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HEALTHCARE REFORM BUSINESS FORUM

Control the Financial and Legal Impacts of Healthcare Reform on Your Business

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1300 pages and 8 years

- **Patient Protection and Affordable Care Act (March 23, 2010)**
- **Though there are lots of unknowns, now is the time to start addressing the challenges of this massive legislation and the multiple effective dates (2010 to 2018) and changes.**

1300 pages and 8 years

- **Provide a high level review of the changes**
- **Observations regarding planning of resources and time**
  - **Short-term Provisions to be implemented by plan sponsors as of January 1, 2011, or even sooner in some cases.**
  - **Long term changes cause more concern, specifically beginning in the enrollment period of 2014 group insurance (less than 40 months).**

1300 pages and 8 years

- Prioritize,
- Manage
- And plan
  - The process of
    - Assessing the law,
    - Evaluating the application of the provisions,
    - Implementing the changes

1300 pages and 8 years

- Review
  - Business Plan
  - Current and deferred compensation
  - Retention policies (employees & records),
  - Cost of Capital,
  - Cash planning and
  - Pricing of goods and services

1300 pages and 8 years

- Employer's Workforce Challenge:
  - Composition of their workforce
  - Wage levels and different positions,
  - Competition for their employees,
  - Part time labor,
  - Multiple locations (states),
  - Automation
  - Outsourcing and
  - Constant Communication with employees

1300 pages and 8 years

- This act also contains multiple provisions which will affect
  - Retiree health benefits,
  - Education of medical service providers,
  - Drug costs for those on Medicare,
  - Taxes on investments,
  - Business structures, and
  - Additional information required to be accumulated and reported.

Patient Protection and Affordable Care Act (the “Act”)

Overview of Implementation Timeline

Benefits Requirements

Excepted Benefits Exemption

Excepted Benefits Exemption

- Important for employers to first identify all plans or benefit packages
- Identify whether some benefits are exempt from Act provisions
- Identifying options can be complicated – consult legal counsel (especially if company offers retiree medical)

Excepted Benefits Exemption

Traditional Excepted-Benefit Plans are generally not subject to benefit mandates such as:

- Limited Scope Vision
- Limited Scope Dental
- Retiree Only Plans
- Medigap policies
- AD&D

Grandfathered Plans

What Difference Does it Make?

Grandfathered Plans Are Not Subject to Certain Act Requirements:

- Preventive Care Requirements
- New Claims & Appeals Procedures
- Annual Reporting (wellness care, quality of care, premium rebates)
- Primary Care Physician Choice
- Emergency Care Cost Sharing Limitations
- Cost Sharing Restrictions (maximum copays & deductibles)
- Nondiscrimination rules under 105(h) for fully-insured plans

What is a Grandfathered Plan?

- A grandfathered plan is one in existence on 3/23/2010
- New employees, current employees & family members may join plan
- Interim Final Rules & Proposed Rules

Protecting Grandfathered Status

- Plan must include grandfathered plan statement in benefit materials
- Model language is provided in regulations
- Plan must maintain records of plan documentation re terms of plan in effect on 3/23/2010
- Based upon each “benefit package made available under a group health plan or health insurance coverage.”

Protecting Grandfathered Status

- Any of following may cause a loss of grandfathered status:
  - For fully-insured plans, entering into a new policy, certificate or contract on or after 3/23/2010
  - Elimination of benefits - elimination of all or substantially all benefits to diagnose or treat a particular condition
  - Changes to cost sharing (such as increases in deductibles or co-payments)
  - Decrease in employer contribution rate for any tier of coverage in effect on 3/23/2010 by more than 5 percentage points
  - Changes in annual limits - includes adding a new annual limit, adding a new annual limit that is less than prior lifetime limit, decreasing annual limit

Protecting Grandfathered Status

- Self-insured plans may change third party administrators without jeopardizing status
- Plan may be amended in accordance with other law (such as mental health parity) without violating grandfathered status

Protecting Grandfathered Status

Merger, Acquisition or Business Restructuring

- Anti-abuse rule: If principal purpose is to cover new individuals under a grandfathered plan, then plan loses grandfathered status

Protecting Grandfathered Status

- Also lose status if:
  - Employees are transferred into a plan from a plan on which the employees were covered on 3/23/2010; and
  - Comparing terms of plans & treating transferee plan as if it were an amendment of the transferor plan (plan being transferred), the plan would otherwise lose its grandfathered status; and
  - There was no bona fide reason to transfer the employees into the transferee plan. (Plant closure is an example of a bona fide reason to transfer employees.)

