UBA PPACA Advisor

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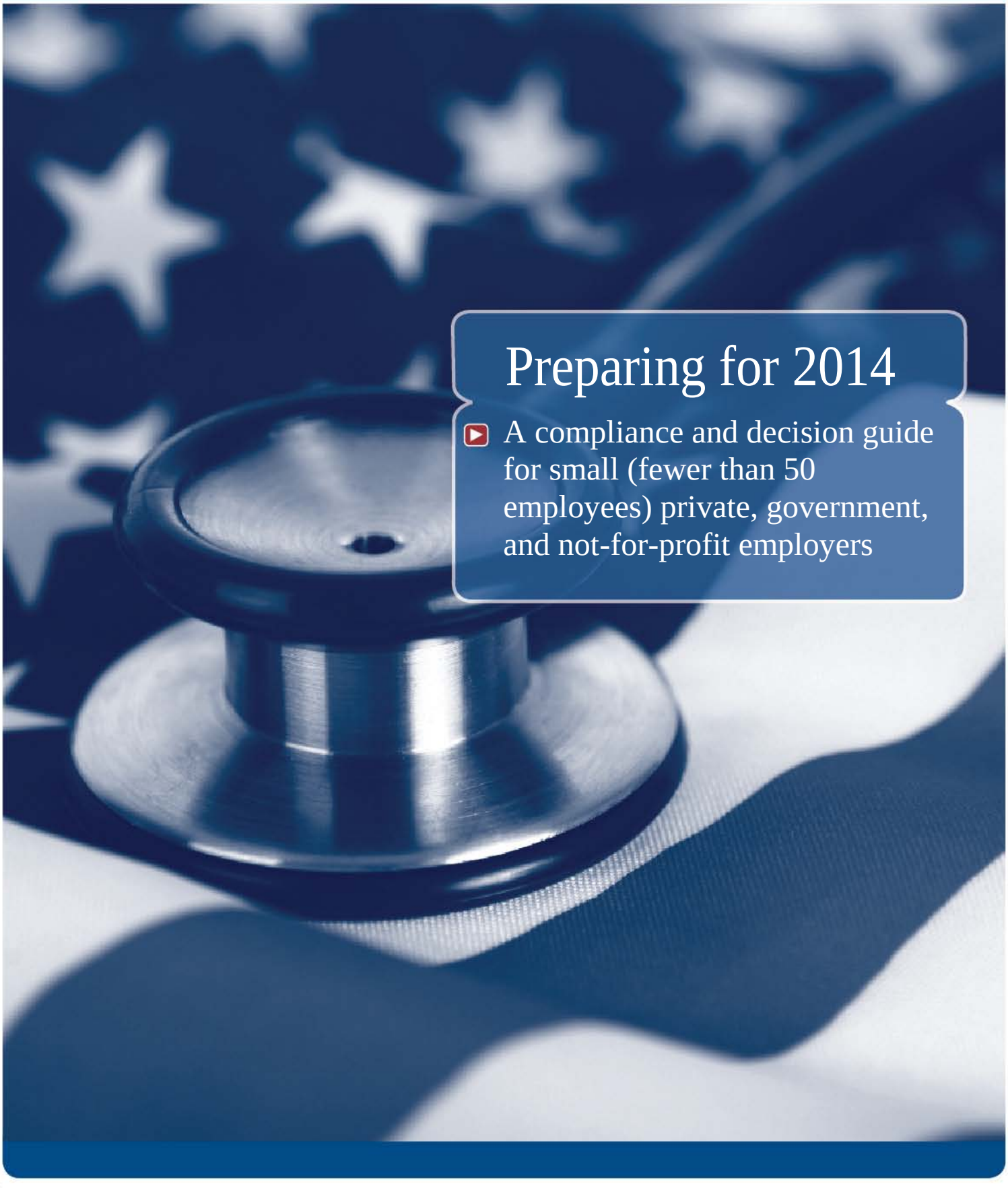

Preparing for 2014

A compliance and decision guide for small (fewer than 50 employees) private, government, and not-for-profit employers

This guide is intended to provide information to help employers understand their obligations and opportunities at the heart of the Patient Protection and Affordable Care Act of 2010 (PPACA) is implemented in 2014 and 2015. This law is complicated, and each employer will need to base its decisions on its particular situation.

