Introduction

Affordable Care Act Overview of Changes

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Introduction

Affordable Care Act
Overview of Changes

Presented by:

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• On June 28, 2012 the Supreme Court declared the individual mandate to be permissible exercise of Congress’s taxing powers under the Constitution.

• The mandate was not a penalty, but a tax and was allowed under Congress’s power to tax under Article 1 of the Constitution.

• The government's arguments that the Constitution's Commerce Clause or the Necessary and Proper Clause authorized Congress to enact Health Reform were rejected.

• The mandate that requires people to purchase health insurance or make a shared-responsibility payment does not regulate existing commercial activity, but instead compels individuals to become active in commerce by purchasing a product.
Overview of Changes Until Now
• An employer must report on an employee’s Form W-2 the aggregate cost of the employee’s health insurance coverage sponsored by the employer, excluding the amount of any salary reduction contribution to a flexible spending arrangement.

• “Aggregate cost” is determined under “rules similar to” the COBRA rules for applicable employer-sponsored coverage (including employee and employer contributions).

• Reporting is optional for 2011 and required for 2012 for employers who issued 250 or more Form W-2 in 2011.
The new Form W-2 reporting requirement applies only to “applicable employer-sponsored coverage”, and does not include the following:

This term generally includes any employer-provided coverage under an insured or self-insured health plan, but is subject to numerous exceptions, including exceptions for:

- accident-only insurance;
- disability income insurance;
- long-term care coverage;
- coverage only for a specified disease;
- hospital indemnity or other fixed indemnity insurance;
- stand-alone dental, or vision coverage.
- HRAs;
- Certain health flex plans; and
- Certain EAPs, on-site clinics and wellness plans
A four-page “summary of benefits and coverage” (“SBC”) is required to be provided to applicants and enrollees before enrollment or re-enrollment.

SBC’s are created by the insurance carriers. However, employers are responsible for their distribution.

First SBC must distributed by the first open enrollment occurring after September 23, 2012 or for those who enter the plan any other time, the plan or policy year beginning after September 23, 2012.
Who Must Be Furnished With Four-Page Summaries?

• Generally, the four-page summaries must be distributed to all applicants (at the time of application), policyholders (at issuance of the policy), and enrollees (at initial enrollment and annual enrollment).

• The four-page summaries required under health care reform must be provided to applicants, policyholders, and enrollees and beneficiaries.

• Can be provided by paper or electronically.

• The four-page summaries must be presented in a “culturally and linguistically” appropriate manner.
Each SBC must include:

- uniform definitions (see Uniform Glossary of Terms below) as well as an internet address leading to a uniform glossary and information such as a phone number, on how to obtain a paper copy of the uniform glossary;

- a description of the plan's coverage for each category of benefits, including exceptions, reductions and limitations;

- cost-sharing provisions such as coinsurance, co pays and deductibles;

- renewability and continuation of coverage information;

- coverage examples (see SBC ‘Coverage Examples' below);

- an internet address for obtaining a list of the network providers;

- an internet address for additional information about any prescription drug coverage;

- a statement that the SBC is only a summary and an explanation of the document, such as the plan document or certificate of insurance, which should be consulted for more information;

- contact information for questions or for obtaining a copy of the plan document, certificate of insurance, insurance policy or certificate of insurance, whichever is applicable; and

- for coverage beginning on or after Jan. 1, 2014, a statement as to whether the plan provides minimum essential coverage and pays at least 60 percent of the total cost of the benefit.
When Must the SBC be Distributed?

• **At Open Enrollment (Renewal)** The SBC must be included with open enrollment materials.
  • If the plan or insurer requires participants or beneficiaries to renew in order to maintain coverage for a succeeding plan year, a new SBC must be provided no later than the date the renewal materials are distributed.
  • If renewal is automatic, the proposed rules provide that the SBC must be furnished no later than 30 days prior to the first day of the new plan year, but there is a seven day rule if the policy is not yet issued.

• **At Initial Enrollment** - The SBC for each benefit package offered for which the participant or beneficiary is eligible must be provided as part of any written application materials that are distributed by the plan or insurer for enrollment.

• If the plan does not distribute written application materials for enrollment, the SBC must be distributed no later than the first date the participant is eligible to enroll in coverage for the participant and any beneficiaries.

