 2016. These regulations provide clarifications relating to expatriate health plans, excepted benefit plans, and essential health benefits relating to lifetime and annual limits, as discussed below.

Expatriate Health Plans

The Expatriate Health Coverage Clarification Act of 2014 "EHCCA" (Public Law 113-235, enacted December 16, 2014) made expatriate health plans exempt from certain Affordable Care Act (ACA) mandates that apply to health plans (see HRB 105, *Expatriate Plans Exempt from ACA*, 1/8/15). In order for the exemption to apply, the expatriate plan must meet certain criteria as to eligibility including dependent coverage, the types of covered benefits and services, and the ability to meet the minimum essential coverage standards. While certain ACA mandates may not apply, expatriate health coverage remains subject to ACA provisions such as the employer shared responsibility (ESR) provisions including the Section 6055 and 6056 reporting obligations. As a reminder, individuals with no U. S. sources of income are not counted for purposes of the ESR obligation.

According to the proposed rules, an expatriate health plan must satisfy certain requirements, as follows:

1. Substantially all, i.e., 95% of employees covered under the plan, excluding those living in their home country, must be *qualified expatriates*. Generally, there are three types of qualified expatriates:
    - *Category A expatriates* are those employees who have been transferred or assigned to the United States by their employer for a specific or temporary purpose or assignment.
    - *Category B expatriates* are U. S. nationals who work outside the United States for a period of at least 180 days in a consecutive 12-month period that overlaps with the plan year.
    - *Category C expatriates* are members of a group of similarly situated individuals travelling or relocating internationally for certain tax-exempt purposes, such as non-profit or charitable service.
2. An expatriate health plan must provide coverage for inpatient hospital services, outpatient facility services, physician services, and emergency services. Coverage for such services must be available in certain countries depending on the type of qualified expatriates covered by the plan. Less than 5% of the benefits provided under an expatriate health plan can be so-called "excepted benefits" (see the discussion of Excepted Benefit Plans, below).

3. The plan sponsor must reasonably believe that benefits provided by the plan satisfy the minimum value standard, i.e., the plan covers a minimum of 60% of the total allowed cost of benefits expected to be incurred under the plan.
4. If an expatriate health plan provides dependent coverage of children, such coverage must be available until the child attains age 26, unless the child is already receiving dependent coverage.

Both entities issuing expatriate health insurance (insurer or issuer) as well as administrators of self-insured expatriate health plans are required to:

1. Maintain network provider agreements for direct claims payments with health care providers in eight or more countries;
2. Maintain call centers in three or more countries, and accepts calls from customers in eight or more languages;
3. Process a minimum of $1 million in claims in foreign currency equivalents during the preceding calendar year;
4. Have global evacuation/repatriation coverage available;
5. Maintain legal and compliance resources in three or more countries; and
6. Have licenses or other authority to sell insurance in more than two countries, including the United States.

Excepted Benefit Plans

Certain types of health plans are excepted from the provisions of the ACA including:

- Accident-only insurance plans, including accidental death and dismemberment;
- Disability income coverage;
- Liability insurance, including general liability or automobile liability insurance;
- Workers' compensation or similar insurance;
- Credit-only insurance;
- Coverage for on-site medical clinics; and
- Limited scope dental benefits, vision benefits, or long term care benefits, if they are provided under a separate policy or contract, and are otherwise not an integral part of a group health plan.

The proposed regulations make clarifications as to what types of plans are deemed to be excepted, as follows:

- *Hospital indemnity or other fixed indemnity insurance policies covering specified disease or illness, hospital indemnity insurance, or fixed dollar indemnity insurance* as long as certain conditions are met. The proposed regulations specifically address these types of plans and revise the conditions necessary for hospital indemnity and other fixed indemnity insurance in the group market to be considered "excepted benefits". Specifically, during the application or enrollment process, individuals must be notified that this type of coverage is not considered to be major medical coverage. This would not qualify as minimum essential coverage (MEC) for individual shared responsibility purposes. This means that unless the individual has other MEC or is exempt from the requirement, the individual could become subject to the individual shared responsibility penalty. The regulations include model language that can be used by group health plans and insurers to satisfy the notice requirement.

  With regard to hospital and fixed indemnity policies that only reimburse a fixed amount per period such as day or weeks, the proposed regulations clarify that the amount of benefits provided under these policies must be determined without regard to the type of items or services received. In addition, a policy that provides benefits in varying amounts based on

the type of procedure or item received would not satisfy the condition that benefits be provided on a per day (or per other time period, such as per week) basis. Further, hospital indemnity or other fixed indemnity insurance policy that provides benefits for certain services at a fixed amount per day, but in varying amounts depending on the type of service, would not meet the condition that benefits be provided on a per day (or per other time period, such as per week) basis.

- *Short-term, limited-duration insurance* is generally intended to fill temporary coverage gaps when individuals transition between coverages. The regulations propose to limit short term coverage to a period of three months or less to coordinate with the one-time exemption from the minimum essential coverage requirement. These types of plans must also provide notification in application and enrollment materials that such coverage does not meet the requirements of minimum essential coverage, and thus the individual may be subject to individual shared responsibility penalty.

- *Travel Insurance.* These regulations clarify that certain travel-related insurance products are deemed to be excepted benefits. For this purpose, travel insurance means coverage for personal risks incident to planned travel, which may include interruption or cancellation of a trip or event, loss of baggage or personal effects, damages to accommodations or rental vehicles, and sickness, accident, disability, or death occurring during travel, provided that the health benefits are not offered on a stand-alone basis and are incidental to other coverage. For this purpose, travel insurance does not include major medical plans that provide comprehensive medical protection for travelers with trips lasting 6 months or longer, including, for example, those working overseas as an expatriate or military personnel being deployed.

Essential Health Benefits (EHB) – Lifetime and Annual Dollar Limits

For purposes of the essential health benefit calculation, these regulations propose to slightly modify the methodology for determining a benchmark plan. As a reminder, a self-funded plan can use any of the 51 state-based benchmark plans, or the Federal Employee Health Benefit Plan-based benchmark plan, to make its EHB determination. The EHB determination is important for compliance with the no annual or lifetime limit, as well as for the cost share restrictions of the ACA.

Effective Date

Comments on these proposed regulations must be submitted to the tri-agencies by August 9, 2016. These regulations proposed to become applicable for plan or policy years beginning January 1, 2017; however, these regulations can be relied upon now.

Next Steps

- ❑ If you are an employer subject to the ACA's employer shared responsibility (ESR) requirements and have employees working abroad, determine whether those employees are qualified expatriates. Make certain the plan qualifies as expatriate coverage. Remember that individuals with no U.S. sources of income need not be counted as full-time employees for ESR obligations.

- ❑ If you offer indemnity coverage, make certain it qualifies as an excepted benefit; or, make certain the coverage complies with all of the requirements of the ACA.

Proposed Regulations – Individual Shared Responsibility

On July 8, 2016, the IRS released **proposed regulations** addressing certain aspects of the individual shared responsibility requirements of the ACA. Generally, these regulations do not directly impact employers; however, several provisions warrant consideration by employers subject to the ACA's employer shared responsibility provisions in that they impact the employer's offer of coverage.

- **Annual Offer of Health Coverage.** All individuals must maintain a minimum level of coverage or be subject to tax penalties. Employers subject to the employer shared responsibility provisions (one who employs 50+ employees) must annually offer full-time employees (those working 30 or more hours per week) health coverage that is adequate and affordable or risk an excise tax. These regulations emphasize the importance of the annual offer of minimum essential coverage (MEC). In order to avoid the risk of an excise tax, an offer of MEC must be made every year. As an example, if an individual has declined the offer of coverage in Year 1, in which case, the individual would be denied premium assistance, but if an offer is not made in Year 2, then the individual would be entitled to premium assistance; thus, putting the employer at risk. The moral of the story is to offer coverage every year.

- **Excepted Benefits.** The regulations affirm that an employer's offer of excepted benefits (see page 2 of this HRB for examples of excepted benefits), even if the individual enrolls in the excepted benefit, would not preclude the individual's eligibility for premium assistance. The moral of this story is that an offer of only excepted benefits puts the employer at risk of an employer's shared responsibility penalty.

- **Opt-outs of Coverage.** In December, 2015, IRS Notice 2015-87 addressed a cash-out arrangement for purposes of determining affordability, pursuant to which an employer offers health coverage, and if the employee declines the coverage, the employee would receive cash (see CBIZ *HRB 116, Year-end Wrap-Up*). These proposed regulations build on this scenario as follows:
  - An *unconditional opt-out* arrangement, i.e., one in which the employee can decline the employer's offer of coverage and take cash would result in affordability being determined by combining the employee's cost of coverage plus the cash pay-out, without regard to proof of other coverage. For example, the employee's cost of coverage is $100; the employee receives $200 for declining coverage. In this scenario, the affordability determination would be based on $300.
  - If the offer of coverage is *conditional*, i.e., contingent on proof of other coverage, the cash-out portion is not included in the affordability calculation, according to these regulations, but only if the conditional opt-out qualifies as an eligible opt-out. What this means is that the individual must attest to the fact that he/she and his/her "tax family", i.e., all of whom the taxpayer is responsible for ensuring health coverage such as the spouse and/or dependents, have, in fact, other minimum essential coverage (MEC). The other MEC cannot be individual coverage or marketplace coverage. In effect, it must be, for example, coverage from a spouse's employer.

  As a reminder, the only way to offer a choice between qualified benefit, such as employer's contribution toward health coverage and cash is through the terms of a written IRC Section 125 (cafeteria) plan. What this means that any opt-out arrangement must be documented in a Section 125 plan.

Effective Date. Written comments on these proposals must be received by September 6, 2016.

IRS Releases Draft 2016 1094/1095 Series Forms

The Internal Revenue Service (IRS) issued draft 2016 forms for the annual reporting that will be due in 2017 by employers subject to the Affordable Care Act's shared responsibility requirements, as well as by plans providing minimum essential coverage (MEC):

- Form 1095-B, *Health Coverage*
- Form 1094-B, *Transmittal of Health Coverage Information Returns*
- Form 1094-C, *Transmittal of Employer-Provided Health Insurance Offer and Coverage Information Returns*
- Form 1095-C, *Employer-Provided Health Insurance Offer and Coverage*

These forms are used to satisfy the IRC Section 6055 and 6056 reporting requirements. The Form 1094-B and 1095 B-series is used for reporting MEC; and the Form 1094 and 1095-C series is used for reporting employer provided coverage by employers subject to the ACA's shared responsibility requirement. It is important to note that these forms are drafts only and subject to change. At this point, it appears that these draft forms are substantially similar to the 2015 forms. As soon as these forms and the relevant instructions are finalized and released by the IRS, we will provide additional information.

About the Author: Karen R. McLeese is Vice President of Employee Benefit Regulatory Affairs for CBIZ Benefits & Insurance Services, Inc., a division of CBIZ, Inc. She serves as in-house counsel, with particular emphasis on monitoring and interpreting state and federal employee benefits law. Ms. McLeese is based in the CBIZ Kansas City office.

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Health Reform Bulletin

CBIZ

Subject: 1) Finalized 2016 ACA Reporting Forms 1094 and 1095 Series; 2) Section 1557 Nondiscrimination Notice Requirement; 3) Transitional Reinsurance Fee Reminder; and 4) IRS Warns of Fake ACA Tax Bills

Date: October 20, 2016

FINALIZED 2016 ACA REPORTING FORMS 1094 AND 1095 SERIES

The Internal Revenue Service (IRS) issued final 2016 forms for the annual reporting that will be due in 2017 by employers subject to the Affordable Care Act's shared responsibility requirements, as well as by plans providing minimum essential coverage (MEC). These forms are used to satisfy the IRC Section 6055 and 6056 reporting requirements. The Form 1094-B and 1095 B-series is used for reporting MEC. The Form 1094-C and 1095-C series is used for reporting employer provided coverage by an applicable large employer ("ALE") subject to the ACA's shared responsibility requirement who employ 50 or more full-time employees. Employer size is determined as of December 31st in the year prior to the reporting year. For 2016 reporting purposes, employer size is determined as of December 31, 2015. Below are links to the particular forms and instructions:

HEALTH INSURANCE COVERAGE REPORTING BY INSURERS AND SPONSORS OF SELF-FUNDED PLANS (IRC § 6055)

- Instructions for 2016 Forms 1094-B and 1095-B (PDF or HTML)
- Form 1094-B, *Transmittal of Health Coverage Information Returns*
- Form 1095-B, *Health Coverage*

EMPLOYER HEALTH INSURANCE REPORTING REQUIREMENT (IRC § 6056)

- Instructions for 2016 Forms 1094-C and 1095-C (PDF or HTML)
- Form 1094-C, *Transmittal of Employer-Provided Health Insurance Offer and Coverage Information Returns*
- Form 1095-C, *Employer-Provided Health Insurance Offer and Coverage*

Deadlines for Filing and Distributing Forms 1094 and 1095

The reporting and disclosure obligations remain substantially the same as last year. The 2016 Forms 1094-B and 1095-B, and the 2016 Forms 1094-C and 1095-C reports must be submitted to the IRS no later than February 28, 2017; or by March 31, 2017 if filing electronically. Individuals listed in the 2016 Forms 1094 and 1095 must be furnished copy of the relevant Form 1095 by January 31, 2017.

There is no indication at this time that these filing dates will be extended. The good faith standard for compliance available for the 2015 reporting year would not necessarily be available for the 2016 reporting year. However, a reasonable cause situation which may render an ALE incapable of meeting the reporting deadlines might be considered by the IRS.

Generally, these forms are similar to the 2015 forms. Narrowing our focus on the C series of the forms, following are a few clarifications and modifications:

- Several forms of transitional relief were available in 2015. To the extent the relief is no longer available, references to this relief have been removed.
- **Definition of full-time employee**. For purposes of determining full-time status, the instructions clarify that a monthly method or look back method are the only two ways to determine full-time status.
- **Reporting ALE members.** With regard to the Form 1094-C, if an ALE member belongs to an aggregated ALE group and checks "Yes" on Line 21 of the Form 1094-C, then it must also complete Part IV of the Form. This section of the form requires the names and EINs of other ALE members of the aggregated ALE group who were members at any time during the calendar year. The instructions clarify that the reporting ALE member need not include itself in Part IV.
- **Part II, Employee Offer of Coverage - Form 1095-C, Lines 14-16**
  In Lines 14 to 16, the employer reports on offers of coverage, affordability and any applicable safe harbor codes. Of particular note, certain codes are used in Line 14 to specify the type of coverage offered and in Line 16 to specify any safe harbor codes that may apply, such as the employee is no longer employed or not a full-time employee.
  - *Reporting offers of spousal coverage*. The 2016 instructions provide for two new codes 1J and 1K which address conditional offers of spousal coverage. A conditional offer is defined as an offer of coverage that is subject to one or more reasonable, objective conditions such as offering coverage to an employee's spouse only when the spouse is ineligible for Medicare or group health coverage sponsored by another employer. Code 1J would be used to indicate MEC providing minimum value offered to employee and conditionally offered to spouse but not offered to dependents. Code 1K indicates MEC providing minimum value was offered to employee, MEC was offered to dependents, and MEC conditionally offered to the spouse.
  - The instructions clarify that Code 1G is used to report individuals offered coverage who are not full-time. This code can only be used if, in fact, the individual was not full-time for the entire year.
  - *COBRA continuation coverage*. The method for reflecting offers of coverage for an individual entitled to COBRA due to termination of employment differ from reporting COBRA due to a reduction In hours. If COBRA is offered to a former employee or his/her spouse and dependents due to termination of employment, code 1H (no offer of coverage) would be entered on Line 14 for any month that COBRA applies; and code 2A (employee not employed during the month) would be entered on Line 16, without regard to whether the employee and his/her spouse and dependents actually enroll in COBRA coverage. In the event of a reduction in hours, an offer of COBRA made to the employee and his/her spouse and dependents would be reported on line 14 as an offer of coverage, but only for the individuals who were offered COBRA coverage. If the employee's dependent initially declines coverage and thus, not entitled to COBRA, the reporting would reflect that there was no offer of coverage. This would preserve the dependent's potential eligibility for premium tax credits and potentially reduce the ALE's risk of penalty for failure to offer dependent coverage.

    Example. During an open enrollment period, ABC Company offers MEC that meets the minimum value standard to Tom and his spouse and dependents. Tom elects to enroll in employee-only coverage starting January 1. On June 1, Tom experiences a reduction in hours that results in loss of eligibility for coverage under the plan. As of June 1, ABC Company terminates Tom's existing coverage and offers COBRA coverage but does not extend the offer to his spouse and dependents. ABC Company would enter code 1E (MEC providing minimum value offered to employee and at least MEC offered to dependent(s) and spouse) on line 14 for months January to May, and then enter code 1B (MEC providing minimum value offered to employee only) on line 14 for months June to December.

- In Line 16, an ALE would enter a Section 4980H safe harbor or other relief codes. There are instances when more than one code may apply to the same employee in the same month. The general rule of thumb is, if MEC is offered, then code 2C would apply. However, this code would not apply where there is a multi-employer plan or when individuals are offered COBRA. Further, the instructions clarify that a safe harbor code used to identify one of the three affordability standards, i.e., W-2 (code 2F), federal poverty level (code 2G) or rate of pay level (code 2H) should not be entered on line 16 for any month that the ALE did not offer MEC to at least 95% of its full-time employees and their dependents.

- ***Coverage in more than one type of comprehensive health coverage.*** In Part III of the Form 1095-C, the instructions follow prior guidance, as well as **proposed regulations** issued on August 15, 2016, relating to reporting of more than one type of coverage. If an employer sponsors a health reimbursement arrangement (HRA) in conjunction with a comprehensive self-funded plan, the information provided in Part III of the Form 1095-C need only reflect the comprehensive health plan. If an individual is covered by an insured plan of the employer and an HRA, the employer would not complete Part III. If the individual is covered by HRA and comprehensive coverage of another employer, for example, a spouse's employer plan, then Part III reporting would be required to reflect coverage under the HRA.
- ***Soliciting Taxpayer Identification Numbers (TIN).*** For purposes of the MEC reporting required by IRC Section 6055 and reported on the Form 1095–B and Form 1095–C, Part III, the above-mentioned proposed regulations provide some clarifications to assist reporting entities in obtaining taxpayer identification numbers (TIN) needed to complete the filings. These rules also apply to self-insured employers who are required to file Part III of the Form 1095–C.
  - *Missing TINs*. An initial request for an individual's TIN may be solicited at the time the insurer or employer receives application for new coverage, or when adding an individual to existing coverage. If the TIN is not received, then a second solicitation may be made within 75 days, and if necessary, a third solicitation be made by December 31st of the year following the initial solicitation. Where a reporting entity is unable to obtain the TIN, the birth date of a covered individual could be used.
  - *Incorrect TINs*. In the event of an incorrect TIN, the existing rules under the tax code apply. These rules require three attempts to obtain TINs or Social Security Numbers for all covered lives:
    - The first occurs when the individual becomes covered by the plan.
    - The second occurs by December 31st of the first year of coverage; however, if the coverage begins in December, the second solicitation can occur by January 31st of the next year.
    - The third and final solicitation must occur by the next December 31st (or January 31st if applicable).
  - And finally, the proposed rules address instances of *soliciting TINs of covered individuals*. A solicitation for a TIN requested from the primary insured would be treated as a solicitation of all individuals covered under the primary insured's plan. However, in the event where individuals are added to the coverage, then a separate individualized solicitation must be made to each individual when they are added to the plan.

Information reporting penalties. The instructions include updated penalties for failure to provide the information return or provide correct payee statement.

- The penalty for failure to file a correct information return is $260 for each return for which the failure occurs, with the total penalty cap of $3,193,000 for a calendar year.
- The penalty for failure to provide a correct payee statement is $260 for each statement for which the failure occurs, with the total penalty cap of $3,193,000 for a calendar year.
- Special rules apply that increase the per-statement and total penalties if there is intentional disregard of the requirement to file the returns and furnish the required statements.

Additional information relating to ALE obligations including the ACA Information Returns (AIR) system, can be found on the IRS's dedicated webpage, *ACA Information Center for Applicable Large Employers (ALEs)*. Also see:

- *Questions and Answers about Information Reporting by Employers on Form 1094-C and Form 1095-C*
- *Questions and Answers on Information Reporting by Health Coverage Providers* (Section 6055)

SECTION 1557 NONDISCRIMINATION NOTICE REQUIREMENT

As a follow-up to our prior discussion relating to the ACA's Section 1557 nondiscrimination rules (see *Final HHS Rules Address Nondiscrimination in Health Plans*, CBIZ Health Reform Bulletin 118, 6/1/16), affected covered entities are required to provide certain notification to individuals beginning October 16, 2016.

As background, Section 1557 of the ACA provides for open access to health coverage, programs and activities by all individuals. In other words, individuals cannot be discriminated against or prohibited from participating in health related programs or denied health coverage on the basis of race, color, national origin, sex, age, or disability. Generally, these regulations apply to insurers and third party administrators receiving federal funding, as well as self-funded employers receiving federal funding such as hospitals and nursing homes. These rules do not apply to employers sponsoring self-funded plans as long as the employer does not receive federal funding, which may include Medicare Part D retiree drug subsidies.

A covered entity is required to provide initial and on-going notification to beneficiaries, enrollees, applicants, and members of the public. The purpose of the notification is to inform them that the covered entity does not discriminate on the basis of race, color, national origin, sex, age, or disability in its health programs and activities. In addition, the notice must provide information relating to the availability of:

1. Appropriate auxiliary aids and services, including qualified interpreters for individuals with disabilities and information in alternate formats, free of charge and in a timely manner, together with an explanation of how to obtain the aids and services;
2. Language assistance services, including translated documents and oral interpretation, free of charge and in a timely manner, when such services are necessary to provide meaningful access to individuals with limited English proficiency;
3. Grievance procedures together with an explanation of how to file a grievance, as well as how to file a discrimination complaint with the HHS Office of Civil Rights.

The posting must be placed in a conspicuous location of the covered entity. Notifications and taglines can be included in communications routinely provided to beneficiaries, enrollees, applicants, and members of the public, as well as made available through the entity's website.

The HHS Office of Civil Rights has prepared a model notice, a model nondiscrimination statement, and a model tagline, all available in 64 different languages. These can be found on OCR's translated resources webpage. OCR has also provided a table displaying the top 15 languages spoken by individuals with limited English proficiency in each state and the U. S. territories. The table, together with FAQs, can be accessed from OCR's dedicated web page.

Additional information about Section 1557, including FAQs can be obtained from the HHS' Office of Civil Rights website.

TRANSITIONAL REINSURANCE FEE REMINDER

This will be the last year for collection of the transitional reinsurance fee. As background, the Affordable Care Act imposes the transitional reinsurance fee, the goal of which is to help stabilize premiums in the individual market due to enrollment of higher risk individuals in the marketplace. All insurers and plan sponsors of self-funded plans providing major medical coverage are required to contribute to this reinsurance fund over a three year period from 2014 through 2016.

The contribution rate for the 2016 benefit year is $27 per covered life. Contributions can be made in one payment of $27 per covered life (combined collection); or, made in two-part payment of $21.60 per covered life (first collection) and $5.40 per covered life (second collection).

The annual enrollment count (based on first 9 months of the calendar year) must be submitted by November 15, 2016 on the "*ACA Transitional Reinsurance Program Annual Enrollment Contributions Submission Form*" available via www.pay.gov. The reporting form will auto-calculate contribution amounts and allow payments to be made in one or two installments.

Deadlines

- If making one payment of the fee, the *2016 ACA Transitional Reinsurance Program Annual Enrollment Contributions Submission Form* must be submitted by November 15, 2016; the full fee must be paid by January 17, 2017.
- If opting to make two payments, the Form must be filed by November 15, 2016; the first part of the two payments must be paid by January 17, 2017; the second payment is due by November 15, 2017.

The Centers for Medicare and Medicaid Services released a *2016 Reinsurance Contributions Information Guide* that provides additional information.

IRS WARNS OF FAKE ACA TAX BILLS

The IRS is alerting taxpayers to be on guard against fake emails purporting to contain an IRS tax bill relating to the Affordable Care Act. Generally, the scam involves an email which contains a fraudulent version of CP2000 notices for tax year 2015 as an attachment. Additional information to assist in identifying these scams is available on the IRS website.

About the Author: Karen R. McLeese is Vice President of Employee Benefit Regulatory Affairs for CBIZ Benefits & Insurance Services, Inc., a division of CBIZ, Inc. She serves as in-house counsel, with particular emphasis on monitoring and interpreting state and federal employee benefits law. Ms. McLeese is based in the CBIZ Kansas City office.

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Health Reform Bulletin

CBIZ

Subject: 1) 2017 Inflationary Adjustments; 2) Final Rules: Excepted Benefits, Lifetime and Annual Limits, and Short-Term, Limited-Duration Insurance; and 3) Whistleblower and Retaliation Protections

Date: November 14, 2016

2017 Inflationary Adjustments

In Revenue Procedure 2016-55, the IRS released 2017 inflationary or cost of living adjustments relating to several types of benefits, as follows:

- **Small Business Tax Credit (SBTC).** Small businesses and tax-exempt employers who provide health care coverage to their employees under a qualified health care arrangement are entitled to a tax credit, as established by the Affordable Care Act. To be eligible for the small business tax credit, the employer must employ less than 25 full-time equivalent employees whose average annual wages are less than $52,400 (indexed for 2017; the wage ceiling in 2016 was $51,800).

  The tax credit phases out for eligible small employers when the number of its full-time employees (FTEs) exceeds 10; or, when the average annual wages for the FTEs exceeds $26,200 in the 2017 tax year (the phase-out wage limit for 2016 was $25,900).

  As a reminder, only qualified health plan coverage purchased through a SHOP marketplace is available for the tax credit, and only for a 2-consecutive year period.

- **Individual Shared Responsibility Penalty.** The Affordable Care Act imposes a penalty for individuals who fail to maintain minimum essential coverage (MEC). For 2017, the flat dollar penalty amount for failure to maintain MEC remains unchanged from 2016 ($695). Thus, the penalty is calculated based on the greater of 2.5% of family income; or $695 per adult, $347.50 per child (family maximum: $2,085).

- **Premium Tax Credit for Coverage under a Qualified Health Plan.** Individuals who buy coverage through the marketplace and meet certain income criteria may be eligible for an advance credit payment wherein a portion of the premium is made directly to the insurer to cover the cost of coverage. The amount of an individual's premium tax credit is reduced by the amount of any advance credit payments made during the year. If the advance credit payment for a taxable year exceeds the premium tax credit limit, the individual would owe the excess as additional tax, subject to certain inflationary limits.

  For tax years beginning in 2017, the limitation on tax imposed for excess advance credit payments is determined using the following table (note, these amounts are the same as 2016 limits):

Household Income (as percent of poverty line)	Limitation amount for unmarried individuals (other than surviving spouse and health of household)	Limitation amount for all other taxpayers
Under 200%	$300	$600
Between 200% and 300%	$750	$1,500
Between 300% and 400%	$1,275	$2,550

- **Increase in Tax Information Reporting Penalties**

  The IRS can assess penalties when certain tax information is not provided on a timely basis. Specifically, penalties may be assessed for failure to file information returns or provide payee statements, such as the Form W-2 and Form 1099, and notably, the Affordable Care Act's Forms 1094 and 1095, or related payee statements. Beginning in 2017, these penalties will increase, as follows:

  - The penalty for failure to file a correct information return is $260 for each return for which the failure occurs, with the total penalty cap of $3,218,500 for a calendar year.
  - The penalty for failure to provide a correct payee statement is $260 for each statement for which the failure occurs, with the total penalty cap of $3,218,500 for a calendar year.

  Special rules apply that increase the per-statement and total penalties if there is intentional disregard of the requirement to file the returns and furnish the required statements.

- **Sunset of AGI Threshold Exemption for Itemized Medical Expenses**

  Among the many provisions of the Affordable Care Act, the law increased the percentage threshold for itemized deductions of unreimbursed medical expenses. Beginning in the 2013 tax year, the threshold increased from 7.5% of an individual's adjusted gross income (AGI) to 10%. The ACA provided for a temporary exemption of the increased AGI threshold for individuals aged 65 or over. This exemption applies to tax years beginning after December 31, 2012 and ending before January 1, 2017. Thus, beginning next year, the 10% itemization threshold will apply to taxpayers aged 65 and over.

  Currently, there are some legislative proposals moving through the halls of Congress to revoke the increased threshold for all tax payers which would also include those in the 65 and over bracket. We will keep you informed if any of these proposals are enacted.

- **Patient-Centered Outcomes Research Institute Fee**

  The Patient Centered Outcome Research (PCOR) fee is required to be reported annually to the IRS on the second quarter Form 720 and paid by its due date, July 31, is based on the average number of lives covered under the policy or plan. For plan years ending between October 1, 2015 and October 1, 2016, the fee was $2.17. The fee increases to $2.26 for policy and plan years ending between October 1, 2016 and October 1, 2017, according to IRS Notice 2016-64. For additional information about the PCOR fee, see IRS webpage, questions and answers and chart of plans subject to the fees.

Final Rules: Excepted Benefits, Short-Term Limited-Duration Insurance, and Lifetime and Annual Limits – Essential Health Benefits

The tri-agency governance of the ACA (Departments of Labor, Treasury and Health and Human Services) released final rules on October 31, 2016 addressing excepted benefits, lifetime and annual limits, and short-term limited duration insurance. These regulations make certain clarifications to the proposed rules issued this summer (see CBIZ *HRB 120 - Proposed Regulations*, 7/13/16), as follows.

- **Excepted Benefits.** Certain types of health plans are excepted from the provisions of the ACA. The final regulations address supplemental coverage and travel insurance as excepted benefits.

  - *Supplemental coverage*. The final regulations clarify that to be excepted, supplemental coverage must be specifically designed to fill gaps in the primary coverage, such as cover cost sharing (coinsurance or deductibles), non-essential health benefits or both. These plans cannot be dependent on coordination.

  - *Travel Insurance*. The final regulations affirm that certain travel-related insurance products are deemed to be excepted benefits and thus, exempt from ACA market provisions. For this purpose, travel insurance means coverage for personal risks incident to planned travel, which may include interruption or cancellation of a trip or event, loss of baggage or personal effects, damages to accommodations or rental vehicles, and sickness, accident, disability, or death occurring during travel, provided that the health benefits are not offered on a stand-alone basis and are incidental to other coverage.

    Travel insurance does not include major medical plans that provide comprehensive medical protection for travelers with trips lasting 6 months or longer, including, for example, those working overseas as an expatriate or military personnel being deployed.

- **Short-term, limited-duration insurance** is generally intended to fill temporary coverage gaps when individuals transition between coverages. The final regulations affirm the proposal of limiting short term coverage to a period of less than 3 months to coordinate with the one-time exemption from the minimum essential coverage (MEC) requirement. These types of plans must also provide notification in application and enrollment materials that such coverage does not meet the requirements of MEC and thus, the individual may be subject to individual shared responsibility penalty. The regulations provide model language for notification purposes:

  "THIS IS NOT QUALIFYING HEALTH COVERAGE ("MINIMUM ESSENTIAL COVERAGE") THAT SATISFIES THE HEALTH COVERAGE REQUIREMENT OF THE AFFORDABLE CARE ACT. IF YOU DON'T HAVE MINIMUM ESSENTIAL COVERAGE, YOU MAY OWE AN ADDITIONAL PAYMENT WITH YOUR TAXES."

- **Essential Health Benefits (EHB) – Lifetime and Annual Dollar Limits**
  For purposes of the essential health benefit calculation, these regulations affirm the methodology for determining a benchmark plan. As a reminder, a self-funded plan can use any of the 51 state-based benchmark plans, or the Federal Employee Health Benefit Plan-based benchmark plan, to make its EHB determination. Now that states have selected their benchmark plans, the number of options have been reduced to some degree. Details about each state's particular benchmark plan can be found on the Center for Consumer Information & Insurance Oversight's website (http://www.cms.gov/cciio/resources/data-resources/ehb.html). The EHB determination is important for compliance with the no annual or lifetime limit, as well as for the cost share restrictions of the ACA.

These regulations do not finalize certain other topics addressed in the proposed regulations, specifically the fixed indemnity policies covering specified disease or illness and expatriate health coverage. The government continues to mull over how best to handle these types of arrangements.

Effective date. These final regulations become effective on December 30, 2016, and apply to group health plans and insurers beginning on the first day of the first plan year beginning on or after January 1, 2017.

Whistleblower and Retaliation Protections

The ACA includes a whistleblower provision to protect employees from adverse employment action or retaliation from either obtaining government assistance through premium assistance or a cost share by participating in the marketplace, as well as affording protection from alleged violations of ACA compliance by employers. To this end, the Department of Labor's Occupational Safety and Health Administration (OSHA) is charged with handling and enforcing these protections on behalf of individuals. On October 13, 2016, OSHA released **final rules** relating to whistleblower protections and procedures for filing complaints that clarify the interim rules issued several years ago (see HRB 67, *Whistleblower Protections for ACA Violations*, 2/28/13).

As background, the whistleblower provisions are intended to protect employee rights to benefits such that an employee cannot be punished or retaliated against for challenging an employer's compliance with the market reform provisions of the ACA. Included among these provisions are:

- Coverage of dependents;
- Discrimination based on health status;
- Prohibition of plan rescissions; and
- Annual and lifetime limits for health plans.

Further, the whistleblower law protects individuals from retaliation for seeking government assistance, which would come in the form of health coverage premium assistance or a cost share by purchasing coverage through the marketplace. Individuals who fall below 400% of the federal poverty level may be entitled to such government assistance if their employers do not offer adequate coverage at an affordable rate.

For this purpose, an adverse employment action or retaliation includes anything that affects any of the terms, conditions or privileges of employment, including the provision of benefits. Examples of retaliation include threatening or refusing to hire or re-hire; firing; demoting; reducing hours, or denying employee benefits.

The final OSHA regulations revise some of the procedures that an individual would follow for purposes of filing a complaint. The complaint, whether oral or written, must be filed with OSHA within 180 days of alleged retaliation; the complaint can be submitted online via OSHA's website (http://www.osha.gov/whistleblower/WBComplaint.html). OSHA then has 60 days to respond to the complaint and issue a preliminary order to correct a deemed violation. Both parties to the complaint would then have 30 days to file an objection and request a hearing before an administrative law judge. If no hearing is requested, the provisions of the preliminary order stand.

It should also be noted that these rules do not, in any way, limit an individual's rights under other laws, such as ERISA Section 510 that prohibits interference with one's protected rights.

About the Author: Karen R. McLeese is Vice President of Employee Benefit Regulatory Affairs for CBIZ Benefits & Insurance Services, Inc., a division of CBIZ, Inc. She serves as in-house counsel, with particular emphasis on monitoring and interpreting state and federal employee benefits law. Ms. McLeese is based in the CBIZ Kansas City office.

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Health Reform Bulletin

Subject: IRS Delays Disclosure Date for 2016 Form 1095
Date: November 18, 2016

The IRS has just issued guidance (Notice 2016-70) providing that the ACA-imposed due date for furnishing benefit statements (Form 1095-B and Form 1095-C) to individuals is extended from January 31, 2017 to March 2, 2017. This presents an interesting situation since the paper filings to the IRS are due by February 28, 2017. Like last year, the guidance provides that taxpayers can file their personal income tax return without having to attach the relevant Form 1095 to their tax returns. Taxpayers should keep these Forms in their personal records.

So far, the filing due dates of the 2016 Forms 1094-B and 1095-B, and the 2016 Forms 1094-C and 1095-C reports to the IRS have not been extended. These reports must be submitted to the IRS no later than February 28, 2017; or by March 31, 2017 if filing electronically.

In addition, this guidance reinstates the good faith compliance standard that was allowed for the 2015 filings due in 2016.

This guidance is scheduled to be officially published on December 5, 2016.

As future developments may occur, we will keep you apprised.

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Subject: 1) Qualified Small Employer HRAs and 2) Year-end Reminders
Date: December 14, 2016

QUALIFIED SMALL EMPLOYER HEALTH REIMBURSEMENT ARRANGEMENTS (HRA)

On December 13, 2016, President Obama signed the 21st Century Cures Act (H.R. 34). In part, this law re-establishes the ability of small employers, those not subject to the Affordable Care Act's employer shared responsibility provisions, to provide their employees a stand-alone health reimbursement arrangement (HRA), known as a "qualified small employer HRA". In order to establish the qualified HRA, the employer must provide no other health coverage. The HRA can be used to reimburse health insurance premium for individual coverage purchased either through or outside the marketplace. As is true for all HRAs, the plan can only be funded with employer dollars. Following is a summary of the criteria for these qualified HRA plan designs.

For purposes of sponsoring a qualified HRA, an **eligible small employer** is one who:

1. Employs fewer than 50 employees on business days during the preceding calendar year (i.e., employers exempt from the ACA's employer shared responsibility requirements); and
2. Does not offer group health insurance to its employees.

An **eligible employee** is defined as any employee of the eligible small employer. However, certain employees need not be offered coverage under a qualified HRA including:

- Employees who have not completed 90 days of service;
- Employees who have not attained age 25;
- Part-time or seasonal employees;
- Employees covered by a collective bargaining agreement where health benefits have been the subject of good faith bargaining; and
- Employees who are nonresident aliens with no U.S. source of income.

A **qualified HRA** is an arrangement that:

1. Is funded solely by the eligible small employer; no salary reduction contributions can be made under this arrangement; and
2. Provides, following the employee's proof of coverage, for the payment or reimbursement for medical care expenses, as defined in IRC Section 213(d)), including premium for health coverage through the individual market, incurred by the eligible employee or his/her family members.

The annual amount of payments and reimbursements is capped at $4,950 for employee-only, or $10,000 for arrangements that provide for payments or reimbursements for the employee's family members. Both of these limits are subject to inflationary adjustments.

The HRA must be made available on uniform basis. However, certain variations of payments or reimbursements based on family size or age are permitted. In addition, the amount of available reimbursements are adjusted on a pro-rated basis for employees who enter the HRA mid-year.

Impact of other laws

A qualified small employer HRA would be exempt from the market provisions of the Affordable Care Act. However, it is important to note that a qualified small employer HRA would still be considered a "group health plan" for purposes of the ACA's Cadillac tax, scheduled to take effect in 2020; though, it is very probable that the Cadillac tax will be modified or repealed between now and then.

A qualified small employer HRA would not be subject to COBRA continuation of health coverage requirements.

Coordination with ACA subsidies

Any ACA premium tax credit available to an eligible employee would be reduced by 1/12th of the employee's permitted benefit under the HRA for any month in which the employee is covered by the HRA. Further, a qualified HRA would be treated as affordable coverage for a month if the excess of the amount that would be paid by the employee as premium for self-only coverage under the second lowest silver plan offered in the relevant individual insurance market, over 1/12th of the employee's permitted benefit under the HRA does not exceed 1/12th of 9.5% of the employee's household income.

Reporting and disclosure obligations

The law establishes some reporting and disclosure obligations for a qualified HRA:

1. *Form W-2 reporting.* An employee's total permitted benefits received under a qualified HRA must be reported on the Form W-2. The form will be amended to include a box in which to report the amount.
2. *Written notice to employees.* Employers establishing a qualified HRA are required to provide a written notice to eligible employees about the availability of the program. This notice is to be provided annually no later than 90 days prior to the beginning of the program year. The notice must include the following type of information:
    - A statement of the amount of the eligible employee's permitted benefit under the arrangement for the year;
    - A statement that the eligible employee should provide the information relating to his/her permitted benefit amount to any marketplace in which the employee applies for advance payment of the premium assistance tax credit; and
    - A statement that if the employee is not covered under minimum essential coverage for any month, then the employee may be subject to the ACA's individual shared responsibility penalty for such month, and that reimbursements under the arrangement may be includible in gross income.

Effective date. This law allows for the establishment of qualified HRAs beginning after December 31, 2016.

In addition, the law grants relief for HRAs in existence prior to this law's enactment that would have otherwise been violative of the market provisions of the ACA.

YEAR-END REMINDERS

❑ EMPLOYER SHARED RESPONSIBILITY PROVISIONS

- **Applicability.** For purposes of the ACA's employer shared responsibility requirement as well as the reporting and disclosure requirements, applicable large employer (ALE) status is determined each calendar year, based on the average size of the employer's workforce during the prior year. Thus, if you averaged at least 50 full-time employees, including full-time equivalent employees, during 2015, you are most likely an ALE for 2016 and are subject to the reporting and disclosure requirements due in early 2017.

