



Health Care Reform 2020!

A Comprehensive Overview of Updated Regulations & Compliance Guidance

Oklahoma City Association of Health Underwriters (July 9, 2020)

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Today's presenter

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What Individual Mandate Repeal Means for ERs

- ACA's individual and ER mandates are intertwined, so will eliminating the individual mandate start to unwind the ER mandate?
- The 2017 tax act, signed into law Dec. 22, 2017, effectively repeals the ACA's requirement that most Americans obtain ACA-compliant health coverage, effective in 2019.
- Much remains to be seen, but for now, ERs must *continue to comply* with the ACA, including its ER mandates.
- ERs must continue to focus on avoiding ER *"pay-or-play"* penalties and *ER "reporting responsibilities."*
- Other new tax reform legislation may effect ACA tax provisions, but for now – ACA is here to stay along with ER reporting requirements.

When will new AHPs be available?

- New DOL rules issued June 21, 2018, expands the ability of ERs, including sole proprietors and self-employed workers to participate in **Association Health Plans (“AHPs”)**:
 - State, city, county, or multi-state metro area;
 - Businesses in a common trade, industry line of business, or profession in any area, including nationwide.
 - AHPs are EE welfare benefit plans under ERISA (e.g. disclosure, reporting, and MEWA provisions apply*).
 - AHPs do not have to comply with ACA’s “minimum essential benefits” or “minimum value” provisions.
 - AHP to be established under new rule:
 - All associations (new or existing) may establish **fully-insured** AHP starting 9/1/18;
 - Existing associations that sponsor **self-insured** AHP on or before 6/21/18 may expand under the new rule starting 1/1/19;
 - All other associations (new or existing) may establish **self-insured** AHP starting 4/1/19.
 - IRS guidance clarifies that ERs do not become ALEs merely by participating in AHPs.
- * **State MEWA laws apply**



Part 1

Overview



What is Health Care Reform?

- The term “*health care reform*” refers to comprehensive health care law passed in 2010, known as the Affordable Care Act (“ACA”), including various regulations and other implementing guidance.
- An array of requirements for individuals, employers (“ERs”), and health plans designed to ensure a minimum level and quality of health care.

The U.S. Supreme Court upheld the constitutionality of the individual mandate in June 2012, in a 5-4 vote. Since the Court’s decision, compliance efforts are moving full speed ahead with major provisions effective in 2014.

When is Health Care Reform Effective?

- Most of ACA's market reform provisions that apply to ER-sponsored group health plans ("GHPs") (also referred to as "PHSA or ACA mandates") are already in effect **beginning in 2010**; but its provisions were to be effective at varying times over an 8-year period.
- **Individual mandate.** Starting in 2014, a tax penalty applies (with certain exceptions) to individuals who do not maintain a certain level of health insurance. **The 2017 tax act reduced to \$0 the tax penalty for going without coverage beginning in 2019.**
- **Marketplace.** Exchanges got off to a rocky start, but were finally up and running in 2014, thru which individuals and small ERs can buy "affordable" health insurance.
- **Pay or play penalty tax.** Starting in 2015 (originally 2014), certain large ERs ("ALEs") may be subject to tax penalties if they do not provide "*affordable minimum value*" health coverage to its full-time employees ("FTEs"). This tax **ONLY** applies if a FTE receives subsidized coverage thru the Exchange. Delayed until 2016, for mid-size ERs.

When is Health Care Reform Effective?

(cont' d)

- Additional **consumer protection requirements** apply to insurers, including:
 - Guaranteed availability and renewability of coverage;
 - Review and disclosure of rate increases; and
 - Medical Loss Ratio (“MLR”) standards.
- New **administrative and other requirements** for GHPs were added, including:
 - Summary of Benefits and Coverage (“SBCs”);
 - Enhanced claims and appeal standards;
 - W-2 reporting of the value of coverage; and
 - Automatic enrollment for large ERs (200+ EEs)-**repealed 11/2/15.**
- New **fees** and payments applied to “GHPs” on a temporary basis: PCOR fees (ended 2019) and reinsurance contributions (ended 2016).
- Other provisions are effective even later, including the so-called “**Cadillac tax,**” that was to go into effect in 2018- **delayed until 2022, and now fully repealed as of 12/20/19.**



Sources of Laws

- **Two statutes** provide the statutory requirements for health care reform:
 - H.R. 3590, the Patient Protection and Affordable Care Act, Pub. L. No. 111-148 (“PPACA”), which was signed into law on March 23, 2010; and
 - H.R. 4872, the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152 (“HCERA”), which was signed into law on March 30, 2010.

Sources of Laws (cont'd)

- These laws made **amendments** to:
 - Internal Revenue Code (“Code”);
 - ERISA;
 - Social Security Act (“SSA”);
 - Public Health Service Act (“PHSA”); and
 - Fair Labor Standards Act (“FLSA”)
- **Regulations and other guidance** come from various agencies (often jointly), including:
 - Health and Human Services (“HHS”);
 - Department of Labor (“DOL”); and
 - Treasury (“IRS”).