• **At Special Enrollment** - The plan or insurer must also provide the SBC to special enrollees (employees and dependents with the right to enroll in coverage midyear upon specified circumstances) within 90 days of enrollment.

• **Upon Request** - The plan or insurer provide the SBC to a participant or beneficiary upon request, as soon as practicable, but in no event later than seven business days following the request.
Penalty for failure to provide new summary:

- A penalty of not more than $1,000 may apply for each willful failure to provide the required plan summary or advance summary of a material modification.

- Each participant who fails to receive a required summary (or summary of material modification) is counted separately in determining the amount of the penalty, so it appears that a willful failure to timely provide 5 participants with a summary could result in a fine of up to $5,000.
Medical Loss Ratio Rebates

• Insurers are required to make the first round of rebates by August 2012 based on their 2011 MLR.

• Insurers must generally provide rebates for individuals covered by group health plans to the policyholder—typically the employer sponsoring the plan.

• Who receives the rebate depends on the plan provisions and who paid the premiums.

• Proportional rebates or premium tax holidays must be given to employees who pay for a portion of their premiums.
Overview of changes during 2013
Health Flexible Spending Accounts

• The $2,500 limit on annual salary reduction contributions to health FSAs offered under cafeteria plans, effective for plan years beginning after December 31, 2012.

• Applies to employee contribution only.

• All health FSAs offered under cafeteria plans must comply.

• The limit does not apply to Dependent Care FSAs, HRAs or HSAs.
Health Flexible Spending Accounts

- The $2,500 amount is indexed for inflation for taxable years beginning after December 31, 2013.
- The $2,500 limit is reduced for short plan years.
- By its terms, the $2,500 limit applies to health FSA salary reduction contributions and not to other employer contributions.
• The employee portion of the hospital insurance tax part of FICA, currently amounting to 1.45% of covered wages, is increased by 0.9% on wages that exceed a threshold amount for tax years beginning after 12/31/2012.

• The additional tax is imposed on the combined wages of both the taxpayer and the taxpayer’s spouse, in the case of a joint return.

• The threshold amount is $250,000 in the case of a joint return or surviving spouse, $125,000 in the case of a married individual filing a separate return, and $200,000 in any other case.
So, in 2013, a single individual with wages of $230,000 will owe HI tax at a rate of 1.45% on the first $200,000 of wages, and HI tax at a rate of 2.35% on the remaining $30,000 of wages for the year.

Employers will be responsible for collecting and remitting the additional tax on wages that exceed $200,000.

An individual will be responsible for the additional tax if the amount withheld from his or her wages is insufficient.

The employer portion of the HI tax remains unchanged (at 1.45%).
Medicare Tax on Unearned Income

- Additional Medicare contribution tax will be imposed on the unearned income of individuals, estates and trusts, reduced by the deductions properly allocable to such income.
- Individuals pays a tax equal to 3.8% of the lesser of net investment or the excess of modified adjusted gross income over the threshold amount.
- The threshold amount is $250,000 in the case of a joint return or surviving spouse, $125,000 in the case of a married individual filing a separate return, and $200,000 in any other case.

Net investment income does not include distributions from a qualified retirement plan.

- The tax applies to a trade or business only if it is a passive activity with respect to the taxpayer or it consists of trading financial instruments or commodities.
Employers are required to provide all new hires and current employees with a written notice about the health benefit Exchange and some of the consequences if an employee decides to purchase a qualified health plan through the Exchange in lieu of employer-sponsored coverage.

Employees hired on or after the effective date must be provided the Notice of Exchange at the time of hiring.

Employees employed on the effective date must be provided the Notice of Exchange no later than the effective date.
With this notice, employees must be informed of the following:

• The existence of an Exchange, given a description of the services provided by the Exchange, and told how to contact the Exchange to request assistance.
• They may be eligible for a premium tax credit or a cost-sharing reduction (under PPACA 1402) through the Exchange if the employer plan’s share of the total cost of benefits under the plan is less than 60%.
• If they purchase a qualified health plan through the Exchange, then they may lose any employer contribution toward the cost of employer-provided coverage; and all or a portion of employer contributions to employer-provided coverage may be excludable for federal income tax purposes.
This entity will be funded in part by fees (sometimes referred to as “PCOR fees” or “CER fees”) paid by certain health insurers and applicable sponsors of self-insured health plans.