- **Affordability Standard.** For purposes of determining affordability, coverage under an employer-sponsored plan is deemed affordable if the employee's required contribution to the plan does not exceed 9.66% (indexed for 2016; 9.69 % in 2017) of the employee's household income for the taxable year, based on the cost of single coverage in the employer's least expensive plan.

- **Increase in Excise Tax Penalties.** The chart below reflects the amount of penalties for purposes of calculating the 'no coverage' excise tax (IRC § 4980H(a)), and the 'inadequate or unaffordable' excise tax (IRC § 4980H(b)) for 2016 and 2017, as well as the proposed amounts for 2018. These are the excise taxes that could apply if an applicable large employer is found not to have offered health coverage to a full-time employee.

'NO COVERAGE' EXCISE TAX IRC § 4980H(a)		'INADEQUATE OR UNAFFORDABLE' EXCISE TAX IRC § 4980H(b)	
2016	$2,160	2016	$3,240
2017	$2,260	2017	$3,390
2018 (proposed)	$2,320	*2018 (proposed)*	$3,480

- **Reporting and Disclosure Obligations**
  The Forms 1094 and 1095 are used to satisfy the IRC Section 6055 and 6056 reporting requirements. The Form 1094-B and 1095 B-series is used for reporting minimum essential coverage (MEC) by insurers and sponsors of self-funded plans. The Form 1094-C and 1095-C series is used for reporting employer provided coverage by an applicable large employer subject to the ACA's shared responsibility requirement.

  Deadlines
  - The Forms 1094 and 1095 must be filed with the IRS by February 28, 2017 (by March 31, 2017 if filing electronically)
  - The Form 1095 must be furnished to individuals listed in Forms 1094 and 1095 by March 2, 2017.

❑ Other ACA-related Fees

- *Patient-Centered Outcomes Research Institute (PCORI) Fees.* For policy and plan years ending between Oct. 1, 2016, and Oct. 1, 2017, the PCORI fee will be $2.26 multiplied by number of covered lives under policy or plan. The PCORI fees are paid annually via IRS Form 720 (generally due July 31st of each year).

- Suspended ACA fees include:
  - Cadillac tax (suspended until 2020);
  - Health insurance provider fee suspended in 2017; and
  - Excise tax on medical devices suspended for sales made from January 1, 2016, through December, 31, 2017.

❑ ACA Cost-Share Restrictions

The chart below reflects the 2017 inflationary adjustments applicable to out-of-pocket (OOP) limits including deductibles, co-insurance and co-payments in ACA plans. These cost-share restrictions apply to insured plans offered via the marketplace, and insured and self-funded plans offered outside marketplace. These amounts differ from the OOP limits applicable to high deductible health plans used in conjunction with a health savings account (HSA).

2017 Inflationary Adjustments

	2017		2016	
ACA PLANS - OUT-OF-POCKET LIMITS	*Self-only*	*Family*	*Self-only*	*Family*
Note: For 2018, the proposed OOP limits are $7,350 for self-only; $14,700 for family	$7,150	$14,300	$6,850	$13,700
HEALTH SAVINGS ACCOUNTS	*Individual*	*Family*	*Individual*	*Family*
HDHP Annual Deductible	$1,300	$2,600	$1,300	$2,600
HDHP Annual Out-of-Pocket Limit	$6,550	$13,100	$6,550	$13,100
Contribution Limit	$3,400	$6,750	$3,350	$6,750

ACA-required Reporting Reminders

Form	*To Whom*	*Due Date*
Form W-2. ACA-required reporting includes: ◆ Aggregate cost of health coverage (Box 12, using Code DD). *Note, employers filing <250 Form W-2s per year remain exempt from reporting the aggregate cost of health coverage on the Form W-2 until future IRS guidance is issued.* ◆ Additional Medicare tax withholding on earnings exceeding $200,000 per calendar year (Box 6)	Internal Revenue Service (IRS) http://www.irs.gov/ Form W-2 Instructions (2016)	January 31, 2017
Form 720 for purposes of Patient Centered Outcome Research (PCOR) fee	IRS	July 31st of each year
ACA Transitional Reinsurance Program Annual Enrollment Contributions Submission Form If making one payment of the fee, the 2016 form must be filed by November 15, 2016; full fee due by January 17, 2017. If opting to make two payments, Form must be filed by November 15, 2016; the first part of two payments due by January 17, 2017; the second payment due by November 15, 2017.	Centers for Medicare & Medicaid Services (CMS) via www.pay.gov	November 15, 2016 *Note: 2016 is the last year of this filing obligation and payment of fee*

Additional ACA-Related Disclosure Reminders

Note: This is not an exhaustive list of ACA-required disclosures. For a more descriptive list of notice obligations relating to the ACA and other welfare benefit plans, ask your CBIZ representative for a Chart of Notice Obligations.

Form	*To Whom*	*Due Date*
Summary of Benefits and Coverage (SBC) ◆ Summary of Benefits and Coverage Template for use *before* April 1, 2017 (**pdf** or **word**) ◆ Summary of Benefits and Coverage Template for use *on or after* April 1, 2017 (**pdf** or **word**) ◆ **Uniform Glossary of Coverage and Medical Terms** for use *before* April 1, 2017 ◆ **Uniform Glossary of Coverage and Medical Terms** for use *on or after* April 1, 2017 *Note: The model SBC and Uniform Glossary above are the English versions. These model documents are also available in Chinese, Navajo, Spanish and Tagalog from CCIIO's **website***	All plan participants	From Plan Sponsor to Plan Participants: 1. Upon application 2. By the first day of coverage 3. Within 90 days of enrollment by special enrollees 4. Upon contract renewal 5. Upon request
Advanced 60-day Notice of Material Change in Benefits	All plan participants	No later than 60 days prior to any material change in any terms of plan affecting Summary of Benefits and Coverage (SBC) content not reflected in the most recently-provided SBC (other than in connection with renewal or reissuance of coverage)
Notice of Marketplace Options ◆ Model notice for use by employers **who offer coverage** to some or all employees: ◆ English (**pdf** or **word**) ◆ Spanish (**pdf** or **word**) ◆ Model notice for employers who **do not offer health coverage:** ◆ English (**pdf** or **word)** ◆ Spanish (**pdf** or **word**)	All new hires including full-time and part-time employees, without regard to eligibility status for the health plan	Within 14 days of date of hire

Increased Penalties for Certain Compliance Violations

	Prior Penalty Amount	*New Penalty Amount*
FAILURE TO PROVIDE SUMMARY OF BENEFITS AND COVERAGE	Up to $1,000 per failure	Up to $1,087 per failure
FAILURE TO FILE A CORRECT INFORMATION RETURN (*Examples*: Forms 1094/1095 and W-2)	$250 for each return (total penalty cap of $3M per calendar year)	$260 per return (total penalty cap of $3,193,000 per calendar year)
FAILURE TO PROVIDE CORRECT PAYEE STATEMENT *(Examples: Forms 1094/1095 and W-2)*	$250 for each return (total penalty cap of $3M per calendar year)	$260 per statement (total penalty cap of $3,193,000 per calendar year)

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Health Reform Bulletin

CBIZ

Subject: 1) Updated Employer Shared Responsibility Guidance; 2) ACA Implementation Guidance; 3) Gender Identity Discrimination: Preliminary Injunction Issued; 4) Final Rules - Premium Tax Credit; and 5) 2018 Benefit and Payment Parameters.

Date: January 10, 2017

Updated Employer Shared Responsibility Guidance

The IRS recently updated their series of Questions and Answers (Q&As) relating to the ACA's employer shared responsibility requirement, as well as the required reporting and disclosure obligations.

- **Employer Shared Responsibility Provisions Under the ACA.** All public and private employers employing 50 or more full-time equivalent employees on business days in the prior calendar year must offer minimum essential coverage (MEC) to their employees on an annual basis or risk the imposition of an IRC Section 4980H penalty. For example, the number of employees employed in 2016 will determine employer size for 2017. These Q&As provide a general overview of the employer shared responsibility requirements, how to identify full-time employees, what constitutes an offer of coverage, the affordability and minimum value standards, as well as the process for determining liability and calculation of the IRC Section 4980H penalties.
- **Reporting by Employers on Form 1094-C and Form 1095-C.** These Q&As provide additional information about completing the Forms 1094-C and 1095-C for calendar year 2016 that are required to be filed in 2017. As a reminder, the Forms 1094 and 1095 must be filed with the IRS by February 28, 2017 (by March 31, 2017 if filing electronically). The Form 1095-C must be furnished to individuals by March 2, 2017.

- **Reporting Offers of Health Insurance Coverage by Employers (Section 6056).** Employers subject to the employer shared responsibility provisions are required to report their offers of health coverage to their employees. This set of Q&As provide a more detailed explanation relating to who is required to report the offers, as well as the methods and timeframes for reporting the offers of coverage.

ACA Implementation Guidance

On December 20, 2016, the ACA tri-governing agencies (Departments of HHS, Labor and Treasury) issued an **implementation FAQ**. Following is a brief summary of this guidance.

- **Special enrollment for group health plans.** In accordance with this guidance, loss of individual market eligibility, including coverage purchased through a marketplace, qualifies as a HIPAA special enrollment event for group health plan coverage as long as the loss of coverage was not due to failure to timely pay premium, or fraud or misrepresentation by the individual. As a reminder, special enrollment means that an individual can join the employer's plan outside of the open enrollment period.

- **Coverage for women's health preventive services**
  - The ACA requires non-grandfathered plans in the individual and group markets to provide specified women's health preventive services at no cost to plan participants. The types of preventive services to be covered are based on recommendations by several agencies, such as the U. S. Preventive Services Task Force (USPSTF) and the Health Resources and Services Administration (HRSA). HRSA updated its Women's Preventive Services Guidelines on December 20, 2016 (available at: http://www.hrsa.gov/womensguidelines2016/). These updated guidelines become applicable to both individual and group plans on the first plan year that begins on or after December 20, 2017 (January 1, 2018 for calendar year plans).
  - In a separate **implementation FAQ** released on January 9, 2017, the tri-governing ACA agencies affirm that religiously affiliated organizations and closely held corporations with religious objections to providing some or all of the contraceptive services can continue to utilize the existing self-certification process to opt out of providing this type of coverage. This conclusion is drawn following the agencies' review of over 54,000 responses received as a result of their solicitation for public input on the matter.

- **Qualified small employer HRAs**. As mentioned in our year-end ***Health Reform Bulletin 124***, the recently enacted *21st Century Cures Act* re-establishes the ability of small employers to provide their employees a stand-alone health reimbursement arrangement (HRA), known as a "qualified small employer HRA". A qualified HRA is an arrangement that:
  1. Is funded solely by a small employer who is exempt from the ACA's employer shared responsibility requirements (employs fewer than 50 employees on business days during the preceding calendar year) and who does not currently offer health coverage;
  2. The arrangement provides, following the employee's proof of coverage, for the payment or reimbursement of medical care expenses (as defined in IRC Section 213(d)), including premium for health coverage through the individual market, incurred by the eligible employee or his/her family members. The annual amount of payments and reimbursements is capped at $4,950 for employee-only, or $10,000 for arrangements that provide for payments or reimbursements for the employee's family members; and
  3. The HRA is available on uniform basis.

  This law allows for the establishment of qualified HRAs beginning after December 31, 2016.

  In addition, the Cures Act extended relief to HRAs in existence prior to this law's enactment that would have otherwise been violative of the market provisions of the ACA; and thus, subject to the $100 per day penalty, per affected person (the IRC Section 4980D penalty) and required to report the violation on the Form 8928. The implementation FAQ issued December 20th affirms that the extended relief granted by the Cures Act applies to certain employer-paid arrangements that pay or reimburse individual health premium, or Medicare Part B or Part D premiums for plan years beginning on or before December 31, 2016. This relief does not extend to stand-alone HRAs or other arrangements to reimburse employees for medical expenses other than insurance premiums that had not previously been granted relief.

  With regard to individual premium paid by over-2% shareholder of an S-Corporation, the FAQ affirms reliance on the guidance provided in IRS Notice 2015-17. In a nutshell, the relief granted in Notice 2015-17 provides that there would be no penalty for failure to comply with the ACA's market provisions when an over-2% shareholder's individual health premium is reimbursed.

Gender Identity Discrimination: Preliminary Injunction Issued

On December 31, 2016, a preliminary injunction was ordered by the U.S. District Court for the Northern District of Texas, temporarily suspending the requirement to comply with certain aspects of Section 1557 of the Affordable Care Act. As background, Section 1557 of the ACA prohibits discrimination in the delivery of health services based on race, color, national origin, sex, age, or disability. This preliminary injunction temporarily suspends the requirement for insurers, plans and health care providers to comply with gender identity component of the law. Following issuance of the injunction, the HHS Office for Civil Rights has indicated that it will continue to enforce all other aspects of the law in accordance with the Court's decision. At this point, it is unclear how much impact this preliminary injunction will have on health plans that have already implemented changes.

As a reminder, employers including employer-sponsored self-funded health plans who do not receive federal funding, are not directly subject to Section 1557 of the ACA. However, employers employing 15 or more employees, whether private or public sector, are subject to Title VII of the Civil Rights Act of 1964 which includes a prohibition against sex discrimination. Further, federal contractors are subject to Executive Order 11246 which prohibits sex discrimination in employment by covered contractors. For additional explanation of these rules, see our *Benefit Beat* article, *Attention Self-funded Plan Sponsors: Be Aware of Potential Discriminatory Benefits* (8/8/16).

Final Rules - Premium Tax Credit

On December 19, 2016, the IRS released **final regulations** relating to the premium tax credit applicable to individuals who enroll in individual marketplace coverage. While these rules do not directly impact employers, one of the issues for employers subject to the ACA's employer shared responsibility provisions who allow cash-outs relates to how affordability is determined when a cash-out option is available. Unfortunately, the government has not yet provided final rules on this matter. Thus, the prior guidance provided in IRS Notice 2015-87 and proposed regulations issued in July, 2016 (see CBIZ *Health Reform Bulletin 120*), remain in effect, as follows.

For purposes of determining affordability, pursuant to which an employer offers health coverage, and if the employee declines the coverage, the employee would receive cash, depends on whether the opt-out arrangement is unconditional or conditional:

- An *unconditional* opt-out arrangement, i.e., one in which the employee can decline the employer's offer of coverage and take cash would result in affordability being determined by combining the employee's cost of coverage plus the cash pay-out, without regard to proof of other coverage. For example, the employee's cost of coverage is $100; the employee receives $200 for declining coverage. In this scenario, the affordability determination would be based on $300.
- If the offer of coverage is *conditional*, i.e., contingent on proof of other coverage, the cash-out portion is not included in the affordability calculation, according to these regulations, but only if the conditional opt-out qualifies as an eligible opt-out. What this means is that the individual must attest to the fact that he/she and his/her "tax family", i.e., all of whom the taxpayer is responsible for ensuring health coverage such as the spouse and/or dependents, have, in fact, other minimum essential coverage (MEC). The other MEC cannot be individual coverage or marketplace coverage. In effect, it must be, for example, coverage from a spouse's employer.

As a reminder, the only way to offer a choice between qualified benefit, such as employer's contribution toward health coverage and cash is through the terms of a written IRC Section 125 (cafeteria) plan. What this means that any opt-out arrangement must be documented in a Section 125 plan.

2018 Benefit and Payment Parameters

On December 22, 2016, the Department of Health and Human Services (HHS) published **final rules,** together with a **Fact Sheet**, relating to Benefit and Payment Parameters for 2018. These uniform standards are intended for health insurers and the marketplace to ensure health coverage options for consumers, as well as provide planning guidance for insurers and employers. Following are certain highlights of these rules that may be of interest to employers.

HHS Inflationary Percentage for 2018. The Affordable Care Act directs the Secretary of HHS to determine an annual premium adjustment percentage that is used to set the rate of increase for three parameters detailed in the law. For 2018, the premium adjustment percentage is approximately 16.17%, reflecting an increase of 2.6% from 2017. This percentage is calculated based on the projections of average per enrollee employer-sponsored insurance premiums from the National Health Expenditures Accounts that is calculated by the CMS Office of the Actuary. The percentage adjustment is applicable to:

1. The maximum annual limitation on cost sharing. The Affordable Care Act imposes certain cost-sharing restrictions, such as deductible and out-of-pocket limits on health plans. These annual out of pocket limits apply to insured plans offered through the marketplace, and insured and self-funded plans offered outside marketplace. Below are cost sharing limitations for 2016 through 2018:

	Self-only Coverage (Individual)	Other than Self-only Coverage (Family)
2016	$6,850	$13,700
2017	$7,150	$14,300
2018	$7,350	$14,700

2. The required contribution percentage by individuals for minimum essential health coverage for purposes of determining eligibility for a hardship exemption under the individual shared responsibility requirement (IRC Section 5000A). One of these exemptions occurs if the cost to the individual to purchase coverage exceeds 8,1% (for 2016; 8.16% for 2017) of household earnings. In 2018, the required contribution percentage will actually decrease to 8.05% of household earnings for purposes of exemption from the individual shared responsibility requirement. This affordability standard is distinct from the employer's shared responsibility affordability standard and distinct from the affordability standard for being entitled to premium assistance.

3. The assessable payment amounts under IRC Section 4980H(a) and (b) relating to employer shared responsibility. The chart below reflects the amount of penalties for purposes of calculating the 'no coverage' excise tax (IRC § 4980H(a)), and the 'inadequate or unaffordable' excise tax (IRC § 4980H(b)) for 2016 through 2018. These are the excise taxes that could apply if an applicable large employer is found not to have offered health coverage to a full-time employee.

'No Coverage' Excise Tax IRC § 4980H(a)		'Inadequate or Unaffordable' Excise Tax IRC § 4980H(b)	
2016	$2,160	2016	$3,240
2017	$2,260	2017	$3,390
2018	$2,320	2018	$3,480

Annual Open Enrollment Period. For the 2018 plan year, the annual open enrollment period for obtaining coverage through the marketplace will run from November 1, 2017 through January 31, 2018.

Federal Exchange User Fees. Insurers participating in the federal marketplace are subject to a user fee to help pay for the operational expenses of the marketplace. For 2016 and 2017, the user fee rate is 3.5% of the monthly premium charged by the insurer. Based on CMS' enrollment and premium projections, the 3.5% user fee in 2018 will remain the same.

About the Author: Karen R. McLeese is Vice President of Employee Benefit Regulatory Affairs for CBIZ Benefits & Insurance Services, Inc., a division of CBIZ, Inc. She serves as in-house counsel, with particular emphasis on monitoring and interpreting state and federal employee benefits law. Ms. McLeese is based in the CBIZ Kansas City office.

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Subject: **President Trump's Executive Order relating to the Affordable Care Act**
Date: January 23, 2017

In one of his first orders of business, President Trump signed an Executive Order relating to the Affordable Care Act. This Executive Order can be viewed as a blueprint or vision statement for how the President would like to see the Affordable Care Act administered in a manner to "*...minimize the unwarranted economic and regulatory burdens of the Act, and prepare to afford the States more flexibility and control to create a more free and open healthcare market*".

Accordingly, his directive to Administrative Agencies is:

> "*...to the maximum extent permitted by law....exercise all authority and discretion available to them to waive, defer, grant exemptions from, or delay the implementation of any provision or requirement of the Act that would impose a fiscal burden on any State or a cost, fee, tax, penalty, or regulatory burden on individuals, families, healthcare providers, health insurers, patients, recipients of healthcare services, purchasers of health insurance, or makers of medical devices, products, or medications.*"

This Executive Order does not change the law. Repealing or amending the law remains within the purview of the Congress. As new heads of administrative agencies (Departments of Health and Human Services, Treasury and Labor) are appointed and in place, and as matters evolve, we will provide you with new relevant information. In the meantime, it is important to continue to comply with the law as it stands today, including complying with the insurance market provisions, taxes and fees, as well as the reporting and disclosure requirements of the ACA.

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Subject: **The GOP Proposal to Repeal and Replace the Affordable Care Act**
Date: March 9, 2017

As follow-up to President Trump's Executive Order in January (see CBIZ *Health Reform Bulletin 126),* the 115th Congress has begun the process of trying to modify the Affordable Care Act (ACA). On March 6, 2017, a two-part reconciliation bill, known collectively as the "**American Health Care Act**" (AHCA), was introduced by the Republican leadership. The proposal was passed through the Ways and Means Committee and the Energy and Commerce Committees today. And by the time you are reading this, it is likely that additional action has been taken. Speaker Paul Ryan has indicated that it is his intent to make every effort to move this legislation as quickly as possible. The reality is that this may, or may not, happen.

Following is a brief summary of certain aspects of the AHCA, with particular focus on the potential impact on employer-sponsored health care. Before getting into specifics of the proposal, it may be helpful to understand that a full repeal of the ACA would require a super majority of 60 votes to get through the Senate. A reconciliation measure, on the other hand, only requires a simple majority of 51 votes in the Senate but is only available for revenue and budgetary provisions. For this reason, the AHCA leaves most of the ACA's provisions in place.

The AHCA would **retain** certain ACA insurance market reforms such as:

- Coverage of:
  - ✓ Preexisting conditions;
  - ✓ Adult children up to age 26;
  - ✓ 10 essential health benefit categories; and
  - ✓ Preventive benefits with no cost sharing.
- No cap on lifetime and annual limits.
- Guaranteed availability and renewability of coverage.
- Out-of-pocket expenditure caps.
- Prohibition of discrimination based on health status, race, nationality, disability, age, or sex
- Cadillac tax on high cost of employer-sponsored coverage. While this provision is currently delayed until 2020, the AHCA further delays the effective date until 2025.
- The income threshold for the medical expense tax deduction would be returned to 7.5% of income from 10% under the ACA.

The AHCA intends to **expand** Health Savings Accounts (HSA) beginning in 2018 in the following ways:

- Would increase the annual tax-free contribution limit to equal the limit on out-of-pocket cost sharing under qualified high deductible health plans. Thus, the basic limit would be $6,550 in the case of self-only coverage and $13,100 in the case of family coverage beginning in 2018 (subject to indexing);
- Both spouses could make catch up contributions to the same HSA;
- Would modify qualified medical expense definition to include over-the-counter medications;

- Would reduce tax penalty for HSA withdrawals used for non-qualified expenses from 20 percent to 10 percent; and
- Would create a special rule for certain medical expenses incurred prior to establishing an HSA.

The AHCA would **repeal** certain ACA provisions including:

- The **individual mandate** which requires individuals to maintain minimum health coverage or pay a tax. While the AHCA retains the actual provision of the law, the amount of the penalty is reduced to zero in the proposal and would be made retroactive to those impacted by the penalty in 2016.

  Instead of the individual mandate, under AHCA, beginning in open enrollment for benefit year 2019, there would be a 12-month look-back period to determine if an individual experienced a lapse in continuous health coverage of 63 days or longer. If the gap in coverage exceeds 63 days, then the individual would be assessed a flat 30 percent late-enrollment surcharge on top of the base premium. This late-enrollment surcharge would be the same across all markets, regardless of health status.

- The **employer shared responsibility mandate** that requires public and private employers employing 50 or more full-time employees to offer adequate and affordable health coverage to their employees. While the AHCA retains the provision of the law, the potential penalties pursuant to IRC Section 4980H(a), the "no coverage" excise tax, and Section 4980H(b), the "inadequate or unaffordable" excise tax, is reduced to zero. If this provision is preserved in the final law, it would be made retroactive to those impacted by the penalty in 2016. As for the required Form 1094/1095 reporting by employers and insurers, the AHCA appears to retain this reporting and disclosure obligation.

- The **Small Business Tax Credit,** beginning in 2020.

Additional **repeals** include the following, which would become effective in 2018:

- Flexible medical spending account cap (currently indexed in 2017 at $2,600);
- Health insurance tax imposed on insurers;
- Reduction of Medicare Part D retiree drug subsidy;
- Medicare tax imposed on high earners – the unearned income and 0.9 percent tax surcharge;
- Medical device excise tax;
- Branded prescription drug tax;
- As mentioned above in the HSA section and as applicable to other reimbursement arrangements, the tax favored status of over-the-counter medications would be returned; and
- The 3.8% net investment tax on individuals, estates, and trusts with income above certain levels.

The AHCA would also repeal the ACA premium tax credits. The AHCA would replace this with an advanced, refundable tax credit for the purchase of state-approved, major medical health insurance and unsubsidized COBRA coverage for U. S. citizens who do not have access to employer or government-sponsored coverage, or who are otherwise exempt. The credits are age-adjusted as follows:

Age of Individual	*Amount of Credit*
Under 30	$2,000
Between 30 and 39	$2,500
Between 40 and 49	$3,000
Between 50 and 59	$3,500
Over 60	$4,000

The credits are capped at $14,000, and are available to individuals whose income is less than $75,000 per year ($150,000 joint filers). The credit phases out by $100 for every $1,000 in income higher than those thresholds.

Additional AHCA Provisions

- The proposal calls for a change in permissible age variations in health insurance premium rates. Currently, the law limits the cost of the most generous plan for older individuals to three times the cost of the least generous plan for younger individuals. The AHCA would loosen the ratio to five-to-one and allows states to set their own ratio.

- The AHCA would create a "Patient and State Stability Fund" to provide:
  - ✓ Financial assistance to high-risk individuals and those with high utilization rates;
  - ✓ Reinsurance incentives to stabilize individual market premium;
  - ✓ Promotion of participation and insurance options in individual and small group markets;
  - ✓ Promotion of preventive, dental, vision, mental health and substance abuse services; and
  - ✓ Direct provider reimbursement.

The Path to Passage

The newly-appointed HHS Secretary Tom Price states that the AHCA is "*a work in progress*"; the first step being this legislation. The second step would be a review of all ACA-related regulations and pronouncements, followed by the third step of additional legislation.

According to Speaker Paul Ryan, now that the Ways and Means and the Energy and Commerce Committees have completed their markups of the bill, the proposal now travels to the Budget Committee, followed by a review from the Rules Committee. Once these committee reviews are accomplished, the AHCA would go to the floor for a final vote. It would then go to the Senate for consideration.

In this passage path, however, are many sources of contention against the proposal including:

- ✓ Democrats;
- ✓ Conservative Republicans;
- ✓ Moderate Republicans, particularly in states expanding Medicaid;
- ✓ Lack of scoring by the Congressional Budget Office; and
- ✓ Interest groups such as the American Association of Retired Persons (AARP), the American Medical Association (AMA), and the American Hospital Association (AHA), among others.

We will keep you apprised as developments occur. In the interim, remember that the Affordable Care Act still remains in force.

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Health Reform Bulletin

CBIZ

Subject: House Passes the American Health Care Act
Date: May 5, 2017

On May 4, 2017, the House passed the American Health Care Act of 2017 ("AHCA", H. R. 1628). Since the initial bill was officially introduced on March 20, 2017 (see *The GOP Proposal to Repeal and Replace the Affordable Care Act*, HRB 127, 3/10/17), there have been several amendments made to the law's text. The bill will now progress to the Senate for consideration; its fate in the Senate is unclear at this point. Every indication is that the bill with undergo significant scrutiny and probably substantial change. Following is a brief overview of certain provisions of the bill passed by the House.

Individual and employer shared responsibility provisions. While the AHCA retains the actual language of the current law as it relates to potential penalties, the employer shared responsibility "no coverage" excise tax, and the "inadequate or unaffordable" excise tax, as well as the penalty applicable to individuals who fail to maintain essential health coverage, is reduced to zero. If these provisions are preserved in the final law, they would be made retroactive to those impacted by the penalty in 2016.

For individuals, the AHCA would repeal the ACA's premium assistance tax credit and cost-sharing available to individuals who fall below 400% of the federal poverty level, replacing it with an advanced, refundable tax credit for the purchase of state-approved, major medical health insurance and unsubsidized COBRA coverage for U. S. citizens who do not have access to employer or government-sponsored coverage, or who are otherwise exempt. The credits are age-adjusted as follows:

Age of Individual	Amount of Credit
Under 30	$2,000
Between 30 and 39	$2,500
Between 40 and 49	$3,000
Between 50 and 59	$3,500
Over 60	$4,000

The credits are capped at $14,000, and are available to individuals whose income is less than $75,000 per year ($150,000 joint filers). The credit phases out by $100 for every $1,000 in income higher than those thresholds.

Market reforms. While AHCA purports to maintain many of the market provisions of the ACA such as coverage of adult children up to age 26 and the prohibition of caps on lifetime and annual limits, it grants states the right to seek a waiver of a 10-year duration for certain purposes. In particular, states could apply for waivers to establish their own essential health benefit package in the individual and small group market (the initial bill would have retained the ACA's ten essential health benefits mandate), as well as set their own cost sharing limits, including out-of-pocket limits.

With regard to preexisting conditions, a state could seek a waiver that would permit health status underwriting for individuals who experience extended gaps in coverage. Accordingly, the bill would address gaps in coverage by allowing insurers to impose a 30% premium increase for 12-months if an individual experiences more than a 63-day gap in coverage. As an alternative, states establishing a high risk pool could engage in more aggressive underwriting for individuals who will be placed in the high risk pool.

The latest amendment to AHCA provides for an additional $8 billion in federal funds for the period between 2018 and 2023 to be allocated to states with health status underwriting waivers.

Waivers could also be sought to allow aged-based or other premium rating. Currently, the law limits the cost of the most generous plan for older individuals to three times the cost of the least generous plan for younger individuals. The AHCA would loosen the ratio to five-to-one and allows states to set their own ratio. The aged-based rating provision in creating much concern for AARP, among many other professional associations and patient advocacy groups.

Repeal of ACA provisions. Among the ACA provisions that would be repealed include:

- The Small Business Tax Credit, beginning in 2020;
- Flexible medical spending account cap (currently $2,600, indexed for 2017);
- Health insurance tax imposed on insurers;
- Reduction of Medicare Part D retiree drug subsidy;
- Medicare tax imposed on high earners – the unearned income and 0.9 percent tax surcharge;
- Medical device excise tax;
- Branded prescription drug tax;
- For health savings accounts and other reimbursement arrangements, the tax favored status of over-the-counter medications would be returned; and
- The 3.8% net investment tax on individuals, estates, and trusts with income above certain levels.

With regard to other ACA-imposed taxes, the AHCA further delays the imposition date of the Cadillac tax on high cost of employer-sponsored coverage until 2026. In addition, the income threshold for the medical expense tax deduction would be returned to 5.8% of income, from 10% under the ACA. Notably, this bill does not repeal the ACA's Patient-Centered Outcomes Research (PCOR) fee. The ACA's requirement to pay the transitional reinsurance fee sunset last year in 2016.

With regard to the employer's reporting obligation under the ACA to include the cost of health coverage on the Form W-2, the bill would create a new entry on the W-2 whereby the employer would indicate whether an individual was offered coverage. Presumably, ultimately, this could take the place of the current IRC Section 6056 reporting obligations, i.e., the C series of the Forms 1094 and 1095. Though again, for the moment, this obligation remains in full force and effect.

HSA Expansion. The AHCA intends to expand Health Savings Accounts (HSA) beginning in 2018 in the following ways:

- ✓ Would increase the annual tax-free contribution limit to equal the limit on out-of-pocket cost sharing under qualified high deductible health plans (HDHP), subject to indexing. For 2017, the HDHP annual out-of-pocket limit is $6,550 for individual/self-only coverage, $13,100 for family coverage. In 2018, the HDHP out of pocket limit is indexed at $6,650 for individual/ self-only and $13,300 for family;
- ✓ Both spouses could make catch up contributions to the same HSA;
- ✓ Would modify qualified medical expense definition to include over-the-counter medications;

- ✓ Would reduce tax penalty for HSA withdrawals used for non-qualified expenses from 20 percent to 10 percent; and
- ✓ Would create a special rule for certain medical expenses incurred prior to establishing an HSA.

Changes to Medicaid. The ACHA would roll back the Medicaid expansion framework established by the ACA. The bill would create a per-capita Medicaid funding system and allow states to impose a work requirement for certain able-bodied individuals.

We will keep you updated as this bill progresses in the Senate. In this interim, remember the Affordable Care Act has not been repealed, and remains in full force and effect.

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Health Reform Bulletin

CBIZ

Subject: 1) Indexed MEC Adjustments; 2) PCOR Fee Reminder; 3) Revised Expiration Date for Model Marketplace Notices, and 4) Coverage of Preeclampsia Screening

Date: June 13, 2017

Indexed Adjustments for Minimum Essential Coverage (MEC)

Certain Affordable Care Act (ACA) standards are subject to inflationary adjustments. To this end, the IRS released Revenue Procedure 2017-36 which provides indexed adjustments to required contributions relating to minimum essential coverage beginning in 2018, as follows:

- **Affordability Standard – Employer Shared Responsibility Mandate**

  Of particular note for employers subject to the ACA's employer shared responsibility mandate, those who fail to offer minimum essential coverage to their full-time employees or fail to offer adequate and affordable coverage may be subject to an excise tax if at least one of its employees qualifies for premium assistance through a marketplace. Coverage under an employer-sponsored plan is deemed affordable to a particular employee if the employee's required contribution to the plan does not exceed 9.56 percent (indexed for 2018; down from 9.69 percent in 2017) of the employee's household income for the taxable year, based on the cost of single coverage in the employer's least expensive plan.

  If an employer does not know an individual's household earnings, it can use one of three safe harbors for purposes of determining affordability; they are:

  - A *Form W-2 determination* in which the employer's lowest cost self-only coverage providing minimum value does not exceed 9.69 percent (indexed for 2017; 9.56 percent for 2018), of the employee's Form W-2 wages (Box 1) for the calendar year.

  - A *rate of pay method* in which the minimum value cannot exceed 9.69 percent (indexed for 2017; 9.56 percent for 2018), of an amount equal to 130 hours, multiplied by the employee's hourly rate of pay as of the first day of the coverage period. For salaried employees, the monthly salary is used instead of the 130 hour standard. An employer can apply this method to hourly employees if they experience a reduction in pay during the year; however, this methodology cannot be used for commissioned sales people.

  - A *Federal poverty line (FPL) standard* in which cost of single coverage does not exceed 9.69 percent (indexed for 2017; 9.56 percent for 2018) of the individual federal poverty line rate for the applicable calendar year, divided by twelve. An employer is permitted to use the poverty guidelines in effect six months prior to the beginning of the plan year. The Department of Health and Human Services released the 2017 FPL standards in January, 2017 (see *HHS Releases 2017 Federal Poverty Guidelines, Benefit Beat*, 2/15/17).

Indexed Adjustments for Minimum Essential Coverage, cont'd

- **Hardship Exemption.** The required contribution percentage by individuals for MEC for purposes of determining eligibility for a hardship exemption under the individual shared responsibility requirement (IRC Section 5000A). One of these exemptions occurs if the cost to the individual to purchase coverage exceeds a certain percentage of household earnings. For 2017, the required contribution percentage is 8.16 percent of household earnings for purposes of exemption from the individual shared responsibility requirement. In 2018, the percentage will decrease to 8.05 percent. This affordability standard is distinct from the employer's shared responsibility affordability standard and distinct from the affordability standard for being entitled to premium assistance.

- **Premium Tax Credit.** The following contribution percentages are used to determine whether an individual is eligible for affordable employer-sponsored MEC for the 2017 and 2018 tax years:

Household income percentage of Federal poverty line	Initial percentage *2017*	Final percentage *2017*	Initial percentage *2018*	Final percentage *2018*
Under 133%	2.04%	2.04%	2.01%	2.01%
Between 133% and 150%	3.06%	4.08%	3.02%	4.03%
Between 150% and 200%	4.08%	6.43%	4.03%	6.34%
Between 200% and 250%	6.43%	8.21%	6.34%	8.10%
Between 250% and 300%	8.21%	9.69%	8.10%	9.56%
Between 300% and 400%	9.69%	9.69%	9.56%	9.56%

PCOR Annual Fee Reminder

July 31st is fast approaching and it's time to begin planning payment of the ACA's Patient-Centered Outcomes Research (PCOR) fee. Virtually, all health plans, whether insured or self-funded, are subject to these fees. The PCOR fee is assessed on the average number of lives covered under the policy or plan. For policy and plan years ending between October 1, 2016 and October 1, 2017, the fee is $2.26 per covered life. For plan years ending between October 1, 2015 and October 1, 2016, the fee was $2.17.

The fee is to be paid once a year in connection with IRS Form 720, *Quarterly Federal Excise Tax Return*. For insured plans, the insurer is obligation to file the Form 720 by July 31st following the close of the policy year. For self-funded plans, the plan sponsor is obligated to file the Form 720 by July 31st of the calendar year following the plan year end.

As a reminder, the PCOR fee is an employer responsibility and cannot be paid from plan assets, including participant contributions.

For additional information about the PCOR fee, see IRS **webpage**, **Questions and Answers** and **Chart of Plans Subject to the Fees**.

Model Notice of Marketplace Options – Revised Expiration Date

The ACA requires all employers to provide a Notice of Marketplace Options to their employees explaining the pros and cons of buying coverage through the marketplace. The notice of marketplace options must be provided to all new hires including full-time and part-time employees, without regard to eligibility status for the health plan, within 14 days of date of hire.

There are two different versions of the model notice – one to be used by employers who offer health coverage to some or all employees, and the other version is to be used by employers who do not offer health coverage. These model notices are subject to approval by the Office of Management and Budget (OMB) on a periodic basis. The OPM have recently approved another set of these model notices, which have now been re-issued to reflect a new expiration date of May 31, 2020. While the expiration date of the notices has been changed, there are no substantive changes made to the language contained in these model notices. The re-issued model notices are available in both English and Spanish, and can be viewed and/or downloaded from the Department of Labor's website.

Preventive Services - Coverage of Preeclampsia Screening

The ACA requires health plans to cover certain preventive services, without imposing any cost-sharing requirements (co-pay, co-insurance, or deductible), when such services are delivered by in-network providers. The types of covered preventive services, some of which are recommended by the U. S. Preventive Services Task Force (USPSTF), are updated periodically. The USPSTF recently announced its recommendation on April 25, 2017 for screening pregnant women for preeclampsia with blood pressure measurements throughout pregnancy. This particular recommendation is graded with a B rating which means, generally, that compliance with the recommendation takes effect one year from the time it is issued. Thus, for plan years beginning on or after April 25, 2018, non-grandfathered group health plans must provide coverage of preeclampsia screenings for covered pregnant women.

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Subject: Senate Releases Health Care Reform Proposal
Date: June 23, 2017

The Senate has now made public its health care reform bill, named the "*Better Care Reconciliation Act of 2017*". In many ways, it tracks the House bill passed on May 4, 2017 (see the CBIZ *Health Reform Bulletin 128 – House Passes the American Health Care Act*, 5/5/2017).

In effect, both House and Senate bills would repeal most of the Affordable Care Act (ACA) taxes, with the exception of the so-called Cadillac tax, an excise tax imposed on high cost health coverage. According to both bills, the imposition of the Cadillac tax would be delayed until 2026.

Like the House bill, the Senate bill does not outright repeal the individual mandate nor does it repeal the employer shared responsibility requirement but reduces the applicable tax penalties to zero.

One of the most significant aspects of both bills relates to the impact on individuals who do not have access to employer-provided health coverage. As a reminder, the ACA provided for expansion of Medicaid. Certain states did, in fact, expand Medicaid to individuals earning below 138% of poverty. The Senate bill would allow the so-called expansion states to continue to receive federal money for their Medicaid expansion for a few more years than the House bill, phasing it out between 2020 and 2024. In a more global way, the Senate bill would allow states to either take a block grant or per capita allotment to provide care for the Medicaid population. There is concern that both the House and Senate bills would significantly reduce coverage for, and funding for those below certain income thresholds and those in poverty. While this does not directly impact employers, it arguably does impact overall health care costs in that if fewer people are covered, there would be more cost shifting to the paying population. This is bound to create significant discussion as efforts are made to merge the House and Senate bills.

Another major difference between the House and Senate bills relates to the premium tax credits, currently made available under the ACA tor individuals earning below 400% of poverty. The Senate bill would continue these tax credits but would restrict the group eligible for them. The House bill would provide a refundable tax credit, based on earnings, as discussed in HRB 128.

At this point, the Senate is waiting for the Congressional Budget Office to score its bill which is expected to be released next week. The bill would then be considered on the floor of Congress. Several Senators have already indicated uncertainty about the bill.

The process is sure to evolve and we will keep you updated as matters progress. In the interim, remember the Affordable Care Act has not been repealed, and remains in full force and effect.