Your UBA advisor is well-prepared to assist you with your decision making.

CONTENTS

UNDERSTANDING PPACA

THE BASICS OF PPACA

What is PPACA intended to do?

One of the main purposes of PPACA is to reduce the number of Americans without health coverage. This is being done by:

- Requiring most Americans to have some type of health insurance or pay a penalty
- Making it easier for individuals to obtain coverage, by:
  - Creating insurance "exchanges" or "marketplaces"
  - Incenting employers to provide coverage to all full-time employees
  - Removing barriers for those who have medical problems[1]

When does PPACA begin?

Parts of the law are already in effect, and parts will take effect in 2013. But the main parts of the law will take effect in 2014 and 2015.

What happens in 2014?

- The individual mandate, which requires most people to have some type of medical coverage in effect or pay a tax, begins
- Exchanges are to be in effect in each state to make it simpler for individuals and small employers to purchase coverage

What happens in 2015?

- Employers who have 50 or more employees must provide health coverage that meets minimum requirements, or pay a tax. This requirement is often called "play or pay" or "employer-shared responsibility."

[1] This includes eliminating pre-existing condition limitations in all plans, and requiring insured plans in the individual and small-employer markets to follow rules regarding guaranteed issue and renewal and community rating.

INDIVIDUAL RESPONSIBILITIES

How do people avoid the individual mandate tax?

To avoid the tax, a person must have "minimum essential" coverage. This coverage can be obtained through the person's employer, Medicare, Medicaid, TRICARE, some VA programs, an individual policy or an exchange.

What happens if a person doesn't have the required coverage?

The person will have to pay a tax, which will be collected with their federal income tax. The tax is being phased in – it is:

- 1 percent of income or $95, whichever is greater, in 2014
- 2 percent of income or $325, whichever is greater, in 2015
- 2.5 percent of income or $695 (indexed), whichever is greater, in 2016 and later years

If an entire family is without coverage, the tax applies to each adult. Fifty percent of the tax applies to each child under age 19. There is a family maximum of three times the individual adult tax.

What if the person can't afford coverage?

Premium tax credits (which may be claimed during the year, rather than waiting until the person files their federal income tax return) are available to help pay a person's premium if:

- They do not have access to adequate coverage through their employer, and
- They obtain coverage through a government exchange, and
- Their income is between 100 percent and 400 percent of the Federal Poverty Level (FPL). (The amount of the credit is graduated based on income, so that a person whose income is 100 percent of FPL will only pay 2 percent of their income for coverage and those at 400 percent of FPL will pay 9.5 percent.)

People below 133 percent of FPL will receive coverage through an expanded Medicaid program, unless their state opts out of expanded Medicaid.

Additionally, people with incomes of 100 percent - 250 percent of FPL will be eligible for reduced cost sharing (deductibles, coinsurance and copayments) if they obtain coverage through the exchange. The amount of cost-sharing assistance is graduated based on income.

If an individual is without coverage for a short period (less than three straight months) no penalty will apply.

EXCHANGES

What's an exchange?

An exchange is an entity set up in each state to make it simpler for people to compare health insurance options. The exchanges will not provide insurance, but they will oversee the insurance options available through the exchanges and provide resources such as plan summaries to individuals to help them choose a plan.

How will exchanges work?

Each state will have one or more exchanges, which will be run, at the state's choice, by either a state agency or a not-for-profit organization.

The exchanges will be responsible for:

- Plan management functions – certifying and overseeing "qualified health plans" and assigning price and quality scores to plans in the exchange. (The exchange can either accept all insurers/plans that meet the guidelines or be an "active purchaser" of coverage and negotiate with insurers who wish to participate in an exchange.)
- Consumer assistance – operating the website and a toll-free call center, providing a cost of coverage calculator and creating a Navigator program to help people understand their choices
- Eligibility determinations and enrollment – determination of eligibility for premium and cost-sharing subsidies, and coordinating enrollment in the exchange, Medicaid and CHIP
- Billing small employers who choose to purchase from the exchange

Each exchange must provide benefits that meet certain criteria, called "essential health benefits," at certain coverage levels, called "metal levels" and with certain cost-sharing limits.