Fees are payable in connection with policy/plan years ending after September 30, 2012, but stop applying for policy/plan years ending after September 30, 2019.

While insurers will file reports and pay the fees for insured policies, self-insured plan sponsors must file reports and pay these fees.

Employers that have HRA plans are subject to the fees and subsequent filings. Plan sponsors and insurers will file IRS Form 720 to report the fees and make annual payments. This return must be filed each year by July 31 of the calendar year immediately following the last day of the policy year (for insured plans) or the plan year (for self-insured plans).
Overview of Changes During 2014
Employer Mandate

Are you a large or small employer?

• An employer is large if it employed an average of at least 50 full-time employees on business days during the preceding calendar year.
• For 2014 an employer may use any preceding 6 month period for determination of full-time status.
• Size to be determined on annual basis.
• In determining the number of full-time employees, an employer must add up the total number of hours worked in a month by part-time employees, divide by 120, and add that number to the number of full-time employees.
• A “full-time employee” for any month is an employee who is employed for an average of at least 30 hours of service per week.
• Record keeping needed to do this
• When calculation of full-time equivalency do not include more than 120 hours per month for each part-time employee.
Exceptions for seasonal employees

• Special rules apply to seasonal employees
• If an employers work force exceeds 50 for 4 months or less these individuals are not counted toward determination of their employer size as large or small.
Employer Mandate

Are you a large employer or small?

1. Number of full time employees (30 hours) average per week  
   A. ______

2. Number of part time employees hours worked per month  
   Part time # of hours ___ ÷ 120  
   B. ______

   Total A & B  
   __________

3. If total is greater than 49 you are a large employer

4. If you are less than 50 employees you are currently not subject to the Employer Mandate.
Employer Mandate

Small Employer

• Small employers are not subject to the 30 hour rule.
• Small employers do not have to offer coverage to the employees who work over 30 hours.
• Employees who are not offered coverage can buy coverage from the individual marketplace, federal assistance in the form of cost sharing subsidies or premium tax credits will be available.
Employer Mandate

Small Employer Minimum Essential Coverage

An employee will be eligible for premium tax credits and cost sharing subsidies if they are offered coverage that does not meet:

Minimum Value Test
• A plan that provides 60% coverage with respect to the total allowed costs and benefits will be deemed having minimum values.
• Starting in 2014 all small group plans will comply to the minimum value test by law.

Affordability Test
• Employer plan that charges an employee premium that does not exceed 9.5% of wages.

If an employee is offered coverage that does not meet both the minimum value test and affordability test they will be eligible subsidies from the individual marketplace.
Employer Mandate

Small Employer Coverage 2014 & Beyond
How Will Small Groups Buy Coverage?

• Small Groups will have several options for purchasing coverage beyond 2014.
• The Small Business Health Options Program (SHOP) is the federally run marketplace (Delayed until 2015)
• Private Exchanges- Market places offered through a single or several carriers with simplified plans and guidelines, and greater experience level
• Group Insurance brokers and agents will still probably be around to simplify the plans and offerings
Large Employers

• Certain large employers may be subject to penalty taxes for failing to offer health care coverage for all full-time employees, offering minimum essential coverage that is unaffordable, or offering minimum essential coverage under which the plan's share of the total allowed cost of benefits is less than 60%.

• The penalty tax is due if any full-time employee is certified to the employer as having purchased health insurance through an Exchange with respect to which a tax credit or cost-sharing reduction is allowed or paid to the employee.
Employer Mandate

Large Employers

• Large employers who do not offer “minimum essential coverage” and have at least one full-time employee who receives premium tax credits would be assessed a fee of $2,000.

