Health Reform

Employer Penalty Delay: What are the Consequences?

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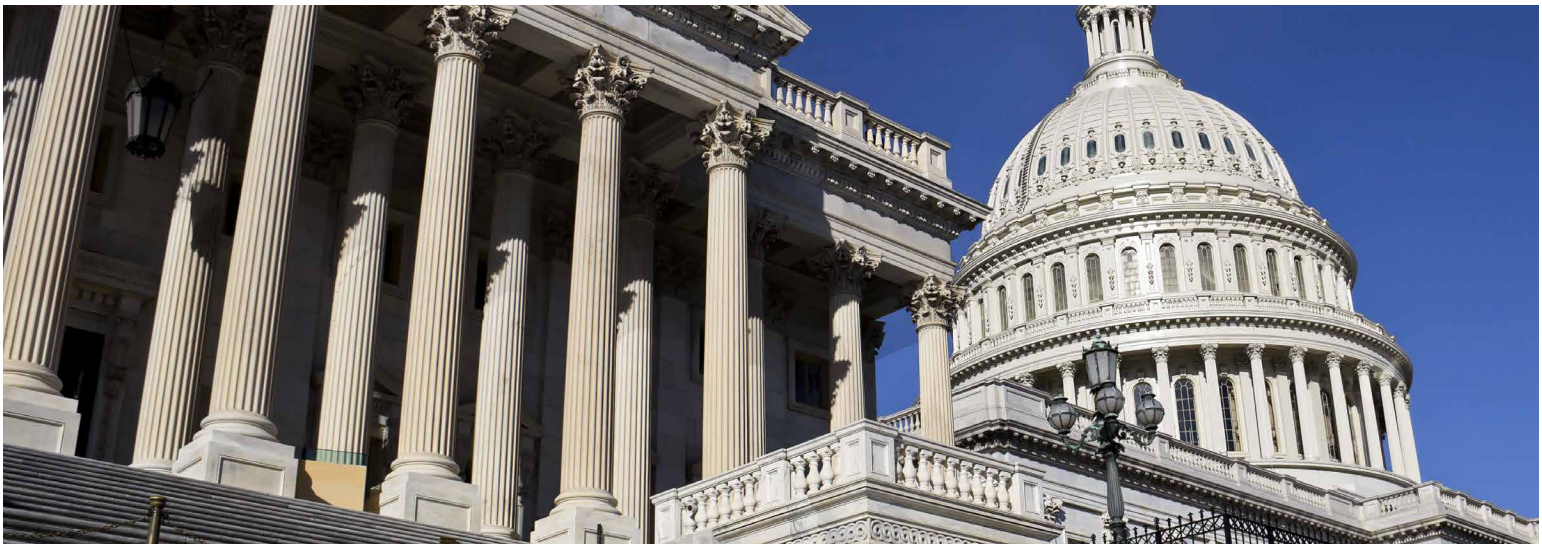

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The employer penalty provisions and two reporting requirements under the Affordable Care Act have been delayed until 2015. Although Notice 2013-45 was released, it does little to expand on the earlier announcement of the delay. The Notice does provide further guidance on the transition relief that operates to delay these provisions. It is important to note that the employer penalties and applicable reporting requirements will be fully effective in 2015. The Notice confirms the following:

- No employer shared responsibility payments will be assessed for 2014. Large employers will not be penalized for failing to offer health insurance coverage to full-time employees and their dependents, nor for offering full-time employees and their dependents unaffordable or coverage not of a minimum value. Employers are encouraged to maintain and expand health coverage in 2014.

- Insurers, self-insured employers, government agencies and other reporting entities are not required to comply with reporting requirements under Code Sections 6055 and 6056 in 2014. However, voluntary compliance is encouraged, as real-world testing of reporting systems and plan designs will contribute to a smoother transition to full implementation in 2015.

- The delay does not impact an individual's ability to receive a premium tax credit in the Exchange (also called the Health Insurance Marketplace) if s/he satisfies certain household income requirements and is not eligible for affordable, minimum value coverage and is not enrolled in minimum essential coverage.