What benefits must be provided?

The available "essential health benefits" must be equal to the scope of benefits provided by a typical employer plan. Each state has determined the essential health benefits package to be offered in the exchange in its state, based on the benefits provided by a benchmark plan in the state.

Essential health benefits include services in each of these 10 categories:

- **Ambulatory (i.e., outpatient) patient services**
- **Emergency services**
- **Hospitalization**
- **Maternity and newborn care**
- **Mental health and substance use disorder services, including behavioral health treatment**
- **Prescription drugs**
- **Rehabilitative and habilitative services and devices (e.g., speech, physical and occupational therapy, for both those who had mastered the skill and lost it due to illness or injury, or for those who have not yet mastered the skill)**
- **Laboratory services**
- **Preventive and wellness services and chronic disease management**
- **Pediatric services, including oral (dental) and vision care**

What are the coverage or metal levels?

PPACA sets standard coverage levels, which are sometimes called the "metal plans." There will be four[2] levels of benefits available through the exchanges:

- **PLATINUM**
  - designed to pay 90 percent of covered claims costs
- **GOLD**
  - designed to pay 80 percent of covered claims costs
- **SILVER**
  - designed to pay 70 percent of covered claims costs
- **BRONZE**
  - designed to pay 60 percent of covered claims costs

What are the cost-sharing limits in an exchange?

The annual out-of-pocket maximum cannot be more than the limits for health savings account (HSA)-compatible high-deductible health plans. For 2014 those amounts will be $6,350 for self-only coverage and $12,700 for family coverage.

Who can enroll in an exchange?

Any eligible individual may enroll in an American Health Benefit Exchange (also called a Health Insurance Marketplace), even if they have access to coverage through their employer or Medicare. All U.S. citizens, nationals and noncitizens who are lawfully present (e.g., in the U.S. with a work or study visa) may enroll.

Small employers (those with 50 or fewer employees[3]) also may enroll in a Small Business Health Options Program (SHOP) through an exchange. Beginning in 2017, states will have the option to open their exchanges to large employers.

In many respects, the individual and small employer exchanges will operate the same way, but there are some differences.

Although the details of an exchange plan may vary from insurer to insurer (e.g., different deductibles, copays or managed care requirements), all plans at a given level must, on an actuarial basis, be equivalent.

[2] Individuals under age 30 and individuals with very low incomes may be offered catastrophic coverage.

[3] Beginning in 2016, states must define "small employer" as having 100 or fewer employees. This change will only affect insurance requirements, not the employer tax threshold.

Are there limits on stopping and starting coverage in an exchange?

People may only enroll in an exchange during open enrollment or if they have a special enrollment event.

The first open enrollment will be from Oct. 1, 2013 to March 31, 2014. Coverage will begin on Jan. 1, 2014, for those enrolling by mid-December 2013. Coverage will begin on the first of the following month for those enrolling between mid-December 2013 and the end of March 2014. For years after 2014, annual open enrollment for individuals will be from Oct. 15 to Dec. 7, with a Jan. 1 effective date.

People who have a special enrollment event (such as marriage, birth, adoption, loss of coverage under an employer plan, or loss of coverage that was affordable and met minimum value requirements) will have a special enrollment period in which they can elect coverage through an exchange, or change plans within the exchange.

What happens if my state decides not to set up an exchange, or isn't ready by January 2014?

If a state decides not to set up an exchange or if the exchange won't be ready by 2014, the federal government, through the Department of Health and Human Services (HHS), will perform the services on behalf of the state (a "federally facilitated exchange," or FFE). HHS is also willing to do some, but not all, of the exchange's services – this is called a state partnership FFE.

There will not be a purely federal exchange. There is currently controversy about whether people in states that do not create a state exchange will be eligible for the premium tax credits, although it is the federal government's position that they will be.

What happens if a person lives in one state and works in another?