Abbreviations

ACA- Affordable Care Act

AHP- Association Health Plan

ALE- Applicable Large ER

CBP- Collectively Bargained Plan

Code or **IRC-** Internal Revenue Code

DOL- Department of Labor

EE- Employee

EHB- Essential Health Benefits

ER- Employer

FSA- Flexible Spending Account

FTE- Full-time EE

FTEE- Full-time Equivalent EE

GHP- Group Health Plan

GFHP- Grandfathered Health Plan

HHS- Department of Health and Human Services

HRA- Health Reimbursement Arrangement

HSA- Health Savings Account

IRS- Internal Revenue Service

MEC- Minimum Essential Health Care Coverage

MLR- Medical Loss Ratio

NGFHP- Non-Grandfathered Health Plan

PCE- Preexisting Condition Exclusion

PY- Plan Year

SEP- Special Enrollment Provision or Period

SBC- Summary of Benefits and Coverage



Part 2

ACA Mandates



Which Plans and Insurers Must Comply with ACA Mandates?

- Generally, ACA mandates **apply to**:
 - GHPs; and
 - Insurers offering “group” or “individual” health insurance coverage.

- **GHP means**:
 - An “employee welfare benefit plan” [as defined by ERISA § 3(1)];
 - Provides medical care to EEs* or dependents (including items and services paid for as medical care);
 - Directly, or thru insurance, reimbursement, or otherwise.

- * Term “EE” includes both current and former EEs.

Retiree-Only Plans and Excepted Benefits

- Certain “*retiree-only*” plans and “*excepted benefits*” are exempt from the ACA mandates.
- “*Retiree-only*” plans include GHPs that on the 1st day of the PY has <2 participants who are current EEs.
- “*Excepted benefits*” include specified non-major medical types of coverage, including:
 - Accident or disability income insurance;
 - Liability and supplemental liability insurance;
 - Workers’ compensation insurance;
 - On-site medical clinics;
 - “Stand-alone” dental, vision, or long-term care benefits;
 - Certain specified disease or hospital indemnity (or other fixed indemnity) insurance; and
 - Certain types of coverage designed to supplement a GHP.

Tip: New rules for determining “stand-alone” status for self-insured plans- additional cost requirement no longer applies, however EE must have option to enroll or decline coverage.

HSAs, HRAs, and Health FSAs

- Most HSAs and Archer Medical Savings Accounts are exempt from ACA mandates.
- “Retiree-only” HSAs and HRAs providing only “*excepted benefits*” are exempt from ACA mandates.

Tip: HRAs that are not “*integrated*” with a non-HRA GHP, generally cannot continue beyond 2013 unless coverage is limited only to “*excepted benefits*” or it otherwise complies with ACA mandates (e.g., no annual or lifetime \$ limits on “*essential health benefits*” and preventive health services without any cost sharing).

- Health FSAs that meet certain conditions are “*excepted benefits*,” thus exempt from ACA Mandates.*

* Health FSAs are not excluded from other ACA rules (e.g., subject to indexed \$2,500 cap on salary reductions). For 2020, the \$ limit on EE salary reduction contributions is \$2,750 (up from \$2,700).





How does ACA interact with State Law?

- **ERISA preemption:**
 - Title 1 of ERISA “preempts” any and all state laws insofar as they “relate to” an ERISA GHP (e.g., sponsored by a private ER);
 - Except to the extent “health insurance coverage” offered in connection with such plan is subject to any applicable state law that “regulates insurance” (e.g., *fully-insured GHP*).
- **Fully-insured GHPs** are subject to any state law that “regulates insurance.” To the extent a state law provides additional benefits or protections, state law applies.
- **ERISA self-insured GHPs** generally are not subject to any state laws that “regulates insurance” or “establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers in connection with group health insurance coverage.”*

* Unlike self-insured plans sponsored by private-sector ERs, self-insured non-federal “*governmental plans*” and “*church plans*” generally may be subject to state laws and regulations.

Consequences of Non-Compliance for GHPs

- **Penalties** differ depending on type of entity and violation.
- **Three agencies** (IRS, DOL, and HHS) provide oversight and enforcement.
- **Plan Sponsors and ERs:**
 - Failure to comply with an **ACA mandate** will potentially trigger a non-deductible excise tax of \$100/day under IRC § 4980D “*with respect to each individual to whom such failure relates*”;^{*}
 - * Non-federal “*governmental plans*” and health insurers are potentially subject to similar PHSA civil penalties of up to \$100/day.

Burwell v. Hobby Lobby- HHS regs implementing ACA’s contraception mandate could have resulted in fines up to \$1.3 million/day (\$100/day x # of affected EEs) if Hobby Lobby’s GHP didn’t provide benefits for certain contraceptives (e.g., morning/week after pills and IUDs). U.S. Supreme Court ruled (June 30, 2014) in favor of Hobby Lobby in a 5:4 opinion. The court found that the mandate substantially burdens the exercise of owners’ religion and HHS regs failed to satisfy the Religious Freedom Restoration Act’s (“RFRA”) least restrictive means standard. This is a narrowly-interpreted decision based on facts and circumstances as they relate to a “closely held” family-owned for-profit entity.

CAUTION: This does not allow ERs to stop paying for specific types of coverage under its GHP just because its owners have religious objections to it.