Grandfathered Plans Summary

- Evaluate whether grandfathered status is “worth it”
- If grandfathered status is desired, all plan decisions going forward must be evaluated in light of limitations (will be limited in premium, cost & benefit changes going forward)
- Restructuring plans to take advantage of other Act exceptions may cause the plan to lose grandfathered status

Eligibility Requirements

Requirement to Cover Adult Children

Adult Children

- Effective for plan years beginning on or after 9/23/2010
- Interim & Proposed Rules & IRS guidance released
- Generally, plans with dependent coverage must provide coverage for adult “children” who have not attained age 26
- Until 2014, grandfathered plans do not have to provide coverage if other employer coverage is available

Adult Children - Coverage Mandate

- Health savings accounts are not addressed, but are probably not considered group health plans subject to these requirements, but underlying HDHP is subject to the requirements
- Regulations prohibit employers from charging higher premiums to adult “children”
- No dependency or support tests may be applied to adult “child” coverage

Adult Children - Tax Exemption

- A separate change in the Act provides a gross income exclusion
- Employers could extend tax exempt coverage through the end of the year in which the dependent turns 26
- Example: Child turns 26 on 3/15/2011. Employer could extend coverage through 12/31/2011 & benefits would be excluded for tax purposes. Employer could also cut off coverage on 3/15/2011.

Adult Children - Tax Exemption

- IRS Notice re taxation also encourages employers to adopt coverage extension before 9/23/2010
- Taxation exemption for adult “children” does not currently appear to apply to health savings accounts
- Taxation exemption applies to flexible spending accounts, VEBAs, health reimbursement arrangements, Code § 401(h) retiree medical accounts

Adult Children

Who is a “child”?

- For purposes of tax exclusion, IRS Notice defines child as Code § 152(f)(1) - son, daughter, stepson or stepdaughter, legally adopted child or eligible foster child
- For purposes of coverage mandate regulations for coverage mandate do not define “child” so it is unclear whether all categories currently covered by a plan (which may be more expansive than the Code definition) will have to be covered without any residency, dependency or support requirements which may be currently imposed
- Spouse of child & grandchildren are not required to be covered

Adult Children Summary

- Amendment Deadline: Plans may be amended retroactively to provide coverage for adult "children" effective 3/30/2010 & beyond. If retroactive, amendment must be made by 12/31/2010
- Employers may rely on employee's representation of child's DOB
- Notices required to any children who previously lost coverage & are again eligible because of Act. Must have one-time 30 day enrollment opportunity for all benefit packages available to similarly-situated individuals. Open enrollment may be sufficient.
- Premiums may be raised across board for the plan, but may not target adult "children". Of course, premium increase may risk grandfathered status.

Eligibility Requirements

Preexisting Conditions

Pre-Existing Conditions

- The Act prohibits plans from imposing any preexisting condition exclusion
- Applies to grandfathered plans
- Effective for plan years beginning on or after 9/23/2010 with respect to enrollees or applicants for enrollment who are under age 19
- Effective for plan years beginning on or after 1/01/2014 with respect to all other enrollees
- Interim final regulations issued

Pre-Existing Conditions

- What is a “preexisting condition exclusion”?
- A limitation or exclusion of benefits (including a denial of coverage) based on the fact that the condition was present before the effective date of coverage (or if coverage is denied, the date of the denial) whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that day
- Plans may still exclude benefits for a particular condition if the exclusion applies regardless of when the individual’s condition arose

Eligibility Requirements

Rescissions

Rescissions

- Applies to grandfathered plans
- Effective for plan years beginning on or after 9/23/2010
- Interim final regulations issued

Rescissions

What is a rescission?