The law provides that a person who enrolls as an individual will use the exchange for the state in which they live.

PPACA also calls for the creation of multistate exchanges. The multistate exchanges will be overseen by the federal Office of Personnel Management (OPM) which manages the federal employee health program.

May coverage be purchased outside an exchange?

In most states individual and group coverage will be available outside an exchange. Policies sold outside the exchange will have to follow the same rules as policies sold through the exchange on essential health benefits, metal levels and cost-sharing.

SMALL-EMPLOYER EXCHANGE

How will a SHOP exchange operate?

Beginning in 2014, small employers may choose to provide health coverage to their employees through a Small Business Health Options Program (SHOP) exchange. States may include additional choices for purchase through the SHOP exchange, including employee choice of a plan at a metal level chosen by the employer, but for 2014 states with a federally facilitated exchange will have the employer choose one plan for all of its employees. Most state-run SHOP exchanges will allow employee choice of a plan beginning in 2014.

Are there requirements to participate in a SHOP exchange?

Yes. The employer must have employed an average of one to 50 [4] employees during the prior calendar or plan year. Part-time employees will generally count as full-time equivalent employees (as explained on the next page).

The small employer must offer SHOP coverage to all eligible full-time employees. There is no requirement under PPACA that employer contributions be made, but insurers may require contributions at a certain level. Employers that cannot meet minimum participation requirements may be limited to enrolling during an open enrollment period.

I have employees working in multiple states. How will that work?

Generally, the small employer will enroll all employees in the SHOP exchange in which its principal worksite is located.

Is there annual re-enrollment in the SHOP exchange?

Yes. Employers will participate in the SHOP exchange for a 12-month plan year (which does not need to be a calendar year). If employees are allowed to choose their plan, they will be able to change their plan choice as part of the employer's re-enrollment in the SHOP exchange.

Can new employees enroll midyear? What if an employee has a life event?

Newly eligible employees may enroll midyear, and their coverage will begin on the date they become eligible. An employee who has a special enrollment event may enroll or change plans within 30 days after the event.

4 The state may choose to set the maximum at 50 employees for 2014 and 2015 and all states have chosen to do this. The threshold will increase to 100 in 2016.

Will the SHOP exchange perform billing services for the employer?

Yes. The SHOP exchange will create a single bill with respect to all of the employer's employees, showing the total premium and each employee's and the employer's share.

Are there any special benefits to enrolling in the SHOP exchange?

Employers who enroll in the SHOP exchange may allow employees to pay their premiums on a pre-tax basis. (Employees who enroll in an exchange plan as an individual may not pay their premium on a pre-tax basis.) Beginning in 2014 the small business tax credit will only be available through the SHOP exchange.

EMPLOYER RESPONSIBILITIES

What must I do to avoid the employer taxes?

If you average fewer than 50 full-time employees or full-time employee equivalents during a calendar year, the "shared-responsibility penalty" does not apply – you do not need to provide any medical coverage to employees.

How do I know if I have 50 full-time or full-time equivalent employees?

An employee is counted as a full-time employee if the employee was employed an average of 30 hours per week during the prior calendar year.

An employee counts toward a full-time equivalent employee if the employee worked an average of less than 30 hours per week during the prior calendar year. To calculate the number of full-time equivalent employees for a month, the average hours of all full-time equivalent employees are totaled and then divided by 120.

EXAMPLE: Company A has 30 employees who average 40 hours per week, 10 employees who average 30 hours per week, 20 employees who average 25 hours per week and four employees who average 15 hours per week. (To account for a 30-day month, assume a month is 4.2 weeks.)

Company A has 40 full-time employees [30 + 10] and 19.6 full-time equivalent employees [(20 x 25 x 4.2) + (4 x 15 x 4.2) ÷ 120 = 19.6]. Therefore, Company A has 59 employees for that month for purposes of the penalty.

There are special rules for employers with seasonal employees.

Note: Employers in a controlled group or affiliated service group are combined when deciding how many employees they have.

Do these penalties apply to tax-exempt employers? Do they apply to grandfathered plans?