Consequences of Non-Compliance for GHPs (cont' d)

- Failure to comply with ACA's "pay or play" provisions will potentially trigger a non-deductible excise tax of:
 - \$2,000* (as indexed)/calendar year/FTE "no-offer" penalty under IRC § 4980H(a); and
 - \$3,000** (as indexed)/calendar year/FTE "under-offer" penalty under IRC § 4980H(b).
 - Penalties triggered only when FTE is "certified" to have received subsidized coverage thru an exchange (e.g., premium tax credit or cost sharing reduction).

NEW

*For 2020- \$214.17/\$2,570/year (increase of \$5.84/\$70/year); (estimated based on premium adjustment percentage in the 2020 Notice of Benefit and Payment Parameters.

NEW

**For 2020- \$321.67/\$3,860 (increase of \$9.17/\$110/year).

Tip: Pay or play penalties triggered ONLY when IRS certifies to the ER that the FTE actually enrolled in an exchange and received subsidized coverage thru an exchange.

Consequences of Non-Compliance for GHPs (cont' d)

- Significant changes proposed for Form 5500s for PYs beginning in 2019 have been delayed, at least for the time being.



Tip: The maximum penalty for incorrectly filing or not filing Form 5500 is rising to \$2,133/day, up from \$2,140/day, for penalties assessed after 1/23/19. (See [Delinquent Filer Voluntary Compliance Program](#) on DOL's website: www.dol.gov/ebsa.)



What are Grandfathered Health Plans?

- **GHPs** that have continuously covered at least one person –and not undergone certain specified changes- since March 23, 2010, are excused from some, but not all ACA mandates.
- This rule is referred to as the “**grandfather rule,**” and plans that fall within the rule are referred to as “grandfathered” health plans (“GFHPs”).
- In order to **maintain GF status,** the plan must not:
 - Eliminate benefits;
 - Increase member cost-sharing requirements;
 - Decrease the ER contribution rate; or
 - Change the annual limit structure; in a specified manner or by a specified amount (as applicable) when compared to the coverage that was in effect on March 23, 2010.

Grandfathered Health Plans (cont'd)

- GF status is determined separately for each benefit package (e.g., PPO option, HMO option).
- ER contribution rate is determined on a tier-by-tier basis (e.g., EE-only, EE+1, family).
- Certain wellness programs involving financial penalties or incentives (e.g., surcharges) may impact analysis.
- Plan materials provided to a participant or beneficiary describing benefits must include a statement that the plan believes it is GF, and must provide contact info for Qs and complaints (model language available).
- Plan must maintain records documenting terms of the plan or coverage in effect on March 23, 2010, and other documents necessary to verify, explain, or clarify its status as a GFHP.

Tip: Self-compliance Tool for Part 7 of ERISA: ACA provisions @ www.dol.gov/ebsa/pdf/part7-2.pdf contains a step-by-step Q&A analysis for determining GF status. If plan is not claiming GFHP status, no need to complete.

No Collective Bargaining Exemption Under Health Care Reform

- Virtually **no relief for collectively bargained plans** (“CBPs”).
- No meaningful exception for self-insured CBPs.
- All CBPs in effect on March 23, 2010, treated the same as all other GHPs under general GFHP rules (e.g., GF status unless too many changes made to cost or coverage provisions of plan).
- Minor exception for fully-insured CBAs:
 - Will not lose its GFHP status until termination of the last CBA relating to coverage; and
 - Still required to comply with all ACA changes applicable to GFHPs.

Prohibition Against Lifetime and Annual Limits on Essential Health Benefits

- **Prohibition against \$ limits.**
GHPs (whether grandfathered or not) are generally prohibited from imposing any lifetime dollar limits, and annual dollar limits (first restricted, now prohibited for PYs beginning on or after Jan. 1, 2014) – but only on the value of essential health benefits (“EHB”).
- **For non-EHBs, both lifetime and annual limits are allowed** (so long as otherwise permissible under other federal or state laws).
- **Applies to both in-network and out-of-network EHBs.**

Tip: An exclusion of all benefits for a condition is not to be considered a lifetime or annual dollar limit. However, if any EHBs benefits are provided for a condition, then the lifetime and annual prohibitions apply.

Prohibition Against Lifetime and Annual Limits on Essential Health Benefits (cont' d)

- EHBs include items and services in 10 general categories:
 - Ambulatory 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;
 - Laboratory services;
 - Preventive and wellness services and chronic disease management; and
 - Pediatric services, including oral and vision care.

Prohibition Against Lifetime and Annual Limits on Essential Health Benefits (cont' d)

- **Essential health benefits package (“EHBP”).** Insured health plans in the “individual” and “small group” markets include the EHBP (e.g., they provide (i) EHBs; (ii) comply with limits on cost-sharing; and (iii) offer specified actuarial levels of coverage: **bronze**, silver, **gold**, and platinum).
 - Basic building block of the EHBP is a “**benchmark plan**” designated by each state (or by HHS, in the absence of state action).*
 - * In OK, HHS designated BlueCross BlueShield’s BlueOptions PPO, State CHIP (pediatric dental), and FEP VIP (pediatric vision) as the benchmark plan for individual and small group markets.
- Tip:** ER-sponsored (i) self-insured GHPs; (ii) insured “large” GHPs; and (iii) GFHPs are not required to offer EHBs. However, these plans are prohibited from imposing lifetime and annual dollar limits on any EHBs they do offer. *Note: See separate mandate for preventive health services.*

Prohibition Against Lifetime and Annual Limits on Essential Health Benefits (cont' d)

- Definition of EHBs for purposes of the dollar limit prohibitions. Self-insured GHPs, insured “*large*” GHPs, and GFHPs may use any HHS authorized definition of EHBs, including any available benchmark option (from any state), to define EHBs. (At this time there does not appear to be a definition of EHBs “*authorized by HHS*” other than the benchmark options.)