- A rescission is a cancellation or discontinuance of coverage that has a retroactive effect.
- A cancellation or discontinuance of coverage is NOT a rescission if:
  - It has only a prospective effect; or
  - It has a retroactive effect but is due to a failure to timely pay required premiums.

Rescissions

When are rescissions allowed?

- Rescissions are permissible if the individual:
  - Performs an act, practice or omission that constitutes fraud; or
  - Makes an intentional misrepresentation of material fact.
- Coverage cannot be rescinded retroactively as a result of an inadvertent omission or error on an enrollment form.
- If a retroactive rescission is permitted, the plan or issuer must provide the individual with 30-days advance notice.

Benefits Requirements

Lifetime and Annual Limits

Lifetime and Annual Limits

- Applies to grandfathered plans
- Effective for plan beginning on or after 9/23/2010; Permitted to apply “restricted annual limits” on essential health benefits for plan years beginning prior to 1/01/2014
- Interim final regulations issued

Lifetime and Annual Limits

- The Act prohibits plans from imposing lifetime & annual limits on “essential health benefits” which are:
  - Ambulatory patient services
  - Emergency services
  - Hospitalization
  - Maternity & newborn care
  - Mental health & substance use disorder benefits (including behavioral health treatment)
  - Prescription drugs
  - Rehabilitative & habilitative services & devices
  - Laboratory services
  - Preventive & wellness services & chronic disease management
  - Pediatric services, including oral & vision care

Lifetime and Annual Limits

- Must use “good faith efforts” to comply with a “reasonable interpretation” of the term “essential health benefits” until further regulations are issued
- Regulations do not prohibit:
  - Annual/lifetime limits on specific covered benefits that are not “essential health benefits”
  - An exclusion of all benefits for a particular condition

Lifetime and Annual Limits

- Annual limits phase out:
  - $750,000 - for plan years beginning after September 23, 2010 but before 9/23/2011
  - $1.25 million – for the following plan year
  - $2 million – for the following plan year
- On or after 1/01/2014, annual limits on "essential health benefits" are prohibited

Lifetime and Annual Limits

- Grandfathered plans must ALSO comply with the following to retain grandfathered status:
  - A plan with no annual or lifetime limit on 3/23/2010 may not impose any annual or lifetime limit
  - A plan with a lifetime limit but no annual limit on 3/23/2010 may adopt an annual limit that is no lower than the lifetime limit in place on such date
  - A plan with an annual limit on 3/23/2010 cannot decrease the annual limit

Lifetime and Annual Limits

- Annual/Lifetime limit rules do not apply to:
  - Excepted benefits
  - Health flexible spending accounts (health FSAs)
  - Medical Savings Accounts (MSAs)
  - Health Savings Accounts (HSAs)
  - Health Reimbursement Accounts (HRAs) – but only HRAs that are integrated with other coverage that satisfies the annual/lifetime limit requirements & retiree-only HRAs; Comments requested regarding whether stand-alone, non-retiree HRAs should be exempt from these requirements
  - Special waiver for limited benefit or mini-med plans

Lifetime and Annual Limits

Transition Rules

- Plans must provide individuals whose coverage ended because of reaching the lifetime maximum with an opportunity to re-enroll
- Plan must provide written notice of re-enrollment opportunity
- Model notice issued
- The re-enrollment opportunity must last for at least 30 days & must begin no later than the effective date of this provision

Benefits Requirements:

Choice of Provider

Choice of Provider

- Requirements NOT applicable to grandfathered plans & excepted benefit plans
- Effective for plan years beginning on or after 9/23/2010
- Interim final regulations issued
- Requirements only applicable to plans that require or provide for the designation a primary care physician
- Participant may designate any primary care physician available to accept the participant
- Child participant may designate a pediatrician as his or her primary care physician as long as the provider is in-network & available to accept the child

Choice of Provider

- If the plan covers obstetrical or gynecological care, then the plan may not require a female participant to obtain prior authorization or a referral to see an in-network obstetrics or gynecology specialist
- Plan must provide notice describing a patient's rights relating to choice of provider with any SPD or similar description of benefits
- Model notice has been issued

Benefits Requirements:

Coverage of Emergency Services

Coverage of Emergency Services

- Requirements NOT applicable to grandfathered plans & excepted benefit plans
- Effective for plan years beginning on or after 9/23/2010
- Interim final regulations issued
- Requirements only applicable if a plan provides benefits for services in an emergency department of a hospital

Coverage of Emergency Services

- May not require prior authorization for emergency services regardless of whether such services are in-network or out-of-network; May require notification of emergency services
- Must cover both in-network & out-of-network emergency services

Out-of-Network Cost-Sharing Requirements for Emergency Care

- Deductible or out-of-pocket maximum may be imposed if the cost-sharing requirement generally applies to all out-of-network benefits
- Copayments & coinsurance can't exceed in-network amount
- New rules for determining reasonable & customary charge
- Balance billing permitted

Benefits Requirements:

Preventive Care Coverage

Preventive Care Coverage

- NOT applicable to grandfathered plans & excepted benefits
- Interim final regulations issued
- Effective for plan years beginning on or after 9/23/2010

Preventive Care Coverage

- The Act requires plans to:
  - Provide coverage for designated preventive care services; and
  - Cover such services without the imposition of any cost-sharing requirements (such as a copayment, coinsurance or deductible)
- A complete list of preventive care services required to be covered can be found at www.healthcare.gov/center/regulations/prevention.html

Preventive Care Coverage

Billing and Office Visits

- If a designated preventive care service is billed separately from an office visit, then the plan may impose cost-sharing on the office visit
- If a designated preventive care service is not billed separately from an office visit, then the primary purpose of the office visit must be determined
  - If the primary purpose is the delivery of the preventive care service, then the plan may not impose cost-sharing with respect to the office visit
  - If the primary purpose is not the delivery of the preventive care service, then the plan may impose cost-sharing with respect to the office visit

Preventive Care Coverage

- Not required to cover the designated preventive care services when delivered by an out-of-network provider &, if the plan does cover such services when delivered by an out-of-network provider, it may impose cost-sharing on such services
- May provide coverage for preventive care services that are not on the designated lists & impose cost-sharing on such services (even if the service results from a recommended preventive care service)
- May use “reasonable medical management techniques” to determine the “frequency, method, treatment, or setting” for a designated service to the extent not specified in the recommendation or guideline

Benefits Requirements:

New Claims and Appeals Procedures

New Claims and Appeals Procedures

- Interim Final Rules and agency guidance issued
- Non-grandfathered plans are subject to new claims & appeal procedure requirements for plan years beginning on or after 9/23/2010

New Claims and Appeals Procedures

The regulations provide new requirements in addition to those in the DOL claims procedure regulation

- Appeals process also applies to a rescission of coverage
- Plan must notify a claimant of a benefit determination (whether adverse or not) with respect to a claim involving urgent care as soon as possible, but not later than 24 hours (currently, plans generally have 72 hours)

New Claims and Appeals Procedures

- Increased disclosure requirements
- Additional procedures required to avoid conflicts of interest
- Required to communicate in a culturally & linguistically appropriate manner

New Claims and Appeals Procedures

- "Significant compliance" with the appeals requirements not sufficient, the claimant is deemed to have exhausted the internal claims & appeals process and may initiate external review or suit if there is not strict compliance
- Plan must provide continued coverage pending the outcome of an internal appeal

New Final External Review Requirement

- Most self-insured plans will be subject to new federal review process
- Fully insured plans may be subject to state process
- Self-insured plans must make available external review process
- Plans must contract with independent review organization
- Claimants are not required to use independent review organization before filing lawsuit

PPACA Tax Implications

Changes to Existing Taxes and the Addition of New Taxes

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Old Tax “new” in 2011

- Tax reduction provisions (2001 & 2003) expire in 2010
  - Long term capital gain tax rates will increase from 15% to 20%.
  - Dividend's tax rate will increase from 15% to the ordinary tax rate.
  - AMT exemption reduced to 2003 level, without inflation adjustments
  - Tax rates will increase to 39.6%
  - Projected tax revenue for ten years = $3.7 trillion
- Budget proposal for 2011
  - Extend favorable rates for those with income less than $250,000(jt) or $200,000 (single)
  - For those with “high” income, dividends and gains taxed at 20%
  - Limit tax effect of itemized deductions to 28%