- The delay has no effect on the effective date or application of other health care reform provisions.

Impact of the Delay on Employers

For 2014, employers will be impacted as follows:

No Change for Small Employers (Less than 50 Full-Time Employees). Since the employer penalty only applies to large employers, small employers are unaffected by the delay.

No Need to Determine Large Employer Status. Employers will not need to determine "large employer" status until 2015 since no penalty assessments will apply in 2014. Employers should monitor guidance and prepare to determine size for 2015 application.

No Penalties on Large Employers. The No Coverage Penalty ($2,000 X FTEs – 30) and the Offer Coverage Penalty ($3,000 X # of FTEs who receive assistance in the Exchange) will not apply in 2014. Large employers that do not offer minimum essential coverage to at least 95% of their full-time employees and dependents, or who do offer coverage but the coverage is unaffordable or does not provide a minimum value will not face penalties in 2014 if a full-time employee receives a subsidy in the Exchange. Additionally, the large employer will not face a penalty as to any of the excluded 5% or less of full-time employees who may receive a subsidy in the Exchange in 2014.

Additional Time to Understand Minimum Essential Coverage. Employers who do not offer minimum essential coverage will not be penalized in 2014. While most group health plan coverage will constitute minimum essential coverage, this delay provides an opportunity for further clarification as to whether "bare-bones" or "skinny plans" (plans that provide very limited benefits such as preventive care only) satisfy this requirement. Employers and carriers will need to understand whether existing coverage is considered minimum essential coverage in order to accurately complete an SBC.

Additional Time to Satisfy Minimum Value and Affordability. Since employers will not be penalized on coverage that is not affordable and does not provide a minimum value, employers do not need to ensure 2014 coverage meets these requirements to avoid a penalty. However, this information remains relevant because employers sponsoring group health plans will likely need to understand whether their coverage satisfies affordability and minimum value requirements in order to complete the Notice of Coverage Options (a/k/a the Exchange Notice) and SBCs. Additionally, an employee may not be eligible for subsidies in the Exchange if s/he is eligible for affordable and minimum value group health plan coverage through an employer.

No Transitional Relief for 2014. The transitional relief for 2014 that applied to certain fiscal year plans is no longer applicable since no penalties will be assessed in 2014. It is unclear whether similar transition relief will apply with respect to fiscal year plans for 2015.

Additional Time to Establish Measurement and Stability Periods. Employers will have additional time to set their measurement periods and stability periods to determine

full-time employee status of variable hour and seasonal employees for 2015. We expect further guidance will better clarify how to use these measurement periods and provide answers to many of the outstanding issues that exist with respect to this safe harbor.

No Reporting on Health Plan Coverage. Code Section 6055 requires insurers, self-insured employers, government agencies and other parties that provide health coverage to report information regarding the coverage provided, specifically whether it is minimum essential coverage. Additionally, large employers are required under Code Section 6056 to provide information reporting with respect to the health coverage offered to full-time employees. The transition relief provided by the IRS delays both of these reporting requirements until 2015. We expect proposed rules to be issued this summer. Employers, insurers and other reporting entities are encouraged to voluntarily comply with the information reporting for 2014 once guidance is issued in order to prepare for full application of the requirement in 2015. Compliance is optional and no penalties will be applied for a failure to comply in 2014.

No Employer Verification of Subsidy Eligibility. Recent guidance indicates that employers will not be required to verify an individual's eligibility for a subsidy in the Exchange for 2014 (see discussion below). Individuals will essentially "self-certify" their eligibility in this first year. Procedures are being developed for a validation process that will apply in 2015.

Additional Guidance. We expect additional guidance over the next year to better clarify the requirements of the employer mandate, including identifying full-time employees.

What is Not Impacted by the Delay?

The delay does not affect the effective date or any other application of other ACA provisions. The following provisions remain in effect and continue to apply.