Tip: Non-monetary annual limits (e.g., day or visit limits) paid at a uniform, customary, and reasonable rate are permissible, so long as consistent with other applicable guidance and statutory provisions.

Prohibition Against Lifetime and Annual Limits on Essential Health Benefits (cont' d)

- **Annual Limits and HRAs.** Major disappointment to ERs who had hoped to use “*defined contribution*” approach to pay or reimburse “individual health insurance premiums” on a “*tax favored basis*” for EEs (e.g., non-taxable income to the EE):
 - **§ 125 Cafeteria Plans** cannot pre-tax payment of EE’s premiums for QHP purchased thru an Exchange unless purchased thru the SHOP or FF-SHOP [IRC § 125(f)(3)].
 - **IRS Notice 2013-54 (issued Sept. 13, 2013)**- Neither an HRA nor any “ER payment plan” may be used as a tax-favored method for an ER to pay or reimburse EE premium costs for “individual major medical” coverage (obtained thru an Exchange or otherwise for or on behalf of an individual) due to ACA’s market

Prohibition Against Lifetime and Annual Limits on Essential Health Benefits (cont' d)

reforms prohibition on “annual dollar limits”, as well as requirement to provide first dollar coverage for “preventive services”. Does not apply to (i) “excepted benefits” (e.g., limited scope dental and vision, disability); (ii) retiree-only plans; or (iii) an ER-sponsored arrangement under which EE may choose either cash or an “after tax” amount to be applied toward health coverage.

- **IRS guidance Employer Health Care Arrangements (issued May 14, 2014) and IRS Notice 2015-87 (issued Dec. 16, 2015)-** emphasizes ACA penalties if ERs reimburse EEs' individual insurance premiums.

Prohibition Against Lifetime and Annual Limits on Essential Health Benefits (cont' d)

- **IRS grants relief for small ERs, S-Corps, and Medicare/TRICARE arrangements**, but reiterates excise tax risks of paying EE's individual major medical insurance premiums [IRS Notice 2015-17 (2/18/15)]:
 - Temporary transition relief for non-ALEs (<50 FTE/FTEEs) thru 6/30/15;
 - Relief pending future guidance for certain S-Corp arrangements for 2% shareholders (e.g. >2% ownership);
 - Medicare premium reimbursement arrangements may be integrated with another group health plan offered by ER, subject to certain conditions.
NOTE: Medicare premium arrangements for active EEs may be subject to restrictions under other federal laws (e.g., Medicare Secondary Payer's "anti enticement" provisions for ERs).

Prohibition Against Lifetime and Annual Limits on Essential Health Benefits (cont' d)

- **TRICARE-related HRAs** may be integrated with another group health plan sponsored by ER, subject to certain conditions. **NOTE:** TRICARE “incentive” prohibition rules may restrict to small ERs;
- ER may **increase an EE’s taxable compensation as long as not conditioned** on the purchase of health coverage;
- However, **after-tax ER payment plans (e.g. without cash option) are subject to excise tax.** **NOTE:** In response to question if the compliance issue could be avoided by reimbursing individual premiums with after-tax compensation, IRS made it clear that an after-tax (reimbursement only) approach will not work.

Prohibition Against Lifetime and Annual Limits on Essential Health Benefits (cont'd)

- **Cures Act (signed into law 12/13/16) creates new HRAs for small ERs (“QSEHRA”).**
 - Eff. for **PYs beginning in 2017**, new stand-alone HRA option for **non-ALEs** (e.g., < 50 FTEs/FTEEs) that ***do not* offer a GHP** to any of their EEs;
 - QSEHRAs are **exempt from definition of GHP** for purposes of ACA and COBRA;
 - Must be **funded solely by ER** and reimburse only **IRC § 213(d) medical expenses**;
 - Must be provided to **all eligible EEs** (subject to certain exceptions);
 - ER contributions **up to \$4,950/\$10,000 for family** (indexed for inflation and prorated for partial years);
 - Notice requirement to EE and W-2 reporting-ER must give annual notice to eligible EEs at least 90 days before start of year stating:
 - amount of EE’s permitted benefit;
 - instruct EE to disclose permitted benefit amount to Exchange if EE seeks advance premium tax credit; and
 - warning that if EE does not have MEC for any month, EE might be subject to taxable reimbursements which must be reported by the ER on the EE’s Form W-2.
 - Extended temporary transition relief for small ERs that **reimburse individual health insurance premiums thru PYs beginning in 2016**. (IRS previously indicated that such “employer payment plans” were no longer allowed under the ACA but, in Notice 2015-17, granted temporary relief for small ERs that offered such arrangements thru 6/30/15.