Old Tax "new" in 2011

REVENUE AND OUTLAY PROJECTIONS (IN 2011 GREEN BOOK BUDGET PROPOSAL)

	(in Millions)
Cost of extension of special rates	
Dividend rate at 15%	233,254
Capital Gains at 0%/15%	111,196
Tax rate at 35%	1,574,198
Phase out of itemized deductions and exemptions	179,715
AMT exemption indexed for inflation	658,761
Other	998,443
	3,755,567
Revenue raisers for taxpayers with income over $250,000 (jt) or $200,000 (single)	
Dividend and capital gains at 20%	105,364
Tax rates increased to 39.6%	364,439
Phase out of itemized deductions and exemptions	208,489
Cap tax effect of itemized to 28%	291,175
	969,467

Old Tax "new" in 2011

EXAMPLE OF CHANGE IN TAX RATES ON INVESTMENT INCOME
DIVIDEND AND STOCK SALE COMPARISON

	2010		2011		Proposed 2011*	
Combined tax cost of earnings payment to shareholders						
Income		1,000		1,000		1,000
Tax	35%	(350)	35%	(350)	35%	(350)
Dividend		650		650		650
Tax	15%	(98)	39.6%	(257)	20%	(130)
Net cash		552		393		520
Tax cost		448		607		480
Rate		44.80%		60.70%		48.00%
Tax cost on Company Sale						
Capital Gain		10,000		10,000		10,000
Tax	15%	(1,500)	20%	(2,000)	20%	(2,000)
Net Cash		8,500		8,000		8,000
Net Summary						
Owners-Cash in		9,052		8,393		8,520

* Extend reduced rates for those with income under $250,000 (jt) or $200,000 (single)

Consideration:

- Sale of appreciated assets
- Additional dividend from C Corporation in 2010

New Tax in 2013

Summary of current: Social Security and Medicare rates, limits and income

- Wages:
  - Old Age, Survivors and Disability Insurance (OASDI) tax:
    - 6.2% rate
    - Wages up to an annually-adjusted “wage base” ($106,800 for 2010)
  - Medicare Hospital Insurance (HI) tax:
    - 1.45% rate
    - All wages, regardless of amount.
  - Taxes withheld from salary
  - Employers match and remit taxes

- Self-Employment Income:
  - Self-Employment Contributions Act (SECA):
    - 12.4% rate (OASDI) with annually adjusted base
    - 2.9% rate with no limit
    - One half of tax is deductible

New Tax in 2013

Example reflecting "double hit" for a single taxpayer:

Net investment income of	$100,000		
Wages of	300,000		
S Corporation (active) loss of	-25,000		
and MAGI of	$375,000		
MAGI of	$375,000		
Investment income threshold	200,000		
Income over threshold	175,000		
Lesser of investment income or excess over threshold		$100,000	
Tax at 3.8%			$3,800
Salary	$300,000*		
Base for tax	200,000		
Net		$100,000	
Tax at .9%			$900
Total additional tax			$ 4,700

New Tax in 2013

- Additional Medicare tax (HI) on earned income
- 0.9% tax on individuals on earnings exceeding $200,000 (single) or $250,000 (joint):
  - No employer match
  - Same rate for wages and self employment income
  - Self employed can't deduct the extra tax
  - Retirement income not subject to tax
  - No ceiling on earnings subject to tax
  - Doesn’t add to Social Security history
  - No ceiling on earnings
  - Marriage penalty is $1350

New Tax in 2013

- Additional 3.8% Medicare tax (HI) on investment income
  - Applies when modified gross income exceeds thresholds
  - Based on the lesser of
    - net investment income or
    - the excess of modified adjusted gross income over threshold
  - No ceiling on income subject to tax
  - Investment income includes:
    - Interest, dividends, annuities, royalties, and rents not derived in ordinary course of business
    - Passive trade or business income (including pass through income),
    - Gains from sale of property not in a trade or business