Yes. The penalties apply to all employers – private, government and not-for-profit. They apply to grandfathered plans, and they apply whether the plan is fully insured or self-funded.

Who is an “employee”?

PPACA says that “common law” employees are the employees covered by the law.

If I choose to offer group health coverage even though I have fewer than 50 employees must I offer it to all employees who work 30 or more hours per week?

No, this requirement only applies to employers with 50 or more full-time or full-time equivalent employees.

If I choose to offer group health coverage even though I have fewer than 50 employees must that coverage meet the essential health benefits, metal level and cost-sharing requirements?

Yes. Because of the tax breaks given for group coverage, all employers with insured plans must meet the basic coverage rules.

DECISIONS

What decisions do I need to make as an employer?

The most basic decision is whether to continue to offer health benefits, and if so, whether to offer coverage through the SHOP exchange or a more traditional plan.

What should I consider when making this decision?

Employers should look at:

- Why do I currently offer coverage, when there is no requirement to do this?
- Do I believe that my current reasons for offering coverage will still apply post-2014?
- The potential cost of dropping coverage
- The pros and cons of participating in the SHOP exchange

The "Planning for the Future" chart at the end of this brochure may help you with this process. Details on some things to consider are discussed below.

What are the tax advantages of offering group health benefits?

Employer-provided health benefits have a very favored status under the Internal Revenue Code. While wages are deductible by the employer as a business expense, they are taxable income to employees. In contrast, the employer contribution for health insurance is tax-free to employees regardless whether a Section 125 plan is used, and employee premiums for health insurance can be payroll-deducted on a pre-tax basis through a Section 125 plan. In addition, neither the employer nor the employee pays FICA or FUTA on premiums pre-taxed through a Section 125 plan.

If you decide to not offer group health benefits, leaving employees to purchase coverage through an exchange as an individual, you may have employees demand increased wages to cover the cost of insurance through the exchange (which will not be available on a pre-tax basis except through a SHOP exchange). Wages likely would need to be "grossed up" to cover the employee's additional tax liability, and FICA/FUTA would be payable on the full wage increase.

What are the reporting implications of continuing, modifying or discontinuing coverage?

Some reporting to the federal government will be required regardless whether coverage is offered or not. Details on the reporting requirements, which will begin with 2015, are not available yet.

Employers will be asked to verify whether an employee applying for a premium tax credit (also called a subsidy) is eligible for affordable, minimum value coverage. Employers that do not offer coverage can expect a higher volume of inquiries than those who maintain group coverage. The exchanges will advise employers when an employee has been determined to be eligible for a premium tax credit. Employers will have the right to appeal those determinations.

Employers that wish to purchase coverage through a SHOP exchange will need to complete an application, provide employee applications, coordinate employee status changes and pay the full premium to the exchange.

Are there situations in which dropping coverage would benefit my employees?

Employers with lower-paid employees should remember that no premium tax credit is available if employer coverage that is both affordable and minimum value is offered - even if the employer is small. For some employees, the premium tax credit will be significant. It may be that the best total solution for some employers is a contribution design that is not affordable to those below a certain income level.

How confident am I that the exchanges will be fully operational on Jan. 1, 2014?

If you plan to move employees to the exchange, you may want to have a plan to address the possibility that the exchange in your state may miss the deadline, or may be operating but not well, with attendant disruption to employees' focus on their jobs.

EMPLOYER OBLIGATIONS

What do I need to do between now and January 2014?

Small employers are not subject to the employer-shared responsibility penalty, but they do have obligations under PPACA.

Small employers that do not offer group health coverage still must:

- Provide a notice about the upcoming exchanges to all employees by Oct. 1, 2013. A model notice is available.

Small employers that offer group health coverage must:

- Reduce the maximum employee contribution to $2,500, if the employer sponsors a health flexible spending account (FSA), as of the beginning of the plan year that starts on or after Jan. 1, 2013
- Provide a notice about the upcoming exchanges to all employees by Oct. 1, 2013. A model notice is available
- Be prepared to file an application to participate in the SHOP exchange in the fall of 2013, if interested in using that exchange

What do I need to do in 2014?