Prohibition Against Lifetime and Annual Limits on Essential Health Benefits (cont'd)



- **Final rules pave the way for ERs to offer “individual coverage HRAs” (CHRAs) and “essential health benefits HRAs” (EBHRAs) in 2020.**
 - Allows integration of an HRA with individual health insurance coverage, and thereby satisfying ACA’s prohibition lifetime and annual limits on EHBs and preventive care cost sharing requirements;
 - **Creates excepted benefit HRAs** limited in amount and to the types of coverage for which premiums may be reimbursed;
 - Provides **new premium tax credit eligibility rules** for individuals with individual health insurance coverage;
 - **Clarifies that individual health insurance coverage**, the premiums of which may be reimbursed by an HRA or QSEHRA, **does not become part of an ERISA plan when certain conditions are met**; and
 - Adds **new special enrollment for the individual market** for individuals who gain access to HRAs integrated with individual health insurance coverage or who are provided QSEHRA.
 - **Rules apply to ERs of all sizes** and does not affect the status of HRAs as group health plans.

Prohibition Against Lifetime and Annual Limits on Essential Health Benefits (cont'd)



- **ICHRA.** Funds in this new “individual coverage HRA” will be available to reimburse premiums for individual health insurance, whether offered on or off an ACA exchange, as well as Medicare coverage.
 - ERs can contribute as little or as much as they want. An offer of an ICHRA will count as an offer of coverage under the ACA ER mandate, however to avoid penalties, an ALE must fund the ICHRA sufficiently to meet “affordability requirements.”
 - For any portion of the individual health insurance premium not covered by an ICHRA, ERs may offer pre-tax salary reduction through a § 125 cafeteria plan. This applies ONLY to off-exchange coverage because cafeteria plan rules prohibit the use of pre-tax funds for exchange coverage.
 - EE must enroll in individual health insurance coverage (or Medicare) for each month the EE (or family member) is covered by the ICHRA. This coverage cannot be short-term, limited duration, or consisting solely of “excepted benefits” (e.g., dental or vision).

Prohibition Against Lifetime and Annual Limits on Essential Health Benefits (cont'd)

- ICHRA is offered to a class of **EES to whom a traditional GHP is not offered**.
- ICHRA must be **offered on the same terms to all EEs within a class**. Certain exceptions apply for older workers and for workers with more dependents.
- **Annual opt-out option** for individuals who prefer ACA exchange coverage with premium tax credit.
- **Substantiation and notice requirements** must be met.
- To prevent adverse selection in the individual market, a **minimum class size rule applies** if ER offers a traditional GHP to some EEs and an ICHRA to others based on FT vs. PT status, salary vs. non-salaried status, or geographic area if smaller than a state:
 - 10 EEs for ER with < 100 EEs;
 - 10% of total number of EEs for ER with 100 to 200 EEs; and
 - 20 EEs for ER with 200 or > EEs.

Prohibition Against Lifetime and Annual Limits on Essential Health Benefits (cont'd)

- **EBHRA.** May be offered in addition to a traditional GHP- e.g., to cover the cost of copays, deductibles, coinsurance, and non-covered expenses. To qualify as “EBHRA”:
- Annual contribution limited to \$1,800 (indexed).
 - HRA must be offered in conjunction with a traditional GHP, although EE not required to enroll in GHP.
 - HRA cannot be used to reimburse premiums for individual health insurance coverage, GHP (other than continuing coverage), or Medicare. However, it can reimburse premiums for “excepted benefits” (e.g., dental and vision), as well as short-term limited duration coverage.
 - EBHRA must be uniformly available to all “similarly situated individuals.”



Note: EBHRAs, which can reimburse medical care expenses other than “excepted benefits, are different from an HRA that reimburses only “excepted benefits.” ERs can continue to offer HRAs that reimburse only “excepted benefits,” and those HRAs need not meet the requirements for EBHRAS.

Annual Cost-Sharing Limits

- **Annual Limitation on Deductibles.*** Beginning in 2014, all non-grandfathered “small” group market health plans were to comply with annual limitations on deductibles - ***Repealed 4/4/14!***
- **Annual Limitation on Out-of-pocket .*** Beginning in 2014, all non-grandfathered GHPs (including “small”, “large”, “insured”, and “self-insured”) must comply with annual limitations on out-of-pocket maximums:
 - For 2020- \$8,150 self-only (for 2021-\$8,550)/\$16,300/family (for 2021-\$17,100); including deductibles, coinsurance, and co-pays.
 - Plans that have multiple service providers (e.g., medical-TPA, RX-PBM, but not mental health) had until 2015 to work with service providers to aggregate out-of-pocket maximums. However, plans may allocate out-of-pocket max limits across different benefit categories, so long as combined amount does not exceed overall limit (e.g. for 2020, \$6,150 medical/\$2,000 Rx = \$8,150).

NEW

Tip: Cost sharing limits apply to in-network benefits only. Premiums, amounts incurred for “non-essential” or non-covered services, or balanced billed amounts charged by out-of-network provider are not take into account. *Beginning in 2018, services provided by out-of-network ancillary provider will count towards in-network OOP max if issuer does not provide timely notice that the provider is no longer in-network.*

Tip: Self-only limit applies to each covered individual regardless of whether the coverage is self-only coverage.

* These requirements do not apply to grandfathered plans. Beginning in 2020, health plans may count drug manufacturer’s assistance coupons toward OOP, regardless of whether generic equivalent available.