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Health Reform Bulletin

CBIZ

Subject: 1) IRS Releases Draft 2017 Forms 1094/1095 Series; 2) Summary of Benefits and Coverage Reminder; 3) Return of the Annual Health Insurer Provider Fee; 4) Update on Preventive Services; 5) Reporting QSEHRA Reimbursements; and 6) HPID Requirement Remains Suspended

Date: August 29, 2017

As has been covered extensively in the press, Congress went on its summer recess without repealing, replacing or modifying the Affordable Care Act. What this means for employers is that it is "business as usual", including all reporting obligations, as more fully described below.

So where does health care reform stand at this point? The answer to this question is far from clear.

One aspect of health care reform that may get some bipartisan attention relates to the reimbursement of certain cost share requirements (CSR) for low income individuals who purchase coverage through the marketplace. As background, the legality of reimbursing insurers for these CSRs of low income individuals has been challenged in court. Thus far, the matter has not been resolved and currently, these reimbursements have only been authorized on a month-by-month basis. There is indication that there may be a bipartisan effort to provide a more long term fix for this issue by passing legislation that would authorize the reimbursement of these amounts on an on-going basis to stabilize the individual market.

Another track that is being pursued involves states seeking what is referred to as a Section 1332 waiver from the Department of Health and Human Services (HHS). An approved HHS waiver would exempt a state from compliance with certain aspects of the ACA by proposing its own specific program and process to accomplish the basic tenants of the law.

Until further court or legislative action occurs, the Affordable Care Act remains the law of the land. That said, following are some updates to law.

IRS Releases Draft 2017 Forms 1094/1095 Series

The Internal Revenue Service issued draft 2017 forms for the annual reporting that will be due in 2018 by employers subject to the Affordable Care Act's shared responsibility requirements, as well as by plans providing minimum essential coverage (MEC):

- Form 1095-B, *Health Coverage*
- Form 1094-B, *Transmittal of Health Coverage Information Returns*
- Form 1094-C, *Transmittal of Employer-Provided Health Insurance Offer and Coverage Information Returns*
- Form 1095-C, *Employer-Provided Health Insurance Offer and Coverage*

These forms are used to satisfy the IRC Section 6055 and 6056 reporting requirements. The Form 1094-B and 1095 B-series is used for reporting MEC; and the Form 1094 and 1095-C series is used for reporting employer provided coverage by employers subject to the ACA's shared responsibility requirement. It is important to note that these forms are drafts only and subject to change.

At this point, it appears that these draft forms are substantially similar to the 2016 forms, with the exception of removal of transitional relief on the Form 1094-C which is no longer available. As soon as these forms and the relevant instructions are finalized and released by the IRS, we will provide additional information.

Summary of Benefits and Coverage Reminder

The Affordable Care Act requires individual and group health plans, including grandfathered plans, whether insured or self-funded, to provide participants with a written summary of benefits and coverage (SBC) of the plan. Last year, both the Departments of Labor (DOL) and Health and Human Services (HHS) modified the model SBC templates, the uniform glossary, and related materials that can be used by plan sponsors and insurers. The revised SBC template is to be used beginning on the first day of the first open enrollment period that begins on or after April 1, 2017 relating to coverage for plan years beginning on or after that date. For calendar year plans, this means January 1, 2018. For plans and insurers that do not use an annual open enrollment period, the revised SBC template is to be used beginning on the first day of the first plan year that begins on or after April 1, 2017.

As a reminder, there are five occurrences of providing the SBC to plan participants:

1. Upon application;
2. By the first day of coverage;
3. Within 90 days of enrollment by special enrollees;
4. Upon contract renewal; and
5. Upon request.

The English version of the model summary of benefits and coverage template to be used on or after April 1, 2017 is available from the **DOL's website** in both pdf and word formats. The model **Uniform Glossary of Coverage and Medical Terms** is also available. The Chinese, Navajo, Spanish and Tagalog versions are available from the Center for Consumer Information and Insurance Oversight's **website**.

Return of the Annual Health Insurer Provider Fee

The Affordable Care Act imposes an annual fee upon "covered entities", such as insurers who engage in providing health insurance for U. S. health risks. The assessed fees are apportioned amongst all applicable covered entities (insurers) based on a ratio of net premiums for insuring U. S. risks during the preceding calendar year as compared to the aggregate net premiums for that same year. The fee is assessed when net premiums covering US risks exceed $25 million for the previous year.

The *Consolidated Appropriations Act of 2016* and *Protecting Americans from Tax Hikes Act of 2015* enacted on December 18, 2015, placed a one-year moratorium for the annual fee paid by insurers for 2017 (see HRB 116, *Year-end Wrap Up*, 12/29/15). This means that the fee will re-commence beginning January 1, 2018.

Although employers are not subject to these fees, the covered entity/insurer may pass along some of these costs to employer/policyholders; thus, employers with insured plans may begin seeing this fee reflected in their renewals. Notably, the IRS considers the fee to be part of the insurer's cost of doing business and does not permit any exemption or exclusion from gross income it pays to offset the fees.

Update on Preventive Services

The Affordable Care Act requires health plans to cover certain preventive services, without imposing any cost-sharing requirements (co-pay, co-insurance, or deductible), when such services are delivered by in-network providers. The types of covered preventive services, some of which are recommended by the U. S. Preventive Services Task Force (USPSTF), are updated periodically.

Following are some recently released recommended preventive services. Generally, compliance with USPSTIF recommendations becomes applicable as of the first plan year beginning one year following issuance of the recommendation.

- *Behavioral Counseling: Healthful Diet and Physical Activity for Cardiovascular Disease Prevention in Adults Without Known Risk Factors*. When recommended by the attending primary care physician, non-obese adults without hypertension, dyslipidemia, abnormal blood glucose levels, or diabetes must be offered behavioral counseling for purposes of promoting a healthful diet and physical activity. Release date of recommendation: July 2017.
- *Obesity screening: children and adolescents.* The USPSTF recommends that clinicians screen for obesity in children and adolescents aged 6 years and older, as well as offer or refer them to comprehensive, intensive behavioral interventions to promote improvements in weight status. Release date of recommendation: June 2017.
- *Folic acid supplement*. The USPSTF recommends that all women who are planning or capable of pregnancy take a daily supplement of folic acid of approved strength. Release date of recommendation: January 2017.
- *Statin preventive medication.* The USPSTF recommends that adults with no history of cardiovascular disease (CVD) to use a low- to moderate-dose statin for the prevention of CVD events when criteria are met. Release date of recommendation: November 2016.

A complete list of ACA-required preventive services can be accessed from the **USPSTF website**, as well and the **Healthcare.gov website**.

Reporting QSEHRA Reimbursements

The *21st Century Cures Act*, enacted on December 13, 2016, re-establishes the ability for certain small employers to provide their employees a stand-alone HRA, known as a "qualified small employer HRA" or "QSEHRA". In order to establish a QSEHRA, the employer must provide no other health coverage. The QSEHRA can be used to reimburse health insurance premium for individual coverage purchased either through or outside the marketplace. As is true for all health reimbursement arrangements, the plan can only be funded with employer dollars. See HRB 124, *Qualified Health Plans and Year-End Reminders* (12/14/16) for additional background information about QSEHRAs.

There are two reporting and disclosure obligations for a QSEHRA. One of them is a Form W-2 reporting obligation. An employee's total permitted benefits received under a QSEHRA must be reported on the Form W-2, after the employees provide proof of coverage. The IRS has added a new Code FF for Box 12 of the Form W-2 to report the total amount of permitted benefits under a QSEHRA. The maximum reimbursement for an eligible employee under a QSEHRA is $4,950 ($10,000 if it also provides reimbursements for family members), before indexing for inflation.

It should also be noted that the IRS recently released the draft Form 8962, *Premium Tax Credit*. This form is used by individuals when filing their Form 1040 to calculate the amount of premium tax credit received during the tax year, as well as for purposes of reconciling the advanced payment of the premium tax credit. The draft Form 8962 has been updated to reflect amounts individuals may receive from a QSEHRA. Specifically, if the individual was covered under a QSEHRA, then the employer would have reported the annual permitted benefit on the individual's Form W-2. According to the instructions, if the QSEHRA is deemed affordable for a month, then no premium tax credit would be allowed for the

month. If the QSEHRA is deemed unaffordable for a month, then the individual must reduce the monthly premium tax credit by the monthly permitted benefit amount, and then write "QSEHRA" in the top margin on page 1 of Form 8962 to explain the entry.

HPID Requirement Remains Suspended

The HIPAA Administrative Simplification Rules set forth standards relating to privacy, electronic transactions and security of medical information. A portion of the electronic transaction rules require implementation standards for purposes of streamlining the payment of claims. Specifically, the law requires insured and self-funded health plans to obtain a health plan identifier (HPID).

The Affordable Care Act (ACA) subsequently amended the HIPAA electronic transaction rules to require plans to obtain an HPID for purposes of streamlining claim payments. In addition, plans with an HPID were required to certify its compliance with the electronic transaction standards and operating procedures as it relates to eligibility for health plan transactions, health care claim status transactions, health care electronic funds transfers and remittance advice transactions.

However, on October 31, 2014, the Health and Human Services (HHS) suspended the use of the HPID as well as the certification requirement, due to questions raised by its advisory board about the efficacy of the use of these unique identifiers.

The HHS advisory board conducted a follow-up hearing on the matter on May 3, 2017 and based on testimony it received, it reiterated its former recommendations to rescind the HPID requirement imposed by HIPAA altogether. The board suggested other uses for the HPID for identification of health plans in the federal and state marketplaces, or for the ACA-imposed health plan certification requirement. Nonetheless, health plans should stay tuned in the event future guidance is issued.

About the Author: Karen R. McLeese is Vice President of Employee Benefit Regulatory Affairs for CBIZ Benefits & Insurance Services, Inc., a division of CBIZ, Inc. She serves as in-house counsel, with particular emphasis on monitoring and interpreting state and federal employee benefits law. Ms. McLeese is based in the CBIZ Kansas City office.

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Subject: 1) IRS Releases Finalized 2017 Forms and Instructions for the 1094/1095 Series; 2) Fee Reminders: Health Insurer Provider Fee and Transitional Reinsurance Fee
Date: October 4, 2017

2017 ACA Reporting Forms 1094 and 1095 Series

The 2017 Affordable Care Act reporting is upon us. The forms to be used, and the instructions for those forms, have just been released by the Internal Revenue Service. As a reminder, there are two annual reporting obligations imposed by IRC Section 6055 minimum essential coverage reporting, and by IRC Section 6056, employer shared responsibility reporting.

- The minimum essential coverage (MEC) reporting obligation is accomplished on the Form 1094-B transmittal and Form 1095-B statement to individuals. Generally, this reporting is accomplished by the insurer if the plan is insured. If the plan is self-funded, the employer is obligated to complete the MEC reporting and disclosure.
- Employers subject to employer shared responsibility (those employing 50 or more employees as of December 31, 2016 for the 2017 reporting year), can accomplish the MEC obligation by completing Part III of the Form 1095-C. Employers not subject to employer shared responsibility reporting accomplish the MEC reporting obligation by reporting the B series described above. The employer shared responsibility reporting obligation is accomplished on the Form 1094-C transmittal and the Form 1095-C statement to individuals.

Following are links to the particular forms and instructions:

Health Insurance Coverage Reporting by Insurers and Sponsors of Self-funded Plans (IRC § 6055)

- Instructions for 2017 Forms 1094-B and 1095-B (PDF)
- Form 1094-B, *Transmittal of Health Coverage Information Returns*
- Form 1095-B, *Health Coverage*

Employer Health Insurance Reporting Requirement (IRC § 6056)

- Instructions for 2017 Forms 1094-C and 1095-C (PDF)
- Form 1094-C, *Transmittal of Employer-Provided Health Insurance Offer and Coverage Information Returns*
- Form 1095-C, *Employer-Provided Health Insurance Offer and Coverage*

Deadlines for Filing and Distributing Forms 1094 and 1095

- ✓ Statements to individuals for both the B and C series must be furnished by January 31, 2018. Entities can request an extension for furnishing the statements by sending a letter to the IRS (see the instructions for the required content of the letter to request the extension and mailing address).

- ✓ Electronic filing of the forms must be accomplished by April 2, 2018; or, February 28, 2018 if filing by paper. At this point, no delay has been granted for filing these forms. An automatic 30-day extension is available by filing a Form 8809.

Changes to the Forms and Instructions. Generally, the 2017 forms are similar to the 2016 forms. Narrowing our focus on the C series of the forms, following are a couple clarifications and modifications:

- Several forms of transitional relief were available in 2015. To the extent the relief is no longer available, references to such relief have been removed.
- The instructions clarify that for purposes of the 9.5% affordability safe harbors and qualifying offer method references, the adjusted indexed percentage is 9.66 percent for plan years beginning in 2016, and 9.69 percent for plan years beginning in 2017. For 2018, the percentage decreases to 9.56 percent
- With regard to making corrections to filed forms, the instructions indicate that a Form 1095-C filed with incorrect dollar amounts on line 15, Employee Required Contribution, may fall under a safe harbor for certain *de minimis* errors. The safe harbor generally applies if no single amount in error differs from the correct amount by more than $100. If the safe harbor applies, then the reporting entity would not be required to correct the Form 1095-C to avoid penalties. However, if the recipient elects for this safe harbor not to apply, then the reporting entity may have to issue a corrected Form 1095-C to avoid penalties.
- Part II of the Form 1095-C contains a box to indicate a 2-digit number designating the start month of the plan. The obligation to complete this box remains optional for 2017 reporting purposes.
- Certain multiemployer transition relief is still available.

Information reporting penalties. The penalties for failure to provide the information return or provide correct payee statement remain essentially the same.

- The penalty for failure to file a correct information return is $260 for each return for which the failure occurs, with the total penalty for a calendar year not to exceed $3,218,500.
- The penalty for failure to provide a correct payee statement is $260 for each statement for which the failure occurs, with the total penalty for a calendar year not to exceed $3,218,500.
- Special rules apply that increase the per-statement and total penalties if there is intentional disregard of the requirement to file the returns and furnish the required statements.

Additional information relating to ALE obligations including the ACA Information Returns (AIR) system, can be found on the IRS's dedicated webpage, *ACA Information Center for Applicable Large Employers (ALEs)*. Also see:

- *Questions and Answers about Information Reporting by Employers on Form 1094-C and Form 1095-C*
- *Questions and Answers on Information Reporting by Health Coverage Providers* (Section 6055)

FEE REMINDERS: HEALTH INSURER PROVIDER FEE AND TRANSITIONAL REINSURANCE FEE

- ❑ **Return of the Annual Health Insurer Provider Fee.** As mentioned this summer, covered entities and insurers will become subject to the ACA's health insurer provider fee again, beginning January 1, 2018. These entities were given a one-year moratorium for 2017. Although employers are not subject to these fees, the covered entity/insurer may pass along some of these costs to employer/policyholders; thus, employers with insured plans may begin seeing this fee reflected in their renewals.

- **Transitional Reinsurance Fee Reminder.** The transitional reinsurance fee and related reporting obligation was imposed over a three-year period from 2014 to 2016. For the last year of the program, insurers and plan sponsors of self-funded plans were obligated to submit their 2016 form reflecting the annual enrollment count of covered lives by November 15, 2016. The full fee was due by January 17, 2017. However, for reporting entities who opted to make two payments, the deadline for submitted the Form remains November 15, 2016, with the first part of two payments due by January 17, 2017; the second payment is due by November 15, 2017.

About the Author: Karen R. McLeese is Vice President of Employee Benefit Regulatory Affairs for CBIZ Benefits & Insurance Services, Inc., a division of CBIZ, Inc. She serves as in-house counsel, with particular emphasis on monitoring and interpreting state and federal employee benefits law. Ms. McLeese is based in the CBIZ Kansas City office.

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Health Reform Bulletin

CBIZ

Subject: 1) Executive Order Directing Modifications to the Affordable Care Act; 2) Termination of Cost-Sharing Reductions in Individual Policies; 3) PCOR fee adjustment; and 4) Updates on Preventive Health Services

Date: October 16, 2017

EXECUTIVE ORDER DIRECTING MODIFICATIONS TO AFFORDABLE CARE ACT

An Executive Order, signed on October 12, 2017, promotes modifications of certain aspects of the Affordable Care Act (ACA) (also see press statement). In a nutshell, this Executive Order directs the ACA's governing agencies (Health and Human Services/Labor/Treasury) to address three elements: formation of association health plans, expansion of short-term, limited-duration insurance, and expanding the rules to allow individual premium to be reimbursed through health reimbursement arrangements (HRAs). Briefly, this Executive Order directs the governing agencies to:

1. Develop ways to **expand access to association health plans** (AHPs) for small employers. The intended result would allow AHPs to be available to small businesses that are in the same line of business to join together to offer healthcare coverage to their employees, either through existing organizations or new ones established, for the express purpose of offering group coverage. Formation of AHPs would also allow the purchase of insurance across state lines. Presumably, the Executive Order is suggesting that the regulatory agencies loosen the ERISA rules governing multiple employer welfare arrangements. This would also require coordination with state laws governing association-type plans.
2. **Expand short-term, limited duration benefit plans** which are generally intended to fill temporary coverage gaps when individuals transition between coverages. These types of plans are generally exempt from many of the ACA's insurance market reform mandates. Regulations issued last year restricted these types of policies to a 3-month duration to coordinate with the short-term coverage gap exemption from the minimum essential coverage (MEC) requirement. It is unclear at this point whether any newly designed short-term policies would meet the requirements of MEC, and thus, could put individuals at risk for the individual shared responsibility penalty.
3. **Expand the rules surrounding health reimbursement arrangements** (HRAs) to allow payment of individual premium. Under current law, an HRA can only reimburse individual health premium if the HRA is a retiree-only HRA, or a qualified small employer HRA (QSEHRA).

These agencies are directed to provide their recommendations relating to AHPs and short-term limited duration plans by December 11, 2017; the HRA recommendations are due by February 9, 2018. Further, these agencies are obligated to provide progress reports of their efforts to both the President and Congress by April 10, 2018, and every two years from that date.

It is important to remember that this Executive Order does not change the law as it stands today. As matters evolve, we will provide you with the relevant information. In the meantime, the ACA's insurance market reform requirements and all other aspects of the ACA remain in effect.

Termination of Cost-Sharing Reductions in Individual Policies

The Departments of Health and Human Services and Treasury, by way of a Department of Justice opinion, have announced that the cost-sharing reductions authorized under the Affordable Care Act will cease immediately. The cost-sharing reductions are monies paid to insurers to help offset co-payments and other out-of-pocket costs for certain lower income individuals whose income falls below 250 percent of the federal poverty level and who obtain their coverage through the marketplace. Insurers will continue to be obligated to provide these cost-sharing reductions to eligible individuals but will not receive reimbursement from the federal government.

To this end, insurers have, and will, continue to incorporate this additional cost into premium. In effect, this ultimately increases the premium for coverage. For those obtaining coverage through the marketplace and receiving a premium subsidy, the increased premium will impact the amount of the federal subsidies requirement. As a reminder, the premium subsidy is not impacted with the roll-back of the cost-sharing requirements. Those not entitled to premium subsidy will feel the primary burden of the premium increase.

The day following the announcement of the cost-sharing reduction, state attorneys generals from 18 states and the District of Columbia filed a lawsuit challenging the cost-sharing funding roll-back.

PCOR Fee Adjustment

The IRS has released the adjusted applicable dollar amount for the Patient Centered Outcome Research (PCOR) fee. For policy and plan years ending between October 1, 2016, and October 1, 2017, the PCORI fee was $2.26. The fee increases to $2.39 for policy and plan years ending between October 1, 2017 and October 1, 2018, according to IRS Notice 2017-61. As background, the PCOR fee is assessed on the average number of lives covered under the policy or plan. The fee is required to be reported annually to the IRS on the second quarter Form 720 and paid by its due date, July 31st.

Updates on Preventive Health Services

- **Broadened Accommodations for Women's Health Services**

  The ACA governing agencies (HHS/DOL/IRS) published two sets of interim final regulations on October 13, 2017. These regulations allow virtually any entity, excluding government entities, with sincerely held religious or moral opposition to the women's preventive mandate of the ACA, specifically, contraceptive services, to opt-out of providing these benefits. The regulations do not specifically define what constitutes *sincerely held religious or moral convictions*, but suggests this determination will be made in accordance with state law; how this will play out is unclear.

  Religious Accommodations. Historically, houses of worship (churches) have been the only entities entitled to a full exemption from the women's preventive services mandate. Certain religiously affiliated organizations, including certain closely-held entities, have been able to obtain an accommodation warranting that such entities would not pay for such services, resulting in participants obtaining the excluded services directly from insurers or third party administrators.

  These interim final rules significantly broaden the entities entitled to receive the accommodation, or the exemption, at their discretion. Virtually, any non-government plan, including one sponsored by closely-held and publicly traded entities, private entities, as well as institutions of higher education and private universities offering student health coverage, can either choose the accommodation, i.e., the insurer or third party administrator would provide the services at no cost to their population for some or all of the contraceptive services, or choose to be exempt altogether from providing some or all contraceptive services.

ACCOMMODATIONS BASED ON MORAL CONVICTIONS. Further, a slightly narrower group of entities, specifically, all non-government, non-publicly traded entities, can claim a moral opposition to providing contraceptive services and seek either the accommodation described above, or an exemption, in accordance with the second set of rules.

HRSA EXEMPTION. The specific types of contraceptive benefits and services are based on the women's preventive services guidelines issued by the Health Resources and Services Administration (HRSA). Employers, plans and insurers with a religious or moral objection to providing contraceptive services are exempt from penalties by way of these interim rules for failure to abide by the HRSA recommended guidelines. HRSA has updated its women's health guidelines accordingly.

PARTICIPANT COMMUNICATION. Any employer-sponsored group health plan subject to ERISA should exercise caution if it intends to remove this benefit. In this event, plan sponsors are obligated to communicate the change in benefits to plan participants as a result of removing the benefit. The communication to plan participants can be accomplished by way of providing a summary of material modification.

EFFECTIVE DATE: These interim final rules became effective on October 6, 2017. Comments relating to these rules may be submitted to the governing agencies until December 5, 2017. In the interim, lawsuits challenging these regulations are being contemplated.

- Vision Screenings for Children

  The Affordable Care Act requires health plans to cover certain preventive services, without imposing any cost-sharing requirements (co-pay, co-insurance, or deductible), when such services are delivered by in-network providers. The types of covered preventive services, some of which are recommended by the U. S. Preventive Services Task Force (USPSTF), are updated periodically.

  Since the updated list of preventive services in *Health Reform Bulletin 131*, the USPSTF released its recommendation In September, 2017 for vision screenings, at least once, in all children ages 3 to 5 years to detect amblyopia or its risk factors. Generally, compliance with USPSTF recommendations becomes applicable as of the first plan year beginning one year following issuance of the recommendation.

  A complete list of ACA-required preventive services can be accessed from the USPSTF website, as well and the Healthcare.gov website.

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Health Reform Bulletin

CBIZ

Subject: **1) Employer Shared Responsibility Penalty Assessment Procedures; 2) Qualified Small Employer HRA (QSEHRA) Guidance; 3) Select 2018 Cost of Living Adjustments; and 4) Proposed 2019 Benefit and Payment Parameters**

Date: November 17, 2017

EMPLOYER SHARED RESPONSIBILITY PENALTY ASSESSMENT PROCEDURES

In recent days, the IRS has signaled its intent to begin assessing the Affordable Care Act's employer shared responsibility (ESR) excise taxes. As a reminder, the ESR provisions provide that if an employer does not offer adequate, affordable coverage to its full time employees, and at least one employee qualifies for premium assistance, i.e., the individual's income is between 100 and 400 percent of the federal poverty level, then one of two penalties can be assessed:

- The 'no coverage' excise tax, pursuant to IRC Section 4980H(a), applies if the ALE fails to offer minimum essential coverage to at least 95% [70% in 2015] of its full-time employees working 30 or more hours per week; and at least one employee qualifies for the premium tax credit.
- The 'inadequate or unaffordable' excise tax penalty, pursuant to IRC Section 4980H(b), applies if the employer offers minimum essential coverage, but it either does not meet the minimum value standard, or is unaffordable; and at least one employee qualifies for the premium tax credit.

The chart below reflects the amount of penalties for purposes of calculating the 'no coverage' excise tax (IRC § 4980H(a)), and the 'inadequate or unaffordable' excise tax (IRC § 4980H(b)) for 2015 through 2018.

'NO COVERAGE' EXCISE TAX IRC § 4980H(a)		'INADEQUATE OR UNAFFORDABLE' EXCISE TAX IRC § 4980H(b)	
2015	$2,080	2015	$3,120
2016	$2,160	2016	$3,240
2017	$2,260	2017	$3,390
2018	$2,320	2018	$3,480

Up until the last few days, no guidance had been issued on how these penalties might be assessed. The IRS has just now released guidance in the form of Q&As, specifically, Q&As 55-58 contained in the *Making an Employer Shared Responsibility Payment* discussion of the IRS' ***Questions and Answers on Employer Shared Responsibility Provisions Under the Affordable Care Act***.

In a nutshell, the IRS will send a "Letter 226J" to an applicable large employer (ALE) if it determines, based on the ALE's Forms 1095-C submitted to the IRS, the individual's tax filer information and information received from the marketplace, that for at least one month in the year, one or more of the ALE's full-time employees received premium tax credit to pay for coverage, and the ALE is not qualified for the affordability safe harbor or other 2015 transitional relief. The IRS is poised to begin sending these Letter 226-Js within the next few months; these Letters relate to the 2015 calendar year.

The Letter 226-J will include a description of the IRC Section 4980H penalties, a schedule to make penalty payments, an ALE response form, a list of employees receiving premium tax credit, procedures if ALE disagrees with proposed penalty, actions the IRS will take if ALE fails to respond, as well as IRS contact information. The IRS provides a sample Letter 226-J for viewing, as well as overview for "*Understanding Your Letter 226-J*".

The ALE would need to respond to the IRS within the timeframe specified in the Letter (generally, within 30 days) either affirming that it agrees that the excise tax is due, or that it does not believe the excise tax is due. The employer's response is accomplished by filing a Form 14764, "ESRP Response" to the IRS.

The IRS will then send acknowledgement of ALE response by sending a "Form 227". If ALE disagrees with the proposed payment amount contained in Form 227, the ALE can request a pre-assessment conference with IRS Office of Appeals. If ALE fails to respond to either Letter 226-J or Letter 227, the IRS will then proceed to assess the amount of the proposed ESR payment and issue a notice and demand for payment (Notice CP 220J).

The most important takeaway is for employers who may be impacted to have ready access to their 2015 offers of coverage, as well as their 2015 IRC Section 6056 reporting documentation, accomplished on the Form 1095-C series. If an employer receives a Letter 226-J, it should ensure that it responds timely, and it should work closely with its tax and legal adviser throughout this process.

IMPLEMENTATION GUIDANCE: QUALIFIED SMALL EMPLOYER HEALTH REIMBURSEMENT ARRANGEMENTS

One of the components of the President's Executive Order released last month calls for the government agencies to seek ways to expand the rules surrounding health reimbursement arrangements (HRAs) to allow payment of individual premium (see *Executive Order Directing Modifications to the Affordable Care Act*, CBIZ Health Reform Bulletin 133, 10/16/17). Under current law, an HRA can only reimburse individual health premium if the HRA is a retiree-only HRA, or a qualified small employer HRA (QSEHRA).

In response to the Executive Order, the Internal Revenue Service issued guidance (Notice 2017-67) providing clarifications and addressing implementation of QSEHRAs.

As background and previously discussed in our *Health Reform Bulletin 124*, beginning January 1, 2017, certain eligible small employers can establish a qualified HRA for purposes of paying or reimbursing medical expenses including premium for health coverage through the individual market, incurred by their eligible employees and their family members. The summary below incorporates the IRS guidance into the existing framework of QSEHRAs.

What employers can sponsor a qualified HRA? Generally, a small employer who employs fewer than 50 employees and offers no group coverage to its employees is eligible to sponsor a QSEHRA. Following are some clarifications to these requirements.

For purposes of determining employer size, an *eligible small employer* is one who employs fewer than 50 employees on business days during the preceding calendar year. Where a group of employers is treated as a single employer under the IRC control group rules (IRC Sections 414(b), (c), (m) or (o)), if any member of a control group provides disqualifying health coverage to its employees, then all members of the control group are disqualified from offering a QSEHRA.

With regard to second criteria for a QSEHRA, an eligible employer is one who does not currently offer group health insurance to its employees. This determination is made on a monthly basis.

Who are eligible employees? An *eligible employee* is defined as any employee of the eligible small employer. Retirees, former employees and non-employee owners are not eligible to participate in a QSEHRA. However, certain employees need not be offered coverage under a qualified HRA including:

- Employees who have not completed 90 days of service;
- Employees who have not attained age 25;
- Part-time or seasonal employees. For this purpose, a part-time employee is one who customarily works less than 35 hours per week; a seasonal employee is one who customarily works less than 9 months per year;
- Employees covered by a collective bargaining agreement where health benefits have been the subject of good faith bargaining; and
- Employees who are nonresident aliens with no U.S. source of income.

If an individual's status changes such that he/she is no longer in the excluded categories listed above, then the QSEHRA must be made available to that employee no later than the day immediately following the date the employee is no longer in the excluded category.

What are the requirements of a qualified HRA? A qualified HRA is an arrangement that:

- Is funded solely by the eligible small employer; like any HRA, no employee contributions can be made under this arrangement; and,
- Provides, following the employee's proof of coverage, for the payment or reimbursement for medical care expenses, as defined in IRC Section 213(d)), including premium for health coverage through the individual market, incurred by the eligible employee or his/her family members. The annual amounts of payment and reimbursement are subject to inflationary adjustments. For 2017, the annual amount of payments and reimbursements is capped at $4,950 for employee-only, or $10,000 for arrangements that provide for payments or reimbursements for the employee's family members. For 2018, the total amount of payments and reimbursements increases to $5,050 for employee-only; $10,250 for family coverage.

It should be noted that while an HRA integrated with an employer's group health plan can pay or reimburse Medicare Part B or Part D premium, caution should be exercised by employers paying this type of premium due to Medicare secondary payer rules.

The HRA must be made available on uniform basis. However, certain variations of payments or reimbursements based on family size or age are permitted. In addition, the amount of available reimbursements are adjusted on a pro-rated basis for employees who enter the HRA mid-year. It is important to note that the HRA must be operated on the same terms for all eligible employees of the eligible employer; an eligible employee is not permitted to waive participation in the program.

What are the reporting and disclosure obligations of a QSEHRA? There are two reporting and disclosure obligations of a QSEHRA:

- ***Form W-2 reporting.*** An employee's total permitted benefits received under a QSEHRA must be reported on the Form W-2. These amounts are reported in Box 12, using Code FF of the Form W-2, without regard to the amount of payments or reimbursements actually received. If the QSEHRA permits use of carryover amounts from prior years, those amounts would not be included in the amount reported for the current year.
- ***Written notice to employees.*** Employers establishing a qualified HRA are required to provide a written notice to eligible employees about the availability of the program at least 90 days prior to the beginning of the program year. The IRS guidance clarifies that for employers

sponsoring a QSEHRA during 2017 or 2018, an initial written notice must be provided to eligible employees by the later of February 19, 2018, or 90 days before the first day of the plan year of the QSEHRA. In addition, employers are encouraged to provide employees with information regarding the QSEHRA as soon as possible to allow employees to make informed decisions about health coverage. For newly eligible employee, the initial written notice must be furnished on or before the first day the employee becomes eligible to participate in the QSEHRA.

Contents of notice. The notice must include the following type of information:

1. A statement of the amount of each permitted benefit for which the employee might be eligible. To the extent the permitted benefit varies based on the number of family members covered under the arrangement or their ages, the written notice for an employee may include either each available permitted benefit, or the permitted benefit for which that employee is eligible. For a newly eligible employee whose permitted benefit is prorated, the notice must either include the prorated amount to which the employee is eligible, or specify that the prorated amounts are based on months of coverage, and include the information necessary to calculate the prorated amount. The notice must also include the date on which the QSEHRA is first provided to the eligible employee.
2. A statement that the eligible employee is required to provide the information relating to his/her permitted benefit amount to any marketplace in which the employee applies for advance payment of the premium tax credit (PTC). Further, the notice must provide an explanation that the permitted benefit may affect the eligibility and amount of any PTC and that the employee should retain the written notice because it may be needed to calculate the PTC on the employee's individual income tax return.
3. A statement that if the employee is not covered under minimum essential coverage (MEC) for any month, then the employee may be subject to the ACA's individual shared responsibility penalty for such month, and that reimbursements under the arrangement are includible in gross income.

Method of providing the notice. This annually written notice can be provided in paper, or electronically, as long as the IRS' electronic distribution rules are followed.

Coordination with Health Savings Accounts. Employer contributions to a health savings account that are part of a Section 125 (cafeteria) plan can continue be made without jeopardizing employer eligibility for a QSEHRA. However, if the QSEHRA coverage is not HSA-compatible, an employee will lose HSA eligibility.

What laws impact QSEHRAs? While a QSEHRA is exempt from the Affordable Care Act's insurance market provisions, it would still be considered a "group health plan" for purposes of the ACA's Cadillac tax, scheduled to take effect in 2020, as well as the Patient Centered Outcome Research (PCOR) fee. An employer sponsoring a QSEHRA is not required to file or furnish a Form 1095-B. Further, a QSEHRA would not subject to COBRA continuation of health coverage requirements.

Penalties for non-compliance. Any violations relating to the QSEHRA rules could result in the IRC Section 4980D penalties of up to $100 per day, per participant.

SELECT 2018 COST OF LIVING ADJUSTMENTS

In Revenue Procedure 2017-58, the IRS released 2018 inflationary or cost of living adjustments specific to certain provisions of the Affordable Care Act, as follows.

Small Business Tax Credit (SBTC). Small businesses and tax-exempt employers who provide health care coverage to their employees under a qualified health care arrangement are entitled to a tax credit, as established by the Affordable Care Act. To be eligible for the small business tax credit, the employer must employ fewer than 25 full-time equivalent employees whose average annual wages are less than $53,400 (indexed for 2018; the wage ceiling in 2017 was $52,400). The tax credit phases out for eligible small employers when the number of its full-time employees (FTEs) exceeds 10; or, when the average annual wages for the FTEs exceeds $26,700 in the 2018 tax year (the phase-out wage limit for 2017 was $26,200). As a reminder, only qualified health plan coverage purchased through a SHOP marketplace is available for the tax credit, and only for a 2-consecutive year period.

Individual Shared Responsibility Penalty. The Affordable Care Act imposes a penalty for individuals who fail to maintain minimum essential coverage (MEC). For 2018, the flat dollar penalty amount for failure to maintain MEC remains unchanged from 2017 ($695). The penalty is calculated based on the greater of 2.5 percent of family income; or $695 per adult, $347.50 per child (family maximum: $2,085).

Premium Tax Credit for Coverage under a Qualified Health Plan. Individuals who buy coverage through the marketplace and meet certain income criteria may be eligible for an advance credit payment wherein a portion of the premium is made directly to the insurer to cover the cost of coverage. The amount of an individual's premium tax credit is reduced by the amount of any advance credit payments made during the year. If the advance credit payment for a taxable year exceeds the premium tax credit limit, the individual would owe the excess as additional tax, subject to certain inflationary limits. For tax years beginning in 2018, the limitation on tax imposed for excess advance credit payments is determined using the following table:

Household Income (as percent of poverty line)	*Limitation amount for unmarried individuals (other than surviving spouse and head of household)*	*Limitation amount for all other taxpayers*
Under 200%	$300	$600
Between 200% and 300%	$775	$1,550
Between 300% and 400%	$1,300	$2,600

Increase in Tax Information Reporting Penalties. The IRS can assess penalties when certain tax information is not provided on a timely basis. Specifically, penalties may be assessed for failure to file information returns or provide payee statements, such as the Form W-2 and Form 1099, and notably, the Affordable Care Act's Forms 1094 and 1095, or related payee statements. Beginning in 2018, these penalties will increase, as follows:

- The penalty for failure to file a correct information return is $270 for each return for which the failure occurs, with the total penalty cap of $3,282,500 for a calendar year.
- The penalty for failure to provide a correct payee statement is $270 for each statement for which the failure occurs, with the total penalty cap of $3,282,500 for a calendar year.

Special rules apply that increase the per-statement and total penalties if there is intentional disregard of the requirement to file the returns and furnish the required statements.

2019 Benefit and Payment Parameters

On November 2, 2017, the Department of Health and Human Services (HHS) published proposed Benefit and Payment Parameters for 2019, together with a Fact Sheet. These uniform standards are intended for health insurers and the marketplace to ensure health coverage options for consumers, as well as provide planning guidance for insurers and employers. Following are certain highlights of these rules that may be of interest to employers.

HHS Inflationary Percentage for 2019. The Affordable Care Act directs the Secretary of HHS to determine an annual premium adjustment percentage that is used to set the rate of increase for three parameters detailed in the law. The proposed premium adjustment percentage for 2019 is 1.2516634051 or approximately 25 percent (for 2018, the premium adjustment percentage was approximately 16.17 percent).
This percentage is calculated based on the projections of average per enrollee employer-sponsored insurance premiums from the National Health Expenditures Accounts that is calculated by the CMS Office of the Actuary. The percentage adjustment is applicable to:

1. The maximum annual limitation on cost sharing. The Affordable Care Act imposes certain cost-sharing restrictions, such as deductible and out-of-pocket limits on health plans. These annual out of pocket limits apply to insured plans offered through the marketplace, and insured and self-funded plans offered outside marketplace. Below are cost sharing limitations for 2017 and 2018, together with the proposed 2019 limitations:

	Self-only Coverage (Individual)	Other than Self-only Coverage (Family)
2017	$7,150	$14,300
2018	$7,350	$14,700
2019 (proposed)	*$7,900*	*$15,800*

2. The required contribution percentage by individuals for minimum essential health coverage for purposes of determining eligibility for a hardship exemption under the individual shared responsibility requirement (IRC Section 5000A). One of these exemptions occurs if the cost to the individual to purchase coverage exceeds 8.05 percent (for 2018; this is proposed to increase to 8.3 percent in 2019) of household earnings. This affordability standard is distinct from the employer's shared responsibility affordability standard and distinct from the affordability standard for being entitled to premium assistance.

3. The assessable payment amounts under IRC Section 4980H(a) and (b) relating to employer shared responsibility. For 2019, the proposed 'no coverage' excise tax (IRC § 4980H(a) is calculated at $2,020; and the proposed 'inadequate or unaffordable' excise tax (IRC § 4980H(b) is calculated at $3,120 (see the Chart on page 1 of this HRB for 2015-2018 amounts).

Annual Open Enrollment Period. For the 2019 plan year, the annual open enrollment period for obtaining coverage through the marketplace will run from November 1, 2018 through December 15, 2018.

Federal Exchange User Fees. Insurers participating in the federal marketplace are subject to a user fee to help pay for the operational expenses of the marketplace. For 2017 and 2018, the user fee rate is 3.5% of the monthly premium charged by the insurer. Based on CMS' enrollment and premium projections, the 3.5% user fee in 2019 will remain the same. Insurers in state-based exchanges that use the federal exchange platform will be charged 3 percent.

About the Author: Karen R. McLeese is Vice President of Employee Benefit Regulatory Affairs for CBIZ Benefits & Insurance Services, Inc., a division of CBIZ, Inc. She serves as in-house counsel, with particular emphasis on monitoring and interpreting state and federal employee benefits law. Ms. McLeese is based in the CBIZ Kansas City office.

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Subject: **1) Repeal of Individual Penalty Mandate, 2) Review of Penalties for Compliance Failures, 3) Updates on Women's Preventive Health Services, and 4) Year-end Reminders**

Date: December 22, 2017

While there has been much energy over the past year focused on repealing, replacing, or repealing and replacing the Affordable Care Act (ACA), the bulk of the law remains in full force and effect.

This notwithstanding, Congress passed the "Tax Cuts and Jobs Act" (**H.R. 1**) on December 20, 2017; the President is expected to sign the bill into law. This tax reform bill **repeals the individual penalty mandate.** As background, beginning in 2014, all individuals residing in the United States are required to maintain a minimum level of health coverage, or be subject to a tax penalty. This tax penalty will be repealed, effective for tax years beginning January 1, 2019.

Even so, employers should continue to be diligent in ensuring compliance with all of the other provisions of the law. The **reporting and disclosure obligations and penalties** for not offering adequate and affordable health coverage, at least if you are a large employer remain intact.