Provisions Already Effective and Still in Effect

- Small Business Tax Credits: tax credits for small business (no more than 25 employees and average annual wages of no more than $50,000) of up to 35% when the employer contributes at least 50% of the premium costs.
- Lifetime and Annual Maximums: prohibition on lifetime and unreasonable annual limitations on essential benefits.
- Dependents to Age 26: requires coverage for adult-aged children to age 26. Grandfathered plan can limit to children not eligible to enroll in another employer-sponsored health plan until January 1, 2014.
- No Preexisting Conditions for Young Individuals: prohibits preexisting condition exclusions on anyone under age 19 enrolled in the group health plan.
- No Rescissions: prohibits rescissions of coverage except in cases of fraud or intentional misrepresentation of material fact.
- Preventive Care: requires coverage for certain preventive items and services. For plan years beginning on or after August 1, 2012, this includes coverage for certain women's health items and services, including contraception. Does not apply to grandfathered plans.
- Appeal Process: plans must implement an effective appeals process for appeals of coverage determinations and claims. Does not apply to grandfathered plans.
- Patient Protections: a group health plan that requires designation of primary care provider:
  - must permit each participant to designate any participating primary care provider who is available to accept that individual
  - for a child participant, must permit a person to designate a physician who specializes in pediatrics if the provider participates in the network
  - may not require authorization or referral for OB/GYN doctor
  - must cover emergency services without prior authorization and even if out-of-network. Does not apply to grandfathered plans.
- Medical Loss Ratio: carriers are required to spend 85% of premium on claims for large plans and 80% for small plans. Rebates are available to enrollees if these thresholds are not satisfied.

- No Reimbursement of OTC Medicine: over-the-counter medicines can no longer be reimbursed through health FSAs, HRAs, or HSAs unless prescribed by a doctor.
- HSA Penalty Increase: 20% penalty on distributions from an HSA that are not for qualified medical expenses.
- SBCs: insurers and plan sponsors must provide a 4-page summary of benefits to plan participants. Any material modification to the terms of the plan must be provided 60 days in advance.
- W-2 Reporting: employer that filed 250 or more Forms W-2 the preceding year must include the value of health coverage on employees' W-2s.
- Medicare Tax: increase in Medicare portion of FICA taxes from 1.45% to 2.35% for individuals earning more than $200,000 and joint filers earning more than $250,000.
- Medicare Part D Deduction Reduction: reduction of employer deduction for retiree prescription drug expenses by the amount of the excludible federal subsidy payment received for Part D prescription drug plans for retirees.
- Cap on FSAs: $2,500 cap on annual health flexible spending account contributions (effective for plan years beginning on or after January 1, 2013).

Fees in 2014 Still in Effect

- Transitional Reinsurance Fee: beginning January 1, 2014, a new fee ($63 /covered life in 2014) will be imposed on all health insurance carriers and sponsors of self-insured plans to fund a reinsurance program for Exchange-based coverage. The first fee is due around January 15, 2015.
- Health Insurance Carrier Fee: beginning January 1, 2014, a new annual fee is assessed on the health insurance sector with respect to medical, dental and vision plans. Self-insured plans are exempt, though it is not clear what impact this fee may have on stop-loss policies. The first fee is due no later than September 30, 2014.
- Research Fee: group health plans must pay a new fee to fund the Patient Centered Outcome Research Institute, effective for the first plan year that begins on or after November 1, 2011. The fee is $1/covered life in the first year and $2/covered life in the second year. The first payment for a November 2011/December 2012/January 2012 plan year is due by July 31, 2013. The first payment for any other plan year is due by July 31, 2014.
- Risk Adjustment User Fee: beginning January 1, 2014, a risk adjustment user fee ($0.96/enrollee/year) will apply to carriers of a risk adjustment covered plan (generally a non-grandfathered individual or small group plan).