• An applicable large employer will pay a penalty tax (i.e., make an assessable payment) for any month that—
  • ~(1)~ the employer fails to offer to its full-time employees (and their dependents) the opportunity to enroll in “minimum essential coverage” under an eligible employer-sponsored plan for that month; and
  • ~(2)~ at least one full-time employee of the employer has been certified to the employer as having enrolled for that month in a QHP for which a premium tax credit or cost-sharing reduction is allowed or paid.
Employer Mandate

Large Employer

• If an employee is offered affordable minimum essential coverage under an employer-sponsored plan, then the individual generally is ineligible for a premium tax credit and cost-sharing reductions for health insurance purchased through an Exchange.
• But employees covered by an employer-sponsored plan will be eligible for the premium tax credit if the plan's share of the total allowed costs of benefits provided under the plan is less than 60% of the cost (that is, the plan does not provide “minimum value”), or the premium exceeds 9.5% of the employee's income, (based on W2).

ex:, Employee earns $23,000 x .095 = $2,421 a year or $182.08 a month.
Large Employer

• The penalty tax (assessable payment) is equal to $250 (1/12 of $3,000, adjusted for inflation after 2014) times the number of full-time employees for any month who receive premium tax credits or cost-sharing assistance (this number is not reduced by 30).

• This penalty tax is capped at an overall limitation equal to the “applicable payment amount” (1/12 of $2,000, adjusted for inflation after 2014) times the employer's total number of full-time employees, reduced by 30.
Employer Mandate

Large Employer

Notice to Employer of Premium Assistance:

- The penalty tax is triggered, in part, by the employer receiving a certification that one of its employees is determined to be eligible for a premium assistance credit or a cost-sharing reduction.
- The employee may be eligible because the employer does not provide minimal essential coverage through an employer-sponsored plan.
- Or the employee may be eligible because the coverage the employer offers either is not affordable, or the plan's share of the total allowed cost of benefits is less than 60%.
- The employer must also receive notification of the appeals process established for employers notified of potential liability for penalty taxes.
Employer Mandate

Reporting of Health Insurance Coverage:

• Certain employers are required to report to the IRS whether they offer their full-time employees and their employees' dependents the opportunity to enroll in “minimum essential coverage” under an eligible employer-sponsored plan and to provide certain other information.

• Reporting employers must also provide a related written statement to their full-time employees.
Employer Mandate

Reporting of Health Insurance Coverage:

The employer's return, which must in the form be set out by the IRS, must contain the following information—

- the employer's name, date, and employer identification number (EIN);

- a certification of whether the employer offers its full-time employees and their dependents the opportunity to enroll in “minimum essential coverage” under an eligible employer-sponsored plan (as defined in Code 5000A(f)(2));

- the number of full-time employees the employer has for each month during the calendar year;

- the name, address, and taxpayer identification number (TIN) of each full-time employee employed by the employer during the calendar year and the months (if any) during which the employee and any dependents were covered under a health benefit plan sponsored by the employer during the calendar year; and

- any other information required by the IRS.
Employer Mandate

Reporting of Health Insurance Coverage:

• Employers that offer the opportunity to enroll in “minimum essential coverage” must also report—
  - 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;
  - the employer's share of the total allowed costs of benefits provided under the plan;
  - in the case of an employer that is an applicable large employer, the length of any waiting period with respect to such coverage; and
  - in the case of an employer that is an offering employer, the option for which the employer pays the largest portion of the cost of the plan and the portion of the cost paid by the employer in each of the enrollment categories under such option can offer more than one plan, but one must be minimum.
Employer Mandate

Notice Requirements:

• Employers required to submit a report of health insurance coverage to the IRS must also furnish a written statement to each of their full-time employees whose name was required to be included in the report.

• This statement must include—
  
  - the name, address, and contact information of the reporting employer; and
  - the information required to be shown on the return with respect to the individual.

• The written statement must be furnished to full-time employees on or before January 31 of the year following the calendar year for which the information was required to be reported to the IRS.
Waiting Periods

- A plan must not apply a waiting period that exceeds 90 days.
- Hard 90 day cap employee eligible by 91st day.
- This prohibition applies to group health plans and insurers but not to certain “excepted dental and vision benefits.”
- Grandfathered health plans must also comply with the waiting period requirements.
• A plan may not impose any pre-existing condition exclusion.
• This will be the case whether or not an individual has prior creditable coverage and whether or not the individual is a late enrollee.
• The prohibition includes both denial of enrollment and denial of specific benefits based on a preexisting condition.
• A PEC also includes any limitation or exclusion based on information relating to an individual's health status, “such as a condition identified as a result of a pre-enrollment questionnaire or physical examination given to the individual, or review of medical records relating to the pre-enrollment period.”
Cost Sharing Requirements