As a reminder, the IRS has begun its process for issuing penalty assessments relating to the Affordable Care Act's employer shared responsibility (ESR) provisions (see *Employer Shared Responsibility Penalty Assessment Procedures,* CBIZ HRB 134, 11/17/17). These ESR requirement provides that if an applicable large employer (ALE) fails to offer adequate, affordable coverage to its full time employees, and at least one employee qualifies for premium assistance, then one of two penalties can be assessed: a 'no coverage' excise tax (IRC Section 4980H(a)), or an 'inadequate or unaffordable' excise tax penalty (IRC Section 4980H(b)).

The initial notification, IRS Letter 226J, would be sent to an ALE explaining a potential penalty assessments based on the 2015 calendar year reporting. An ALE receiving such Letter 226J should ensure that it responds to the IRS within the timeframe specified in the Letter (generally, within 30 days) either affirming that it agrees that the excise tax is due, or that it does not believe the excise tax is due. Additional information about this process can be found on the IRS website:

- *Understanding your Letter 226-J*; and
- Q&As 55-58 contained in the "*Making an Employer Shared Responsibility Payment*" discussion of the *Questions and Answers on Employer Shared Responsibility Provisions Under the Affordable Care Act*.

In addition, there are also **penalties applicable to plans that fail to comply with the ACA's insurance market provisions and internal and external claims review procedures**. A plan that fails to satisfy any of these requirements could be subject to an excise tax of $100 per day per affected individual. The self-reporting is done on the **IRS Form 8928**. The reporting must be done by the employer or other responsible entity's tax return filing due date, without extensions. Failure to self-report a violation can result in penalties, which can be as much as 25 percent of the tax due, as well as interest. There is a 'reasonable cause' and 'not-willful' neglect exception available; in which case, interest and penalties would not be imposed as long as a correction of the violation is made within 30 days.

UPDATES ON WOMEN'S PREVENTIVE HEALTH SERVICES

- **Preliminary Court Injunction Issued**

  As summarized in our prior Health Reform Bulletin (see *Broadened Accommodations for Women's Health Services,* CBIZ HRB 133, 10/16/17), two sets of interim final regulations issued in October significantly broaden the entities entitled to receive an accommodation, or the exemption, from providing certain women's health preventive services, specifically, coverage for contraceptive services. The first set of rules provides that virtually any non-government plan, including one sponsored by closely-held and publicly traded entity, private entities, as well as institutions of higher education and private universities offering student health coverage, can either choose the accommodation, i.e., the insurer or third party administrator (TPA) would provide the services at no cost to their population for some or all of the contraceptive services, or choose to be exempt altogether from providing some or all contraceptive services. The second set of rules provides an accommodation or exemption for a slightly narrower group of entities, specifically, all non-government, non-publicly traded entities based on a moral opposition to providing contraceptive services.

  The issuance of these regulations have resulted in numerous legal challenges, two of which have resulted in a nationwide preliminary injunction. The first was imposed by the U.S. District Court for the Eastern District of Pennsylvania on December 15, 2017, in the matter of the *Commonwealth of Pennsylvania v. Trump* by Judge Wendy Beetlestone. The second preliminary injunction was imposed by the U.S. District Court for the Northern District of California on December 21, 2017, in the matter of the *State of California v. HHS* by Judge Haywood Gilliam. According to the nationwide injunction imposed by Judge Gilliam, the Obama era rules are reinstated for the duration of the injunction. For a preliminary injunction to be issued, the court must determine that the plaintiffs 1) have standing, i.e., the right to bring legal action; and significantly for this action, it must be determined that the plaintiffs would likely succeed on the merits; 2) that irreparable harm would occur in absence of the injunction; 3) that equity would be served by imposing the injunction; and, 4) that the public interest would be served through the imposition of the injunction. The presiding judges in these cases speak at great length about how each of these standards have been met, thus, resulting in the issuance of the preliminary injunction to block enforcement of the contraceptive coverage rules.

  Given the unsettled nature of these matters, entities interested in this issue should stay tuned.

- **CMS Guidance: Notice requirements**

  Entities seeking an accommodation from providing coverage for contraceptive services may do so by filing a notice with the insurer, or with the Department of Health and Human Services, stating their objection to providing the services and leaving it to the insurer or third party administrator (TPA) to provide or offer the services to the insureds. As an aside, a TPA can seek an offset on the cost of providing the benefit against its federal exchange user fee.

  On November 30, 2017, the Centers for Medicare and Medicaid Services released **guidance** to assist employers and plan sponsors seeking an accommodation from providing the objectionable benefit in its group health plan. According to this guidance, the entity must communicate the change to plan participants and beneficiaries.

  If an entity using the accommodation method described above wishes to revoke the accommodation, CMS provides two methods to accomplish this:

  1. The *general method* requires the notice be distributed to plan participants at least 30 days prior to the first day of the plan year for which the revocation will apply.
  2. The second method (the *60-day method*) requires that if the accommodation is described in the summary of benefits and coverage (SBC), then a 60-day advanced notice of the change to the SBC can be provided to plan participants. If the accommodation is not described in the SBC, then a 60-day notice method can be used, as long as all plan modification rules, such as the requirement to provide the summary of material modification, is followed.

YEAR-END REMINDERS

❑ EMPLOYER SHARED RESPONSIBILITY PROVISIONS

- **Applicability.** For purposes of the ACA's employer shared responsibility requirement as well as the reporting and disclosure requirements, applicable large employer (ALE) status is determined each calendar year, based on the average size of the employer's workforce during the prior year. Thus, if you averaged at least 50 full-time employees, including full-time equivalent employees, during 2016, you are most likely an ALE for 2017 and are subject to the reporting and disclosure requirements due in early 2018.

- **Affordability Standard.** For purposes of determining affordability, coverage under an employer-sponsored plan is deemed affordable if the employee's required contribution to the plan does not exceed 9.69 percent (indexed for 2017; 9.56 percent in 2018) of the employee's household income for the taxable year, based on the cost of single coverage in the employer's least expensive plan.

- **Increase in Excise Tax Penalties.** The chart below reflects the amount of penalties for purposes of calculating the 'no coverage' excise tax pursuant to Code Section 4980H(a), and the 'inadequate or unaffordable' excise tax pursuant to Code Section 4980H(b) for 2017 and 2018, as well as the proposed amounts for 2019. These are the excise taxes that could apply if an applicable large employer is found not to have offered health coverage to a full-time employee.

'NO COVERAGE' EXCISE TAX IRC § 4980H(a)		'INADEQUATE OR UNAFFORDABLE' EXCISE TAX IRC § 4980H(b)	
2017	$2,260	2017	$3,390
2018	$2,320	2018	$3,480
2019 (proposed)	*$2,020*	*2019 (proposed)*	*$3,120*

- **Reporting and Disclosure Obligations.** The Forms 1094 and 1095 are used to satisfy the IRC Section 6055 and 6056 reporting requirements. The Form 1094-B and 1095 B-series is used for reporting minimum essential coverage (MEC) by insurers and sponsors of self-funded plans. The Form 1094-C and 1095-C series is used for reporting employer provided coverage by an applicable large employer subject to the ACA's shared responsibility requirement.

  Deadlines
  - ✓ The Forms 1094 and 1095 must be filed with the IRS by February 28, 2018 (by April 2, 2018 if filing electronically)
  - ✓ The Form 1095 must be furnished to individuals listed in Forms 1094 and 1095 by January 31, 2018.

❑ **2017 Small Business Tax Credit Form.** The IRS has released the 2017 edition of the Form 8941, together with its instructions, for purposes of calculating the small business tax credit (SBTC). As a reminder, small businesses and tax-exempt employers who provide health care coverage to their employees under a qualified health care arrangement are entitled to a tax credit.

To be eligible for the SBTC, the employer must employ fewer than 25 full-time equivalent employees whose average annual wages are less than $53,400 (indexed for 2018; the wage ceiling in 2017 was $52,400). The tax credit phases out for eligible small employers when the number of its full-time employees (FTEs) exceeds 10; or, when the average annual wages for the FTEs exceeds $26,700 in the 2018 tax year (the phase-out wage limit for 2017 was $26,200).

Only qualified health plan coverage purchased through a SHOP marketplace is available for the tax credit, and only for a 2-consecutive year period. The Form 8941 is filed annually on the employer's tax return as a general business credit; tax exempt entities would file the Form 8941 with its Form 990-T.

- **Additional ACA-related Fees**
  - **Patient-Centered Outcomes Research Institute (PCORI) Fees.** For policy and plan years ending between October 1, 2016, and October 1, 2017, the PCORI fee was $2.26. The fee increases to $2.39 for policy and plan years ending between October 1, 2017 and October 1, 2018, The PCORI fees are paid annually via IRS Form 720 (generally due July 31st of each year).
  - **Cadillac tax** remains suspended until 2020.
  - **Health insurance provider fee** was suspended in 2017; this fee becomes applicable again on January 1, 2018.
  - **Excise tax on medical devices** suspended for sales made from January 1, 2016 through December, 31, 2017; this fee becomes applicable again on January 1, 2018.

- **ACA Cost-Share Restrictions**

  The chart below reflects the 2018 inflationary adjustments applicable to out-of-pocket (OOP) limits including deductibles, co-insurance and co-payments in ACA plans. These cost-share restrictions apply to insured plans offered via the marketplace, and insured and self-funded plans offered outside marketplace. These amounts differ from the OOP limits applicable to high deductible health plans used in conjunction with a health savings account (HSA).

2018 Inflationary Adjustments

	2018		2017	
ACA Plans - Out-of-Pocket (OOP) Limits	*Self-only*	*Family*	*Self-only*	*Family*
Note: For 2019, the proposed OOP limits are $7,900 for self-only; $15,800 for family	$7,350	$14,700	$7,150	$14,300
Health Savings Accounts	*Individual*	*Family*	*Individual*	*Family*
HDHP Annual Deductible	$1,350	$2,700	$1,300	$2,600
HDHP Annual Out-of-Pocket Limit	$6,650	$13,300	$6,550	$13,100
Contribution Limit	$3,450	$6,900	$3,400	$6,750

ACA-required Reporting Reminders

Form	*To Whom*	*Due Date*
Form W-2. ACA-required reporting includes: • Aggregate cost of health coverage (Box 12, using Code DD). *Note, employers filing <250 Form W-2s per year remain exempt from reporting the aggregate cost of health coverage on the Form W-2 until future IRS guidance is issued.* • Total amount of permitted benefits received under a qualified small employer health reimbursement arrangement (QSEHRA) (Box 12 - Code FF) • Additional Medicare tax withholding on earnings exceeding $200,000 per calendar year (Box 6)	Internal Revenue Service (IRS) http://www.irs.gov/ Form W-2 Instructions (2017)	January 31, 2018
Form 720 for purposes of Patient Centered Outcome Research (PCOR) fee	IRS	July 31st of each year

Additional ACA-Related Disclosure Reminders

Note: This is not an exhaustive list of ACA-required disclosures. For a more descriptive list of notice obligations relating to the ACA and other welfare benefit plans, ask your CBIZ representative for a Chart of Notice Obligations.

Form	*To Whom*	*Due Date*
Summary of Benefits and Coverage (SBC) *Note:* Revised SBC template available from Department of Labor (DOL) and CMS Center for Consumer Information & Insurance Oversight (CCIIO) for use beginning April 1, 2017	All plan participants	From Plan Sponsor to Plan Participants: 1. Upon application 2. By the first day of coverage 3. Within 90 days of enrollment by special enrollees 4. Upon contract renewal 5. Upon request

Additional ACA-Related Disclosure Reminders, cont'd

Form	*To Whom*	*Due Date*
Advanced 60-day Notice of Material Change in Benefits	All plan participants	No later than 60 days prior to any material change in any terms of plan affecting Summary of Benefits and Coverage (SBC) content not reflected in the most recently-provided SBC (other than in connection with renewal or reissuance of coverage)

Notice of Marketplace Options
• Model notice for use by employers **who offer coverage** to some or all employees:
  • English (pdf or word)
  • Spanish (pdf or word)
• Model notice for employers who **do not offer health coverage:**
  • English (pdf or word)
  • Spanish (pdf or word)
	All new hires including full-time and part-time employees, without regard to eligibility status for the health plan	Within 14 days of date of hire

Increased Penalties for Certain Compliance Violations

Certain reporting and disclosure obligations could result in civil penalties assessed by the Departments of Labor, Health and Human Services and Treasury. These civil penalties may be adjusted for annual inflationary reasons due to enactment of the Federal Civil Penalties Inflation Adjustment Act Improvements Act of 2015. The 2017 penalties reflected below take effect on January 13, 2017.

	2016 Penalty Amount	2017 Penalty Amount
Failure to provide Summary of Benefits and Coverage	Up to $1,087 per failure	Up to $1,105 per failure
Failure to file a correct information return *(Examples: Forms 1094/1095 and W-2)*	$260 per return (total penalty cap of $3,193,000 per calendar year)	$260 per return (total penalty cap of $3,218,500 per calendar year)
Failure to provide correct payee statement *(Examples: Forms 1094/1095 and W-2)*	$260 per statement (total penalty cap of $3,193,000 per calendar year)	$260 per statement (total penalty cap of $3,218,500 per calendar year)

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Subject: **IRS Delays Certain ACA Disclosures**
Date: January 2, 2018

The IRS issued guidance (**Notice 2018-06**) on December 22, 2017 announcing a delay in providing the Form 1095-B and Form 1095-C disclosure statements to individuals; these statements are generally due by January 31st following the reporting year.

As background, the Forms 1094 and 1095 are used to satisfy the IRC Section 6055 and 6056 reporting requirements. The Form 1094-B and 1095 B-series is used for reporting minimum essential coverage (MEC) by insurers and sponsors of self-funded plans. The Form 1094-C and 1095-C series is used for reporting employer provided coverage by an applicable large employer subject to the Affordable Care Act's shared responsibility requirement.

Notice 2018-06 provides for an extension for the due date for furnishing benefit statements (Form 1095-B and Form 1095-C) to individuals from January 31, 2018 to March 2, 2018. Due to this extension, there will be no further 30-day automatic extension available. Similar to prior disclosure delays issued by the IRS, the guidance provides that taxpayers can file their personal income tax return without having to attach the relevant Form 1095 to their tax returns.

Important to note that the filing due dates of the 2017 Forms 1094-B and 1095-B, and the 2017 Forms 1094-C and 1095-C reports to the IRS have not been extended. These reports must be submitted to the IRS no later than February 28, 2018; or by April 2, 2018, if filing electronically. An automatic 30-day extension of time to file the 1094/1095 forms remains available by submitting the Form 8809 with the IRS on or before the filing due date.

In addition, this guidance reinstates the good faith compliance standard that was allowed in prior years. This means that the potential IRS-imposed penalties for failure to comply with the reporting and disclosure requirements could be reduced or waived, even if incorrect or incomplete information is reported on the return or statement, such as missing and inaccurate taxpayer identification numbers and dates of birth, as long as the responsible reporting entity makes a good faith effort to complete the required forms accurately and timely.

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SUBJECT: 1) Delay of Certain ACA Taxes and Fees; 2) Benefit and Payment Parameters for 2019; and 3) Extended Transition Period for ACA Compliant Policies

DATE: May 7, 2018 *(revised May 24, 2018)*

DELAY OF CERTAIN ACA TAXES AND FEES

On January 22, 2018, President Trump signed H.R. 195. Along with providing short-term government funding, it also extends funding of the Children's Health insurance Program (CHIP) for six years through 2023. This program provides low-cost health coverage to children in families who do not qualify for Medicaid, as well as for pregnant women residing in certain states.

In addition, the law amends three provisions of the Affordable Care Act. Specifically, the law:

- Delays, for two years, the imposition of Code Section 4980I, popularly known as the **Cadillac tax**. The Cadillac tax would be assessed on the amount paid for high cost employer-sponsored health insurance coverage exceeding certain threshold levels ($10,200 for individuals; $27,500 for family, subject to indexing). The type of coverage subject to this tax would generally include all health coverage, whether insured or self-funded. It was to take effect in 2020; the new law delays the effective date until 2022.
- Places a one-year moratorium for the 2019 tax year on the **annual fee** required to be paid by 'covered entities' (insurers) who engage in providing health insurance for U.S. health risks. As described below, this fee had been suspended for the 2017 year, was reinstated for the 2018 year, and now suspended again for the 2019 year.
- Places a two-year moratorium on the 2.3% **medical device excise tax** for 2018 and 2019.

As background, a law enacted in 2015 placed similar extensions and moratoriums (see HRB 116, *Year-end Wrap Up,* 12/29/15). That law extended the effective date of the Cadillac tax from 2018 to 2020, as well as changed the status of the tax from an excise tax to a deductible tax. In addition, it placed a one-year moratorium for the 2017 tax year on the annual health insurer fee, and placed a two-year moratorium on the medical device excise tax for 2016 and 2017.

2019 BENEFIT AND PAYMENT PARAMETERS

On April 9, 2018, the Department of Health and Human Services (HHS) released its finalized Benefit and Payment Parameters for 2019, together with a Fact Sheet. These uniform standards, as required under the Affordable Care Act (ACA) are intended for health insurers and the marketplace to ensure health coverage options for consumers, as well as provide planning guidance for insurers and employers.

These final rules, in large part, mirror some of the proposed parameters released last year (see *Proposed 2019 Benefit and Payment Parameters,* HRB 134, 11/17/17). Following are highlights of these rules that may be of interest to employers.

HHS Inflationary Percentage for 2019. The Secretary of Health and Human Services is charged with determining an annual premium adjustment percentage that is used to set the rate of increase for three parameters detailed in the law. For 2019, the premium adjustment percentage is 1.2516634051, or approximately 25% (approximately 16.17% for 2018). This percentage is calculated based on the projections of average per enrollee employer-sponsored insurance premiums from the National Health Expenditures Accounts, as calculated by the CMS Office of the Actuary.

The percentage adjustment is applicable to the following three parameters:

1. *The **maximum annual limitation on cost sharing***. The ACA imposes certain cost-sharing restrictions, such as deductible and out-of-pocket limits on health plans. These annual out of pocket limits apply to insured plans offered through the marketplace, and insured and self-funded plans offered outside marketplace. Below are cost sharing limitations for 2017 through 2019:

	Self-only Coverage (Individual)	Other than Self-only Coverage (Family)
2017	$7,150	$14,300
2018	$7,350	$14,700
2019	$7,900	$15,800

As a reminder, the out-of-pocket (OOP) limits applicable to high deductible health plans (HDHP) used in conjunction with health savings accounts (HSA) differ from these ACA-imposed cost sharing limits. For 2018, the OOP limits for HDHP plans are $6,650 for single coverage; $13,300 for family coverage. For 2019, the OOP limit for HDHP plans will increase to $6,750 for single coverage; $13,500 for family coverage.

2. The ***assessable payment amounts under IRC Section 4980H(a) and (b)*** relating to employer shared responsibility. Thus far, the Section 4980H(a) and (b) penalty amounts for 2019 have not been issued by the IRS. Based on the HHS inflationary percentage for 2019 contained in the final benefit and payment parameter standards, the estimated 'no coverage' excise tax (IRC Section 4980H(a) is $2,500, and the estimated 'inadequate or unaffordable' excise tax (IRC Section 4980H(b) is $3,750. However, it is important to note that until these inflationary adjusted penalty amounts are officially released by IRS, these are estimated amounts only. The chart below reflects these excise tax penalty amounts for 2017 through 2019.

'No Coverage' Excise Tax IRC § 4980H(a)		'Inadequate or Unaffordable' Excise Tax IRC § 4980H(b)	
2017	$2,260	2017	$3,390
2018	$2,320	2018	$3,480
2019 *(estimated)*	$2,500	2019	$3,750

3. The required contribution percentage by individuals for minimum essential health coverage (MEC) for purposes of determining eligibility for a ***hardship exemption*** under the individual shared responsibility requirement (IRC Section 5000A). One of these exemptions occurs if the cost to the individual to purchase coverage exceeds 8.30% in 2019 (up from 8.05% in 2018) of household earnings.

Note: This affordability standard is distinct from the employer's shared responsibility affordability standard, and distinct from the affordability standard for being entitled to premium assistance. For 2018, coverage under an employer-sponsored plan is deemed affordable to a particular employee if the employee's required contribution to the plan does not exceed 9.56% (9.86% for 2019) of the employee's household income for the taxable year, based on the cost of single coverage in the employer's least expensive plan.

These parameters, together with separately issued guidance, provide for additional circumstances for claiming a hardship exemption from the requirement to maintain MEC. Even though the Tax Cuts and Jobs Act repealed the individual penalty mandate for tax years beginning January 1, 2019, there may be instances when individuals may still need to seek an exemption to qualify for certain coverages. A hardship exemption is now available for individuals who live in counties or geographical areas where there is zero to one issuer offering qualified health plan coverage to satisfy MEC criteria. Individuals claiming this hardship exemption are still required to follow current marketplace enrollment procedures, including completion of a hardship application.

Benchmark Plan Designs. Under current law, states can utilize one of several plan design categories for defining essential health benefits (EHB). A plan is permitted to use any of the 51 state-based benchmark plans, or the Federal Employee Health Benefit Plan benchmark plan to make its EHB determination. For plan years 2020 and beyond, states will have the following additional options for selecting an EHB-benchmark plan. A state can:

1. Select one of the 50 EHB-benchmark plans used by other states for the 2017 plan year;
2. Replace one or more of the ten required EHB categories of benefits under its own benchmark plan used for the 2017 plan year, with the same categories of benefits from another state's EHB-benchmark plan used for the 2017 plan year; or
3. Select a set of benefits tailored as its own EHB-benchmark plan, as long as it meets the scope of benefits requirements and other specified requirements, as outlined in separate CMS guidance.

While self-funded plans, large group market plans and grandfathered group health plans are not required to provide coverage for EHBs, to the extent that the plan does cover EHBs, it must select a benchmark plan. The selected benchmark plan is used to determine which EHBs the plan offers; this is relevant for a number of ACA purposes including restrictions relating to cost-sharing, annual and lifetime limits and preexisting condition exclusions.

Annual Open Enrollment Period. For the 2019 plan year, the annual open enrollment period for obtaining coverage through the federal marketplace will run from November 1, 2018 through December 15, 2018. State marketplaces may have different open enrollment periods.

Special Enrollment Periods. The final benefit and payment parameter rules make changes to the existing special enrollment period criteria for new dependents enrolling in marketplace coverage due to birth, adoption, foster care placement or court order, as well as for pregnant women who lose Children's Health Insurance Program (CHIP) coverage. In addition, the prior coverage requirement applicable to special enrollment events is waived for those individuals who reside in a service area where there is no qualified health plan coverage available. State marketplaces may provide for different special enrollment periods.

Medical Loss Ratio. The ACA's medical loss ratio (MLR) rules require insurers issuing individual and group health plans to spend a minimum of 85% of premium dollars paid by large group plans (80% in small group and individual markets) on medical care and health care quality improvements. The final benefit and payment parameters, together with two separately issued implementation documents, make certain modifications to the methodology used for calculating these MLR amounts. Specifically, the rules allow for a certain fixed percentage of earned premium that would automatically qualify as quality improvement expenses, and eases the rules for states seeking an MLR rebate adjustment in the individual market.

Federal Exchange User Fees. Insurers participating in the federal marketplace are subject to a user fee to help pay for the operational expenses of the marketplace. For 2019, the user fee rate remains at 3.5% of the monthly premium charged by the insurer. Insurers in state-based exchanges that use the federal exchange platform will be charged 3% (up from 2% in 2018).

Small Business Health Options Program (SHOP). As a means to wind down the Small Business Health Options Program (SHOP) through the Federal marketplace platform, the online enrollment process for employers is eliminated. Employers are permitted to directly enroll in the SHOP through a registered marketplace agent, broker, or insurer. For plan years beginning January 1, 2018, both the federal and state-supported SHOP marketplaces will no longer be required to provide employee eligibility, premium aggregation, and online enrollment functionality services.

Extended Transition Period for ACA Compliant Policies

Certain so-called 'grand-mothered' policies in the individual and small group markets that are not grandfathered and have enjoyed exemption from certain market provisions since January 1, 2014. The CMS' Center for Consumer Information and Insurance Oversight have extended the exemption several times and released another extension on the same day the final benefit parameters were released. Accordingly, individual and small group health policies renewing prior to October 1, 2018 (but ending by December 31, 2018) can be renewed, free from many of the ACA's market reforms, including:

- Fair health insurance premiums;
- Guaranteed availability of coverage;
- Guaranteed renewability of coverage;
- Prohibition of pre-existing condition exclusions or other discrimination based on health status with respect to adults, except with respect to group coverage;
- Prohibition of discrimination against individual participants and beneficiaries based on health status except with respect to group coverage;
- Non-discrimination in health care;
- Comprehensive health insurance coverage; and
- Approved clinical trials.

Unless extended again, or if changes are made by Congress or the Trump Administration in the interim, beginning January 1, 2019, these policies must be ACA-compliant.

About the Author: Karen R. McLeese is Vice President of Employee Benefit Regulatory Affairs for CBIZ Benefits & Insurance Services, Inc., a division of CBIZ, Inc. She serves as in-house counsel, with particular emphasis on monitoring and interpreting state and federal employee benefits law. Ms. McLeese is based in the CBIZ Kansas City office.

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Subject: 1) Status of Individual Mandate; 2) Understanding IRS Letter 227; 3) Indexed MEC Adjustments; and 4) PCOR Fee Reminder

Date: June 19, 2018

Status of Individual Mandate

Last year, the mantra for the Affordable Care Act (ACA) went something like this: repeal, repeal and replace, leave it alone, repeal, repeal and replace….

This notwithstanding, the ACA remains the law of the land, with the exception of the penalty tax imposed on individuals for failure to maintain minimum essential coverage (MEC). The Tax Cuts and Jobs Act reduces this tax to zero, effective January 1, 2019. The requirements to maintain health coverage continues to apply, despite the absence of a penalty.

The mantra this year is arguably more subversive: challenge, counter-challenge, defend, do not defend….

In February, a coalition of 20 State Attorneys General from primarily Republican states led by Texas Attorney General Ken Paxton and Wisconsin Attorney General Brad Schimel filed a lawsuit with the U.S. District Court for the Northern District of Texas arguing that repeal of the individual tax should cause the entire ACA to fall.

In April, a coalition of 16 Attorneys General from primarily Democratic states led by California Attorney General Xavier Becerra filed an action to intervene in the lawsuit. A month later, the judge of the Texas Court granted intervention in the matter.

The 20-coalition group who initiated the action is now seeking a preliminary injunction to suspend the law while the case winds its way through the Court. In response, the Democratic coalition of State Attorneys General filed a motion in opposition to a preliminary injunction seeking to ensure all aspects of ACA remain in force while court proceedings are carried out.

Separately, in a relatively unusual move, the U.S. Justice Department (DOJ) filed a response with the Texas Court on June 7, 2018, stating that the DOJ would no longer defend the individual mandate, including the guaranteed issue and preexisting condition limitation prohibition and rate restriction provisions of the law. On the same day, U. S. Attorney General Jeff Sessions a letter sent to Congress defending the DOJ's position that questions the constitutionality of the individual mandate in light of the repeal of the related tax penalty.

In summary, at this point, the ACA remains in full force and effect. From an employer's perspective, this means 'business as usual'.

At minimum, the move by the DOJ fuels discussion and debate for the upcoming November elections. This turn of events may create uncertainty in the individual insurance market as rates are being set for the 2019 year. Similarly there could be some ancillary impact on the group market. All of this uncertainty notwithstanding, bear in mind the importance of complying with the law unless and until it is changed. See the next topic to understand how enforcement is going forth.

Understanding IRS Letter 227

Late in 2017, the Internal Revenue Service began issuing Letters 226J to gather information relating to the imposition of the employer shared responsibility (ESR) tax (see *Employer Shared Responsibility Penalty Assessment Procedures*, CBIZ HRB 134, 11/17/17. The Letter 226J relates to the ESR reporting obligations for the 2015 calendar year reporting. As a reminder, the ESR rules apply to employers employing 50 or more employees.

The next step in this process is an IRS Letter 227, which follows up on Letter 226J. The Letter 227, like the Letter 226J, is not a penalty assessment. The obligation to pay a penalty would be documented on the "Notice CP 220J".

There are five versions of the Letter 227:

- Letter 227-J indicates that there is agreement between the IRS and the taxpayer on the penalty amount and no further action is needed.
- Letter 227-K indicates no penalty amount assessed and no further action needed
- Letter 227-L indicates that the penalty is revised; the taxpayer can agree and request a meeting or can appeal the determination.
- Letter 227-M indicates no change in the penalty. Like the 227-L the taxpayer can agree and request a meeting or appeal the determination.
- Letter 227-N acknowledges results of an appeal and no further response is required.

The IRS has established a dedicated webpage, Understanding Your Letter 227, to further explain the purpose of the Letters, together with an outline of next steps.

In summary, it is important to keep an eye out for these Letters and respond appropriately and timely if indicated to do so. In an informal IRS comment, the majority of the Letters 226 have resulted in no penalty.

Indexed Adjustments for Minimum Essential Coverage (MEC)

Certain Affordable Care Act (ACA) standards are subject to inflationary adjustments. To this end, the IRS released Revenue Procedure 2018-34 which provides indexed adjustments to required contributions relating to minimum essential coverage beginning in 2019, as follows:

- **Affordability Standard – Employer Shared Responsibility Mandate**

  Coverage under an employer-sponsored plan is deemed affordable to a particular employee if the employee's required contribution to the plan does not exceed 9.86% (indexed for 2019; up from 9.56% for 2018) of the employee's household income for the taxable year, based on the cost of single coverage in the employer's least expensive plan.

  As background, employers subject to the ACA's employer shared responsibility mandate who fail to offer minimum essential coverage to their full-time employees or fail to offer adequate and affordable coverage may be subject to an excise tax if at least one of its employees qualifies for premium assistance through a marketplace. If an employer does not know an individual's household earnings, it can use one of three safe harbors for purposes of determining affordability; they are:

  1. A ***Form W-2 determination*** in which the employer's lowest cost self-only coverage providing minimum value does not exceed 9.56% (indexed for 2018; 9.86% for 2019), of the employee's Form W-2 wages (Box 1) for the calendar year.

  2. A ***rate of pay method*** in which the minimum value cannot exceed 9.56% (indexed for 2018; 9.86% for 2019), of an amount equal to 130 hours, multiplied by the employee's hourly rate of pay as of the first day of the coverage period. For salaried employees, the monthly salary is used instead of the 130 hour standard. An employer can apply this method to hourly employees if they experience a reduction in pay during the year; however, this methodology cannot be used for commissioned sales people.

3. A ***Federal poverty line (FPL) standard*** in which cost of single coverage does not exceed 9.56% (indexed for 2018; 9.86% for 2019) of the individual federal poverty line rate for the applicable calendar year, divided by twelve. An employer is permitted to use the poverty guidelines in effect six months prior to the beginning of the plan year. The Department of Health and Human Services released the 2018 FPL standards in January, 2018 (see *HHS Releases 2018 Federal Poverty Guidelines,* *Benefit Beat*, 2/7/18).

- **Premium Tax Credit.** The following contribution percentages are used to determine whether an individual is eligible for a premium tax credit for the 2018 and 2019 tax years:

Household income percentage of Federal Poverty Line	Initial percentage *2018*	Final percentage *2018*	Initial percentage *2019*	Final percentage *2019*
Under 133%	2.01%	2.01%	2.08%	2.08%
Between 133% and 150%	3.02%	4.03%	3.11%	4.15%
Between 150% and 200%	4.03%	6.34%	4.15%	6.54%
Between 200% and 250%	6.34%	8.10%	6.54%	8.36%
Between 250% and 300%	8.10%	9.56%	8.36%	9.86%
Between 300% and 400%	9.56%	9.56%	9.86%	9.86%

PCOR Annual Fee Reminder

July 31st is fast approaching and it's time to begin preparations for payment of the ACA's Patient-Centered Outcomes Research (PCOR) fee. Virtually, all health plans, whether insured or self-funded, are subject to these fees. The PCOR fee is assessed on the average number of lives covered under the policy or plan. For policy and plan years ending between October 1, 2017 and October 1, 2018, the fee is $2.39 per covered life.

The fee is to be paid once a year in connection with IRS Form 720, *Quarterly Federal Excise Tax Return*. For insured plans, the insurer is obligated to file the Form 720 by July 31st following the close of the policy year. For self-funded plans, the plan sponsor is obligated to file the Form 720 by July 31st of the calendar year following the plan year end.

As a reminder, the PCOR fee is an employer responsibility and cannot be paid from plan assets, including participant contributions.

For additional information about the PCOR fee, see IRS webpage, Questions and Answers and Chart of Plans Subject to the Fees.

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Subject: Association Health Plans – Final Rules
Date: June 22, 2018

It has been the goal of the current Administration to expand the availability of association health plans (AHP) to small employers and the self-employed, driven, at least in part, by the growth of the so-called gig economy.

As background, a welfare benefit plan subject to ERISA must be sponsored by an employer for the exclusive benefit of its employees and their beneficiaries. The ERISA definition of employer includes an association acting on behalf of participating employers. Historically, the definition of association has been a difficult standard to meet in that it includes a strict commonality of interest test requiring the association to have a primary existence based on common economic and representational interests among the participating employers beyond the offering of employee benefits. Further, self-employed individuals could not participate in an association unless the self-employed individual employed common law employees.

The Department of Labor published final regulations on June 21, 2018 that expand the definition of association by loosening the commonality of interest standard, and by allowing self-employed individuals to participate, as more fully described below. Notably, an AHP established in accordance with these rules avoids some of the small group health insurance rules imposed by the Affordable Care Act (ACA), such as rate restrictions and the obligation to provide essential health benefits.

Who can sponsor an Association Health Plan?

A bona fide group or association of employers can establish an association group health plan (AHP) as long as it meets the following requirements:

1. The primary purpose of the group or association can be for the purpose of offering and providing health coverage to its employer members and their employees. While the primary purpose of an AHP can be to offer members health coverage, it must also have at least one *substantial business purpose* unrelated to offering and providing health coverage or other employee benefits, such as promoting common business or economic interest in a given trade or employer community. The business purpose need not be a for-profit activity. In addition, employer members must meet a *commonality of interest standard*. This means that the employers must be:
    - In the same trade, industry, line of business or profession; or
    - Each employer has a principal place of business in the same region within the boundaries of a single state or a metropolitan area, even if the metropolitan area includes more than one state, such as Kansas City.
2. Each employer member of the group or association participating in the group health plan is a person who directly acts as an employer of at least one employee who is a participant covered under the plan.
3. The group or association has a formal organizational structure with a governing body and has by-laws or other similar indications of formality.
4. The functions and activities of the group or association, as well as the plan itself, is controlled by its participating employer members. For this purpose, "control" is determined by a facts and circumstances test.

While an insurer or its subsidiary or affiliate cannot establish an AHP, it can participate as a member of the group or association.

Who is eligible to participate in AHP coverage?
An employer-member would be eligible to participate in the AHP, as well as its current and former employees and their spouses and dependent children.

A working owner of a trade or business is eligible to participate in an AHP. For this purpose, a "*working owner*" is an individual who:

1. Has ownership rights in the trade or business, including a partner and other self-employed individual;
2. Receives wages or income from the trade or business; and
3. Either:
   - Works on average, a minimum of 20 hours per week, or a minimum of 80 hours per month for the trade or business, or
   - Receives wages or income from the trade or business in an amount that equals the working owner's cost of AHP coverage for working owner and his/her covered beneficiaries.

This determination must be made when the working owner first becomes eligible for coverage under the group health plan; continued eligibility must be periodically confirmed.

Put simply, a self-employed individual can participate in an AHP even if the self-employed individual does not employ a common law employee.

Is an AHP subject to health status-based discrimination rules?
Yes. These regulations impose nondiscrimination based on health status rules that prohibit associations from red-lining individuals or groups based on their health status. Specifically, employer eligibility to the AHP cannot be conditioned on any health factor of any individual who is or may become eligible to participate in the AHP. Further, employees of different employer members of a group or association cannot be treated differently based on a health factor of one or more individuals of the group. In addition, an AHP plan must comply with the current HIPAA-ACA nondiscrimination rules relating to eligibility for benefits, as well as the rate restriction rules relating to premium and contributions.

Is an AHP a multiple employer welfare arrangement (MEWA)?
Yes. An AHP is a multiple employer welfare arrangement (MEWA) in that it is comprised of two or more unrelated employers including self-employed individuals. This means the rules applicable to MEWAs likewise apply to an AHP. Specifically, a plan administrator or sponsor of a MEWA is required to file an annual Form M-1 with the Department of Labor by March 1st of each year. The Form is intended to ensure that such plans are complying with the Affordable Care Act, the Health Insurance Portability and Accountability Act, and other federal related laws. In addition, plans required to file a Form M-1 must also file the Form 5500 regardless of plan size or type of funding.

Can states continue to regulate AHPs?
Yes, states can continue to regulate MEWAs, including this type of AHP. This means, at this point, an AHP would have to comply with the regulations in each state in which it operates. At this time, because some states prohibit or heavily restrict self-funded MEWAs, it is anticipated that any newly established AHPs will likely be insured, at least initially.

Do federal and state laws continue to apply to the entities participating in the AHP?
Yes. Federal and state laws such as discrimination laws, COBRA, HIPAA, the mental health parity laws, and the like, apply to AHPs. Time will tell how various requirements will be imposed. For example, will COBRA applicability be determined based on the size of the AHP, or the size of the participating employer?

A concern has been raised that certain very small employers participating in an AHP may no longer provide coverage for maternity care. For example, this could result when a very small employer is exempt from the Pregnancy Discrimination Act (applies to employer employing 15 or more employees) and the AHP to which it participates excludes essential health benefits, which would include coverage for maternity-related expenses.

Also, notably, some states, such as Massachusetts and New Jersey, have enacted an individual mandate that requires individuals to be covered by minimum essential coverage or pay a state tax. Other states, such as the

District of Columbia, are considering similar measures. In particular, the New Jersey law specifically contains a provision stating that AHP coverage will not satisfy the individual health coverage mandate unless the AHP meets certain standards.

When do the regulations take effect?
The AHP regulations take effect on August 20, 2018.

When can AHPs be established?
The final rules set forth a staggered schedule for purposes of establishing an AHP, as follows:

- All associations (new or existing) may establish a fully-insured AHP on September 1, 2018;
- Existing associations that sponsored an AHP on or before the date the final rule was published may establish a self-funded AHP on January 1, 2019;
- All other associations (new or existing) may establish a self-funded AHP on April 1, 2019.

Who might find AHPs useful?
It is expected that organizations such as chambers of commerce, trade associations, franchise entities and the like will consider this type of arrangement.

Are there legal challenges to creating an AHP?
There are a number of legal challenges being raised to these rules. In particular, the Massachusetts and New York Attorneys General are questioning the legality of AHPs based on these rules. There are also concerns that have plagued AHPs historically, e.g., misdeeds by the plan or its sponsor or administrator could cause a rise in fraudulent entities, leaving people with unpaid claims.

Where can I find more information about AHPs?
Additional information about association health plans is available from Department of Labor:

- Dedicated DOL webpage: Association Health Plans
- Fact Sheet
- FAQs
- Final rule, *Definition of "Employer" Under Section 3(5) of ERISA-Association Health Plans*

In closing, as is so often the case with new rules, there will be growing pains and lack of certainty that will need to be clarified in future guidance.

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Subject: Short-term Limited Duration Policies – Final Rules
Date: August 3, 2018

An Executive Order issued on October 12, 2017 directed the Affordable Care Act's tri-governing agencies (Departments of Treasury, Labor and Health and Human Services) to issue regulations expanding the availability of short-term limited duration insurance policies.

Currently, the Affordable Care Act (ACA) limits short-term limited duration insurance policies to a period of no more than 3 months. To achieve the goal set forth in the Executive Order, regulations were issued on August 3, 2018 expanding the duration of these policies from 3 months to up to 364 days, with the ability to renew, not to exceed 36 months from the origination date.

Notably, these short-term limited duration policies do not qualify as minimum essential coverage. Further, these policies are not required to comply with the market provisions to which more comprehensive coverage is subject to, such as limitation on preexisting condition exclusions, maternity coverage, mental health coverage, the guaranteed issue and guaranteed renewal requirements, among others.

Proponents to these regulations believe that this change would allow a cost-effective option for individuals. Opponents to the proposal believe that it will diminish the risk pool, leaving only high risk claims individuals in the ACA marketplace.