New Mandated Benefits in 2014 Still in Effect

- Preexisting Conditions: prohibition on all preexisting condition exclusions.
- Benefit Waiting Periods: prohibition on waiting periods in excess of 90 days.
- Annual Maximums: prohibition on annual limitations on essential benefits.
- Dependents to Age 26: grandfathered plans must offer coverage for adult-aged children to age 26 even if eligible to enroll in another employer-sponsored health plan.
- Wellness Programs: incentives may increase to 30% of the cost of coverage for a reward based program (50% for programs designed to prevent or reduce tobacco use).
- Out-of-Pocket Maximum: group health plans must limit out-of-pocket cost sharing (tied to HSA qualified plan limits – maximum of $6,350 self-only/$12,700 family in 2014). Does not apply to grandfathered plans.
- Small Group Rules: small, insured group health plans must offer essential benefits, limit deductibles (cannot exceed $2,000/individual, $4,000/family), and provide a bronze level of coverage. Does not apply to grandfathered plans. Insurance carriers will be subject to new underwriting rules for small, insured groups. Instead of using experience rating, carriers will use community rating and rating restrictions will be restricted to (a) benefit coverage elected (plan and tier), (b) geographic area, (c) age, limited to a ratio of 3 to 1 for adults, and (d) tobacco use, limited to a ratio of 1.5 to 1. Does not apply to grandfathered plans.
- Clinical Trial Coverage: plans may not deny (or limit or impose additional conditions on) the coverage of routine patient costs for items and services furnished in connection with participation in a clinical trial. Does not apply to grandfathered plans.

Future Requirements Still in Effect

- Exchange Notice: employers subject to the Fair Labor Standards Act must provide the Notice of Coverage Options to all employees of the existence of the Exchange no later than October 1, 2013. This notice includes information regarding whether employer coverage is affordable and provides a minimum value. At this point, it is unclear whether the notice will be revised as a result of the delay in the employer penalties.

- Individual Mandate: individuals will be penalized for not having approved health care coverage. Effective January 1, 2014 unless transition relief applies. Transitional relief is available for employees, or individuals having a relationship to an employee, who are eligible to enroll in a non-calendar year eligible employer-sponsored plan with a plan year beginning in 2013 (the 2013-2014 plan year). These employees/individuals will not be liable for the shared responsibility payment for months in 2014 before the 2014-2015 plan year begins. Additionally, any month in 2014 for which an individual is eligible for this transition relief will not be counted in determining a continuous period of less than 3 months for purposes of the short coverage gap

- Subsidies: subsidies available to individuals within 100-400% of the Federal Poverty Level without access to affordable, minimum value employer plan. Effective January 1, 2014. Since the employer penalties are delayed until 2015, employers will not be penalized based on an employee's eligibility for a subsidy in 2014. The Exchange is required to verify applicants' attestations and determine whether applicants are eligible for a subsidy. Part of this process requires the Exchange to contact employers to determine whether the applicant is enrolled in an eligible employer-sponsored plan or is eligible for employer-sponsored affordable, minimum value coverage; however, this verification has also been delayed until 2015. For eligibility determinations that are effective before January 1, 2015, the Exchange may accept attestations without further verification when data is not available from the approved sources.

- Exchanges: Exchanges established for individual and small groups (1-100 employees or 1-50 employees, depending on state law). Exchanges are scheduled to open October 1, 2013 with coverage effective January 1, 2014.

- Discriminatory Plan Designs: imposes Code Section 105(h) self-funded plan nondiscrimination requirements (no discrimination in favor of highly compensated individuals as to eligibility or benefits) on insured plans. Does not apply to grandfathered plans. Effective when future guidance indicates.

- Automatic Enrollment: automatic enrollment with employee opt-out for employer with more than 200 employees. Effective when future guidance indicates.

- Quality Reporting: group health plans must submit an annual report to HHS addressing benefits and provider "reimbursement structures" that may affect the quality of care in certain specified ways. Does not apply to grandfathered plan. Effective when future guidance indicates.

- Cadillac Plan Tax: 40% excise tax imposed on high-cost health plans (above $10,200 for single cove rage and $27,500 for family coverage). Effective January 1, 2018.