• Health care reform requires that “cost-sharing” be limited.
• This requirement applies to all group health plans (including self-insured plans)
• Cost-sharing includes deductibles, co-insurance, co-payments or similar charges, and any other required expenditure which is a qualified medical expense with respect to essential health benefits covered under the plan.
• Cost-sharing does not include premiums, balance billing amounts for non-network providers, or spending for non-covered services.
Overall Cost-Sharing Limitation (Out-of-Pocket Maximum):

- A plan must not impose cost-sharing in excess of the maximum out-of-pocket amount in effect for high deductible health plans for 2014.
- For 2013, the HDHP maximum out-of-pocket expense limit (that is, the sum of the plan’s annual deductible and other annual out-of-pocket expenses (other than premiums) that the insured is required to pay, such as co-payments and co-insurance for an HDHP) cannot exceed $6,250 for self-only coverage and $12,500 for family coverage.
- For 2015 and later years, the maximum is subject to increase.
Cost Sharing Requirements

• **Limit on Annual Deductible:**

  • The annual deductible must not exceed:
    – $2,000, in the case of a plan covering a single individual, or
    – $4,000 in the case of any other plan.
  • The above figures will be indexed and may increase for years after 2014.
  • The maximum deductible amounts may be increased by the maximum amount of reimbursement reasonably available to a participant under a “flexible spending arrangement.”
2014

- U.S. citizens and legal residents are required to have qualifying health coverage.
- Those without coverage pay a tax penalty of the greater of $695 per year up to a maximum of three times that amount ($2,085) per family or 2.5% of household income.
- The penalty will be phased-in according to the following schedule: $95 in 2014, $325 in 2015, and $695 in 2016 for the flat fee or 1.0% of taxable income in 2014, 2.0% of taxable income in 2015, and 2.5% of taxable income in 2016.
Individual Mandate

Beginning after 2016, the penalty will be increased annually by the cost-of-living adjustment.

- Exemptions will be granted for:
  - financial hardship, religious objections,
  - American Indians,
  - those without coverage for less than three months,
  - Undocumented immigrants,
  - incarcerated individuals,
  - those for whom the lowest cost plan option exceeds 8% of an individual’s income, and
  - those with incomes below the tax filing threshold (in 2009 the threshold for taxpayers under age 65 was $9,350 for singles and $18,700 for couples).
Individual Mandate

Subsidies for individuals

To be eligible, individuals must:

• Purchase coverage from a state or federal exchange
• Have incomes between 133% and 400% of federal poverty level (FPL)
• Not have access to minimum essential coverage through their employer or have access to coverage, but it is not affordable
• Premium credits – For any level plan
• Cost-sharing subsidies – Silver Plan only

FPL Income Ranges 133%- 400%
• Individual- $14,856- $44,680
• Family of Four-$30,656-$92,200
Essential Health Benefits

Offers a core package of items and services, and must include:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
Essential Health Benefits

- Rehabilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

States can select a benchmark plan from among several options, including the largest small group private health insurance plan by enrollment in the state. The final rule provides that all plans subject to EHB offer benefits substantially equal to the benefits offered by the benchmark plan.
Actuarial Value, is calculated as the percentage of total average costs for covered benefits that a plan will cover.

• An AV of 70 percent, on average, a consumer could expect to be responsible generally for 30 percent of the costs of all covered benefits in that plan.
• AV’s or metal levels: 60 percent for a bronze plan, 70 percent for a silver plan, 80 percent for a gold plan, and 90 percent for a platinum plan.
• Metal levels will allow consumers to compare plans with similar levels of coverage, with consideration of premiums, provider networks, and other factors, help the consumer make an informed decision.
• A plan can meet a particular metal level if its AV is within +/- 2 percentage points of the standard. The comparable limit this year is $6,250.
Establishment of the Marketplace

States must establish an Health Benefit Marketplace (Exchange).

- If a state does not establish an Marketplace, then the federal government will establish a federally facilitated Marketplace.
- The Exchanges will perform a variety of functions required by health care reform, including certifying QHP’s, determining eligibility for enrollments in QHPs and for insurance affordability programs (e.g., premium tax credits), and responding to customer requests for assistance.
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