Individuals contemplating enrolling in a short-term limited duration policy will need to be aware of the limitations on coverage offered, as well as the potential consequence that coverage could be cancelled. A possible adverse scenario could be where an individual develops a health condition while covered by one of these policies. If his/her policy were to lapse and not be renewed, the individual would not be able to enroll in the marketplace until the open enrollment period, potentially leaving a gap in coverage. Thus, the attractive cost of this type of coverage will need to be weighed against the potential risk.

Notice Requirement

Insurers issuing short-term limited duration insurance policies are required to prominently display one of two versions of a notice (model language below) in both the insurance contract and application materials. The notice language differs depending on whether coverage begins prior to January 1, 2019, or whether coverage begins on or after January 1, 2019. The reason for the two different types of notices relates to the repeal of the individual penalty for failure to maintain minimum essential coverage.

Model notice language for short-term limited duration policies where coverage begins *before* January 1, 2019:

> *This coverage is not required to comply with certain federal market requirements for health insurance, principally those contained in the Affordable Care Act. Be sure to check your policy carefully to make sure you are aware of any exclusions or limitations regarding coverage of preexisting conditions or health benefits (such as hospitalization, emergency services, maternity care, preventive care, prescription drugs, and mental health and substance use disorder services). Your policy might also have lifetime and/or annual dollar limits on health benefits. If this coverage expires or you lose eligibility for this coverage, you might have to wait until an open enrollment period to get other health insurance coverage. Also, this coverage is not "minimum essential coverage." If you don't have minimum essential coverage for any month in 2018, you may have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.*

Model notice language for short-term, limited duration policies where coverage begins *on or after* January 1, 2019:

> *This coverage is not required to comply with certain federal market requirements for health insurance, principally those contained in the Affordable Care Act. Be sure to check your policy carefully to make sure you are aware of any exclusions or limitations regarding coverage of preexisting conditions or health benefits (such as hospitalization, emergency services, maternity care, preventive care, prescription drugs, and mental health and substance use disorder services). Your policy might also have lifetime and/or annual dollar limits on health benefits. If this coverage expires or you lose eligibility for this coverage, you might have to wait until an open enrollment period to get other health insurance coverage.*

State Regulation

It is important to note that a state can regulate the availability and scope of these policies; for example, a state could provide that a short term policy is limited to 90 days. Several states, such as Hawaii, Maryland, Massachusetts, New Jersey, New York and Vermont have recently enacted laws to limit the duration of these policies to 3 months, as well as prohibit renewals or extensions. California and Illinois are currently working through their legislative process to also restrict these policies.

Effective Date

These regulations take effect on October 2, 2018, and apply to policies sold on or after that date.

In closing, there is a school of thought that the Administration will be challenged in that it may have exceeded its authority by expanding the definition of short-term limited duration insurance policies in this manner. Stay tuned for further developments.

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Health Reform Bulletin

CBIZ

Subject: 1) 2018 Forms and Instructions for 1094/1095 Series, and 2) Adjusted PCORI Fee
Date: November 5, 2018

2018 Forms and Instructions for 1094/1095 Series

The 2018 Affordable Care Act reporting is upon us. The forms to be used, and the instructions for those forms, have been released by the Internal Revenue Service. Notably, the required content of the 2018 edition of the forms is essentially the same as the 2017 versions.

There are two annual reporting obligations imposed by IRC Section 6055 minimum essential coverage reporting, and by IRC Section 6056, employer shared responsibility reporting.

- The minimum essential coverage (MEC) reporting obligation is accomplished on the Form 1094-B transmittal and Form 1095-B statement to individuals. Generally, this reporting is accomplished by the insurer if the plan is insured. If the plan is self-funded, the employer is obligated to complete the MEC reporting and disclosure.
- Employers subject to employer shared responsibility (those employing 50 or more employees as of December 31, 2017 for the 2018 reporting year), can accomplish the MEC obligation by completing Part III on the Form 1095-C. Employers not subject to employer shared responsibility reporting accomplish the MEC reporting obligation by reporting on the B series described above. The employer shared responsibility reporting obligation is accomplished on the Form 1094-C transmittal and the Form 1095-C statement to individuals.

The 2018 reporting forms and instructions are available for viewing and downloading from the IRS website:

- ❑ *Health Insurance Coverage Reporting by Insurers and Sponsors of Self-funded Plans (IRC Section 6055)*
  - Instructions for 2018 Forms 1094-B and 1095-B (PDF)
  - Form 1094-B, *Transmittal of Health Coverage Information Returns*
  - Form 1095-B, *Health Coverage*

- ❑ *Employer Health Insurance Reporting Requirement (IRC Section 6056)*
  - Instructions for 2018 Forms 1094-C and 1095-C (PDF)
  - Form 1094-C, *Transmittal of Employer-Provided Health Insurance Offer and Coverage Information Returns*
  - Form 1095-C, *Employer-Provided Health Insurance Offer and Coverage*

Deadlines for Filing and Distributing Forms 1094 and 1095

- ✓ Statements to individuals for both the B and C series must be furnished by January 31, 2019. Entities can request an extension for furnishing the statements by sending a letter to the IRS (see the instructions for the required content of the letter to request the extension and mailing address).

- ✓ Electronic filing of the forms must be accomplished by April 1, 2019; or, February 28, 2019 if filing by paper (paper filing is only available to employers filing fewer than 250 Form W-2s per year). At this point, no delay has been granted for filing these forms. An automatic 30-day extension is available by filing a Form 8809.

Information reporting penalties. The penalties for failure to provide the information return or provide correct payee statement are subject to indexing. Following are the adjusted penalties applicable for the 2019 tax year:

- The penalty for failure to file a correct information return is $270 for each return for which the failure occurs, with the total penalty cap of $3,275,500 for a calendar year.
- The penalty for failure to provide a correct payee statement is $270 for each statement for which the failure occurs, with the total penalty cap of $3,275,500 for a calendar year.

Special rules apply that increase the per-statement and total penalties if there is intentional disregard of the requirement to file the returns and furnish the required statements.

IRS Resources. Additional information relating to ALE obligations, including the ACA Information Returns (AIR) system, can be found on the IRS's dedicated webpage, *ACA Information Center for Applicable Large Employers (ALEs)*. Of particular note:

- *Questions and Answers about Information Reporting by Employers on Form 1094-C and Form 1095-C*
- *Questions and Answers on Information Reporting by Health Coverage Providers* (Section 6055)

As a reminder, an employer subject to the ACA's employer shared responsibility who employs 50 or more employees on business days during the preceding calendar year must offer adequate and affordable health coverage to its full-time employees, or risk a penalty. For 2019, coverage under an employer-sponsored plan is deemed affordable to a particular employee if the employee's required contribution to the plan does not exceed 9.86% (indexed for 2019; 9.56% for 2018) of the employee's household income for the taxable year, based on the cost of single coverage in the employer's least expensive plan.

With regard to potential penalties, the IRC Section 4980H(a) and (b) penalty amounts for 2019 have not been issued by the IRS. Based on the HHS inflationary percentage for 2019 contained in the final benefit and payment parameter standards released on April 9, 2018, the estimated 'no coverage' excise tax is estimated at $2,500; the estimated 'inadequate or unaffordable' excise tax is $3,750. However, it is important to note that until the inflationary adjusted penalty amounts are officially released by IRS, these are estimated amounts only.

Adjusted PCORI Fee

The Internal Revenue Service released the adjusted applicable dollar amount for the Patient Centered Outcome Research Institute (PCORI) fee. For policy and plan years ending between October 1, 2017 and September 30, 2018, the PCORI fee was $2.39. The fee increases to $2.45 for policy and plan years ending between October 1, 2018 and September 30, 2019, according to **IRS Notice 2018-85**.

As background, the PCORI fee is assessed on the average number of lives covered under the policy or plan. The fee is required to be reported annually to the IRS on the second quarter Form 720 and paid by its due date, July 31st.

Under current law, the PCORI fee will no longer be assessed for policy/plan years ending on or after October 1, 2019.

About the Author: Karen R. McLeese is Vice President of Employee Benefit Regulatory Affairs for CBIZ Benefits & Insurance Services, Inc., a division of CBIZ, Inc. She serves as in-house counsel, with particular emphasis on monitoring and interpreting state and federal employee benefits law. Ms. McLeese is based in the CBIZ Kansas City office.

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Subject: 1) ACA – A Year in Review; 2) Women's Preventive Services Update; 3) Form 1095 Benefit Statement Issuance Date Delayed; and 4) Year-end Reminders
Date: December 17, 2018

The Affordable Care Act is akin to the "Energizer Bunny" – no matter what is thrown at it, it keeps on going.

In 2017, the Congress made multiple attempts to repeal, replace, or repeal and replace the law, to no avail. The attempts in 2018 to modify the Affordable Care Act (ACA) were more indirect. Litigation challenging and rescinding various aspects of the ACA continues to reign.

Spoiler Alert: On December 14, 2018, Judge Reed O'Connor of the Fifth Circuit Court of Appeals opined that the individual mandate, in the absence of the tax repealed by the Tax Cuts and Jobs Act, is unconstitutional; and since it is a cornerstone of the ACA, then the entire ACA must fall. This late breaking decision will be appealed and likely be decided by the Supreme Court. In the meantime, the ACA remains in force.

In this *Health Reform Bulletin*, we will look at the issues being considered, and contemplate where we might be going. Beyond these ruminations for the year, this edition also highlights recent pronouncements relating to the women's preventive services mandate, and an extension of the Form 1095 disclosure statements. We've also included some year-end reminders to ensure on-going compliance with the ACA, since it remains the law of the land.

The Affordable Care Act – A Year in Review

The Individual Shared Responsibility Matter

Under the ACA, beginning in 2014, virtually all Americans are required to maintain a minimum level of coverage, called minimum essential coverage (MEC), or be liable for a shared responsibility tax. However, the Tax Cuts and Jobs Act reduced the penalty tax to zero for tax years beginning on January 1, 2019, but left in place the requirement to maintain MEC.

In February, 2018, a coalition of 20 State Attorneys General from primarily Republican states led by Texas Attorney General Ken Paxton and Wisconsin Attorney General Brad Schimel filed a lawsuit with the U.S. District Court for the Northern District of Texas [*Texas v. U.S.*, 4:18-cv-001 67, U.S. District Court, Northern District of Texas (Fort Worth)] arguing that repeal of the individual tax should cause the entire ACA to fall.

In April, a coalition of 16 Attorneys General from primarily Democratic states led by California Attorney General Xavier Becerra filed an action to intervene in the lawsuit. A month later, the judge of the Texas Court granted intervention in the matter. The 20-coalition group who initiated the action sought a preliminary injunction to suspend the law while the case winds its way through the Court. In response, the Democratic coalition of State Attorneys General filed a motion in opposition to a preliminary injunction seeking to ensure all aspects of ACA remain in force while court proceedings are carried out. Oral arguments requesting a preliminary injunction in the matter of Texas v. United States were heard on September 5, 2018. As mentioned above in the *Spoiler Alert*, Judge O'Connor rendered his opinion on December 14, 2018.

On September 13, 2018, the Maryland Attorney General Brian E. Frosh filed a lawsuit in the U.S. District Court for the District of Maryland against the Departments of Health and Human Services, Treasury and Justice, seeking a declaratory judgment affirming the constitutionality of the ACA. AG Frosh argues that the benefits derived from the ACA have improved access to health care for all Marylanders by way of guaranteed access and allowing expansion of Medicaid, as well as reducing overall costs including uncompensated care costs due to community rating and cost sharing restrictions.

Cost Sharing Challenges

The ACA provides that certain low income individuals are entitled to cost share payments for certain out-of-pocket expenses. The cost-sharing reductions are monies paid to insurers to help offset co-payments and other out-of-pocket costs for certain lower income individuals whose income falls below 250% of the federal poverty level and who obtain their coverage through the marketplace.

On October 12, 2017, the Departments of Health and Human Services and Treasury, by way of a Department of Justice opinion, announced that the cost sharing reductions authorized under the ACA would cease immediately. Insurers continue to be obligated to provide these cost sharing reductions to eligible individuals but would not receive reimbursement from the federal government.

To this end, insurers have, and will, continue to incorporate this additional cost into premium. In effect, this ultimately increases the premium for coverage. For those obtaining coverage through the marketplace and receiving a premium subsidy, the increased premium will impact the amount of the federal subsidies requirement. The premium subsidy is not impacted with the rollback of the cost sharing requirements. Those not entitled to premium subsidy will feel the primary burden of the premium increase.

In the meantime, because insurers are still required by law to offer cost share reductions and absorb the costs even without government reimbursement, they were allowed to cover the loss by increasing premium on silver plans ("silver-loading") offered through the marketplaces beginning in 2018. Several states continue to bring forth challenges based on the termination of cost sharing subsidies.

A ruling by Judge Elaine D. Kaplan of the Court of Federal Claims in Montana on September 4, 2018 determined that the law does clearly and unambiguously require cost sharing payments be made pursuant to the ACA, notwithstanding Congress' failure to appropriate them; therefore, insurers are entitled to payment of cost sharing amounts.

Several actions brought by insurers, including a class action lawsuit led by Common Ground Healthcare Cooperative, are seeking reimbursements from the government over the termination of cost sharing reduction payments.

The Executive Order

An **Executive Order** issued on October 12, 2017 directed the ACA's tri-governing agencies (Departments of Health and Human Services, Labor and Treasury) to address three methods to expand health coverage: 1) formation of association health plans, 2) expand short-term, limited-duration insurance, and 3) expand the rules to allow individual premium to be reimbursed through health reimbursement arrangements (HRAs). Thus far, these agencies have fulfilled their directives by issuing blueprints for expanding all three proposals, as follows.

- *Association Health Plans*

  The Department of Labor (DOL) released finalized rules and standards for establishing association health plans (AHP) on June 21, 2018. The overall intent of these rules is to allow small employers and individuals to join together to purchase health coverage without many of the regulatory requirements otherwise imposed on small employers by the ACA. For a more detailed summary of these rules, please see our *Health Reform Bulletin 139*.

  There are a number of legal challenges being raised to these rules. Specifically, a dozen state attorneys generals have filed a lawsuit in the U.S. District Court for the District of Columbia on July 26, 2018 against the DOL challenging the formation of AHPs, based on premise that regulations circumvent requirements of ERISA which requires a commonality of interest standard.

In addition, some states have begun or are considering enacting laws limiting the formation of AHPs, while others setting up the regulatory framework to establish them.

There are also concerns that have plagued AHPs historically, e.g., misdeeds by the plan, or its sponsor or administrator, could cause a rise in fraudulent entities, leaving people with unpaid claims.

Further, the advent of these rules could push the healthier groups out of the small employer market into AHPs. Another concern is whether the plan designs offered by AHP would be less comprehensive than plans offered through the small employer insurance market, thus, leaving people with minimalist coverage, albeit perhaps, at a lower cost.

- *Short-term Limited Duration Policies*
  Under the ACA, short-term limited duration insurance policies are limited to a period of no more than three months. To achieve the goal set forth in the Executive Order, regulations were issued on August 3, 2018 expanding the duration of these policies from three months to up to 364 days, with the ability to renew, not to exceed 36 months from the origination date. See our *Health Reform Bulletin 140* for a summary of these rules.

  Notably, these short-term limited duration policies do not qualify as minimum essential coverage. Further, these policies are not required to comply with the market provisions such as limitation on preexisting condition exclusions, providing maternity and mental health benefits, the guaranteed issue and guaranteed renewal requirements, among others.

  Proponents to these regulations believe that this change would allow a cost-effective option for individuals. Opponents to this type of plan design believe they will diminish the risk pool, leaving only high risk claims individuals in the ACA marketplace.

  States can regulate the availability and scope of these policies; for example, a state could provide that a short-term policy is limited to 90 days. Several states have recently enacted laws to limit the duration of these policies to three months, as well as prohibit renewals or extensions.

  In addition, litigation relating to these types of policies has begun. On September 14, 2018, a coalition of consumer advocates and safety net health plans sued the tri-governing agencies based on the fact that these types of plans do not have to comply with the ACA's market reforms, i.e., individuals could be subject to preexisting condition exclusions, premiums based on health status, limited benefit coverage, as well as the risk of rescission of coverage.

- *Expansion of Health Reimbursement Arrangements (HRAs)*
  Pursuant to the third prong of the Executive Order, the tri-governing agencies published **proposed regulations** on October 29, 2018. Importantly, these regulations are being issued as non-reliant proposed regulations, i.e., these regulations cannot be relied upon at this time. The comment period for these regulations closes December 28, 2018, after which, the agencies will develop final regulations. At the earliest, if these regulations are finalized, they are expected to take effect for plan years beginning on or after January 1, 2020.

  In a nutshell, the proposed regulations allow two additional types of HRAs. One type of HRA would allow integration with an individual health policy. Under current law, an HRA can only be integrated with a comprehensive group health plan in order to avoid the market provisions of the ACA. The other type of HRA would allow an excepted benefit HRA with a limited dollar amount. Following is a brief summary of these two types of HRAs.

  Individual-Integrated HRA. Under this design, an employer can integrate an HRA with individual health coverage if certain conditions are met:
  1. *Enrollment in individual coverage.* To participate in the HRA, the individual must actually enroll in individual coverage for each month covered by the HRA. Individual coverage providing only excepted-benefits would not qualify for this purpose. The HRA must also provide that, subject to applicable

COBRA or other continuation of coverage requirements, if the individual health coverage terminates, the individual cannot then seek reimbursement under the HRA for claims incurred once that coverage terminates. Further, if the HRA-participant or his/her dependent loses individual coverage, then the individual would forfeit the HRA. Individuals participating in this type of HRA would be ineligible for premium assistance that might otherwise be available.

2. *No traditional group coverage allowed.* A plan sponsor who offers an HRA integrated with individual coverage to a class of employees cannot also offer traditional group health plan coverage to the same class of employees. Thus, there can be no choice between an HRA integrated with individual coverage and a traditional group plan.
3. *Same terms and conditions*. The HRA integrated with individual coverage must be offered on the same terms with regard to the amount and conditions to all participants within a class. Notably, the regulations allow age-based adjustments to the maximum amount of reimbursement, as well as adjustments if the participant adds additional dependents.
4. *Opt-out*. The HRA must allow individuals to opt-out and waive future reimbursements from the HRA at least annually. Upon termination of employment, the remaining amounts in the HRA are forfeited, or the participant is permitted to permanently opt-out of and waive future reimbursements from the HRA.

Excepted-Benefit HRA. These regulations would allow a limited purpose type of HRA to be offered to a class of employees who are offered other comprehensive group health coverage. The HRA, in this instance, could be used to reimburse up to $1,800 per year (subject to inflationary indexing) for excepted benefits such as dental and vision.

No dual HRA coverage. If these rules are finalized in their current form, no employee is eligible for both an excepted HRA and an individual-integrated HRA.

Impact on ACA's Employer Shared Responsibility Provision. The proposed HRA rules indicate future rulemaking for employers subject to the ACA's employer shared responsibility (ESR) requirement that would allow a safe harbor arrangement; thus, protecting an applicable large employer adopting this type of HRA from the risk of ESR penalties. The government continues to look for ways (see IRS Notice 2018-88) to ensure that an individual-integrated HRA could be designed to allow an employer who is subject to the ESR requirement avoid the risk of penalty by offering adequate and affordable coverage with this type of HRA. Further, the government is contemplating ways in which an individual-integrated HRA could satisfy the IRC Section 105(h) discrimination rules, currently applicable to self-funded plans.

As mentioned at the beginning of this HRA discussion, these are not reliant regulations, therefore, no action can be taken based on these regulations at this time. The current law prohibiting employers from contributing to individual premium, other than through a qualified small employer HRA (QSEHRA) or retiree-only HRA, still apply. It should also be noted that these types of proposed HRAs could be impacted by on-going ACA related litigation mentioned above; in particular, the *Texas v. United States* matter, challenging the constitutionality of the individual mandate. I suspect there will be many comments submitted on these regulations, and they are likely to evolve in the months to come. HRAs will certainly be a topic for further consideration in 2019.

Expansion of State Waiver Process

Under current law, states can apply for a waiver from certain provisions of the ACA by seeking what is known as a Section 1332 Innovation Waiver from the federal government. This type of waiver allows a state to pursue alternative approaches for coverage in the individual and small group markets, among other goals. Recently, the government **announced** the establishment of "State Relief and Empowerment Waivers". This type of waiver is intended to expand opportunities to states, and provide more flexibility in their design of providing health benefits to low income individuals.

Women's Preventive Services Update

In October 2017, the governing agencies issued two sets of interim final regulations that significantly broaden the entities entitled to receive an accommodation, or the exemption, from providing certain women's health preventive services, specifically, coverage for contraceptive services (see *Health Reform Bulletin* 133). One set

of rules provides that virtually any non-government plan, including one sponsored by closely-held and publicly traded entity, private entities, as well as institutions of higher education and private universities offering student health coverage, can either choose the accommodation, i.e., the insurer or third party administrator (TPA) would provide the services at no cost to their population for some or all of the contraceptive services, or choose to be exempt altogether from providing some or all contraceptive services. The second set of rules provides an accommodation or exemption for a slightly narrower group of entities, specifically, all non-government, non-publicly traded entities based on a moral opposition to providing contraceptive services.

On November 15, 2018, the agencies issued final regulations on this matter, which take effect on January 14, 2019. In essence, the final rules mirror the interim final regulations in that the religious and moral exemption to contraceptive services mandate is available to all non-government entities; an exemption based on moral convictions is available to all entities except government and publicly traded entities. Further, the optional accommodation process for seeking an exemption from the mandate continues to be made available.

Form 1095 Benefit Statement Issuance Date Delayed

On November 29, 2018, the IRS issued guidance (Notice 2018-94) announcing an extension for providing the 2018 Form 1095-B and Form 1095-C disclosure statements to individuals; these statements are generally due by January 31st following the reporting year. Thus, the due date for furnishing benefit statements (Form 1095-B and Form 1095-C) to individuals has been extended from January 31, 2019 to March 4, 2019. Due to this extension, there will be no further 30-day automatic extension available. Similar to prior disclosure delays issued by the IRS, the guidance provides that taxpayers can file their personal income tax return without having to attach the relevant Form 1095 to their tax returns.

As background, the Forms 1094 and 1095 are used to satisfy the IRC Section 6055 and 6056 reporting requirements (the 2018 forms are discussed in our *Health Reform Bulletin 141*). The Form 1094-B and 1095 B-series is used for reporting minimum essential coverage (MEC) by insurers and sponsors of self-funded plans. The Form 1094-C and 1095-C series is used for reporting employer provided coverage by an applicable large employer subject to the Affordable Care Act's shared responsibility requirement.

Important to note that the filing due dates of the 2018 Forms 1094-B and 1095-B, and the 2018 Forms 1094-C and 1095-C reports to the IRS have not been extended. These reports must be submitted to the IRS no later than February 28, 2019; or by April 1, 2019, if filing electronically. An automatic 30-day extension of time to file the 1094/1095 forms remains available by submitting the Form 8809 with the IRS on or before the filing due date.

In addition, this guidance reinstates the good faith compliance standard that was allowed in prior years. This means that the potential IRS-imposed penalties for failure to comply with the reporting and disclosure requirements could be reduced or waived, even if incorrect or incomplete information is reported on the return or statement, such as missing and inaccurate taxpayer identification numbers and dates of birth, as long as the responsible reporting entity makes a good faith effort to complete the required forms accurately and timely.

Year-end Reminders

- ❑ **Preventive Health Services**

  Prior to the beginning of each plan year, a group health plan sponsor or administrator should review its coverage for preventive services to determine whether any additional benefits need be offered. For insured plans, generally, the insurer manages this process.

  As background, the Affordable Care Act requires health plans to cover certain preventive services, without imposing any cost-sharing requirements (co-pay, co-insurance, or deductible), when such services are delivered by in-network providers. The types of covered preventive services, some of which are recommended by the U. S. Preventive Services Task Force (USPSTF), are updated periodically. Generally, once the USPSTF approves a particular recommendation, the service would become applicable as of the first plan year beginning one year following issuance of the recommendation. The USPSTF website provides a list of its recommended A and B preventive services by date and alphabetically. Further, a complete list of ACA-required preventive services can be accessed from the Healthcare.gov website.

Employer Shared Responsibility Provisions

- ***Applicability.*** For purposes of the ACA's employer shared responsibility requirement as well as the reporting and disclosure requirements, applicable large employer (ALE) status is determined each calendar year, based on the average size of the employer's workforce during the prior year. Thus, if you averaged at least 50 full-time employees, including full-time equivalent employees, during 2017, you are most likely an ALE for 2019 and are subject to the reporting and disclosure requirements due in early 2019.
- ***Affordability Standard.*** For purposes of determining affordability, coverage under an employer-sponsored plan is deemed affordable if the employee's required contribution to the plan does not exceed 9.86% (indexed for 2019; 9.56% in 2018) of the employee's household income for the taxable year, based on the cost of single coverage in the employer's least expensive plan.
- ***Increase in Excise Tax Penalties.*** The chart below reflects the amount of penalties for purposes of calculating the 'no coverage' excise tax pursuant to Code Section 4980H(a), and the 'inadequate or unaffordable' excise tax pursuant to Code Section 4980H(b) for 2017 and 2018, as well as the estimated amounts for 2019. These are the excise taxes that could apply if an applicable large employer is found not to have offered health coverage to a full-time employee.

'No Coverage' Excise Tax IRC § 4980H(a)		'Inadequate or Unaffordable' Excise Tax IRC § 4980H(b)	
2017	$2,260	2017	$3,390
2018	$2,320	2018	$3,480
2019 (estimated)	*$2,500*	*2019 (estimated)*	*$3,750*

- ***Reporting and Disclosure Obligations.*** The Forms 1094 and 1095 are used to satisfy the IRC Section 6055 and 6056 reporting requirements. The Form 1094-B and 1095 B-series is used for reporting minimum essential coverage (MEC) by insurers and sponsors of self-funded plans. The Form 1094-C and 1095-C series is used for reporting employer provided coverage by an applicable large employer subject to the ACA's shared responsibility requirement.
  - ✓ Forms 1094 and 1095 must be filed with the IRS by February 28, 2019 (paper filings) or, E-file by April 1, 2019.
  - ✓ As mentioned above, the deadline for furnishing the Form 1095 to individuals listed in Forms 1094 and 1095 has been extended from January 31, 2019 to March 4, 2019.

Small Business Tax Credit (SBTC).

Small businesses and tax-exempt employers who provide health care coverage to their employees under a qualified health care arrangement are entitled to a tax credit, known as the small business tax credit (SBTC). To be eligible for the SBTC, the employer must employ fewer than 25 full-time equivalent employees, whose average annual wages are less than $54,200 (indexed for 2019; the wage ceiling in 2018 is $53,200). The tax credit phases out for eligible small employers when the number of its full-time employees (FTEs) exceeds 10; or, when the average annual wages for the FTEs exceeds $27,100 in the 2019 tax year (the phase-out wage limit in 2018 is $26,600). As a reminder, only qualified health plan coverage purchased through a SHOP marketplace is available for the tax credit, and only for a 2-consecutive year period.

For purposes of calculating the SBTC, the Form 8941 is filed annually on the employer's tax return as a general business credit; tax exempt entities would file the Form 8941 with its Form 990-T. The IRS has released the 2018 edition of the Form 8941, together with instructions, for purposes of calculating the small business tax credit.

Additional ACA-related Fees

Patient-Centered Outcomes Research Institute (PCORI) Fees. For policy and plan years ending between October 1, 2017 and September 30, 2018, the PCORI fee was $2.39. The fee increases to $2.45 for policy and plan years ending between October 1, 2018 and September 30, 2019. The PCORI fees are paid annually via IRS Form 720 (generally due July 31st of each year). Under current law, the PCORI fee will no longer be assessed for policy/plan years ending on or after October 1, 2019.

Moratorium on Certain ACA Fees. As a reminder, a short-term government funding law enacted in January of this year placed moratoriums on three ACA-related fees (see *Health Reform Bulletin* 137):

- Code Section 4980I, popularly known as the **Cadillac tax** that would be assessed on the amount paid for high cost employer-sponsored health insurance coverage exceeding certain threshold levels ($10,200 for individuals; $27,500 for family, subject to indexing) which was to take effect in 2020 has been suspended until 2022.
- A one-year moratorium applies for the 2019 tax year on the **annual fee** required to be paid by 'covered entities' (insurers) who engage in providing health insurance for U.S. health risks. This fee had been suspended for the 2017 year, was reinstated for the 2018 year, and suspended again for the 2019 year.
- A two-year moratorium applies to the 2.3% **medical device excise tax** for 2018 and 2019.

❑ ACA Cost Share Restrictions

The chart below reflects the 2019 and 2018 inflationary adjustments applicable to out-of-pocket (OOP) limits including deductibles, co-insurance and co-payments in ACA plans. These cost-share restrictions apply to insured plans offered via the marketplace, and insured and self-funded plans offered outside marketplace. These amounts differ from the OOP limits applicable to high deductible health plans used in conjunction with a health savings account (HSA).

	2019		*2018*	
	SELF-ONLY	FAMILY	SELF-ONLY	FAMILY
ACA Plans - Out-of-Pocket (OOP) Limits	$7,900	$15,800	$7,350	$14,700
Health Savings Accounts	INDIVIDUAL	FAMILY	INDIVIDUAL	FAMILY
HDHP Annual Deductible	$1,350	$2,700	$1,350	$2,700
HDHP Annual Out-of-Pocket Limit	$6,750	$13,500	$6,650	$13,300
Contribution Limit	$3,500	$7,000	$3,450	$6,900

ACA-required Reporting Reminders

Form	*To Whom*	*Due Date*
Form W-2. ACA-required reporting includes: ◆ Aggregate cost of health coverage (Box 12, using Code DD). *Note, employers filing <250 Form W-2s per year remain exempt from reporting the aggregate cost of health coverage on the Form W-2 until future IRS guidance is issued.* ◆ Total amount of permitted benefits received under a qualified small employer health reimbursement arrangement (QSEHRA) (Box 12 - Code FF) ◆ Additional Medicare tax withholding on earnings exceeding $200,000 per calendar year (Box 6)	Internal Revenue Service (IRS) http://www.irs.gov/ Form W-2 Instructions (2018)	January 31, 2018
Form 720 for purposes of Patient Centered Outcome Research (PCOR) fee	IRS	July 31st of each year

Additional ACA-Related Disclosure Reminders

Note: This is not an exhaustive list of ACA-required disclosures. For a more descriptive list of notice obligations relating to the ACA and other welfare benefit plans, ask your CBIZ representative for a Chart of Notice Obligations.

Form	*To Whom*	*Due Date*
Summary of Benefits and Coverage (SBC) *Note: SBC template available from Department of Labor (DOL) and CMS Center for Consumer Information & Insurance Oversight (CCIIO)*	All plan participants	From Plan Sponsor to Plan Participants: 1. Upon application 2. By the first day of coverage 3. Within 90 days of enrollment by special enrollees 4. Upon contract renewal 5. Upon request
Advanced 60-day Notice of Material Change in Benefits	All plan participants	No later than 60 days prior to any material change in any terms of plan affecting Summary of Benefits and Coverage (SBC) content not reflected in the most recently-provided SBC (other than in connection with renewal or reissuance of coverage)
Notice of Marketplace Options ◆ Model notice for use by employers **who offer coverage** to some or all employees: ▪ English (**pdf** or **word**) ▪ Spanish (**pdf** or **word**) ◆ Model notice for employers who **do not offer health coverage:** ▪ English (**pdf** or **word)** ▪ Spanish (**pdf** or **word**)	All new hires including full-time and part-time employees, without regard to eligibility status for the health plan	Within 14 days of date of hire

Increased Penalties for Certain Compliance Violations

Federal government agencies who enforce the ACA, including the Departments of Labor, Treasury and Health and Human Services, have authority to adjust civil penalties attributable to compliance failures. As a general rule, the DOL announces its respective adjusted penalties in January of each year; thus, at the time of this writing, the 2019 amounts have not been announced yet, and designated "to be determined"(TBD) below.

	2019 Penalty Amount	*2018 Penalty Amount*
Failure to provide Summary of Benefits and Coverage	TBD *(minimum of 2018 amount)*	Up to $1,128 per failure
Failure to file a correct information return *(Example: Form 1094/1095 and W-2)*	$270 per return (total penalty cap of $3,339,000 per calendar year)	$270 per return (total penalty cap of $3,275,500 per calendar year)
Failure to provide correct payee statement *(Example: Forms 1094/1095 and W-2)*	$270 per statement (total penalty cap of $3,339,000 per calendar year)	$270 per statement (total penalty cap of $3,275,500 per calendar year)

The information contained herein is not intended to be legal, accounting, or other professional advice, nor are these comments directed to specific situations. The information contained herein is provided as general guidance and may be affected by changes in law or regulation. The information contained herein is not intended to replace or substitute for accounting or other professional advice. Attorneys or tax advisors must be consulted for assistance in specific situations. This information is provided as-is, with no warranties of any kind. CBIZ shall not be liable for any damages whatsoever in connection with its use and assumes no obligation to inform the reader of any changes in laws or other factors that could affect the information contained herein.

Subject: **1) Status of ACA Litigation; 2) Murky Future of AHPs; 3) Benefit and Payment Parameters for 2020; and 4) Extended Transition Period for ACA Compliant Policies**

Date: May 10, 2019

Status of ACA Litigation

Litigation challenging and rescinding various aspects of the Affordable Care Act (ACA) continues to reign. Last December, Judge Reed O'Connor of the Fifth Circuit Court of Appeals opined that the individual mandate, in the absence of the tax repealed by the Tax Cuts and Jobs Act, is unconstitutional; and since it is a cornerstone of the ACA, then the entire ACA must fall (see our prior CBIZ Health Reform Bulletin 142). Briefs to appeal the Court's ruling were submitted on May 1, 2019 by a collective group of State Attorneys General, as well as individuals. Of particular note, the Department of Justice (DOJ) also filed its brief stating that it would no longer defend any aspects of the law whereas previously, the DOJ indicated it would defend certain aspects of the law. Oral arguments on the matter is expected to begin the week of July 8, 2019.

Meanwhile, the law continues to be in full force and effect.

Murky Future of Association Health Plans

The future of formation and operation of association health plans is in a state of quagmire. Last year, the Department of Labor (DOL) released rules to permit formation of an amplified version of association health plans. For an overview of these rules, see our CBIZ Health Reform Bulletin 139 (6/22/18) and the update contained in HRB 142 (12/14/18). While newly formed association health plans have been established pursuant to the amplified rules, there are a number of legal challenges being raised.

As background, generally, ERISA applies to single employer welfare benefit plans. A single employer includes a group of commonly controlled entities, as defined in IRC Section 414. When two or more unrelated employers participate in a single health benefit plan, a multiple employer welfare arrangement (MEWA) exists. In this instance, ERISA applies at the individual employer level unless the MEWA qualifies as a bona fide association. To qualify as a bona fide association, two requirements must be satisfied; a commonality of interest requirement, and a control test, as follows:

1. The *commonality of interest* requirement provides that the entity maintaining the bona fide association and the participating employers, must be tied by a common economic or representational interest beyond simply the provision of benefits. This is a facts-and-circumstances test; some of the factors considered in determining the commonality of interest test are:
    - How does the bona fide association solicit members?
    - Who is entitled to participate? Who actually participates?
    - How is the bona fide association formed?
    - What is the bona fide association's purpose?
    - What is the relationship of the participating members beyond the bona fide association membership?
2. The *control test* requires that the individual employer-members have the right to control and direct the activities of the plan, i.e., the bona fide association cannot exist for the primary purpose of offering health coverage.

If these two tests are not satisfied, then ERISA applies at the individual employer level. This means that each participating employer-member is responsible for its own 5500 requirement, its own disclosure requirements, such as plan documentation, summary plan descriptions, summary of material modifications, HIPAA compliance documents, compliance with the ACA, and so forth. The participating employer-members could appoint the association as plan administrator, which would make the association responsible for these disclosures. Conversely, if ERISA applies at the association level, then the association is responsible for these disclosures.

Amplified Association Health Plans

The regulations issued last summer expand the current criteria for establishing a bona fide association plan (referred to herein as "amplified AHP") wherein ERISA would apply at the association level. These rules are intended to make it easier to satisfy the commonality of interest test for participating employers by limiting the standards to either a common geographic area or by common industries. Further, the regulations relax the control requirement test by indicating that the primary purpose of the association can be to provide group health benefits. Self-employed individuals are able to participate in these types of amplified AHPs even if the self-employed individual employs no employees.

A group or association of employers can establish an amplified AHP as long as it meets the following requirements:

1. The primary purpose of the group or association is formed for the purpose of offering and providing health coverage to its employer-members and their employees. While the primary purpose of an amplified AHP can be to offer employer-members health coverage, it must also have at least one *substantial business purpose* unrelated to offering and providing health coverage or other employee benefits, such as promoting common business or economic interest in a given trade or employer community. In addition, employer-members must meet a *commonality of interest standard*. This means that the employer-members be:
    - In the same trade, industry, line of business or profession; or
    - Each employer-member has a principal place of business in the same state or metropolitan area, even if it crosses state-lines, such as in the Washington D.C. or Kansas City metropolitan areas.
2. The functions and activities of the group or association, as well as the plan itself, is controlled by its participating employer-members. For this purpose, "control" is determined by a facts and circumstances test.

Legal Challenges

Following release of the DOL rules, 11 states and the District of Columbia challenged the authority of these amplified AHP regulations in *State of New York et al. v. United States Department of Labor et al* (Civ. Action 18-1747, D.C. D.C]). On March 28, 2019, the U. S. District Court for the District of Columbia ruled on the matter.

First, the Court found that the DOL exceeded its authority in the broadened definition of "association". Of particular concern to the Court is the lack of any significant commonality of interest standard as required by ERISA. As noted above, amplified AHPs can be established specifically for the purpose of providing health coverage, whereas ERISA requires bona fide association health plans to exist independent of the provision of health care. Further, the Court took exception with the new rules permitting self-employed individuals to participate in an amplified AHP because, by its very nature, ERISA is intended to specifically protect employee-participants.

The Court deemed certain parts of the amplified AHP regulations be vacated, i.e., held invalid; specifically, the broadened definition of "bona fide group or association of employers" and the "commonality of interest" provisions contained in the definition of employer, and the provisions relating to "dual treatment of working owners as employers and employees".

The Court returned the amplified AHP regulations to the Department of Labor (DOL) for further consideration. Following the Court's ruling, the DOL released a statement of its position, together with FAQs, relating to the effect of the court ruling on the matter. Accordingly, the agency intends to work with HHS, the states and other affected parties to minimize consequences of the conflict in the following ways:

- Insured AHPs formed in accordance with the DOL's amplified AHP regulations issued last year can continue coverage in force through the end of the plan year (or if later, the contract term). Beyond the end of the plan year or contract term, the coverage could be subject to ACA's insurance market reform rules applicable to small employer plans, essential health benefits, and premium rating rules.
- The DOL intends to make efforts to ensure claim payments incurred by current participants and beneficiaries covered under an amplified AHP are made.
- Further, no enforcement action will be made by the DOL for potential violations, as long as benefit claims continue to be made; and, as long as the amplified AHP-members show good faith reliance on the broadened rules through the end of the applicable plan year or contract term.

The future of existing AHPs formed in accordance with the amplified AHP regulations issued last year remains uncertain. Stay tuned for developments.

Benefit and Payment Parameters for 2020

The Department of Health and Human Services published its finalized **Benefit and Payment Parameters for 2020** on April 25, 2019, together with a **Fact Sheet**. These uniform standards, as required under the Affordable Care Act, are intended for health insurers and the marketplace to ensure health coverage options for consumers, as well as provide planning guidance for insurers and employers. Following are highlights of these rules:

- **Cost-sharing limits**. The ACA imposes certain cost-sharing restrictions, such as deductible and out-of-pocket limits on health plans. These annual out of pocket limits apply to insured plans offered through the marketplace, and insured and self-funded plans offered outside marketplace. Below are cost sharing limitations for 2018 through 2020:

	Self-only Coverage (Individual)	*Other than Self-only Coverage (Family)*
2018	$7,350	$14,700
2019	$7,900	$15,800
2020	$8,150	$16,300

  As a reminder, the out-of-pocket (OOP) limits applicable to a high deductible health plan (HDHP) used in conjunction with a health savings account (HSA) differs from these ACA-imposed cost sharing limits. For 2019, the OOP limit for HDHP plans is $6,750 for single coverage; $13,500 for family coverage. It is anticipated that the IRS will release the 2020 inflationary adjustments applicable to HSAs in the near future.