Small employers that do not offer group health coverage:

- Will receive inquiries from the exchanges regarding employees who are applying for premium tax credits

Small employers that offer group health coverage:

- Will receive inquiries from the exchanges regarding employees who are applying for premium tax credits
- Must amend the plan to:
  - Remove all annual dollar limits on essential health benefits
  - Provide coverage for those in clinical trials for services outside the trial[5]
  - Limit cost sharing (out-of-pocket maximums)[5]
  - Remove pre-existing condition limitations for adults
  - Cover dependent children to age 26 even if they are eligible for coverage through their own employer's plan[6]
- Limit eligibility waiting periods to 90 days
- Calculate and pay the transitional reinsurance fee if the plan is self-funded
  - The fee will probably be due in January 2015
  - Insurers are responsible for calculating and paying the fee for fully insured plans but will likely pass the cost on

[5] Does not apply to grandfathered plans

[6] Ends a special provision for grandfathered plans

What are the limits on waiting periods?

In most instances, you will not be able to have an eligibility waiting period of more than 90 days. (An entry date of the first of the month after 90 days of employment will not be allowed. You may have a shorter waiting period – or no waiting period – if you prefer.)

What else will happen in 2014?

Small non-grandfathered group plans that are fully insured will experience modified community rating. They will also be required to offer plans that provide essential health benefits at the metal levels and within the cost-sharing limits.

What do I need to do in 2015?

Most employers will need to begin reporting to the IRS on coverage offered and available (the first reports are actually due in 2016).

What else will I need to do?

Nondiscrimination rules will apply to insured plans at some point (an effective date has not been set). This requirement will not apply to grandfathered plans. Nondiscrimination rules already apply to self-funded plans.

Beginning in 2018, a 40 percent, nondeductible, excise tax will apply to high-cost health coverage. This is also called the tax on "Cadillac" plans. For 2018 the tax will apply to amounts above $10,200 for single coverage and $27,500 for family coverage. Employee and employer contributions will be combined when deciding if the threshold has been exceeded. The cost of medical coverage (including dental and vision if inseparable from medical), health reimbursement account (HRA) contributions, health flexible spending account (FSA) contributions, employer contributions to an HSA, and the cost of onsite clinic coverage all count toward the high-cost trigger. Higher limits apply to certain retirees and those in high-risk occupations. The trigger amount will be increased annually.

Although not a requirement, beginning in 2014 employers may provide a wellness incentive/penalty of up to 30 percent of the premium. An incentive/penalty of up to 50 percent may be used in connection with tobacco use. (Currently, the limit is 20 percent.)

I've heard about an automatic enrollment requirement. What is that?

At some point, employers with more than 200 full-time employees will need to automatically enroll employees who do not either enroll or specifically decline coverage. An effective date has not been set. This requirement will not apply to small employers.

What should I already be doing to comply with PPACA?

If your plan is **not** grandfathered, it:

- Must cover the employee's dependent children until the dependent reaches age 26 – even if the child is married or employed
- May not exclude pre-existing conditions for children under age 19
- May not have a lifetime dollar maximum on any "essential health benefit"
- May not have an annual dollar limit on an "essential health benefit" that is over $2 million for plan years beginning on or after Sept. 23, 2012, unless you have obtained a waiver from HHS
- May not retroactively rescind coverage, except for fraud or material misrepresentation or for nonpayment of premium by certain terminated employees
- Must cover emergency services at in-network level regardless of provider
- If a primary care physician (PCP) must be chosen, allow each person to choose their own PCP and allow a pediatrician to be the designated PCP
- Must allow women to see an OB-GYN without a referral
- Must have a specific and comprehensive process for handling claims appeals
- Must provide first-dollar coverage for preventive care, including contraception
  - The contraception requirement does not apply to religious employers
  - Not-for-profit religious-affiliated organizations that object to contraception for religious reasons may decline to cover these costs, but their insurer or administrator will be required to provide this coverage
- May not reimburse over-the-counter drugs under a health FSA, an HRA or an HSA unless the drug is prescribed by a doctor

You should also:

- Promptly distribute medical loss ratio rebates if any are received from the insurer
- Provide summaries of benefits and coverage (SBCs) to all enrollees (beginning with the plan year that starts on or after Sept. 23, 2012)
- Withhold an extra 0.9 percent FICA/Medicare tax on employees who earn more than $200,000, once the employee reaches $200,000 in paid wages for the year (beginning in 2013)
- Calculate and pay the Patient Centered Outcomes Fee (PCORI) by July 31 if the plan is self-funded (the first fee was due in July 2013 for plan years ending between Oct. 1, 2012 and Dec. 31, 2012; plans with later plan years must begin paying the fee in July 2014). Insurers are responsible for calculating and paying the fee for insured plans but will likely pass the cost on.

If your plan is grandfathered, it:

- May not have a lifetime dollar maximum on any "essential health benefit"
- May not have an annual dollar limit on an "essential health benefit" that is more than $2 million for plan years beginning on or after Sept. 23, 2012, unless you have obtained a waiver from HHS
- Must cover the employee's dependent children until the dependent reaches age 26 – even if the child is married – however, an employed child who is eligible for coverage through the child's employer may be excluded until 2014
- May not exclude pre-existing conditions for children under age 19
- May not retroactively rescind coverage, except for fraud or material misrepresentation or for non-payment of premium by certain terminated employees
- May not reimburse over-the-counter drugs under a health FSA, an HRA or an HSA unless the drug is prescribed by a doctor

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- Withhold an extra 0.9 percent FICA/Medicare tax on employees who earn more than $200,000, once the employee reaches $200,000 in paid wages for the year (beginning in 2013)
- Calculate and pay the Patient Centered Outcomes Fee (PCORI) by July 31 if the plan is self-funded (the insurer will pay the fee if the plan is insured, but probably will pass he cost on)

What is a grandfathered plan?

A grandfathered plan is a plan that has only made permitted changes to its benefits design and cost structure since March 23, 2010. The permitted changes are described in detail by the regulatory agencies and severely limit changes in cost sharing.

Compared with their coverage in effect on March 23, 2010, grandfathered plans:

- **cannot significantly cut or reduce benefits**
- **cannot raise coinsurance percentages**
- **cannot raise copayments by more than the greater of $5 (adjusted annually for medical inflation) or a percentage equal to medical inflation plus 15 percentage points**
- **cannot raise deductibles by more than medical inflation plus 15 percentage points**
- **cannot lower employer contribution percentage by more than 5 percentage points**
- **cannot add or tighten an annual limit on an essential health benefit**

PLANNING FOR THE FUTURE

Employers will need to decide if they want to offer coverage going forward. Things to think about include:

Why do I offer group health coverage now, when I don't have to? (e.g., recruiting, retention, productivity, paternalism)	
Do I think those reasons will still apply post-2014?	
Do I think my competitors will discontinue group health coverage?	
Would I benefit from doing something different from my competitors?	
If I drop group health coverage, do I think my employees will demand additional compensation?	
Do I fully understand the tax break I get from offering group health benefits?	
Do I think the exchanges will be ready in 2014?	
If not, is continuing the status quo until 2015 something to consider?	
Would my employees be better off with the premium tax credit?	
Are health benefits an important part of my total compensation package?	

Employers who decide to offer coverage going forward should think about:

Does it make sense to enroll in a SHOP exchange?	
If I enroll in a SHOP exchange, should I amend my Section 125 plan to allow pre-tax payment of SHOP premiums?	
If I keep a traditional plan, should I consider a plan design change?	
How will I budget for additional claim costs resulting from higher costs?	
Do I need to staff for additional reporting?	
Have I staffed to handle inquiries from and about the exchange?	

Employers who decide not to offer coverage going forward should think about:

Have I considered how to handle requests for additional compensation?	
Have I fully considered the tax breaks group health plans get?	
Have I considered a plan design change instead?	
Have I considered enrolling in a SHOP exchange?	
How will I communicate this decision to employees?	
Do I need to staff for additional reporting?	
Have I staffed to handle inquiries from and about the exchange?	

Penalties for Employers Not Offering Adequate Coverage under the Affordable Care Act Beginning in 2015

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