New Tax in 2013

- Additional Medicare tax (HI) on investment income
  - Investment income does not include:
    - Tax exempt interest,
    - Veteran benefits,
    - Excluded gains for sale of personal residences,
    - Retirement and IRA distributions
    - Income subject the earned income surcharge
    - Pass-through income (and the computed gain or loss from the disposition of same) if the taxpayer materially participates

New Tax in 2013

- Additional Medicare tax (HI) on investment income
- Thresholds:
  - Individuals: $200,000 (single), $250,000 (joint) and $125,000 (separate filers)
  - Note: marriage penalty again ($5,700)
  - Estates & trusts: amount where the highest income tax bracket begins ($11,150)

New Tax in 2013

EXAMPLE OF CHANGE IN TAX RATES ON INVESTMENT INCOME

		2010			2013
Combined tax cost of earnings payment to shareholders					
Income		1,000	Income		1,000
Tax	35%	(350)	Tax	35%	(350)
Dividend		650	Dividend		650
Tax	15%	(98)	Tax	23.8%	(155)
Net cash		552	Net cash		495
Tax cost		448	Tax cost		505
Rate		44.80%	Rate		50.50%
Tax cost on Company Sale					
Capital Gain		10,000	Capital Gain		10,000
Tax	15%	(1,500)	Tax	23.8%	(2,380)
Net Cash		8,500	Net Cash		7,620
Net Summary					
Total net cash			Total net cash		
Owners-Cash in		9,052	Owners-Cash in		8,155

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New Tax in 2014

- Individuals **must** have medical insurance or pay a penalty.
- The penalty is equal to the *greater* of a *fixed amount* or a *% of household income over the tax filing threshold amount.*
-
  - *Tax filing threshold* amount - 2010 - $9,350 for singles and $18,700 for couples
  - 2014 = $95 per person or 1% of excess
  - 2015 = $325 per person or 2% of excess
  - 2016 and later = $695 per person or 2.5% of excess
  - For example, a single individual in 2017 with income of 90,000 would have a penalty of $2,227 if he doesn't have insurance. If insurance costs more than $186 per month, he could save money by paying the penalty and electing insurance coverage when coverage is needed.

New “Tax” in 2014

Individuals **must** have medical insurance or pay a penalty.

- Exemptions
  - Financial hardship (to be determined),
  - Religious objections,
  - American Indians
  - Those without coverage for less than three months,
  - Aliens not lawfully present in the U.S.,
  - Incarcerated individuals,
  - Those for whom the lowest cost plan option exceeds 8% of household income (under the local Exchange),
  - Those with incomes below the tax filing threshold,
  - And those residing outside of the U.S.
- Other:
  - The IRS can't levy to collect the penalties.
  - Government assistance
    - Income under 400% of the federal poverty level ($43,320-single or $88,200-family
    - Purchase insurance (2%-9.5% of household income)
    - Co pays could be reduced up to two thirds.
  - By applying for assistance, the individual's employer may be subject to penalties.

New “Tax” in 2018

- A 40 percent “Cadillac” excise tax on high-cost health insurance plans
- Applies to employer and self insured plans
- Based on the "cost of insurance" in excess of $10,200 (single)and $27,500 (families)
- The *cost of the insurance* includes
  - amounts added to health flexible spending accounts, health reimbursement accounts and health savings accounts and other supplementary health benefits.
  - all benefits regardless of the taxability to the employee or the contributions by the employee and disclosed on form W-2
  - Self employed cost is the deduction allowed on page 1 of Form 1040
  - Does not include the value of vision and dental plans, liability, accident or liability (if exempt from HIPPA), medical benefits as secondary benefit (car insurance), independent non-coordinated plans paid by employee (for example, cancer policies)
- Excise tax is not deductible.
- Tax paid by insurance company and reimbursed by employer.
- This penalty could be projected and the indirect cost may be subject to disclosure on financial statements

Employer Coverage Penalty Structure

Employer Penalties and Vouchers

Penalties

- Penalties apply to large employers for failing to offer minimum essential coverage or offering unaffordable coverage if at least one employee receives credit for exchange coverage.
- Definition of minimum essential coverage includes coverage under an “eligible employer-sponsored plan.”
- “Eligible employer sponsored plan” includes governmental plans or other coverage offered in the small or large group market within a state; includes a grandfathered health plan offered in a group market.
- Unclear whether self-insured plan is included.