- **Affordability standard – individual coverage**. The required contribution percentage by individuals for minimum essential health coverage (MEC) for purposes of determining eligibility for a hardship exemption under the individual shared responsibility requirement (IRC Section 5000A) occurs if the cost to the individual to purchase coverage exceeds 8.24% for 2020 (decreased from 8.30% in 2019) of household earnings.

  This affordability standard is distinct from the employer's shared responsibility affordability standard, and distinct from the affordability standard for purposes of entitlement to premium assistance. For 2019, coverage under an employer-sponsored plan is deemed affordable to a particular employee if the employee's required contribution to the plan does not exceed 9.86% of the employee's household income for the taxable year, based on the cost of single coverage in the employer's least expensive plan.

- **Prescription Drugs.** Beginning in 2020, an insurer issuing both individual and group health plans of any size can, but is not obligated to, count manufacturer offsets, such as coupons and the like, toward an individual's maximum out-of-pocket limit under the health plan if there is a medically-appropriate generic drug available. The insurer cannot adopt these so-called accumulator programs if there is no generic equivalent available.

- **Benchmark Plan Designs.** Under current law, states can utilize one of several plan design categories for defining essential health benefits (EHB). A plan is permitted to use any of the 51 state-based benchmark plans, or the Federal Employee Health Benefit Plan benchmark plan to make its EHB determination.

The final 2020 benefit and payment parameters maintains these standards; as such, for plan years 2020 and beyond, states have the following additional options for selecting an EHB-benchmark plan. A state can:

- Select one of the 50 EHB-benchmark plans used by other states for the 2017 plan year;
- Replace one or more of the ten required EHB categories of benefits under its own benchmark plan used for the 2017 plan year, with the same categories of benefits from another state's EHB-benchmark plan used for the 2017 plan year; or
- Select a set of benefits tailored as its own EHB-benchmark plan, as long as it meets the scope of benefits requirements and other specified requirements, as outlined in separate CMS guidance.

It is important to remember that a self-funded plan, even though it is not required to comply with all EHBs, must select a safe harbor benchmark plan against which it measures EHBs that it does, in fact, offer. This is relevant for a number of ACA purposes including restrictions relating to cost-sharing, annual and lifetime limits and preexisting condition exclusions.

- **Annual Open Enrollment Period.** For the 2020 plan year, the annual open enrollment period for obtaining coverage through the federal marketplace will run from November 1, 2019 through December 15, 2019. State marketplaces may have different open enrollment periods.

- **Special Enrollment Periods.** The final benefit and payment parameter rules establish a new special enrollment period for individuals who enroll in "off-exchange" individual coverage, and experience a sudden decrease in household income and are determined to be newly eligible for the advanced premium tax credit. The individual would have a 60-day special enrollment window, and must provide proof of the change in income, as well as proof of prior minimum essential coverage.

- **Federal Exchange User Fees.** Insurers participating in the federal marketplace are subject to a user fee to help pay for the operational expenses of the marketplace. For 2020, the user fee rate is reduced to 3.0% (3.5% for 2019) of the monthly premium charged by the insurer. Insurers in state-based exchanges that use the federal exchange platform will be charged 2.5% (down from 3.0% in 2019).

Extended Transition Period for ACA Compliant Policies

Certain so-called 'grand-mothered' policies in the individual and small group markets that are not grandfathered and have enjoyed exemption from some of the ACA's insurance market reform provisions since January 1, 2014. The CMS' Center for Consumer Information and Insurance Oversight has extended the exemption several times, and granted another exemption on March 25, 2019.

Accordingly, individual and small group health policies renewing prior to October 1, 2020 (but ending by December 31, 2020) can be renewed, free from many of the ACA's market reforms, including:

- Fair health insurance premiums;
- Guaranteed availability of coverage;
- Guaranteed renewability of coverage;
- Prohibition of pre-existing condition exclusions or other discrimination based on health status with respect to adults, except with respect to group coverage;
- Prohibition of discrimination against individual participants and beneficiaries based on health status except with respect to group coverage;
- Non-discrimination in health care;
- Comprehensive health insurance coverage; and
- Approved clinical trials.

Unless extended again, or if changes are made by Congress or the Administration in the interim, beginning January 1, 2021, these policies must be ACA-compliant.

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Subject: **1) Health Reimbursement Arrangements – Summary of Final Rules; 2) PCORI Annual Fee Reminder and 3) Nationwide Permanent Injunction Ordered for Certain Women's Health Preventive Services**

Date: June 18, 2019

Health Reimbursement Arrangements - Summary of Final Rules

Two new types of health reimbursement arrangements (HRA) are sanctioned by **final regulations**, scheduled to be published on June 20, 2019.

As a result of an Executive Order issued on October 12, 2017, the Affordable Care Act's tri-governing agencies (Departments of Health and Human Services, Labor and Treasury) were charged with developing regulations to expand existing rules to allow individual premium to be reimbursed through health reimbursement arrangements (HRAs). The tri-governing agencies released a set of non-reliance proposed regulations on October 29, 2018 (summarized in CBIZ HRB 142), setting forth the framework for two additional types of HRAs:

- Individual-Coverage HRA ("IC-HRA"): An individually integrated HRA used with individual health coverage obtained via public marketplace or private market
- Excepted Benefit HRA ("EB-HRA"): A new type of stand-alone HRA that can be used to pay out-of-pocket medical expenses

As background, an HRA is a self-funded health plan funded strictly with employer dollars. These monies can be used to pay qualified medical expenses. Because an HRA is a health plan, it is generally subject to all of the market provisions of the Affordable Care Act. By design, an HRA is not compliant with certain aspects of these market provisions.

Existing Integrated HRAs

Previously issued guidance affirms that as long as an HRA is integrated with a comprehensive group health plan, then it would be deemed to satisfy the market provisions of the ACA. The two types of integration are known as *minimum value integration* and *no minimum value integration*. In both methodologies, the HRA can only be available to individuals actually covered by an ACA-compliant plan. For both methodologies, an ACA-compliant plan can be that of the employer sponsoring the HRA (the individual's employer), or it can be a plan offered by another employer, such as a spouse's employer. Also for both methodologies, the individual must be given the opportunity, at least annually, to permanently waive participation in the HRA.

- In the *no minimum value integration*, the HRA is limited to reimbursing co-pays, co-insurance, deductibles, and premiums of the ACA compliant plan with which the HRA is integrated. In addition, the HRA may reimburse medical expenses that do not qualify as essential health benefits.
- In the *minimum value integration*, the ACA compliant plan with which the HRA is integrated must meet minimum value (MV) standard. Minimum value means that the plan covers at least 60% of the cost of medical services. Unlike the no minimum value HRA, it can reimburse any medical expense permitted by IRC §213(d).

In addition, a retiree-only HRA, one that only covers fewer than two participants who are active employees, is generally exempt from the market provisions of the ACA' and therefore, need not be integrated with a comprehensive health plan.

The existing integration rules created an issue with regard to individual health insurance policies. The *21st Century Cures Act* provided for the establishment of qualified small employer HRAs (QSEHRA) to allow certain small employers (one who employs fewer than 50 employees and does not offer group health insurance) to establish a stand-alone HRA, beginning January 1, 2017. Such QSEHRA can be used for paying or reimbursing medical expenses, including premium for health coverage through the individual market, incurred by their eligible employees and their family members. For a summary of QSEHRAs, see our prior CBIZ HRB 134 and HRB 124.

Two New Types of HRAs

Beginning in January 2020, employers can choose to offer an HRA integrated with individual coverage (IC-HRA), or an excepted benefit HRA (EB-HRA). Following is a brief look at these new HRAs.

Individual Coverage HRA (IC-HRA)

An HRA integrated with individual coverage, whether obtained through or outside marketplace, is known as an IC-HRA. Individual health coverage also includes Medicare Parts A, B, C and D policies (only permissible if the Medicare secondary payor rules do not apply). Coverage that does not qualify as individual coverage for purposes of an IC-HRA are short-term, limited duration insurance, or coverage consisting solely of dental, vision, or similar "excepted benefits."

Enrollment in individual coverage. To participate in the HRA, the individual must actually enroll in individual coverage for each month covered by the HRA. Individual coverage providing only excepted-benefits would not qualify for this purpose. The employer offering an IC-HRA must obtain an attestation from HRA participants and their dependents that the individual is, in fact, covered by acceptable individual coverage for the plan year. Such attestation must be accomplished on an annual basis. Further, IC-HRA participants are required to substantiate individual coverage each time reimbursement is sought. See *Procedures for proof of coverage and substantiation of medical expenses*, below.

New special enrollment period. A new 60-day special enrollment period will be made available in the individual market for those who become newly eligible for participating in an IC-HRA. This is intended to facilitate enrollment in individual coverage since that is a requirement for participating in an IC-HRA.

No traditional group coverage allowed. A plan sponsor who offers the IC-HRA to a particular class of employees cannot also offer traditional group health plan coverage to the same class of employees. Thus, there can be no choice between participating in an IC-HRA and a traditional group plan.

Same terms and conditions. An IC-HRA must be offered on the same terms with regard to the amount and conditions to all participants within a class (see *Permitted Classes of Employees*, below). The employer funding must be uniform, but there can be differences based on family size and age, as long as the oldest age classification is no more than three times the youngest age classification.

Opt-out. The HRA must allow individuals to opt-out and waive future reimbursements from the HRA at least annually. Upon termination of employment, the remaining amounts in the HRA are forfeited, or the participant is permitted to permanently opt-out of and waive future reimbursements from the HRA.

Affordability. The regulations include a complex formula for determining whether an IC-HRA is affordable for purposes of eligibility for marketplace premium assistance. According to these regulations, for purposes of determining affordability, the employer's annual contribution to the IC-HRA for monthly single coverage amount, minus the monthly premium for the lowest-cost silver plan for self-only coverage cannot exceed 9.86% (indexed for 2020) of an individual's household earnings. Presumably, the current three safe harbors available for employer shared responsibility purposes (federal poverty level, rate of pay, or W-2) could be used for the IC-HRA affordability standard. It is expected that future guidance will clarify this, as well as provide a methodology that could be used by employers subject to the employer's shared responsibility provisions.

Procedures for proof of coverage and substantiation of medical expenses. The HRA must establish procedures for individuals to verify their enrollment in individual health coverage for the plan year. Proof of coverage can be obtained by third party, or written attestation by the individual indicating the insurer and dates of coverage. The HRA must also establish a procedure for participants to substantiate medical expenses when seeking reimbursement. The DOL provides a model attestation (available in both **word** and **pdf** format) for both the annual and on-going substantiation of coverage that can be used for this purpose.

Notice requirement. Written notice about the availability of the HRA must be provided to eligible individuals at least 90 days prior to the beginning of each plan year, as well as when an individual becomes eligible mid-year. The regulations set forth the contents that must be included in the notice such as the maximum dollar amount available, conditions for reimbursement, the required proof of individual coverage, a statement that the individual coverage is not subject to ERISA, the right to opt-out, information relating to the premium tax credit, among other content requirements. The DOL provides a model notice that can be used for this purpose (available in both **word** and **pdf** format). The information contained in the model notice must be customized to the particular HRA.

Use of salary reduction via cafeteria plan. In the event that individual policy premium cannot be paid in full with IC-HRA dollars, the balance could be paid by salary reduction dollars through a Section 125 (cafeteria) plan, but only for individual policies purchased outside the marketplace.

However, there are reasons why allowing individual premium paid through a Section 125 cafeteria plan is not prudent, one of which is employer sponsorship. The regulations provide that individual policies integrated with IC-HRA will not be deemed employer-sponsored as long as the employer is not, in any way, involved with endorsing, paying for, mandating or encouraging use of the policy.

Loss of individual coverage. The HRA must provide that, subject to applicable COBRA or other continuation of coverage requirements, if the individual health coverage terminates, the individual cannot then seek reimbursement under the HRA for claims incurred once that coverage terminates. Further, if the HRA-participant or his/her dependent loses individual coverage, then the individual would forfeit the HRA. Individuals participating in this type of HRA would be ineligible for premium assistance that might otherwise be available.

Excepted Benefit HRA (EB-HRA)

An excepted benefit HRA (EB-HRA), unlike an IC-HRA, can be made available to individuals who are eligible for comprehensive group health coverage. As such, the HRA would not be subject to the ACA market reform rules.

In this type of arrangement, the HRA must provide up to $1,800 in benefits per year (subject to inflationary indexing) to reimburse expenses for excepted benefits. As is true for all HRAs, only qualifying medical expenses can be reimbursed. While generally premium cannot be reimbursed from an EB-HRA other than COBRA premium, excepted benefit premium, such as vision and dental premium, and in limited circumstances, premium for short term limited duration insurance policies, is permissible.

The EB-HRA cannot be an integral part of the group plan and must be made available to all employees of a class (see *Permitted Classes of Employees*, below).

Permitted Classes of Employees

For purposes of both types of HRAs, permissible classes of employees include:

- Full-time, part-time and seasonal employees;
- Employees working in the same geographic location (generally, the same insurance rating area, state, or multi-state region);
- Employees in a unit of employees covered by a particular collective bargaining agreement;
- Employees who have not satisfied a waiting period;
- Non-resident aliens with no U.S.-based income;
- Salaried workers and non-salaried workers (such as hourly workers);
- Temporary employees of staffing firms; or
- Any group of employees formed by combining two or more of these classes.

The HRA could also be offered to former employees, however, if it is offered to one or more former employees within a class of employees, then the HRA must be offered to the former employees on the same terms as to all other employees within the class.

Generally, class determination is based on the common law status of an employer. This is true even if the employer is part of a control group. For determining certain classes of employees, for example, full-time vs part-time employees, employees located within certain geographic areas, or salary vs hourly employees, a minimum class size equally the lesser of 20 employees, or 10% of the workforce, must be satisfied. This is to ensure that employers do not establish small classes targeted at certain populations.

No dual HRA coverage

An employee cannot participate in both an IC-HRA and an EB-HRA.

Conclusion

These regulations are complex and demand significant analysis, not only by employers considering offering these new types of HRAs, but also much must be discerned by the ACA marketplaces, as well as the individual insurance industry. Certainly additional guidance will be issued, and time will tell how much traction these types of HRAs achieve.

PCORI Annual Fee Reminder

The July 31st deadline for reporting and payment of the ACA's Patient-Centered Outcomes Research Institute (PCORI) fee is fast approaching.

Virtually, all health plans, whether insured or self-funded, are subject to these fees. The PCORI fee is assessed on the average number of lives covered under the policy or plan. For policy and plan years ending between October 1, 2018 and September 30, 2019, the fee is $2.45 per covered life.

The fee is to be paid in connection with filing the IRS Form 720, *Quarterly Federal Excise Tax Return*. For insured plans, the insurer is obligated to file the Form 720 by July 31st following the close of the policy year. For self-funded plans, the plan sponsor is obligated to file the Form 720 by July 31st of the calendar year following the plan year end.

For calendar year plans, the 2018 filing due by July 31, 2019 will be the last filing, absent any change in the law, and assuming no short plan year in 2019. For plan or policy years ending on or before September 30, 2019, the last filing will be due by July 31, 2020.

As a reminder, the PCOR fee is an employer responsibility and cannot be paid from plan assets, including participant contributions.

For additional information about the PCOR fee, see the IRS' webpage, Questions and Answers and Chart of Plans Subject to the Fees.

Nationwide Permanent Injunction Ordered for Certain Women's Health Preventive Services

The ACA's contraceptive services mandate has been fraught with legal challenges and litigation since the enactment of the law. The law itself exempts church plans sponsored by a qualified religious employer. Further litigation and regulatory action over the years provided exemptions for non-government plans.

Final regulations issued by the ACA's tri-governing agencies (Departments of Labor, Health and Human Services and Treasury) that provide for an exemption and accommodation process took effect on January 14, 2019. These rules provide that virtually any non-government plan, including one sponsored by closely-held and publicly traded entities, private entities, as well as institutions of higher education and private universities offering student health coverage, to opt out of some or all of the contraceptive mandates, either through seeking an accommodation process, or by exempting itself through a self-certification process.

An accommodation or exemption option is also available for a slightly narrower group of entities, specifically, all non-government, non-publicly traded entities based on a moral opposition to providing contraceptive services.

The same day the final rules took effect, a nationwide preliminary injunction to block enforcement of the final regulations was ordered by courts in California and Pennsylvania. The California injunction applies to the 13 states involved in the lawsuit, while the Pennsylvania injunction applies nationwide. These injunctions are now on appeal in the Ninth and Third Circuits.

Then, on June 5, 2019, Judge Reed O'Connor of U.S. District Court for the Northern District of Texas issued a nationwide permanent injunction against the contraceptive services mandate. The injunction is based on the premise that the imposition of requiring individual and group health plans sponsored by religious entities to comply with the contraceptive services mandate or to seek the accommodation process violates the Religious Freedom Restoration Act. This injunction means that the contraceptive services mandate will not be enforced against any individual or group coverage objecting to mandate based on religious grounds.

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Health Reform Bulletin

CBIZ

Subject: 1) 2020 Indexed Adjustments for MEC and ESR Penalties; 2) Proposed Rules for Individual Coverage Health Reimbursement Arrangements; and 3) FAQ Guidance Clarifies Cost Sharing – Prescription Drug Coupons

Date: October 9, 2019

2020 Indexed Adjustments for Minimum Essential Coverage (MEC)

In Revenue Procedure 2019-29, the Internal Revenue Service released certain affordability standards for 2020 as they apply to the Affordable Care Act (ACA), as follows:

- **Affordability Standard – Employer Shared Responsibility Mandate**

  Coverage under an employer-sponsored plan is deemed affordable to a particular employee if the employee's required contribution to the plan does not exceed 9.78% (indexed for 2020; decreased from 9.86% in 2019) of the employee's household income for the taxable year, based on the cost of single coverage in the employer's least expensive plan.

  As background, employers subject to the ACA's employer shared responsibility mandate who fail to offer minimum essential coverage to their full-time employees or fail to offer adequate and affordable coverage may be subject to an excise tax if at least one of its employees qualifies for premium assistance through a marketplace. If an employer does not know an individual's household earnings, it can use one of three safe harbors for purposes of determining affordability; they are:

  1. A *Form W-2 determination* in which the employer's lowest cost self-only coverage providing minimum value does not exceed 9.86% (for 2019; 9.78% in 2020), of the employee's Form W-2 wages (Box 1) for the calendar year.

  2. A *rate of pay method* in which the minimum value cannot exceed 9.86% (for 2019; 9.78% in 2020), of an amount equal to 130 hours, multiplied by the employee's hourly rate of pay as of the first day of the coverage period. For salaried employees, the monthly salary is used instead of the 130 hour standard. An employer can apply this method to hourly employees if they experience a reduction in pay during the year; however, this methodology cannot be used for commissioned sales people.

  3. A *Federal poverty line (FPL) standard* in which cost of single coverage does not exceed 9.86% (for 2019; 9.78% in 2020) of the individual federal poverty line rate for the applicable calendar year, divided by twelve. An employer is permitted to use the poverty guidelines in effect six months prior to the beginning of the plan year. The Department of Health and Human Services released the 2019 FPL standards in January, 2019 (see *2019 Federal Poverty Level Guidelines, Benefit Beat*, 2/12/19).

Plan Calendar Year	Prior Year's Federal Poverty Level (1 Person Household)	Affordability Percentage	Maximum Monthly Contribution (Self-Only Coverage
2020	$12,940	9.78%	$101.79
2019	$12,140	9.86%	$99.75
2018	12,060	9.56%	$96.08

- **Premium Tax Credit.** The following contribution percentages are used to determine whether an individual is eligible for a premium tax credit for the 2019 and 2020 tax years:

Household income percentage of Federal Poverty Line)	Initial percentage *2019*	Final percentage *2019*	Initial percentage *2020*	Final percentage *2020*
Under 133%	2.08%	2.08%	2.06%	2.06%
Between 133% and 150%	3.11%	4.15%	3.09%	4.12%
Between 150% and 200%	4.15%	6.54%	4.12%	6.49%
Between 200% and 250%	6.54%	8.36%	6.49%	8.29%
Between 250% and 300%	8.36%	9.86%	8.29%	9.78%
Between 300% and 400%	9.86%	9.86%	9.78%	9.78%

Employer Shared Responsibility Penalties for 2020

The amount of penalties for purposes of calculating the 'no coverage' excise tax (Code Section 4980H(a)), and the 'inadequate or unaffordable' excise tax (Code Section 4980H(b)) is subject to annual indexing. Below is a chart reflecting the penalties for 2018 to 2020. These amounts are based on the HHS inflationary percentage contained in its annual benefit and payment parameter standards for the relevant year, and as officially released by the Internal Revenue Service.

'No Coverage' Excise Tax IRC Section 4980H(a)		*'Inadequate or Unaffordable' Excise Tax IRC Section 4980H(b)*	
2018	$2,320	2018	$3,480
2019	$2,500	2019	$3,750
2020	$2,570	2020	$3,860

Proposed Rules for Individual Coverage Health Reimbursement Arrangements (IC-HRA)

An individual coverage health reimbursement arrangement (IC-HRA) is an arrangement that is integrated with individual health coverage.

An Executive Order issued on October 12, 2017 called for expansion of existing rules to allow individual premium be reimbursed through health reimbursement arrangements. A set of non-reliance proposed regulations were issued on October 29, 2018 (summarized in *CBIZ Health Reform Bulletin 142*), setting forth the framework for two new additional types of HRAs:

- Individual-Coverage HRA ("IC-HRA"): An individually integrated HRA used with individual health coverage obtained via public marketplace or private market
- Excepted Benefit HRA ("EB-HRA"): A new type of stand-alone HRA that can be used to pay out-of-pocket medical expenses

The IRS issued implementation regulations for establishing these new types of HRAs on June 20, 2019 (see *CBIZ Health Reform Bulletin 144*). These rules apply to plan years beginning on or after January 1, 2020.

In a nutshell, an IC-HRA is deemed to be minimum essential coverage (MEC) for ACA purposes, as long as all of the requirements of an IC-HRA are satisfied. Employers of any size can offer an IC-HRA, which raises a question for an employer subject to employer shared responsibility requirements about how it can satisfy its obligations. As a reminder, an employer employing 50 or more full-time employees, while not required to offer health coverage to its employees, may be at risk of a tax penalty if adequate and affordable coverage is not offered to its full-time employees.

To provide clarification about this issue, the IRS published **proposed reliant regulations** on September 30, 2019. These regulations address two general topics, as further discussed below: the IC-HRA coordination with employer shared responsibility provisions, and the IC-HRA integration with the Code Section 105(h) discrimination rules.

Coordination with Employer Shared Responsibility Provisions

Generally, an IC-HRA will be deemed minimum essential coverage (MEC), as defined by the ACA. Therefore, if an employer offers an IC-HRA compliant plan, this should satisfy the Code Section 4980H(a) offer of MEC requirement. The question then becomes, *how can an employer satisfy the adequate and affordability requirement, i.e., the plan meets the minimum value standard that requires the plan to cover a minimum of 60% of the total allowed cost of benefits expected to be incurred under the plan, and the affordability standard, in order to avoid the risk of an IRC Section 4980H(b) penalty?*

According to these regulations, if IC-HRA meets affordability standards described below, it will be deemed to meet minimum value standard. As mentioned above, coverage under an employer-sponsored plan is deemed affordable to a particular employee if the employee's required contribution to the plan does not exceed 9.78% (indexed for 2020) of the employee's household income for the taxable year, based on the cost of single coverage in the employer's least expensive plan.

AFFORDABILITY SAFE HARBORS

Under an IC-HRA, the affordability standard is based on the excess of premium for self-only coverage under the lowest cost silver plan offered in the rating area where the employee resides, over the self-only amount the employer makes newly available to the employee under the IC-HRA. Notably, it is only new amounts added each year that are considered in the calculation of the employee's cost. If this amount does not exceed the indexed household income threshold, then the IC-HRA is deemed affordable. For this purpose, the employer can use any of the three safe harbors currently available, as outlined above (the Form W-2 determination, the rate of pay method, or the federal poverty line standard).

For purposes of determining the lowest cost silver plan for a location, the CMS Center for Consumer Information and Insurance Oversight (CCIIO) provides a "**Premium Lookup Tool**" (and related data dictionary) that can be used by individuals and employers. This tool allows users in states participating in the federal marketplace and state-based marketplaces using the federal platform to access the lowest cost silver plan data by geographic location. The CCIIO is working with states that operate their own marketplace platforms to provide similar information.

To illustrate the affordability calculation for purposes of an IC-HRA, following is one of several examples provided by CCIIO that is based on the employee's residence:

- *Jane (single, no dependents) estimated household income in 2020 is $51,000.*
- *Jane's employer offers its employees an IC-HRA starting on January 1, 2020 that reimburses $2,400 of medical care expenses for single employees with no children.*
- *The self-only monthly premium for the lowest cost silver plan (LCSP) offered through the marketplace for the rating area where Jane resides is $500.*
- *Jane's required contribution is $300, which is lower than the product of the required contribution percentage and her household income divided by 12.*
  The calculation would be:
  - *$500 - $200 = $300 (Jane's required contribution: self-only LCSP monthly premium – monthly ICHRA amount)*
  - *($51,000 x .0978)/12= $415.65 (1/12th of the product of Jane's household income for the tax year and the required contribution percentage)*

In this example, the ICHRA is deemed affordable, and Jane would not be eligible for the premium tax credit.

LOCATION SAFE HARBOR

These regulations propose that the employer can use the lowest cost silver plan rate, or the employment location to which the individual is required to report; thus, reducing the number of locations that the employer needs to calculate.

LOOK-BACK MONTH SAFE HARBOR

The proposed rules also provide a look-back month safe harbor wherein an employer with a calendar year plan can use the lowest cost silver plan for self-only coverage for January of the prior year. For a non-calendar year plan, the employer can use the lowest cost silver plan for January of the current year.

AGE-BASED SAFE HARBOR

These proposed rules do not include an age-based safe harbor. The IRS is seeking comments about how to coordinate this type of calculation with the current premium tax credit rules. Some suggested proposals are to use the lowest cost silver plan for the lowest age band in the individual market based on the employee's location, or calculate the rate based on the employee's age on the first day of the IC-HRA plan year.

Application of Code Section 105(h) Discrimination Rules

Generally, an HRA is self-funded health plan subject to the Code Section 105(h) discrimination rules which impose tax consequences if a plan discriminates in favor of highly compensated employees. According to these proposed regulations, an IC-HRA that only reimburses individual health premium will be exempt from these rules. If the IC-HRA reimburses expenses such as deductibles, co-pays, and the like, in addition to premium, it would be subject to the Section 105(h) discrimination rules. The regulations propose that as long as IC-HRA complies with the IC-HRA classification standards listed below, including the age-based standard (wherein the oldest age classification cannot exceed three times the youngest age classification), it would be deemed compliant with the Section 105(h) discrimination rules. Under an IC-HRA, permissible classes of employees include:

- ✓ Full-time, part-time and seasonal employees;
- ✓ Employees working in the same geographic location (generally, the same insurance rating area, state, or multi-state region);
- ✓ Employees in a unit of employees covered by a particular collective bargaining agreement;
- ✓ Employees who have not satisfied a waiting period;
- ✓ Non-resident aliens with no U.S.-based income;
- ✓ Salaried workers and non-salaried workers (such as hourly workers);
- ✓ Temporary employees of staffing firms; or
- ✓ Any group of employees formed by combining two or more of these classes.

The IC-HRA could also be offered to former employees, however, if it is offered to one or more former employees within a class of employees, then the HRA must be offered to the former employees on the same terms as to all other employees within the class.

Generally, class determination is based on the common law status of an employer. This is true even if the employer is part of a control group. For determining certain classes of employees, for example, full-time vs part-time employees, employees located within certain geographic areas, or salary vs hourly employees, a minimum class size equally the lesser of 20 employees, or 10% of the workforce, must be satisfied. This is to ensure that employers do not establish small classes targeted at certain populations.

Notice Obligation

Once an IC-HRA has been established, the sponsoring employer is obligated to provide a written notice about the availability of the program to all eligible employees at least 90 days prior to the beginning of each plan year. For the first year of compliance, if the employer adopts the IC-HRA within 120 days prior to the beginning of the plan, the 90-day advanced notice period can be shortened to the date that the individual first becomes eligible for the plan. The Department of Labor provides a model notice (Word and PDF) that can be used for this purpose which must be customized to the particular IC-HRA. In practicality, the employer should provide the notice in time for its employees to review their marketplace options. For coverage in 2020, the open enrollment period in the federal marketplace runs from November 1 through December 15, 2019.

Reporting and Disclosure Obligations

An employer establishing an IC-HRA would be subject to Code Section 6055 and 6056 reporting obligations. As background, the Forms 1094 and 1095 are used to satisfy the IRC Section 6055 and 6056 reporting requirements. The Form 1094-B and 1095 B-series is used for reporting minimum essential coverage (MEC) by insurers and sponsors of self-funded plans. However, self-insured applicable large employers file the Form 1095-C and use Part III of that form, rather than Form 1095-B, to report information required under section 6055. The Form 1094-C and 1095-C series is used for reporting employer provided coverage by an applicable large employer subject to the ACA's shared responsibility requirement. The IRS is currently reviewing the need to modify these reporting rules as they apply to an IC-HRA. This is due, in part, because the penalty for individuals who fail to obtain MEC has been reduced to zero. Until further guidance is provided, employers should be prepared to satisfy these future reporting obligations.

Effective Date
These regulations become effective for periods beginning after December 31, 2019. While these rules are proposed, they are reliant regulations. Therefore, an employer planning to establish an IC-HRA can rely on this guidance.

FAQ Guidance Clarifies Cost Sharing – Prescription Drug Coupons

In April, 2019, the Department of Health and Human Services issued a modified cost-sharing regulation as part of its 2020 Benefit and Payment Parameters addressing prescription drug manufacturer discounts, such as coupons and the like. This was addressed in *CBIZ Health Reform Bulletin 143* (5/10/19).

According to this modified rule, beginning in 2020, an insurer issuing both individual and group health plans of any size can, but is not obligated to, count manufacturer offsets, such as coupons and the like, toward an individual's maximum out-of-pocket limit under the health plan if there is a medically-appropriate generic drug available. The insurer cannot adopt these so-called accumulator programs if there is no generic equivalent available.

This modified rule created some lack of clarity and ambiguity with regard to the scope and application of this guidance. On August 26, 2019, the Departments of HHS, Labor and Treasury issued a **set of FAQs**, stating that they recognize the confusion, and anticipate issuing clarification when the 2021 Benefit and Payment Parameters are issued. Any modification to the rule would then take effect in 2021.

In the meantime, the FAQ guidance states that the governing agencies will not pursue any enforcement action against an insurer or group health plan if a plan excludes coupons from cost-sharing limitations, even if there is no medically-appropriate generic prescription drug available. Important to note, however, is that states continue to have authority to impose additional restrictions on plans subject to state insurance laws. Be aware that insured plans would need to comply if such law is imposed.

About the Author: Karen R. McLeese is Vice President of Employee Benefit Regulatory Affairs for CBIZ Benefits & Insurance Services, Inc., a division of CBIZ, Inc. She serves as in-house counsel, with particular emphasis on monitoring and interpreting state and federal employee benefits law. Ms. McLeese is based in the CBIZ Kansas City office.

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Health Reform Bulletin

CBIZ

Subject: **1) IRS Releases Draft 2019 Forms 1094/1095 Series; and 2) Revised Summary of Benefits and Coverage Templates for 2021**
Date: November 14, 2019

IRS Releases Draft 2019 Forms 1094/1095 Series

On November 13, 2019, the IRS released draft versions of the Form 1094/1095 series. These forms are used to satisfy the annual reporting obligations imposed by IRC Section 6055 minimum essential coverage reporting, and by IRC Section 6056, employer shared responsibility reporting. As background:

- The minimum essential coverage (MEC) reporting obligation is accomplished on the Form 1094-B transmittal and Form 1095-B statement to individuals. Generally, this reporting is accomplished by the insurer if the plan is insured. If the plan is self-funded, the employer is obligated to complete the MEC reporting and disclosure.
- Employers subject to employer shared responsibility (those employing 50 or more employees as of December 31, 2018 for the 2019 reporting year), can accomplish the MEC obligation by completing Part III on the Form 1095-C. Employers not subject to employer shared responsibility reporting accomplish the MEC reporting obligation by reporting on the B series described above. The employer shared responsibility reporting obligation is accomplished on the Form 1094-C transmittal and the Form 1095-C statement to individuals.

The 2019 reporting forms and instructions are available for viewing and downloading from the IRS website. However, it is important to reiterate that these are only draft versions at this point and subject to change:

Health Insurance Coverage Reporting by Insurers and Sponsors of Self-funded Plans (IRC Section 6055)

- Draft Instructions for 2019 Forms 1094-B and 1095-B
- Draft 2019 Form 1094-B, *Transmittal of Health Coverage Information Returns*
- Draft 2019 Form 1095-B, *Health Coverage*

Employer Health Insurance Reporting Requirement (IRC Section 6056)

- Draft Instructions for 2019 Forms 1094-C and 1095-C
- Draft Form 1094-C, *Transmittal of Employer-Provided Health Insurance Offer and Coverage Information Returns*
- Draft Form 1095-C, *Employer-Provided Health Insurance Offer and Coverage*

Deadlines for Filing and Distributing Forms 1094 and 1095

- ✓ Statements to individuals for both the B and C series must be furnished by January 31, 2020. Entities can request an extension for furnishing the statements by sending a letter to the IRS (see the instructions for the required content of the letter to request the extension and mailing address).
- ✓ Electronic filing of the forms must be accomplished by March 31, 2020; or, February 28, 2020 if filing by paper (paper filing is only available to employers filing fewer than 250 returns per year). At this point, no delay has been granted for filing these forms. An automatic 30-day extension is available by filing a Form 8809.

Information reporting penalties. The penalties for failure to provide the information return or provide correct payee statement are subject to indexing. Following are the adjusted penalties applicable for the 2020 tax year:

- The penalty for failure to file a correct information return is increased to $280 (up from $270 in 2019) for each return for which the failure occurs, with the total penalty cap of $3,392,000 (up from $3,339,000 in 2019) for a calendar year.
- The penalty for failure to provide a correct payee statement is increased to $280 (up from $270 in 2019) for each statement for which the failure occurs, with the total penalty cap of $3,392,000 (up from $3,339,000 in 2019) for a calendar year.

Special rules apply that increase the per-statement and total penalties if there is intentional disregard of the requirement to file the returns and furnish the required statements.

As a reminder, an employer subject to the ACA's employer shared responsibility who employs 50 or more employees on business days during the preceding calendar year must offer adequate and affordable health coverage to its full-time employees, or risk a penalty. For 2020, coverage under an employer-sponsored plan is deemed affordable to a particular employee if the employee's required contribution to the plan does not exceed 9.78% (indexed for 2020; decreased from 9.86% in 2019) of the employee's household income for the taxable year, based on the cost of single coverage in the employer's least expensive plan.

With regard to potential penalties, the amount of penalties for purposes of calculating the 'no coverage' excise tax (Code Section 4980H(a)), and the 'inadequate or unaffordable' excise tax (Code Section 4980H(b)) is subject to annual indexing. Below is a chart reflecting the penalties for 2018 to 2020. These amounts are based on the HHS inflationary percentage contained in its annual benefit and payment parameter standards for the relevant year, and as officially released by the Internal Revenue Service.

'No Coverage' Excise Tax IRC Section 4980H(a)		*'Inadequate or Unaffordable' Excise Tax IRC Section 4980H(b)*	
2018	$2,320	**2018**	$3,480
2019	$2,500	**2019**	$3,750
2020	$2,570	**2020**	$3,860

Revised Summary of Benefits and Coverage (SBC) Templates for 2021

The Affordable Care Act requires individual and group health plans to provide participants with a written summary of benefits and coverage (SBC) of the plan. On November 8, 2019, the CMS' Center for Consumer Information & Insurance Oversight (CCIIO) released revised model SBC templates, uniform glossary and related materials. These documents must be used by plan sponsors and insurers for policy/plan years beginning on or after January 1, 2021 (relates to coverage for plan years

beginning on or after that date). For plans and insurers that do not use an annual open enrollment period, the revised SBC template is to be used beginning on the first day of the first plan year that begins on or after January 1, 2021.

Only minor changes have been made to the templates from the 2017 editions. Of particular note, references to the individual shared responsibility penalty have been omitted in light of the repeal of the penalty by the Tax Act and Jobs Credit. The majority of changes involve the coverage examples.

All of these revised documents are available on CCIIO's website in 5 languages (English, Spanish, Chinese, Tagalog and Navajo). As a reminder, the SBC must be provided to participants upon application, by the first day of coverage, within 90 days of special enrollment period, upon contract renewal and upon request.

About the Author: Karen R. McLeese is Vice President of Employee Benefit Regulatory Affairs for CBIZ Benefits & Insurance Services, Inc., a division of CBIZ, Inc. She serves as in-house counsel, with particular emphasis on monitoring and interpreting state and federal employee benefits law. Ms. McLeese is based in the CBIZ Kansas City office.

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Subject: Form 1095 Benefit Statement Issuance Date Delayed

Date: December 3, 2019

The Forms 1094 and 1095 are used to satisfy the IRC Section 6055 and 6056 reporting requirements. The B series of the forms are used to report minimum essential coverage. Employers subject to the IRC Section 6056 employer shared responsibility reporting requirement can accomplish this by completing Part III of the C series forms. The C series of these forms are used for reporting employer provided coverage by an applicable large employer subject to the Affordable Care Act's shared responsibility requirement.

As of the date of this writing, the 2019 finalized versions of these forms have not been released by the IRS. The draft versions of the forms were released on November 13, 2019 (see *CBIZ Health Reform Bulletin 146*).

On December 2, 2019, the IRS issued guidance (Notice 2019-63) announcing an extension for providing the 2019 Form 1095-B and Form 1095-C disclosure statements to individuals; these statements are generally due by January 31st following the reporting year. The due date for furnishing benefit statements (Form 1095-B and Form 1095-C) to individuals has been extended from January 31, 2020 to March 2, 2020. Due to this extension, there will be no further 30-day automatic extension available. Similar to prior disclosure delays issued by the IRS, the guidance provides that taxpayers can file their personal income tax return without having to attach the relevant Form 1095 to their tax returns.

This guidance also makes a change in the method for furnishing the Form 1095-B to individuals. Rather than furnish the Form 1095-B to individuals, a reporting entity is permitted to post a notice on its website stating that individuals can obtain their Form 1095-B upon request. The reporting entity must include an email address and a physical address for submitting the request, together with a telephone number for individuals to contact the entity with any questions. The reporting entity is also obligated to furnish the Form 1095-B within 30 days upon receiving a request from an individual.

Important to note, however, is that those employers who are subject to the IRC Section 6056 employer shared responsibility reporting obligation (employers employing 50 or more employees) and who sponsor self-funded plans must continue to complete Part III of the Form 1095-C. In other words, these employers cannot take advantage of the posting methodology described above to satisfy their IRC Section 6055 reporting obligation. The employer can use the simplified posting method for those individuals who are not required to be reflected in IRC Section 6056 reporting obligation.

The IRS guidance further states that the filing due dates for the 2019 Forms 1094-B and 1095-B, and the 2019 Forms 1094-C and 1095-C reports to the IRS are not extended. These reports must be submitted to the IRS no later than February 28, 2020 (or, by March 31, 2020 if filing electronically). An automatic 30-day extension of time to file the 1094/1095 forms remains available by submitting the Form 8809 with the IRS on or before the filing due date.

In addition, this guidance reinstates the good faith compliance standard that was allowed in prior years. This means that the potential IRS-imposed penalties for failure to comply with the reporting and disclosure requirements could be reduced or waived, even if incorrect or incomplete information is reported on the return or statement, such as missing and inaccurate taxpayer identification numbers and dates of birth, as long as the responsible reporting entity makes a good faith effort to complete the required forms accurately and timely.

Coordination of State Individual Mandate Laws

Several states have imposed an individual shared responsibility requirement wherein residents must maintain minimum essential coverage (MEC) or pay a state tax. These states are California (commences 2020 reporting year), District of Columbia (2019 reporting year, due June 30, 2020), Massachusetts (ongoing, with 1099HC as the reporting vehicle, due between November 1 and November 30 annually), New Jersey (2019 reporting year, due March 31, 2020), Rhode Island (commences 2020 reporting year), and Vermont (commences 2020 reporting year). Employers and insurers providing MEC are subject to annual reporting obligations to the relevant state tax department, and are required to provide written documentation to individuals attesting to coverage. Some of the state revenue departments have indicated that employers using the federal 1094/1095 forms would satisfy the state-required reporting obligation. At this time, this means that entities who are obligated to accomplish MEC reporting in these states will likely not be able to avail themselves of the simplified posting method described above. Affected entities will need to continue monitoring the state requirements for future changes if revisions are made to the federal forms.