NEW

Annual Cost-Sharing Limits (cont'd)

➤ **IRS announced 2020 HSA Contribution Limits for HDHP Coverage, HDHP Minimum Deductibles, and HDHP Out-of-Pocket Maximums.**



- HSA contribution limits for HDHP coverage for 2020- \$3,550 self-only (a \$50 increase from 2019)/\$7,100 family (a \$100 increase from 2019);
- HDHP minimum deductibles for 2020- \$1,400 self-only (\$50 increase from 2019)/\$2,800 family (\$100 increase from 2019); and
- HDHP out-of-pocket maximums for 2020- \$6,900 self-only (a \$150 increase from 2019)/\$13,800 family (a \$300 increase from 2019).
- **Tip:** Scrutinize family coverage HDHP for “embedded” individual deductibles (e.g., an individual deductible \$1,500 within the family deductible \$3,000 cannot be lower than the minimum required deductible for HDHP family coverage).

Prohibition on Preexisting Condition Exclusions

- GHP (whether grandfathered or not) and group health insurance issuers **prohibited from imposing any preexisting condition exclusions (“PCE”)**, effective for PYs beginning on or after Jan. 1, 2014.*

Tip: PCE means any limitation or exclusion of benefits (including a denial of coverage) applicable to an individual as a result of information relating to an individual’s health status before the individual’s effective date of coverage (or if coverage is denied, the date of denial), such as a condition identified as a result of a pre-enrollment questionnaire or a physical examination given to the individual, or a review of medical records relating to the pre-enrollment period.

- * For PYs beginning on or after September 23, 2010, applies to individuals under age 19 only.

- **Elimination of requirement to issue Certificates of Creditable Coverage (HIPAA Certificates)** applies beginning Dec. 31, 2014.

Prohibition Against Excessive Waiting Periods

- Effective for PYs beginning on or after Jan. 1, 2014, a GHP (whether grandfathered or not) is **prohibited from imposing a waiting period of more than 90 days** for an EE's coverage to become effective.
- Coverage must be effective no later than 91st day of entering eligible class.
- **Other conditions for eligibility generally permissible** (e.g., sales goals, earning certain level of commissions, licensure requirements, completing certain # of hours capped at 1,200 hrs, or a reasonable bona fide employment-based “orientation period” not to exceed one month).

Tip: The “*orientation period*” would allow ERs to offer coverage on the 1st day of the month following a 90-day waiting period, and also allow coordination with the coverage start dates that would avoid penalties under the final ER “pay or play” provisions (e.g., 1st day of the month following 3 full calendar months).

Prohibition Against Excessive Waiting Periods (cont'd)

EXAMPLE 1: Compliance with both the waiting period limit and ER pay or play. ALE with a 1-month orientation period combined with plan eligibility provision that provides coverage will begin on the 1st day of the 3rd month beginning on or after the last day of the EE's orientation period. Jane is hired as a FTE on 1/6. She completes her 30-day orientation period on 2/5, and pursuant to the plan's terms, became eligible for coverage on 5/1. Jane's waiting period is 84 days (assuming 28 days in Feb.), and her coverage begins by the 1st day of the 4th full calendar month of her employment.

NOTE: Because coverage is offered to Jane by the 1st day of the 4th full calendar month of her employment, the entire period between her hire date (1/6) and the date coverage is available (5/1) is a *“limited non-assessment period”* for purposes of pay or play rules.

Prohibition Against Excessive Waiting Periods (cont'd)

EXAMPLE 2: Compliance with the waiting period limit but not pay or play. ALE with a 1 month orientation period combined with plan eligibility provision that provides coverage will begin following completion of the orientation period and a 90-day waiting period. John is hired as a FTE on 1/6. He completes his 30-day orientation period on 2/5, and pursuant to the plan's terms, becomes eligible for coverage on 5/6 (assuming 28 days in Feb). John's waiting period is 90 days, but his coverage begins after the 1st day of the 4th full calendar month of employment.

NOTE: Because John was not offered coverage by the required date (5/1), that period is not considered a *"limited non-assessment period"*. However, because his start date was not on the 1st day of the month, the period from his start date (1/6) thru the end of that month (1/31) would be a *"limited non-assessment period"* for purposes of pay or play penalties. Thus, the penalty exposure would not begin until Feb.

Prohibition Against Rescission

- **Rescission.** GHPs (whether grandfathered or not) are prohibited from retroactively cancelling or discontinuing (“rescinding”) coverage of any individual, unless the individual or person seeking coverage on his or her behalf:
 - Performs an act, practice, or omission that constitutes fraud; or
 - Individual makes an intentional misrepresentation of a material fact, as prohibited by the coverage.
- Retroactive cancellation and discontinuance of coverage is not rescission if attributable failure to timely pay premiums.
- Must provide at least **30 days advanced written notice** to each participant who would be affected by rescission.

Dependent Coverage to Age 26

- **Dependent coverage for adult children.** GHP (whether grandfathered plan or not) that provides dependent coverage of children must extend that coverage **to age 26**:
 - Regardless of marital or student status;
 - Financial support;
 - Residency;
 - Employment;
 - Tax dependency;
 - Eligibility for other coverage;* or
 - Any other factor.

* For PYs beginning before Jan. 1, 2014, GFHP may exclude a child who is eligible for coverage under another ER-sponsored GHP (except for a plan maintained by an ER of either of the child's parents).