Are you a large employer?

at least 50 FT equivalent workers

- Including FT (30+ hours/week) and PT workers (prorated)
- Excluding seasonal workers (up to 120 days per year)

Yes

No

Are any of your FT employees receiving premium credit for exchange coverage?

Yes

No

Do you have more than 30 FT employees?

Yes

No

Do you provide health insurance?

Yes

No

No Penalty

Pay monthly penalty 1/12 x $2,000 x (number of FT employees – 30)

Pay monthly penalty, *lesser of*:

- 1/12 x $2,000 x (number of FT employees – 30)
- 1/12 x $3,000 x (number of FT employees receiving credits for exchange coverage)

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Free Choice Vouchers

- An employer who offers “minimum essential coverage” & pays any portion of the premium must provide free choice vouchers to each “qualified employee.”
- Qualified employee is an employee whose required contributions are greater than 8% & less than 9.8% of household income & whose household income does not exceed 400% of the Federal Poverty Line. A qualified employee may not participate in the employer’s plan.
- Voucher is equal to monthly amount the employer would have contributed toward the cost of employer coverage.

PPACA – The Miscellaneous Details

What's Left – Bits & Pieces

BITS AND PIECES

- **Challenge:**
  - **Multiple definitions**
  - **Increases**
    - **in the volume of documentation,**
    - **in access to confidential information**
    - **and in reporting**
- **Resources:**
  - **IT Department**
  - **HR Department**
  - **Management**

BITS AND PIECES

Reporting changes:

- **2011** ***Change to W-2 reporting:***
  - Disclose the value of health care benefits with values computed using Cobra premiums.
- **2012** ***Change to Form 1099 reporting:***
  - Disclose in annual payments over $600 to corporations ($19.2 billion revenue)
- **2014** ***Additional reporting of insurance offering:***
  - New reporting requirements for any employer with more than 50 FTE
  - employer identification and address,
  - insurance offered to employees and their dependents,
  - number of full time employees, by month,
  - *detailed* employee information, and
  - number of months the employee was covered by the plan
- **2018** **Total value of health cost disclosed on W-2 (Cadillac tax):**
  - The *cost of the insurance* includes
    - Insurance premiums, amounts added to health flexible spending accounts, health reimbursement accounts and health savings accounts and other supplementary health benefits, regardless of taxability
    - Not: vision and dental plans, liability, accident or liability (if exempt from HIPPA), medical benefits as secondary benefit (car insurance), independent non-coordinated plans paid by employee (for example, cancer policies)

BITS AND PIECES

Multiple definitions of employees and employers

- **2010** ***Credit for providing health insurance by eligible small employer***
  - *An eligible small employer (*ESE) no more than 25 full-time equivalent employees ("FTEs") and pay at least 50% of the cost.
  - *FTE* is computed based upon a 2080 hour year with seasonal employees hours excluded.
- **2011** **Simple Cafeteria Plans for *eligible small employer*s**
  - Employer with an average of 100 or fewer employees on business days during either of the two preceding years.
  - Eligible employee: 1000 hours of service in prior year
- **2014** **Employer Penalties for not offering affordable insurance:**
  - Employers with more than 50 FTE employees
  - FTE based on an average of 30 hours/week or 120 hours/month
- **2014** **Use of cafeteria plans by small employers for insurance premiums:**
  - For 2014 and 2015, no more than 50 employees.
  - For 2016 up to 100 employees
  - After 2016, more than 100
  - Employee count based on 30 hours per week FTE

BITS AND PIECES

Guidelines to be developed by 2014:

Source documentation, privacy guidelines and reporting issues have not been addressed.

BITS AND PIECES

Guidelines to be developed by 2014:

Household income has to be disclosed to obtain the following:

- Exemption from required insurance by individuals
- Reduction in Copayments
- Refundable tax credits
- Free Choice voucher from an offering employer

What will be the source for the information, who will retain this information and who will have access to this information?

What Didn't We Cover?

Questions & Answers

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