About the Author: Karen R. McLeese is Vice President of Employee Benefit Regulatory Affairs for CBIZ Benefits & Insurance Services, Inc., a division of CBIZ, Inc. She serves as in-house counsel, with particular emphasis on monitoring and interpreting state and federal employee benefits law. Ms. McLeese is based in the CBIZ Kansas City office.

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Subject: 1) Year-end wrap-up; 2) Proposed Transparency in Coverage Rules; 3) Final 2019 Forms and Instructions for ACA Reporting; 4) Revised SBC Templates for 2021; 5) Year-end Reminders

Date: December 17, 2019

Health care reform will continue to be hotly discussed, debated, and yes, litigated in 2020.

The *Texas v. U.S.* case concerning the constitutionality of the Affordable Care Act (ACA) continues to languish in the Fifth Circuit Court of Appeals, following oral arguments in July (see CBIZ Health Reform Bulletins 143 and 142). The general thought is that, whatever the outcome, the matter may well find its way to the Supreme Court.

Other health care reform concepts continue to be litigated, including the Department of Labor's expanded association health plan rules (see CBIZ Health Reform Bulletin 143). The issue of whether these rules stand will be decided by the Court of Appeals for the District of Columbia.

Arguments from insurers seeking billions of dollars in reimbursement from the federal government pursuant to the ACA's risk corridor program were just heard in the Supreme Court. A decision in the case is expected next summer. Litigation also continues with regard to unpaid cost share reduction payments owed to insurers. Oral arguments in four cases are scheduled in federal circuit courts in January, while other cases are stayed pending outcome of the Supreme Court's decision relating to the risk corridor matter.

The year-end government spending bill currently being deliberated in Capitol Hill includes provisions that would repeal three highly unpopular ACA taxes including the so-called Cadillac tax on high cost employer sponsored health insurance, which has been delayed several times but scheduled to take effect in 2022. The bill would also repeal the annual health insurer tax and the medical device excise tax, both of which have been off and on in the past couple years. Further, this bill would extend the Patient-Centered Outcomes Research Institute (PCORI) fee for ten years. By law, the PCORI fee is no longer assessed for policy/plan years ending on or after October 1, 2019. At this point it is uncertain whether this bill will become law in its current form. Stayed tuned for future developments.

What Congress will do in the upcoming election year is uncertain. There seems to be bipartisan support for addressing prescription drug cost containment, as well as so-called surprise medical bills. The primary culprits for surprise medical bills include air ambulance expenses, emergency room expenses, and in-network surgery care that is provided, unbeknownst to the patient, by an out of network provider. There is agreement that something has to be done about the issue, but the specifics of "how" remains debatable. It is anticipated that the surprise billing and prescription drug cost containment concepts will continue to be discussed through early part, if not further, into 2020.

Proposed Transparency in Coverage Rules

On November 27, 2019, the tri-governing ACA agencies (Departments of Health and Human Services, Labor and Treasury) released **proposed rules**, together with a **fact sheet**, that, if finalized, would impose extensive disclosure obligations upon group health plans and insurers. These rules were issued pursuant to an **Executive Order** released earlier this year, directing these agencies to facilitate access to information for individuals about their expected out of pocket costs prior to receiving care.

According to these proposed rules, non-grandfathered group health plans and insurers issuing individual and group health plans would be required to make the following information available to participants, beneficiaries and enrollees:

1. An individual's cost-sharing information including an estimate of out of pocket costs for covered items or services furnished by a particular provider;
2. Accumulated amounts the participant or beneficiary has incurred to date;
3. Negotiated rates for in-network providers for the requested covered item or service; and
4. Out-of-network allowed amounts for the requested covered item or service when furnished by an out-of-network provider.

Access to this information must be provided in real-time accuracy through an internet-based self-service tool, as well as in paper form upon request. Further, affected entities would be required to provide access to price transparency information such as in-network provider negotiated rates and historical out-of-network allowed amounts to the public, including consumers, researchers, employers and third party developers,

The comment period on these proposed rules closes on January 14, 2020. There will likely be significant comments both supporting and opposing these regulations. It is certainly possible that the regulations will change significantly before finalized.

Final 2019 Forms and Instructions for ACA Reporting

The IRS has released final versions of the forms and instructions that are used to satisfy the IRC Section 6055 and 6056 reporting (draft versions were released in November – see CBIZ HRB 146). Notably, the required content of the 2019 edition of the forms is essentially the same as the 2018 versions.

As background, there are two annual reporting obligations imposed by IRC Section 6055 minimum essential coverage reporting, and by IRC Section 6056, employer shared responsibility reporting.

- The minimum essential coverage (MEC) reporting obligation used to satisfy the IRC Section 6055 is accomplished on the Form 1094-B transmittal and Form 1095-B statement to individuals. Generally, this reporting is accomplished by the insurer if the plan is insured. If the plan is self-funded, the employer is obligated to complete the MEC reporting and disclosure.
- Employers subject to employer shared responsibility (those employing 50 or more employees as of December 31, 2018 for the 2019 reporting year), accomplish MEC reporting obligation by completing Part III on the Form 1095-C. Employers not subject to employer shared responsibility reporting accomplish the MEC reporting obligation by reporting on the B series described above. The employer shared responsibility reporting obligation is accomplished on the Form 1094-C transmittal and the Form 1095-C statement to individuals.

The 2019 reporting forms and instructions are available for viewing and downloading from the IRS website:

- *Health Insurance Coverage Reporting by Insurers and Sponsors of Self-funded Plans (IRC Section 6055)*
  - **Instructions** for 2019 Forms 1094-B and 1095-B (**PDF**)
  - **Form 1094-B**, *Transmittal of Health Coverage Information Returns*
  - **Form 1095-B**, *Health Coverage*

- *Employer Health Insurance Reporting Requirement (IRC Section 6056)*
  - **Instructions** for 2019 Forms 1094-C and 1095-C (**PDF**)
  - **Form 1094-C**, *Transmittal of Employer-Provided Health Insurance Offer and Coverage Information Returns*
  - **Form 1095-C**, *Employer-Provided Health Insurance Offer and Coverage*

Deadlines for Filing and Distributing Forms 1094 and 1095

- ✓ **IRS Notice 2019-63** extended the deadline for providing the 2019 Form 1095-B and Form 1095-C disclosure statements to individuals (see CBIZ Health Reform Bulletin 147). While these statements are generally due by January 31st following the reporting year, the due date for furnishing benefit statements (Form 1095-B and Form 1095-C) to individuals has been extended from January 31, 2020 to March 2, 2020. Due to this extension, there will be no further 30-day automatic extension available. Similar to prior disclosure delays issued by the IRS, the guidance provides that taxpayers can file their personal income tax return without having to attach the relevant Form 1095 to their tax returns. Further, IRS Notice 2019-63 allows reporting entities obligated to furnish the their 2019 Form 1095-B by way of website posting as long as certain requirements are met (see HRB 147).
- ✓ Electronic filing of the forms must be accomplished by March 31, 2020; or, February 28, 2020 if filing by paper. An automatic 30-day extension of time to file the 1094/1095 forms remains available by submitting the Form 8809 with the IRS on or before the filing due date.

IRS Resources. Additional information relating to ALE obligations, including the ACA Information Returns (AIR) system, can be found on the IRS's dedicated webpage, *ACA Information Center for Applicable Large Employers (ALEs)*. Of particular note:

- *Questions and Answers about Information Reporting by Employers on Form 1094-C and Form 1095-C*
- *Questions and Answers on Information Reporting by Health Coverage Providers* (Section 6055)

Revised Summary of Benefits and Coverage (SBC) Templates for 2021

As mentioned in our prior CBIZ Health Reform Bulletin, the CMS' Center for Consumer Information & Insurance Oversight (CCIIO) recently issued a revised SBC template, uniform glossary and related materials. These documents are required to be used by plan sponsors and insurers for policy/plan years beginning on or after January 1, 2021 (relates to coverage for plan years beginning on or after that date). For plans and insurers that do not use an annual open enrollment period, the revised SBC template is to be used beginning on the first day of the first plan year that begins on or after January 1, 2021. All of these revised documents are available on **CCIIO's website** in 5 languages (English, Spanish, Chinese, Tagalog and Navajo).

Failure to provide the SBC could result in HHS penalties, as well as penalties imposed by the Departments of Labor and Treasury. For HHS purposes, the potential civil penalty for willful failure to provide the SBC in 2020 has been increased to $1,156 per failure (up from $1,128 in 2019).

Year-end Reminders

❑ Preventive Health Services

Prior to the beginning of each plan year, a group health plan sponsor or administrator should review its coverage for preventive services to determine whether any additional benefits need be offered. For insured plans, generally, the insurer manages this process.

As background, the Affordable Care Act requires health plans to cover certain preventive services, without imposing any cost-sharing requirements (co-pay, co-insurance, or deductible), when such services are delivered by in-network providers. The types of covered preventive services, some of which are recommended by the U. S. Preventive Services Task Force (USPSTF), are updated periodically. Generally, once the USPSTF approves a particular recommendation, the service would become applicable as of the first plan year beginning one year following issuance of the recommendation. The USPSTF website provides a list of its recommended A and B preventive services by date and alphabetically. Further, a complete list of ACA-required preventive services can be accessed from the Healthcare.gov website.

❑ Employer Shared Responsibility Provisions

- *Applicability.* For purposes of the ACA's employer shared responsibility requirement as well as the reporting and disclosure requirements, applicable large employer (ALE) status is determined each calendar year, based on the average size of the employer's workforce during the prior year. Thus, if you averaged at least 50 full-time employees, including full-time equivalent employees during 2019, you are most likely an ALE for 2020, and are subject to the reporting and disclosure requirements due in early 2021.

- *Affordability Standard.* For purposes of determining affordability, coverage under an employer-sponsored plan is deemed affordable if the employee's required contribution to the plan does not exceed 9.78% (indexed for 2020; decreased from 9.86% in 2019) of the employee's household income for the taxable year, based on the cost of single coverage in the employer's least expensive plan.

- *Increase in Excise Tax Penalties.* The chart below reflects the amount of penalties for purposes of calculating the 'no coverage' excise tax pursuant to Code Section 4980H(a), and the 'inadequate or unaffordable' excise tax pursuant to Code Section 4980H(b) for 2018 to 2020. These are the excise taxes that could apply if an applicable large employer is found not to have offered health coverage to a full-time employee. These amounts are based on the HHS inflationary percentage contained in its annual benefit and payment parameter standards for the relevant year, and as officially released by the Internal Revenue Service.

'No Coverage' Excise Tax IRC Section 4980H(a)		*'Inadequate or Unaffordable' Excise Tax IRC Section 4980H(b)*	
2018	$2,320	2018	$3,480
2019	$2,500	2019	$3,750
2020	$2,570	2020	$3,860

❑ **Small Business Tax Credit (SBTC).** Small businesses and tax-exempt employers who provide health care coverage to their employees under a qualified health care arrangement are entitled to a tax credit, known as the small business tax credit (SBTC). To be eligible for the SBTC, the employer must employ fewer than 25 full-time equivalent employees, whose average annual wages are less than $54,200 (indexed for 2019; the wage ceiling in 2018 is $53,200).

The tax credit phases out for eligible small employers when the number of its full-time employees (FTEs) exceeds 10; or, when the average annual wages for the FTEs exceeds $27,100 in the 2019 tax year (the phase-out wage limit in 2018 is $26,600). As a reminder, only qualified health plan coverage purchased through a SHOP marketplace is available for the tax credit, and only for a 2-consecutive year period.

For purposes of calculating the SBTC, the Form 8941 is filed annually on the employer's tax return as a general business credit; tax exempt entities would file the Form 8941 with its Form 990-T. The IRS has released the 2019 edition of the **Form 8941** for purposes of calculating the small business tax credit.

❑ Additional ACA-related Fees

Patient-Centered Outcomes Research Institute (PCORI) Fees. By law, the PCORI fee is no longer assessed for policy/plan years ending on or after October 1, 2019. For calendar year plans, the last fee and Form 720 filing was due by July 31, 2019. For plan years ending on or before September 30, 2019, the last fee and Form 720 filing will be due by July 31, 2020.

Certain ACA Taxes and Fees.

- Code Section 4980I, popularly known as the **Cadillac tax** that would be assessed on the amount paid for high cost employer-sponsored health insurance coverage exceeding certain threshold levels ($10,200 for individuals; $27,500 for family, subject to indexing) which was to take effect in 2020 remains suspended until 2022.
- Previously suspended, both the **annual fee** required to be paid by 'covered entities' (insurers) who engage in providing health insurance for U.S. health risks, and the **2.3% medical device excise tax** become applicable beginning with the 2020 tax year.

❑ ACA Cost Share Restrictions

The chart below reflects the 2020 and 2019 inflationary adjustments applicable to out-of-pocket (OOP) limits including deductibles, co-insurance and co-payments in ACA plans. These cost-share restrictions apply to insured plans offered via the marketplace, and insured and self-funded plans offered outside marketplace. These amounts differ from the OOP limits applicable to high deductible health plans used in conjunction with a health savings account (HSA).

	2020		2019	
	Self-only	*Family*	*Self-only*	*Family*
ACA Plans - Out-of-Pocket (OOP) Limits	$8,150	$16,300	$7,900	$15,800
Health Savings Accounts	*Individual*	*Family*	*Individual*	*Family*
HDHP Annual Deductible	$1,400	$2,800	$1,350	$2,700
HDHP Annual Out-of-Pocket Limit	$6,900	$13,800	$6,750	$13,500
Contribution Limit	$3,550	$7,100	$3,500	$7,000

ACA-required Reporting Reminders

Form	*To Whom*	*Due Date*
Form W-2. ACA-required reporting includes: ◆ Aggregate cost of health coverage (Box 12, using Code DD). *Note: employers filing <250 Form W-2s per year remain exempt from reporting the aggregate cost of health coverage on the Form W-2 until future IRS guidance is issued.* ◆ Total amount of permitted benefits received under a qualified small employer health reimbursement arrangement (QSEHRA) (Box 12 - Code FF) ◆ Additional Medicare tax withholding on earnings exceeding $200,000 per calendar year (Box 6)	Internal Revenue Service (IRS) http://www.irs.gov/ Form W-2 Instructions (2019)	January 31, 2020
Form 720 for purposes of Patient Centered Outcome Research (PCOR) fee *Note: Fee no longer assessed for policy/plan years ending on or after Oct. 1, 2019*	IRS	▪ *For calendar year plans*: last fee and Form 720 filing was due by July 31, 2019 ▪ *For plan years ending before Sept. 30, 2019*: last fee and Form 720 filing due by July 31, 2020

Additional ACA-Related Disclosure Reminders

Note: Below are select ACA-required disclosures. For a more descriptive list of notice obligations relating to the ACA and other welfare benefit plans, ask your CBIZ representative for a Chart of Notice Obligations.

Form	*To Whom*	*Due Date*
Summary of Benefits and Coverage (SBC) ◆ Currently applicable SBC template and related materials available from **EBSA** and **CCIIO** ◆ SBC template and related materials to be used for policy/plan years beginning on or after January 1, 2021 available from **CCIIO**	All plan participants	From Plan Sponsor to Plan Participants: 1. Upon application 2. By the first day of coverage 3. Within 90 days of enrollment by special enrollees 4. Upon contract renewal 5. Upon request
Advanced 60-day Notice of Material Change in Benefits	All plan participants	No later than 60 days prior to any material change in any terms of plan affecting Summary of Benefits and Coverage (SBC) content not reflected in the most recently-provided SBC (other than in connection with renewal or reissuance of coverage)

Additional ACA-Related Disclosure Reminders, cont'd

Form	*To Whom*	*Due Date*
Notice of Marketplace Options ◆ Model notice for use by employers **who offer coverage** to some or all employees: ▪ English (**PDF** or **Word**) ▪ Spanish (**PDF** or **Word**) ◆ Model notice for employers who **do not offer health coverage:** ▪ English (**PDF** or **Word**) ▪ Spanish (**PDF** or **Word**)	All new hires including full-time and part-time employees, without regard to eligibility status for the health plan	Within 14 days of date of hire

Increased Penalties for Certain Compliance Violations

Federal government agencies who enforce the ACA, including the Departments of Labor, Treasury and Health and Human Services, have authority to adjust civil penalties attributable to compliance failures.

	2020 Penalty Amount	2019 Penalty Amount
Failure to provide Summary of Benefits and Coverage	$1,156 per failure	$1,128 per failure
Failure to file a correct information return *(Example: Form 1094/1095 and W-2)*	$280 (penalty cap: $3,392,000)	$270 (penalty cap: $3,339,000)
Failure to provide correct payee statement *(Example: Forms 1094/1095 and W-2)*	$280 (penalty cap: $3,392,000)	$270 (penalty cap: $3,339,000)

About the Author: Karen R. McLeese is Vice President of Employee Benefit Regulatory Affairs for CBIZ Benefits & Insurance Services, Inc., a division of CBIZ, Inc. She serves as in-house counsel, with particular emphasis on monitoring and interpreting state and federal employee benefits law. Ms. McLeese is based in the CBIZ Kansas City office.

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Subject: 1) Circuit Court Ruling on ACA; and 2) Repeal and Extension of Certain ACA Taxes
Date: December 26, 2019

Fifth Circuit Court Ruling on ACA

On December 18th, the Fifth Circuit Court of Appeals issued its **opinion** in the on-going *Texas v. U.S.* litigation stating that the individual mandate is invalid in that its validity depended on the imposition of a tax for failure to maintain coverage. When Congress reduced this tax to zero, the validity of the individual mandate was lost, according to this Court. What the Court did not decide is whether the entirety of the Affordable Care Act (ACA) must fall due to the invalidation of the individual mandate. Rather, the Court is returning the matter to the lower court from which it came for further consideration.

What this means, in practical terms, is, at least at this moment, all aspects of the ACA, other than the individual mandate and certain ACA taxes (see article below), remain in full force and effect while the matter continues to be considered by the courts.

Stay tuned for further developments. General thought is that the lower court will take its time to review matters and any decision may not be rendered until after the 2020 election. It is also possible that other actions could be taken. In the meantime, keep moving forward with ACA compliance.

Repeal and Extension of Certain ACA Taxes

A broad sweeping government appropriations bill (*Further Consolidated Appropriations Act, 2020*, Pub. L. No. 116-94) was signed into law on December 20, 2019.

Of particular note, this law repeals three highly unpopular ACA taxes including:

1. The so-called Cadillac tax on high cost employer sponsored health insurance exceeding certain threshold limits, which was scheduled to take effect in 2022, is repealed;
2. The annual fee imposed on covered entities (insurers) who engaged in providing health insurance for U.S. health risks is repealed, effective in 2021, i.e., the tax imposed for 2020 will continue to apply; and
3. The 2.3% excise tax imposed on manufacturers and importers for sales of certain medical devices.

The Appropriations Act also includes a provision that extends the Patient-Centered Outcomes Research Institute (PCORI) fee for ten years. The PCORI fee was set to expire for policy/plan years ending on or after October 1, 2019 but the fee will now continue to be assessed through 2029.

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Subject: 1) Final CMS Benefit and Payment Parameters for 2021; and 2) Annual PCORI Fee and Filing
Date: May 15, 2020

HHS Benefit and Payment Parameters for 2021

On May 14, 2020, the HHS' Centers for Medicare & Medicaid Services (CMS) published **Final Benefit and Payment Parameters for 2021**, together with a **Fact Sheet**. These uniform standards, as required under the Affordable Care Act (ACA), are intended for health insurers and the marketplace to ensure health coverage options for consumers, as well as provide planning guidance for insurers and employers. These regulations take effect on July 13, 2020.

Following are highlights of the final rules:

Cost-sharing Limits

The ACA imposes certain cost-sharing restrictions, such as deductible and out-of-pocket limits on health plans. These annual out of pocket limits apply to insured plans offered through the marketplace, and insured and self-funded plans offered outside marketplace. Below are cost sharing limitations for 2020 and 2021:

	Self-only Coverage (Individual)	Other than Self-only Coverage (Family)		Self-only Coverage (Individual)	Other than Self-only Coverage (Family)
2020	$8,150	$16,300	**2020**	$8,150	$16,300
2021	$8,550	$17,100	**2021**	$8,550	$17,100

As a reminder, the out-of-pocket (OOP) limits applicable to high deductible health plans (HDHP) used in conjunction with health savings accounts (HSA) differ from these ACA-imposed cost sharing limits. For 2020, the OOP limit for HDHP plans is $6,900 for single coverage; $13,800 for family coverage. The 2021 limits applicable to HSA-compatible HDHP coverage have not been issued by the IRS yet.

Affordability Standard – Individual Coverage

The required contribution percentage by individuals for minimum essential health coverage (MEC) for purposes of determining eligibility for a hardship exemption under the individual shared responsibility requirement (IRC Section 5000A) occurs if the cost of purchasing coverage exceeds a certain percentage of the individual's household earnings. The affordability standard for individual coverage is increased slightly in 2021 to 8.27% of household earnings (up from 8.24% in 2020).

This affordability standard is distinct from the employer's shared responsibility affordability standard, and distinct from the affordability standard for purposes of entitlement to premium assistance. For

2020, coverage under an employer-sponsored plan is deemed affordable to a particular employee if the employee's required contribution to the plan does not exceed 9.78% of the employee's household income for the taxable year, based on the cost of single coverage in the employer's least expensive plan. To date, the IRS has not announced the employer's shared responsibility affordability standard for 2021.

Employer Shared Responsibility Penalties

The CMS inflationary percentage contained in the final 2021 benefit and payment parameter standards is used for calculating the cost share limits and the individual coverage affordability standard as described above. This percentage is also used for purposes of calculating the potential penalty assessments applicable to the employer shared responsibility provisions. Using this percentage calculation contained in the 2021 benefit and payment parameters, the estimated 'no coverage' excise tax pursuant to IRC Section 4980H(a) is estimated to increase from $2,570 in 2020 to $2,700 in 2021. The estimated 'inadequate or unaffordable' excise tax pursuant to IRC Section 4980H(b) is estimated to increase from $3,860 in 2020 to $4,060 in 2021. However, it is important to note that until these inflationary adjusted penalty amounts are officially released by IRS, the 2021 limits are estimated amounts only.

Update: Prescription Drug Coupons and Cost Sharing

Consistent with the walk-back of the guidance in last year's final regulations (see *FAQ Guidance Clarifies Cost Sharing - Prescription Drugs*, CBIZ HRB 145), CMS re-considered the matter, and states that insurers and health plans be permitted, but not required to, apply pharmaceutical manufacturer direct support, including prescription drug coupons and other cost cutting mechanisms, toward the annual limitation on cost sharing without regard to whether a medically appropriate generic equivalent is available. As a reminder, a couple of the concerns with what was proposed last year related to discouraging the use of generic prescription drugs.

Further, the impact of drug manufacturer direct support, including coupons, on HSA eligibility remains unclear. The IRS and Department of Treasury may provide guidance in the future. In the meantime, plans intended to be HSA-compatible HDHPs should ensure that the required HSA required minimum statutory deductible, which for 2020 are $1,400 for individual coverage or $2,800 for family coverage, is satisfied.

Although no specific disclosure is required by insurers and group health plans relating to the effects of drug manufacturer direct support cost sharing limitations, CMS encourages transparency with regard to how direct manufacturer support amounts count towards the annual limitation on cost sharing. For example, CMS encourages this type of information to be prominently displayed on insurer websites, as well as include the information in brochures, plan summary documents, and other collateral material provided to enrollees and participants. As a reminder, ERISA requires clear and accurate communications. Thus, plans subject to ERISA should make certain that any impact resulting from drug manufacturer subsidies be clearly communicated to participants.

Also keep in mind that some state insurance laws have rules applicable to insured contracts that would dictate how prescription drug coupons and the like would apply to cost accumulator programs.

Excepted-Benefit HRA – Notice Obligation

These regulations impose a new notice obligation for sponsors of excepted benefit health reimbursement arrangements (EB-HRA). As background, beginning January 1, 2020, an EB-HRA can be established and made available to individuals who are eligible for comprehensive group health coverage. An EB-HRA provides up to $1,800 in benefits per year (subject to inflationary indexing) to reimburse expenses for excepted benefits.

Under the final benefit and payment parameter rules, for EB-HRA plan years beginning in January 2021, EB-HRA plan sponsors must provide a notice that describes eligibility requirements, annual or lifetime caps, or other limits on benefits under the plan, together with a description or summary of the benefits. This notice must be provided no later than 90 days after an employee enrolls in the EB-HRA, and annually thereafter.

Method of providing notice. For plans subject to ERISA, this notice obligation is accomplished by way of their existing required communications, such as the requirement to provide the summary plan description. For plans exempt from ERISA such as state and local governments, the EB-HRA notice must be provided under similar timing and distribution methods as required by ERISA. For these entities, procedures will be developed by HHS and presumably set forth in future guidance.

QSEHRA - Special enrollment periods

These rules extend the same special enrollment opportunity currently available under individual coverage HRAs to qualified small employer HRAs (QSEHRA). As such, individuals who newly gain access to a QSEHRA have 60 days to enroll in individual market coverage (either on or off the marketplace), or change plans, under a special enrollment period.

Federal Exchange User Fees

Insurers participating in the federal marketplace are subject to a user fee to help pay for the operational expenses of the marketplace. The amount for state-based exchanges utilizing the federal platform for 2021 retains the current 2.5% user fee rate of the monthly premium charged by the insurer as applicable in 2020.

Annual PCORI Fee and Filing Reminder

As a reminder, the *Further Consolidated Appropriations Act, 2020* enacted last December extends the Patient-Centered Outcomes Research Institute (PCORI) fee obligations for ten years (see *Repeal and Extension of Certain ACA Taxes* in CBIZ HRB 149). While it was set to expire for policy/plan years ending on or after October 1, 2019, the fee will continue to be assessed through 2029.

Payment of the annual PCORI fee together with the Form 720 filing deadline is approaching. The PCORI fee is assessed on the average number of lives covered under the policy or plan. For policy and plan years ending between October 1, 2018 and September 30, 2019, the fee is $2.45 per covered life. The fee is to be paid in connection with filing the IRS Form 720, *Quarterly Federal Excise Tax Return*. For insured plans, the insurer is obligated to file the Form 720 by July 31 following the close of the policy year. For self-funded plans, the plan sponsor is obligated to file the Form 720 by July 31 of the calendar year following the plan year end.

To date, the IRS has not released the PCORI fee amount for plan years extending beyond September 30, 2019. Further, while several IRS tax form filings have been extended due to the coronavirus situation, there has been no extension announced for filing the Form 720. Thus, entities subject to the PCORI fee must file the Form 720 filing and pay the PCORI fee by July 31, 2020. Affected entities are encouraged to monitor the IRS's dedicated **webpage** for PCORI updates and developments.

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Subject: Annual PCORI Fee and Filing
Date: June 10, 2020

The IRS released the adjusted applicable dollar amount for the Patient Centered Outcome Research Institute (PCORI) fee. For policy and plan years ending between October 1, 2018 and September 30, 2019, the fee is $2.45 per covered life. The fee increases to $2.54 per covered life for policy and plan years ending between October 1, 2019 and before October 1, 2020, according to IRS Notice 2020-44.

As background, the PCORI fee is assessed on the average number of lives covered under the policy or plan. While the PCORI fee was set to expire for policy/plan years ending on or after October 1, 2019, the *Further Consolidated Appropriations Act, 2020* enacted last December extends the PCORI fee obligations for ten years (see *Repeal and Extension of Certain ACA Taxes* in CBIZ HRB 149). The fee will continue to be assessed through 2029.

Virtually all health plans, whether insured or self-funded, are subject to the PCORI fees. With regard to reimbursement type plans, health reimbursement arrangements (HRA) and medical flexible spending account (FSA) plans are subject to these fees. However, FSA plans that qualify as HIPAA-excepted plans are not subject to these fees. The PCORI fee does not apply to stand alone dental or vision plans. The IRS provides a chart for determining the applicability of the PCORI fee to types of insurance coverage or arrangements and whether such coverage or arrangement is subject to the fee, and the person or entity responsible for paying the fee.

The PCORI fees are assessed on the insurer of an insured plan. For a self-funded plan, the plan sponsor is required to pay the fee on behalf of its plan. Because the law provides that the PCORI fees are to be paid by the plan sponsor, at least for plans subject to ERISA, the fees cannot be paid from plan assets.

The IRS indicates that affected entities may continue to use one of the four existing methods to calculate the average number of covered lives for purposes of the fee - actual count method, snapshot method, member months method, and state form method. In addition, entities may use any "*reasonable method*" for calculating the average number of covered lives for the policy or plan years ending on or after October 1, 2019, and before October 1, 2020. If using a reasonable method, it must be applied consistently for the duration of the year and used for all policies reported on Form 720 for that year.

As in prior years, the fee is required to be reported annually to the IRS on the second quarter Form 720, *Quarterly Federal Excise Tax Return,* and paid by its due date, July 31, 2020. As of the day of this writing, the IRS released an updated draft version of the Form 720 reflecting the PCORI fee

adjustment discussed above. Once finalized, both the form and instructions will be available from the IRS webpage, About the Form 720.

Additional information about the PCORI fee is available on the IRS' dedicated PCORI webpage and Questions and Answers. The agency indicates that it is in the process of updating these webpages to reflect the extension of the fee, as well as the adjusted amount.

About the Author
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Ms. McLeese is based in the CBIZ Kansas City office.

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Subject: 1) Supreme Court Ruling – Women's Preventive Services Mandate; and 2) Re-issued Model Marketplace Notices

Date: July 9, 2020

Supreme Court Ruling - Women's Preventive Services Mandate

In a 7-2 decision, the Supreme Court determined that the women's preventive health services regulations issued on November 15, 2018, can stand. These regulations provide a way for health plans to opt out of covering contraceptive services.

As background, the Affordable Care Act requires health plans to cover certain preventive services, without imposing any cost-sharing requirements (co-pay, co-insurance, or deductible), when such services are delivered by in-network providers. One of the approved types of covered preventive services is contraceptive methods including prescribed FDA-approved methods and sterilization procedures, and patient education and counseling, in accordance with the guidelines recommend by the Health Resources and Services Administration (HRSA).

The original law specifically exempted church plans sponsored by qualified religious employers from providing contraceptive services. The final 2018 regulations issued by the tri-governing agencies (Departments of Labor, Health and Human Services, and IRS) provide that virtually any non-government plan, including one sponsored by closely-held and publicly traded entity, private entities, as well as institutions of higher education and private universities offering student health coverage, to opt out of some or all of the contraceptive mandates based on religious grounds, either through seeking an accommodation process, or by exempting itself. An accommodation or exemption option was also made available for a slightly narrower group of entities, specifically, all non-government, non-publicly traded entities based on a moral opposition to providing contraceptive services.

To seek the accommodation, the entity must either:

1. Submit a self-certification form to the insurer or third party administrator using EBSA Form 700, Certification Form for Eligible Organizations; or,
2. Self-certify to the Department of Health and Human Services (HHS) or the Department of Labor, using the model HHS Self-certification Form.

To exempt itself from the obligation, the entity must simply exclude the offending coverage.

On July 8, 2020, the Supreme Court ruled on the matter in the case of *Little Sisters of the Poor Saints Peter and Paul Home v. Pennsylvania, et. al.* (No. 19-431, S. Ct. Jul. 8, 2020). According to this opinion, and at least for the time being, the final regulations stand as issued in 2018. It is likely challenges to these rules will continue under any number of theories; one of which might be that HRSA exceeded its authority, and that the rules are arbitrary and capricious.

Interplay with other laws. The ACA's contraceptive coverage rules notwithstanding, the Pregnancy Discrimination Act, applicable to employers employing 15 or more employees, requires that if a plan covers preventive health services and/or coverage for prescription drugs, devices and services for medical conditions, it must likewise provide equal coverage for contraceptive services, drugs and devices. Further, plans subject to state insurance laws may still be required to provide coverage for these types of services.

Re-issued Model Marketplace Notices

The ACA requires all employers to provide a notice of marketplace options to their employees explaining the pros and cons of obtaining coverage through the health insurance marketplace. The DOL's Employee Benefits Security Administration (EBSA) provides two model Marketplace Notices that can be used to communicate this information to employees.

As with many government-issued model forms, these forms must undergo periodic review by the Office of Budget and Management prior to reissuance. EBSA has recently reissued the model marketplace forms with a revised expiration date of June 30, 2023. There have been no changes made to content from prior versions of the model forms.

As background, all employers subject to the Fair Labor Standards Act (FLSA) are required to provide the Marketplace Notice to their employees. The FLSA generally applies to virtually all employers employing at least one employee.

The notice must be provided to all newly hired employees, including full-time and part-time employees, without regard to eligibility status for the health plan, within 14 days from the date of hire.

Both model notices can be viewed and/or downloaded from the **DOL-EBSA website**. One model notice is to be completed by employers offering coverage, and the other for employers who do not offer coverage.

- Model notice for use by employers who **offer** coverage to some or all employees:
  English (PDF or Word) or Spanish (PDF or Word)
- Model notice for employers who **do not offer** health coverage:
  English (PDF or Word) or Spanish (PDF or Word)

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Subject: Updates: Employer Shared Responsibility Reporting Obligations; 2) Employer Shared Responsibility Penalties for 2021; and 3) 2021 Indexed Adjustments for Minimum Essential Coverage

Date: October 6, 2020

Updates: Employer Shared Responsibility Reporting Obligations

Here we are in the fourth quarter of 2020, and employers subject to Affordable Care Act's employer shared responsibility requirements are likely beginning to think about their 2020 filing obligation. To date, the IRS has not released the 2020 Form 1094 and 1095 series. The agency posted draft versions of these forms in July (discussed below), but has not released final versions of the forms or instructions.

In the interim, the IRS issued transitional relief (Notice 2020-76) on October 2, 2020, addressing matters relating to the 2020 reporting year for purposes of meeting the Code Sections 6055 and 6056 obligations. This relief is similar to that which has been provided in prior years.

First, the IRS provides an extension for furnishing 2020 Form 1095-B and Form 1095-C to individuals from January 31, 2021, to March 2, 2021. There is no further 30-day automatic extension available.

Reporting entities required to furnish their Form 1094-B to individuals can continue to use the simplified posting method to fulfill this obligation. This method allows the reporting entity to post a notice on its website stating how individuals can obtain their Form 1095-B upon request. The reporting entity must include an email address and a physical address for submitting the request, together with a telephone number for individuals to contact the entity with any questions. The reporting entity is also obligated to furnish the Form 1095-B within 30 days upon receiving a request from an individual.

Important to note, however, is that those employers who are subject to the IRC Section 6056 employer shared responsibility reporting obligation (employers employing 50 or more employees) and who sponsor self-funded plans must continue to complete Part III of the Form 1095-C. In other words, these employers cannot take advantage of the posting methodology described above to satisfy their IRC Section 6055 reporting obligation. The employer can use the simplified posting method for those individuals who are not required to be reflected in IRC Section 6056 reporting obligation.

Secondly, there will be no extension available for entities required to file their Forms 1094 and 1095 with IRS. These forms will be due on March 1, 2021 for paper filings, or March 31, 2021 for efilers. An automatic 30-day extension of time to file the 1094/1095 forms remains available by submitting the Form 8809 with the IRS on or before the filing due date.

And finally, the IRS suggests that this will likely be the last year the agency will offer an automatic delayed date for furnishing the Form 1095 to individuals, as well as offer good faith effort relief from late-filing penalties.

As for the draft 1094 and 1095 forms, following are the forms made available as of the date of this writing:

- Draft 2020 Form 1095-C, *Employer-Provided Health Insurance Offer and Coverage*
- Draft 2020 Form 1094-C: *Transmittal of Employer-Provided Health Insurance Offer and Coverage Information Returns*
- Draft 2020 Form 1095-B, *Health Coverage*
- Draft 2020 Form 1094-B, *Transmittal of Health Coverage Information Returns*

Specific to the 2020 draft Form 1095-C, the biggest change is the addition of 8 new reporting codes for Line 14 which is used to describe the type of employer coverage offered to individuals, together with related changes made to Lines 15 and 17. These new codes apply to individual coverage health reimbursement arrangements (IC-HRA). An IC-HRA is an HRA that can be offered in conjunction with individual coverage, whether obtained through or outside marketplace, as well as Medicare Parts A, B, C and D policies. The new codes to be used in Line 14 specific to IC-HRAs are Codes 1L through 1S A similar change is noted in the draft 2020 Form 1094-B. This form adds a new code to designate coverage under an IC-HRA in Line 8, which is used to designate the type of coverage in which individuals are enrolled.

Employer Shared Responsibility Penalties for 2021

The IRS has officially released the 2021 employer shared responsibility excise tax amounts. These annual amounts, which are calculated monthly, are reflected in Q&A 55 of the IRS' *Questions and Answers on Employer Shared Responsibility under the ACA*.

As a reminder the ACA imposes an excise tax on applicable large employers employing 50 or more full-time employees who either do not offer health coverage, or do not offer adequate and affordable coverage, to their full time employees.

- The 'no coverage' excise tax pursuant to IRC Section 4980H(a) will increase to $2,700 in 2021.
- The 'inadequate or unaffordable' excise tax pursuant to IRC Section 4980H(b) will increase to $4,060 in 2021.

Below is a chart reflecting these penalties for 2019 to 2021:

'No Coverage' Excise Tax IRC Section 4980H(a)		*'Inadequate or Unaffordable' Excise Tax IRC Section 4980H(b)*	
2019	$2,500	**2019**	$3,750
2020	$2,570	**2020**	$3,860
2021	$2,700	**2021**	$4,060

2021 Indexed Adjustments for Minimum Essential Coverage (MEC)

In Revenue Procedure 2020-36, the Internal Revenue Service released certain affordability standards for 2021 as they apply to the Affordable Care Act (ACA), as follows:

- ❑ Affordability Standard – Employer Shared Responsibility Mandate

  Coverage under an employer-sponsored plan is deemed affordable to a particular employee if the employee's required contribution to the plan does not exceed 9.83% (indexed for 2021, up from 9.78% for 2020) of the employee's household income for the taxable year, based on the cost of single coverage in the employer's least expensive plan.

  As background, employers subject to the ACA's employer shared responsibility mandate who fail to offer minimum essential coverage to their full-time employees or fail to offer adequate and

affordable coverage may be subject to an excise tax if at least one of its employees qualifies for premium assistance through a marketplace. If an employer does not know an individual's household earnings, it can use one of three safe harbors for purposes of determining affordability; they are:

1. A *Form W-2 determination* in which the employer's lowest cost self-only coverage providing minimum value does not exceed 9.78% (for 2020; 9.83% in 2021), of the employee's Form W-2 wages (Box 1) for the calendar year.
2. A *rate of pay method* in which the minimum value cannot exceed 9.78% (for 2020; 9.83% in 2021), of an amount equal to 130 hours, multiplied by the employee's hourly rate of pay as of the first day of the coverage period. For salaried employees, the monthly salary is used instead of the 130 hour standard. An employer can apply this method to hourly employees if they experience a reduction in pay during the year; however, this methodology cannot be used for commissioned sales people.
3. A *Federal poverty line (FPL) standard* in which cost of single coverage does not exceed 9.78% (for 2020; 9.83% in 2021) of the individual federal poverty line rate for the applicable calendar year, divided by twelve. An employer is permitted to use the poverty guidelines in effect six months prior to the beginning of the plan year. The Department of Health and Human Services released the 2020 FPL standards in January, 2020 (see ***2020 Federal Poverty Level (FPL) Guidelines***, *Benefit Beat*, 2/10/20).

- **Premium Tax Credit.** The following contribution percentages are used to determine whether an individual is eligible for a premium tax credit for the 2020 and 2021 tax years:

Household income percentage of Federal Poverty Line	Initial percentage 2020	Final percentage 2020	Initial percentage 2021	Final percentage 2021
Under 133%	2.06%	2.06%	2.07%	2.07%
Between 133% and 150%	3.09%	4.12%	3.10%	4.14%
Between 150% and 200%	4.12%	6.49%	4.14%	6.52%
Between 200% and 250%	6.49%	8.29%	6.52%	8.33%
Between 250% and 300%	8.29%	9.78%	8.33%	9.83%
Between 300% and 400%	9.78%	9.78%	9.83%	9.83%

About the Author

Karen R. McLeese is Vice President of Employee Benefit Regulatory Affairs for CBIZ Benefits & Insurance Services, Inc., a division of CBIZ, Inc. She serves as in-house counsel, with particular emphasis on monitoring and interpreting state and federal employee benefits law.
Ms. McLeese is based in the CBIZ Kansas City office.