Tip: Coordination of Benefits. COB rules generally provide that if an individual is covered as an EE under one plan and as a dependent under another plan, the plan in which the individual is the EE is primary. If a child is covered as a dependent under one or more plans, the birthday rule provides that the plan of the parent whose birthday is earlier in the year is primary.

Dependent Coverage to Age 26 (cont' d)

- ACA does not define “children” for this purpose, however agency FAQs indicated that GHP offering dependent coverage only to children that fall within the IRC § 152(f)(1) definition of child (e.g., biological, adopted, step, or eligible foster child) will not fail to satisfy the mandate; and that plan offering coverage to child outside the 152(f)(1) definition (e.g., grandchild or niece) may impose conditions beyond child’s relationship with participant (e.g., financial dependency).

Tip: Avoiding Pay or Play Tax. Beginning in 2015, an applicable large employer (“ALE”) will be subject to pay or play penalties if it fails to offer qualifying coverage to its FTEs and their “dependents.” Dependent is defined to mean an IRC § 152(f)(1) child who has not attained age 26, excluding stepchildren and foster children.

- **Same benefits/same price.** Terms of dependent children coverage may not vary based on age, except for children age 26 or older (e.g., premium surcharge for child over age 18 prohibited).
- Child does not have independent right to enroll.

Tip: GHP provision that allows coverage either as an EE or dependent (but not both) seems permissible, since the child could choose whether to enroll as a dependent (thru EE parent) or for EE coverage.

Coverage of Preventive Health Services Mandate

- **Required Preventive Coverage.** GHPs* must provide coverage without any cost-sharing requirements (e.g., first dollar coverage – no deductibles, coinsurance or co-pays) for certain preventive health services provided by **in-network** providers:
 - Evidence based items or services with an “A” or “B” rating recommended by the U.S. Preventive Services Task Force (“USPSTF”);
 - Routine immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices for the Centers for Disease Control and Prevention;
 - Evidence-informed preventive care and screening for infants, children, and adolescents provided for in comprehensive guidelines supported by Health Resources and Services Administration (“HRSA”);
 - Other evidence-informed preventive care and screenings for women, provided for in comprehensive guidelines supported by HRSA.

* These requirements do not apply to grandfathered plans.

Coverage of Preventive Health Services Mandate (cont'd)

- **On going updates.** Preventive services continue to be updated. GHPs must cover any newly added services for PYs beginning on or after one year following the effective date of the adoption of the recommendation.

Tip: Interaction of Preventive Services Mandate with Mental Health Parity.

Even if plan does not otherwise provide mental health benefits, NGFHPs must provide certain minimum preventive services without cost-sharing, including alcohol misuse screening counseling, depression counseling, and tobacco use screening. Required coverage of preventive services does not trigger a broader requirement to comply with the Mental Health Parity and Addiction Equity Act.

DOL, HHS and IRS jointly issued FAQs about Affordable Care Act Implementation (Part 31) April 20, 2016.

Women's Preventive Services Mandate

- **Additional Women's Wellness Services.** Guidelines for Women's preventive services were issued by HRSA on Aug. 1, 2011, and include coverage for a broad range of items and services provided by in-network providers, including:
 - Contraceptive methods and counseling (with exception for certain religious ERs, including any non-profit entity with religious objections to some or all contraceptives);
 - Breastfeeding support and supplies; and
 - Counseling for interpersonal and domestic violence.
- Coverage without cost-sharing for items and services required to be provided for PYs beginning on or after August 1, 2012.*
- **New recommendations with respect to breast cancer.** Coverage of risk-reducing Rx's (e.g., tamoxifen or raloxifene) for certain women at increased risk for breast cancer, when prescribed by clinicians. Coverage without cost-sharing required to be provided for PYs beginning on or after Sept. 24, 2014.

See Women's Preventive Services Guidelines available at www.hrsa.gov/womensguidelines (as visited April 30, 2016) for a complete list of covered women's preventive services.

- * These requirements do not apply to grandfathered plans.

Contraceptive Mandate- Exemption for Religious ERs

- **Exemption for Religious ERs.**
Exemption for qualifying religious ERs as well as accommodations for any non-exempt non-profit organization with religious objections to some or all contraceptives.*
 - DOL, HHS, and IRS have jointly issued two sets of interim final regs significantly expanding the exemptions from ACA's requirement to provide certain contraceptives w/o cost sharing.
 - 2013 regs require specific notice and self-certification requirements for ERs to their insurer/TPA (Form 700).

* U.S. Supreme Court ruled ACA's contraceptive coverage mandate violates religious rights of a "closely-held" family-owned for-profit entity in its Hobby Lobby decision (June 20, 2014).