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Subject: 1) Final 2020 Forms and Instructions for ACA Reporting; and 2) Inflation-Adjusted Benefit Limit for Excepted Benefit HRA
Date: October 16, 2020

Final 2020 Forms and Instructions for ACA Reporting

The IRS released finalized versions of the forms and instructions that are used to satisfy the IRC Section 6055 and 6056 reporting.

As a reminder, there are two annual reporting obligations imposed by IRC Section 6055 minimum essential coverage reporting, and by IRC Section 6056, employer shared responsibility reporting.

- The minimum essential coverage (MEC) reporting obligation used to satisfy the IRC Section 6055 is accomplished on the Form 1094-B transmittal and Form 1095-B statement to individuals. Generally, this reporting is accomplished by the insurer if the plan is insured. If the plan is self-funded, the employer is obligated to complete the MEC reporting and disclosure.
- Employers subject to employer shared responsibility (those employing 50 or more employees as of December 31, 2019 for the 2020 reporting year), accomplish MEC reporting obligation by completing Part III on the Form 1095-C. Employers not subject to employer shared responsibility reporting accomplish the MEC reporting obligation by reporting on the B series described above. The employer shared responsibility reporting obligation is accomplished on the Form 1094-C transmittal and the Form 1095-C statement to individuals.

The required content of the 2020 edition of the forms is essentially the same as the 2019 forms, with the exception of new reporting codes applicable to individual coverage health reimbursement arrangements (IC-HRA). As background, an IC-HRA is an HRA that can be offered in conjunction with individual coverage, whether obtained through or outside marketplace, as well as Medicare Parts A, B, C and D policies. Specifically, there are 8 new reporting codes for Line 14 of the 2020 Form 1095-C which is used to describe the type of employer coverage offered to individuals, together with related changes made to Lines 15 and 17. A similar change is noted in the 2020 Form 1094-B to designate coverage under an IC-HRA in Line 8, which is used to designate the type of coverage in which individuals are enrolled.

The 2020 reporting forms and instructions are available for viewing and downloading from the IRS website:

- *Health Insurance Coverage Reporting by Insurers and Sponsors of Self-funded Plans (IRC Section 6055)*
  - Instructions for 2020 Forms 1094-B and 1095-B (HTML or PDF)
  - Form 1094-B, *Transmittal of Health Coverage Information Returns*
  - Form 1095-B, *Health Coverage*

- *Employer Health Insurance Reporting Requirement (IRC Section 6056)*
  - Instructions for 2020 Forms 1094-C and 1095-C (HTML or PDF)
  - Form 1094-C, *Transmittal of Employer-Provided Health Insurance Offer and Coverage Information Returns*
  - Form 1095-C, *Employer-Provided Health Insurance Offer and Coverage*

Deadlines for Distributing and Filing Forms 1094 and 1095

- ✓ As discussed in CBIZ Health Reform Bulletin 153, IRS Notice 2020-76 provides an extension for the timeframe required to provide the 2020 Form 1095-B and Form 1095-C disclosure statements to individuals. While these statements are generally due by January 31st following the reporting year, the due date for furnishing benefit statements (Form 1095-B and Form 1095-C) to individuals has been extended from January 31, 2021 to March 2, 2021. Due to this extension, there will be no further 30-day automatic extension available.

  Reporting entities required to furnish their Form 1095-B to individuals can continue to use the simplified posting method to fulfil this obligations. This method allows the reporting entity to post a notice on its website stating how individuals can obtain their Form 1095-B upon request. The reporting entity must include an email address and a physical address for submitting the request, together with a telephone number for individuals to contact the entity with any questions. The reporting entity is also obligated to furnish the Form 1095-B within 30 days upon receiving a request from an individual.

  Important to note, however, is that those employers who are subject to the IRC Section 6056 employer shared responsibility reporting obligation (employers employing 50 or more employees) and who sponsor self-funded plans must continue to complete Part III of the Form 1095-C. In other words, these employers cannot take advantage of the posting methodology described above to satisfy their IRC Section 6055 reporting obligation. The employer can use the simplified posting method for those individuals who are not required to be reflected in IRC Section 6056 reporting obligation.

- ✓ Electronic filing of the forms must be accomplished by March 31, 2021; or, March 1, 2021 if filing by paper. An automatic 30-day extension of time to file the 1094/1095 forms remains available by submitting the Form 8809 with the IRS on or before the filing due date.

Inflationary-Adjusted Benefit Limit for Excepted Benefit HRA

Beginning this year, employers can choose to offer an HRA integrated with individual coverage (IC-HRA), or an excepted benefit HRA (EB-HRA). An EB-HRA is a stand-alone HRA that can be used to reimburse certain Code Section 213(d) expenses such as co-pays and deductibles, as well as premium for certain excepted benefits policies such as dental and vision.

One of the criteria for this type of HRA is a cap or limit on the maximum reimbursement for medical expenses that can be made through the EB-HRA; this amount is subject to inflationary indexing. Beginning December 31, 2019, the limit on reimbursements for medical expenses is $1,800. According to IRS Revenue Procedure 20-43, the maximum contribution amount for plan years beginning prior to January 1, 2022 remains $1,800.

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Subject: 1) On-going ACA Litigation; 2) Impact of Coronavirus on Employer Shared Responsibility Provisions; 3) Transparency in Health Coverage Rules; 4) State Individual Mandate Reporting Update; 5) Year-end Reminders

Date: November 20, 2020

For so many reasons, 2020 has been a year like no other. Court challenges, regulatory changes, and coronavirus notwithstanding, employers must continue to attend to their ACA responsibilities. This edition also discusses the transparency in health plan coverage rules, state-required individual mandate reporting, and a pronouncement relating to the preventive services mandate. And finally, we've included some year-end reminders to ensure on-going compliance with the ACA.

On-going ACA Litigation

Despite the fact that the Affordable Care Act continues to be the law of the land, its provisions continue to be litigated. Most recently, the United State Supreme Court heard oral arguments on November 10, 2020 in a consolidated case (*California v. Texas*, No. 19-840 and *Texas v. California*, No. 19-1019). The primary issues argued before the Court were whether the provision in the Tax Cuts and Jobs Act in 2017 that reduced the individual mandate penalty amount to zero for failure to maintain minimum essential coverage (MEC) renders the provision unconstitutional, and if so, whether the MEC provision is severable from the rest of the ACA, and whether the challengers have a standing to sue. A ruling is expected sometime in the spring of 2021.

Impact of Coronavirus on Employer Shared Responsibility Provisions

As with most everything in 2020, compliance with the employer shared responsibility requirements of the ACA cannot escape untouched by the coronavirus. Employers subject to the employer shared responsibility rules (employs 50 or more full-time employees) must determine who are 'full-time' employees.

The law provides two methods for defining full-time employee; they are: a monthly measurement method, or a lookback method. If a lookback method is used, as typically, it is the most commonly used method, an individual's hours worked are calculated over a measurement period, and based on those hours worked, the individual is deemed full-time for a corresponding stability period. As you know, in 2020, many employees experienced a reduction in hours due to furloughs, layoffs and the like. These reductions in hours will impact full-time determination, and there is potentially both a positive and a negative implication, depending on one's point of view.

The positive impact may be that when the applicable large employer files its 2022 employer shared responsibility statements with the IRS reflecting the 2021 stability period, it may have significantly fewer full-time employees, resulting from individuals not achieving full-time status during the 2020 measurement period.

The downside is that those individuals who do not qualify as full-time may not be eligible for health coverage. As a reminder, the ACA does not define eligibility for health coverage; it simply defines who is a full-time employee. Many health plans have adopted a health plan eligibility standard that mirrors its definition of full-time employee for ACA purposes. If your health plan has adopted this type of eligibility language, you may discover that certain individuals may no longer meet the definition. As a result, employers may want to modify their health plan's definition of eligibility in order to provide coverage for these individuals in 2021.

If a health plan uses a more traditional definition of eligibility, such as 'an individual who is regularly scheduled to work 30 hours or more per week', and assuming that this definition is not tied to an ACA measurement period, then the determination of health plan eligibility will not likely be impacted.

In summary, employers will want to be very careful that they make their full-time employee determination for the 2020 measurement period impacting the 2021 stability period. Further, employers will want to carefully review the eligibility language in their health plan(s), and make changes as appropriate to be consistent with the employer's intent.

Final Transparency in Health Coverage Rules

On November 11, 2020, the tri-governing ACA agencies (Departments of Health and Human Services, Labor and Treasury) released final rules, together with a Fact Sheet, that require extensive disclosure obligations upon group health plans and insurers. The final rules mirror the proposed regulations issued last year (see CBIZ *Health Reform Bulletin 148*). Following is a very brief summary of the requirements.

Applicability. The transparency in coverage regulations apply to both individual and group health plans, whether insured or self-funded. Certain plans are not subject to these rules including grandfathered plans, excepted benefit type plans, account-based plans such as health reimbursement arrangements and medical flexible spending account plans, and short-term limited duration plans.

Effective Dates. These rules adopt a three-year, phased-in approach as follows:

- Beginning in January 2022, disclosures to insureds must be made available in a searchable online format, which would include data points such as billing codes, names of providers, and other cost-sharing characteristics. Further, the information must be made available in paper upon request. Effectively, these disclosures are an advanced explanation of benefits, providing detailed information such as:
  - ✓ Negotiated rates for covered items and services, both in and out of network and including prescription drug information;
  - ✓ An estimate of the insured's cost-sharing responsibility;
  - ✓ The amount the individual has already paid or incurred for the deductible and out-of-pocket expenses;
  - ✓ If the items or services are bundled, a list of that which is included in the bundle; and
  - ✓ An explanatory notice of the insured's obligations prior to items or services being provided.
- For plan years beginning on or after January 1, 2023, price and cost sharing estimates must be provided for a specifically delineated list of 500 items and services.
- For plan years beginning on or after January 1, 2024, price and cost sharing estimates must be disclosed for all items and services.

In addition, insured plans can take credit in their medical loss ratio (MLR) calculations if their insureds chose cost-effective care. Insurers can begin to include this in their MLR calculations for the 2020 reporting year.

Plan sponsors should begin working closely with their insurers and third party administrators (TPAs) to achieve compliance with these rules. Self-funded plan sponsors should also be aware that while the plan sponsor can contractually obligate a TPA to satisfy these obligations, the plan sponsor ultimately remains liable if the TPA fails to comply with these disclosures.

Updates: State-required Individual Mandate Reporting

A handful of states enacted individual mandate laws that require residents to be covered by minimum essential coverage (MEC) or pay a state tax (see our *Benefit Beat* articles from May, 2020 and September, 2019). These states are California, District of Columbia, Massachusetts, New Jersey, Rhode Island and Vermont. Further, certain states require entities who provide MEC to file information returns to the relevant state revenue departments. Most of these states accept the Form 1094 and 1095 series used for federal MEC filing purposes. Recently, several state revenue departments have issued updates relating to these reporting obligations, as reflected in the charts below.

Notably, unlike many other employment laws, these state individual mandates are not based on place of employment; rather, the applicability of the state individual mandate laws is based on state of residence.

Individual State Mandate Reporting				
State	*Covered entities*	*Applicable form(s)*	*Report due*	*Resources*
California	◆ Self-funded plan sponsors, health insurers ◆ Employers required to report the information if insurer does not	Same forms used for federal purposes (Form 1094/1095)	◆ File annually by March 31 ◆ Provide written statement annually by January 31 to individuals	California Franchise Tax Board **Reporting Information**
District of Columbia	◆ Self-insured health plans, fully insured health plans covering min. 50 full-time employees, health insurers ◆ Third party service providers may file forms for applicable entities	Same forms used for federal purposes (Form 1094/1095)	◆ File 30 days after IRS deadline for submitting 1095-B/C forms, including any extensions ◆ Form 1095-B/C satisfies DC obligation; no further benefit statement to individuals required	District of Columbia Office of Tax and Revenue **Updated Guidance**
Massachusetts	◆ Employers, health insurers and other entities that provide health coverage ◆ Employers may contract with TPA to fulfill this obligation	Form MA 1099-HC	Provide annually by January 31 to primary subscriber, and file with Department of Revenue	Massachusetts Department of Revenue **Health Care Reform for Employers**
	◆ Employers with six or more employees	Health Insurance Responsibility Disclosure (HIRD) form	Annual HIRD filing period: begins Nov. 15 and ends Dec. 15	Massachusetts Department of Revenue **HIRD FAQs**

Individual State Mandate Reporting, cont'd				
State	*Covered entities*	*Applicable form(s)*	*Report due*	*Resources*
New Jersey	◆ Employers, health insurers and other entities that provide health coverage ◆ Employers must submit the forms if the insurer does not	◆ Forms 1095-B/C ◆ Form NJ-1095	◆ File report annually by March 31 ◆ For tax year 2020, provide Form 1095-B to each primary enrollee by March 2, 2021	New Jersey Division of Taxation **Guidance**
Rhode Island	◆ Employer/plan sponsors, licensed insurers ◆ Employers may contract with a third party for reporting and disclosure obligations	Forms 1094/1095	◆ File report annually by January 31 (for tax year 2020, deadline extended to March 31, 2021) ◆ Provide written statement annually by January 31 to individuals (for tax year 2020, deadline extended to March 2, 2021)	Rhode Island Division of Taxation **Health Coverage Mandate**
Vermont	As of January 1, 2020, Vermont residents must maintain a minimum level of health coverage. The law requires residents to self-report compliance when filing his/her taxes. There is no penalty for failure to have health coverage.			

Year-end Reminders

❑ Preventive Health Services

Prior to the beginning of each plan year, a group health plan sponsor or administrator should review its coverage for preventive services to determine whether any additional benefits need be offered. For insured plans, generally, the insurer manages this process.

As background, the Affordable Care Act requires health plans to cover certain preventive services, without imposing any cost-sharing requirements (co-pay, co-insurance, or deductible), when such services are delivered by in-network providers. The types of covered preventive services, some of which are recommended by the U. S. Preventive Services Task Force (USPSTF), are updated periodically. Generally, once the USPSTF approves a particular recommendation, the service would become applicable as of the first plan year beginning one year following issuance of the recommendation. The USPSTF website provides a list of its recommended A and B preventive services by date and alphabetically. Further, a complete list of ACA-required preventive services can be accessed from the Healthcare.gov website.

With regard to a **COVID-19 vaccine**, the tri-governing agencies (DOL/IRS/HHS) issued final regulations on November 6, 2020 to clarify how coverage will be provided. As a reminder, the CARES Act enacted in March, 2020 expedited the timeframe in which a coronavirus vaccine will be covered as a preventive service to 15 days from the date a vaccine is sanctioned as a preventive service. The final regulations provide that the cost of a recommended COVID-19 vaccine and its administration, whether obtained in-network or out-of-network, is covered as a preventive service, with no cost share. To meet the requirements of a *qualifying coronavirus preventive service*, including a vaccine, the regulations clarify that such service be FDA-approved, with an A or B rating by the USPSTF, or recommendation by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

Employer Shared Responsibility Provisions

- *Applicability.* For purposes of the ACA's employer shared responsibility requirement as well as the reporting and disclosure requirements, applicable large employer (ALE) status is determined each calendar year, based on the average size of the employer's workforce during the prior year. Thus, if you averaged at least 50 full-time employees, including full-time equivalent employees during 2020, you are most likely an ALE for 2021, and are subject to the reporting and disclosure requirements due in early 2022.

- *Affordability Standard.* For purposes of determining affordability, coverage under an employer-sponsored plan is deemed affordable if the employee's required contribution to the plan does not exceed 9.83% (indexed for 2021; up from 9.78% in 2020) of the employee's household income for the taxable year, based on the cost of single coverage in the employer's least expensive plan.

- *Increase in Excise Tax Penalties.* The chart below reflects the amount of penalties for purposes of calculating the 'no coverage' excise tax pursuant to Code Section 4980H(a), and the 'inadequate or unaffordable' excise tax pursuant to Code Section 4980H(b) for 2019 to 2021. These are the excise taxes that could apply if an applicable large employer is found not to have offered health coverage to a full-time employee. These amounts are based on the HHS inflationary percentage contained in its annual benefit and payment parameter standards for the relevant year, and as officially released by the Internal Revenue Service.

'No Coverage' Excise Tax IRC Section 4980H(a)		*'Inadequate or Unaffordable' Excise Tax IRC Section 4980H(b)*	
2019	$2,500	**2019**	$3,750
2020	$2,570	**2020**	$3,860
2021	$2,700	**2021**	$4,060

Small Business Tax Credit (SBTC). Small businesses and tax-exempt employers who provide health care coverage to their employees under a qualified health care arrangement are entitled to a tax credit, known as the small business tax credit (SBTC). To be eligible for the SBTC, the employer must employ fewer than 25 full-time equivalent employees, whose average annual wages are less than $55,600 (indexed for 2021; the wage ceiling in 2020 is $55,200).

The tax credit phases out for eligible small employers when the number of its full-time employees (FTEs) exceeds 10; or, when the average annual wages for the FTEs exceeds $27,800 in the 2021 tax year (the phase-out wage limit in 2020 is $27,600). As a reminder, only qualified health plan coverage purchased through a SHOP marketplace is available for the tax credit, and only for a 2-consecutive year period.

For purposes of calculating the SBTC, the Form 8941 is filed annually on the employer's tax return as a general business credit; tax exempt entities would file the Form 8941 with its Form 990-T.

Additional ACA-related Fees

Patient-Centered Outcomes Research Institute (PCORI) Fees

The PCORI fee is assessed on the average number of lives covered under the policy or plan. While the PCORI fee was set to expire for policy/plan years ending on or after October 1, 2019, the *Further Consolidated Appropriations Act, 2020* (enacted on December 20, 2019) extends the PCORI fee obligations for ten years. Thus, the fee will continue to be assessed through 2029.

For policy and plan years ending between October 1, 2018 and September 30, 2019, the fee was $2.45 per covered life. The fee increases to $2.54 per covered life for policy and plan years ending between October 1, 2019 and before October 1, 2020, according to IRS Notice 2020-44. Affected entities are required to pay the fees and file the Form 720 by July 31 of each year.

❑ ACA Cost Share Restrictions

The chart below reflects the 2021 and 2020 inflationary adjustments applicable to out-of-pocket (OOP) limits including deductibles, co-insurance and co-payments in ACA plans. These cost-share restrictions apply to insured plans offered via the marketplace, and insured and self-funded plans offered outside marketplace. These amounts differ from the OOP limits applicable to high deductible health plans used in conjunction with a health savings account (HSA).

	2021		2020	
	Self-only	*Family*	*Self-only*	*Family*
ACA Plans - Out-of-Pocket (OOP) Limits	$8,550	$17,100	$8,150	$16,300
Health Savings Accounts	*Individual*	*Family*	*Individual*	*Family*
HDHP Annual Deductible	$1,400	$2,800	$1,400	$2,800
HDHP Annual Out-of-Pocket Limit	$7,000	$14,000	$6,900	$13,800
Contribution Limit	$3,600	$7,200	$3,550	$7,100

❑ Highlights of ACA-related Reporting and Disclosure Reminders

The two tables below reflect certain reporting and disclosure requirements. Of particular note:

- **Clarifications to revised SBC Template for 2021.** As mentioned in *CBIZ Health Reform Bulletin 148*, the DOL and HHS issued a revised summary of benefits and coverage (SBC) template and related materials to be used by plan sponsors and insurers for policy/plan years beginning on or after January 1, 2021 relating to coverage for plan years beginning on or after that date. These documents are available on the DOL-EBSA and/or HHS-CCIIO webpages.

- The IRS issued final versions of the **Forms 1094 and 1095 series** (see *CBIZ Health Reform Bulletin 154*). Paper versions of the forms must be submitted to the IRS by March 1, 2021, or sent electronically by March 31, 2021. The deadline for furnishing benefit statements (Form 1095-B and Form 1095-C) to individuals has been extended from January 31, 2021 to March 2, 2021.

ACA-required Reporting Reminders

Form	*To Whom*	*Due Date*
Form W-2 *ACA-required reporting includes*: ◆ Aggregate cost of health coverage (Box 12, using Code DD). *Note: employers filing <250 Form W-2s per year remain exempt from reporting the aggregate cost of health coverage on the Form W-2 until future IRS guidance is issued.*	Internal Revenue Service (IRS) http://www.irs.gov/ Form W-2 Instructions (2020)	January 31, 2021

ACA-required Reporting Reminders, cont'd

Form	*To Whom*	*Due Date*
Form W-2 reporting, cont'd ◆ Total amount of permitted benefits received under a qualified small employer health reimbursement arrangement (QSEHRA) (Box 12 - Code FF) ◆ Additional Medicare tax withholding on earnings exceeding $200,000 per calendar year (Box 6)	Internal Revenue Service (IRS) http://www.irs.gov/ Form W-2 Instructions (2020)	January 31, 2021
Form 1094/1095 *See CBIZ HRB 154 for discussion of final 2020 Forms and Instructions*		
◆ File Forms 1094/1095	IRS	◆ By paper: March 1, 2021 ◆ Efile: March 31, 2021
◆ Furnish Form 1095; or, certain Form 1095-B reporting entities can utilize simplified posting method	Individuals listed in Forms 1094 and 1095	March 2, 2021
Form 720 Used for purposes of Patient Centered Outcome Research Institute (PCORI) fee	IRS	July 31 of each year

Additional ACA-Related Disclosure Reminders

Note: Below are select ACA-required disclosures. For a more descriptive list of notice obligations relating to the ACA and other welfare benefit plans, ask your CBIZ representative for a Chart of Notice Obligations.

Form	*To Whom*	*Due Date*
Summary of Benefits and Coverage (SBC) SBC template and related materials available from **DOL-EBSA** and/or **HHS-CCIIO** ***Important Note:*** Two versions of these materials available: ◆ One set for plan years beginning on or after Jan. 1, 2021; or, ◆ One set for use on or after April 1, 2017	All plan participants	From Plan Sponsor to Plan Participants: 1. Upon application 2. By the first day of coverage 3. Within 90 days of enrollment by special enrollees 4. Upon contract renewal 5. Upon request
Advanced 60-day Notice of Material Change in Benefits	All plan participants	No later than 60 days prior to any material change in any terms of plan affecting Summary of Benefits and Coverage (SBC) content not reflected in the most recently-provided SBC (other than in connection with renewal or reissuance of coverage)

Additional ACA-Related Disclosure Reminders, cont'd

Form	*To Whom*	*Due Date*
Notice of Marketplace Options ◆ Model notice for use by employers **who offer coverage** to some or all employees: ▪ English (**PDF** or **Word**) ▪ Spanish (**PDF** or **Word**) ◆ Model notice for employers who **do not offer health coverage:** ▪ English (**PDF** or **Word**) ▪ Spanish (**PDF** or **Word**)	All new hires including full-time and part-time employees, without regard to eligibility status for the health plan	Within 14 days of date of hire

Increased Penalties for Certain Compliance Violations

Federal government agencies who enforce the ACA, including the Departments of Labor, Treasury and Health and Human Services, have authority to adjust civil penalties attributable to compliance failures.

Failure to provide Summary of Benefits and Coverage (SBC)	Up to $1,176 per failure *(indexed for 2020)*
Failure to file a correct information return *Example: Form 1094/1095 and W-2*	▪ Avg. annual receipts/3 years ≥$5M: $280 per return (cap of $3,426,000 per calendar year) ▪ Avg. annual receipts/3 years ≤$5M: $280 per return (cap of $1,142,000 per calendar year) *(indexed for 2021)*
Failure to provide correct payee statement *Example: Forms 1094/1095 and W-2*	▪ Avg. annual receipts/3 years ≥$5M: $280 per return (cap of $3,426,000 per calendar year) ▪ Avg. annual receipts/3 years ≤$5M: $280 per return (cap of $1,142,000 per calendar year) *(indexed for 2021)*

About the Author: Karen R. McLeese is Vice President of Employee Benefit Regulatory Affairs for CBIZ Benefits & Insurance Services, Inc., a division of CBIZ, Inc. She serves as in-house counsel, with particular emphasis on monitoring and interpreting state and federal employee benefits law. Ms. McLeese is based in the CBIZ Kansas City office.

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Health Reform Bulletin

CBIZ

Subject: 1) CMS Benefit and Payment Parameters for 2022, 2) Federal Poverty Level Guidelines for 2021, 3) Extended Transition Period for ACA Compliant Policies, 4) Federal Marketplace Special Enrollment Period, 5) Individual Coverage HRA (IC-HRA) Developments

Date: May 11, 2021

CMS Benefit and Payment Parameters for 2022

On May 5, 2021, the Centers for Medicare & Medicaid Services (CMS) published Final Benefit and Payment Parameters for 2022, together with a Fact Sheet. These uniform standards, as required under the Affordable Care Act (ACA), are intended for health insurers and the marketplace to ensure health coverage options for consumers, as well as provide planning guidance for insurers and employers. These regulations take effect on July 6, 2021.

Following are highlights of the final rules of interest to employers:

Cost-Sharing Limits

The ACA imposes certain cost-sharing restrictions, such as out-of-pocket limits on health plans. These annual out of pocket limits apply to insured plans offered through the marketplace, and insured and self-funded plans offered outside marketplace. Below are cost sharing limitations for 2021 and 2022:

	Self-only Coverage (Individual)	Other than Self-only Coverage (Family)
2021	$8,550	$17,100
2022	$8,700	$17,400

For purposes of determining the ACA out-of-pocket limits, these rules use the methodology that was used for the 2015 through 2019 years which result in a lower out-of-pocket limit than the methodology that was used for 2020 and 2021. Further, this methodology will also impact the calculation of the affordability standard which is 9.83% for 2021. This metric is used for determining whether an employer subject to employer shared responsibility (employers employing 50 or more employees) offer affordable coverage. Further, it will impact the calculation of the IRC section 4980H (a) and (b) penalties. Thus far, neither the affordability standard nor the IRC section 4980H (a) or (b) penalties for 2022 have been announced.

As a reminder, the out-of-pocket (OOP) limits applicable to high deductible health plans (HDHP) used in conjunction with health savings accounts (HSA) differ from these ACA-imposed cost sharing limits. Below are the OOP limits for HDHP plans for 2021 and 2022:

	Individual/Self Only		Family	
	2021	2022	2021	2022
Contribution Limit	$3,600	$3,650	$7,200	$7,300
HDHP Annual Deductible	$1,400	$1,400	$2,800	$2,800
HDHP Annual Out-of-Pocket Limit*	$7,000	$7,050	$14,000	$14,100

Benefit Limit for Excepted Benefit HRA

Employers can choose to offer an HRA integrated with individual coverage (IC-HRA), or an excepted benefit HRA (EB-HRA). An EB-HRA is a stand-alone HRA that can be used to reimburse certain Code Section 213(d) expenses such as co-pays and deductibles, as well as premium for certain excepted benefits policies such as dental and vision.

One of the criteria for this type of HRA is a cap or limit on the maximum reimbursement for medical expenses that can be made through the EB-HRA; this amount is subject to inflationary indexing. The maximum contribution amount for plan years beginning in 2022 remains at $1,800.

Reduction in Cost-sharing through the Marketplace for 2022

The Guidance provides that for individuals who purchase health insurance through the marketplace, the maximum annual limitation on cost sharing is below what CMS proposed in November 2020, as noted in the table below.

Eligible individual	Self-only Coverage (Individual)	Other than Self-only Coverage (Family)
Income between 100%-200% of FPL	$2,900	$5,800
Income above 200% through 250% of FPL	$6,950	$13,900

Medical Loss Ratio (MLR) Calculation

The final rules address the calculation of the medical loss ratio (MLR). As a reminder, the MLR rules require insurers issuing individual and group health plans to spend a certain amount of premium dollars on medical care and health care quality improvements. Generally, the MLR rules require insurers to spend at least 85% of premium dollars paid by the large group market (over 100 employees) on medical claims; 80% in the small group (100 or fewer employees) and individual markets.

This Guidance allows insurers to prepay the MLR estimate, such as by providing a premium credit, anytime over the course of the year as long as it does so in a nondiscriminatory manner. This applies for the 2020 reporting year which is due in 2021.

Further, the Guidance provides that beginning for the 2021 reporting year reported in 2022, temporary premium credits can be provided as a result of a public emergency, similar to the premium credits that many insurers provided in the summer of 2020 as a result of the coronavirus public emergency. If

insurers choose to provide this form of premium credit, it might save plan sponsors some headaches in determining how to use MLR refunds.

Special Enrollment Periods

The final rules establish two new special enrollment periods. One for individuals who did not receive timely notice of a triggering event and another one for cessation of employer contributions or government subsidies, such as the American Rescue Plan Act COBRA subsidy. See *Special Edition At Issue:* COBRA Premium Subsidy under the American Rescue Plan

Untimely notice of triggering event

A qualified individual, enrollee, or dependent who did not receive timely notice of a triggering event or was otherwise reasonably unaware that a triggering event occurred, will qualify for an applicable special enrollment period and select a new plan within 60 days of the date that he or she knew, or reasonably should have known, of the occurrence of the triggering event.

The individual will be allowed to choose the earliest effective date that would have been available if he/she had received timely notice of the triggering event.

Cessation of employer contributions or government subsidies to COBRA

A special enrollment period is triggered when a qualified individual or his or her dependent is enrolled in COBRA continuation coverage and employer contributions or government subsidies to COBRA continuation coverage cease.

The triggering event for this special enrollment period would be based on loss of employer contributions or government subsidies to COBRA continuation coverage, rather than the loss of coverage itself. The qualified individual or his/her dependent would have 60 days to select a qualified health plan.

Federal Exchange User Fees

On January 19, 2021, HHS finalized the user fee rates for insurers offering qualified health plans through the federally-facilitated exchanges at 2.25% of total monthly premiums and user fee rates through state-based exchanges on the federal platform at 1.75% of total monthly premiums.

On January 28, President Biden issued an Executive Order directing all agencies to review regulations, orders, guidance, policies, etc. to determine whether such agency actions are inconsistent with this Administration's policy to protect and strengthen the ACA and to make high-quality health care accessible and affordable for every American.

Due to this Executive Order, HHS intends to propose new qualified health plan user fees rates for the 2022 plan year. A new federally-facilitated exchange user fee rate of 2.75% of total monthly premiums; and a new state-based exchange on the federal platform user fee rate of 2.25% of monthly premiums.

Federal Poverty Level Guidelines for 2021

The Department of Health and Human Services has released the **federal poverty level (FPL) guidelines for 2021**. These poverty guidelines are important for a number of reasons, not the least of which is the Affordable Care Act.

- The FPL guidelines are used to determine eligibility for premium assistance and cost-sharing.
- Further, for employer shared responsibility purposes, use of the FPL guidelines is one of three safe harbor methods that can be utilized to determine an individual's household earnings for purposes of satisfying the ACA's affordability standard. Coverage under an employer-sponsored plan is deemed affordable to a particular employee if the employee's required contribution to the plan does not exceed 9.83% (indexed for 2021) of the employee's household income for the taxable year, based on the cost of single coverage in the employer's least expensive plan. If the FPL guidelines safe harbor is used, the maximum individual contribution is $105.51 (indexed for 2021). The W-2 safe harbor determines affordability using Box 1 of the employee's W-2. The rate of pay safe harbor determines affordability based on the employee's hourly rate.
- As background, employers subject to the ACA's employer shared responsibility provisions who fail to offer minimum essential coverage to their full-time employees or fail to offer adequate and affordable coverage may be subject to an excise tax if at least one of its employees qualifies for premium assistance through a marketplace. If an employer is using the FPL as its affordability standard, it is allowed to use the FPL guidelines in effect six months prior to beginning of the plan year. Note: a calendar year plan must use the 2020 FPL guidelines since the 2021 FPL guidelines were not issued when the offer of coverage was made.
- In addition, these FPL guidelines are used to determine eligibility for other federal entitlement programs such as the Children's Health Insurance Program, certain parts of Medicaid, and subsidies for Medicare Part D prescription benefits.

The 2021 FPL guidelines became applicable on January 13, 2021 (unless an office administering a program using the guidelines specifies a different effective date for that particular program). Below is a chart reflecting the 2021 and 2020 levels.

2021 Poverty Guidelines for the 48 Contiguous States and District of Columbia

Note: The FPL limits vary slightly in Alaska and Hawaii

Persons in family/household	*2021 Poverty Guidelines*	*2020 Poverty Guidelines*
1	$12,880	$12,760
2	$17,420	$17,240
3	$21,960	$21,720
4	$26,500	$26,200
5	$31,040	$30,680
6	$35,580	$35,160
7	$40,120	$39,640
8	$44,660	$44,120
More than 8 persons:	Add $4,540 for each additional person	Add $4,480 for each additional person

Additional poverty guidelines are available from the **HHS Office of The Assistant Secretary for Planning and Evaluation**.

Extended Transition Period for ACA Compliant Policies

Certain so-called 'grand-mothered' policies in the individual and small group markets have enjoyed exemption from certain market provisions by way of non-enforcement guidance issued by the CMS' Center for Consumer Information and Insurance Oversight (CCIIO). On January 19, 2021, CCIIO released another **extension** providing that individual and small group non-grandfathered health policies renewing prior to October 1, 2022 (but ending by January 1, 2023) could be renewed, free from many of the ACA's market reforms, including:

- Fair health insurance premiums;
- Guaranteed availability of coverage;
- Guaranteed renewability of coverage;
- Prohibition of pre-existing condition exclusions or other discrimination based on health status with respect to adults, except with respect to group coverage;
- Prohibition of discrimination against individual participants and beneficiaries based on health status except with respect to group coverage;
- Non-discrimination in health care;
- Comprehensive health insurance coverage; and
- Approved clinical trials.

This means that unless extended again, or if changes are made by Congress or the Biden Administration in the interim, beginning January 1, 2023, these policies must be ACA-compliant.

Federal Marketplace Special Enrollment Period

Due to the coronavirus pandemic many state-based marketplaces offered a special enrollment period in the spring of 2020 when the coronavirus emergency started. The federal marketplace, including states that use the federal marketplace platform, did not offer a special enrollment opportunity.

On January 28, 2021, President Biden signed an **Executive Order** making a special enrollment period available in the federal marketplace. CMS has affirmed that the **special enrollment period** will run from February 15, 2021 to August 15, 2021. Below is a list of states that use the federal marketplace.

Alabama	Kentucky*	Ohio
Alaska	Louisiana	Oklahoma
Arizona	Maine*	Oregon*
Arkansas*	Michigan	South Carolina
Delaware	Mississippi	South Dakota
Florida	Missouri	Tennessee
Georgia	Montana	Texas
Hawaii	Nebraska	Utah
Illinois	New Hampshire	Virginia*
Indiana	New Mexico*	West Virginia
Iowa	North Carolina	Wisconsin
Kansas	North Dakota	Wyoming

*State run marketplace but use the federal platform

Note: the following state-based marketplaces have followed suit and are offering a special enrollment period to give people an opportunity to enroll:

State	Special Enrollment Period
California	Until Dec. 31, 2021
Colorado	Until Aug. 15, 2021
Connecticut	Between May 1 and Aug. 15, 2021
District of Columbia	Through the end of the pandemic emergency
Maryland	Until Aug. 15, 2021
Massachusetts	Until July 23, 2021
Minnesota	Until July 16, 2021
Nevada	Until Aug. 15, 2021
New Jersey	Until Dec. 31, 2021
New York	Until Dec. 31, 2021
Pennsylvania	Until Aug. 15, 2021
Rhode Island	Until Aug. 15, 2021
Washington	Until Aug. 15, 2021

Note: these marketplace special enrollment opportunities do not directly impact employer-sponsored group health coverage. They may provide a health coverage opportunity to individuals who may have lost access to employer-sponsored coverage.

Further, the Executive Order directs government agencies to review any standards or positions that impede access to health coverage and to revise or make recommendations for modification. As an example, the government is asking the U.S. District Court of Appeals for the D.C. circuit, which is considering a challenge to the association plan regulations promulgated by the Trump administration, to delay ruling until the Biden administration has a chance to assess its position on the matter (see Health Reform Bulletin 139)

Individual Coverage HRA (IC-HRA) Developments

An individual HRA is a special type of HRA that allows the purchase of individual health insurance policies. In January of 2021, final regulations were issued but not published in the federal register. The Biden Administration has withdrawn those regulations to give its administration the opportunity to review the regulations. The regulations address IC-HRA compliance with employer shared responsibility as well as compliance with the Internal Revenue Code Section 105(h) salary based discrimination rules. Final regulations are similar to the proposed regulations (see Health Reform Bulletin 145). If and when these regulations are re-issued, a more detailed summary will be provided.

The Equal Employment Opportunity Commission (EEOC) has responded to a request about how an IC-HRA can comply with the Age Discrimination in Employment Act (ADEA). In summary, this letter provides that a plan will be ADEA compliant if the employer makes a like contribution to all IC-HRA participants without regard to age. Further, the letter provides that the employer can make a larger contribution for older aged individuals. Compliant with previously issued regulations, the EEOC provides that providing a smaller contribution for older aged individuals would not be compliant.

Finally, the letter affirms that the individual insurance policy used in conjunction with the IC-HRA is not subject to the ADEA. This letter is a good reminder that there are laws in addition to the Internal Revenue Code and ERISA that apply to IC-HRAs.

About the Author

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Subject: 1) Supreme Court Rules on Affordable Care Act; and 2) Annual PCORI Fee and Filing
Date: June 18, 2021

Supreme Court Rules on Affordable Care Act

In a 7-2 decision issued on June 17, the U.S. Supreme Court upheld the Affordable Care Act (ACA). The multi-state lawsuit, *California v. Texas*, was the third challenge to the ACA to reach the Supreme Court.

A group of 20 states led by Texas, ("Plaintiffs"), alleged that because the ACA's monetary penalty for failure to obtain minimum essential coverage was reduced to $0 in 2017, the minimum essential coverage provision was thereby unconstitutional. Plaintiffs sought the following:

1. A finding that Plaintiffs had standing to file this lawsuit;
2. A finding that the minimum essential coverage provision was unconstitutional;
3. A finding that the minimum essential coverage provision was not severable from the rest of the ACA (thereby rendering the whole ACA unconstitutional); and
4. An injunction against enforcement of the ACA.

A Texas federal district court agreed with the Plaintiffs as to points 1, 2, and 3. The 5th Circuit Court of Appeals agreed with the Plaintiffs as to points 1, and 2, but disagreed as to point 3. A group of 21 states led by California sought the Supreme Court's review.

In their decision, the Supreme Court found that the Plaintiffs did not have standing to bring the lawsuit in the first place, "because they have not shown a past or future injury fairly traceable to" the enforcement of the minimum essential coverage mandate. As such, the ACA remains in place, in full force and effect.

It's important to note that by finding that the Plaintiffs did not have standing to bring the lawsuit, the Court did not make any determination regarding the constitutionality of the minimum essential coverage mandate, or whether the mandate renders the entire ACA unconstitutional.

Annual PCORI Fee and Filing Reminder

Payment of the annual PCORI fee together with the Form 720 filing deadline is approaching. The PCORI fee is assessed on the average number of lives covered under the policy or plan. For policy and plan years ending between October 1, 2020 and December 31, 2020, the fee is $2.66 per covered life (for policy and plan years ending between January 1, 2020 and September 30, 2020, the fee is $2.54 per covered life). The fee is to be paid in connection with filing the IRS Form 720, Quarterly Federal Excise Tax Return. For plan years ending in 2020, the fee is to be paid by August 2, 2021.

As background, the PCORI fee is assessed on the average number of lives covered under the policy or plan. Virtually, all health plans, whether insured or self-funded are subject to the PCORI fees. With regard to reimbursement type plans, health reimbursement arrangements (HRA) and medical flexible spending account (FSA) plans are subject to these fees. However, FSA plans that qualify as HIPAA-excepted plans are not subject to these fees. The PCORI fee does not apply to stand alone dental or vision plans. The IRS provides a **chart** for determining the applicability of the PCORI fee to types of insurance coverage or arrangements and whether such coverage or arrangement is subject to the fee, and the person or entity responsible for paying the fee.

The PCORI fees are assessed on the insurer of an insured plan. For a self-funded plan, the plan sponsor is required to pay the fee on behalf of its plan. Because the law provides that the PCORI fees are to be paid by the plan sponsor, at least for plans subject to ERISA, the fees cannot be paid from plan assets.

Additional information about the PCORI fee is available on the IRS' dedicated **PCORI webpage** and **Questions and Answers.**

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