Contraceptive Mandate- Exemption for Religious ERs (cont'd)

- **Accommodations for non-exempt, non-profit entities-** they do not have to contract, arrange, pay, or refer for insurance coverage for these services:
 - Insured GHPs- insurer assumes sole responsibility for providing no cost-sharing contraceptive benefits (the payments are not individual policies);
 - Self-insured GHPs- TPA becomes an ERISA “plan administrator” and claims administrator for the purpose of providing no cost-sharing contraceptive benefits. TPA can provide payments on its own or it can arrange for an insurer or other entity to provide payments;
 - **New rules proposed on birth control coverage and alternate self-certification** issued August 22, 2014. Effective immediately, non-profits, including religious colleges, and hospitals may self-certify their religious objections to DOL or HHS (rather than to their insurer/TPA) using a new model notice. DOL or HHS will then notify the relevant insurer/TPA to provide the coverage at no cost to the organization or company and provide notice of availability of coverage to participants;
 - Separate proposed regs would extend the religious accommodation to certain “*closely-held*” for-profit entities (like Hobby Lobby). HHS requested comments on how to define “closely-held” and appropriate steps to implement; and
 - **DOL, HHS, and Treasury FAQs issued Jul.17, 2014-** *Disclosure with Respect to Preventive Services.* For plans that reduce or eliminate contraceptive services after having provided such coverage, expedited disclosure requirements for material reductions in covered services or benefits apply.

Patient Protections Relating to Choice of Provider and Emergency Services

- ACA mandates pertaining to **patient's choice of health care provider**, and access to emergency services applies to non-grandfathered GHPs.*
- **Patient's choice of health care provider.*** GHP that requires or provides for persons to choose a primary care provider (“PCP”) must allow person to designate any available in-network PCP, including:
 - For a child, any available in-network pediatric physician; and
 - If OB/GYN care is covered, plan cannot require an authorization or referral as a condition for a female enrollee to receive care from an in-network OB/GYN provider.
- **Emergency Services received out-of-network.*** Out-of-network emergency care services to be paid at:
 - In-network copayment amount or coinsurance level (out-of-network providers may still balance bill); and
 - Other cost sharing requirements (e.g., out-of-network deductibles and out-of-pocket maximums) may be imposed if such requirements apply to out-of-network benefits in general.

Coverage and Nondiscrimination Requirements for Participants in Clinical Trials

- **Clinical Trials.** Effective for PYs beginning on or after Jan. 1, 2014, where an individual is covered under a non-grandfathered GHP* is eligible to participate in an approved clinical trial, with respect to treatment of cancer or another life-threatening disease, plan must **not**:
 - Deny the individual's participation in the clinical trial;
 - Deny (or limit or impose additional conditions upon) the coverage of routine patient costs for items or services furnished in connection with the trial; or
 - Discriminate against the individual based on his or her participation in the clinical trial.
- * These requirements do not apply to grandfathered plans.

Prohibition Against Discrimination in Favor of Highly Compensated Individuals

- ACA extends **non-discrimination requirements of IRC § 105(h)(2)**, previously applicable only to self-insured plans, to non-grandfathered fully-insured GHPs*, thus prohibiting such plans from discriminating in favor of “highly compensated individuals” with respect to eligibility or benefits.
- Nondiscrimination requirements were scheduled to apply for PYs beginning on or after Sept. 23, 2010, but the agencies have delayed their application pending the issuance of further guidelines.

* These requirements do not apply to grandfathered plans.

Wellness Programs and Prohibited Discrimination Based on Health Status

- ER-sponsored wellness program incentives increased from 20% to 30% for HIPAA compliant “health contingent” programs- increased to 50% for programs designed to prevent or reduce tobacco use (effective for PYs beginning on or after 1/1/14).
- Wellness programs for tobacco cessation are permitted (but not required) to provide 2nd opportunity later in the PY to avoid the tobacco premium surcharge until renewal or reenrollment for next PY.

Tip: Wellness Incentives and Affordability. Incentives that relate to “tobacco use” under a nondiscriminatory wellness program that affects premiums are treated as earned in determining (e.g., would reduce) an EE’s or a related individual’s required contributions to an ER-provided plan, while incentives that do not relate to tobacco use are treated as not earned for this purpose.

Nondiscrimination in Health Care Providers

- Non-grandfathered GHPs* may **not discriminate against health care providers** with respect to “*participation and coverage*” when provider acting within the scope of that provider’s license (however does not require insurer/plan to contract with any willing provider). Effective for PYs beginning on or after 1/1/14.

* These requirements do not apply to grandfathered plans.

Tip. Non-grandfathered self-insured GHPs need to double check for any discriminatory chiropractic limitations.



What Insurance Mandates Apply?

- **Fair health insurance premiums rating reforms (rating limitations)-** Applicable only in the individual and small group markets. Effective for PYs on or after Jan. 1, 2014, health insurance issuers must comply with ACA's fair health insurance premium requirements*.
 - **Strict modified community rating limitations** for fully-insured individuals and small groups up to 100 EEs (and larger groups purchasing thru an Exchange) with premium variations allowed for:
 - Age (3:1 for adults);
 - **Tobacco use surcharge** only in connection with a wellness program (1.5:1);
 - Family composition and geographic regions to be defined by states;
 - Experience rating prohibited; and
 - Wellness discounts allowed under specific circumstances.

* These requirements do not apply to grandfathered plans.

What Insurance Mandates Apply? (cont'd)

- **Guaranteed-availability rules.** Big change in application of guaranteed-availability rules.
 - Prior to 2014, guaranteed-availability rules only applied to “small group” market, while guaranteed-renewability rules applied to both “small group” and “large group” markets.
 - As of January 1, 2014, ACA extends **guaranteed-availability rules to all group coverage** (regardless if offered in large group or small group market),* but only for those products that are approved for sale in the applicable market segment based on the ER’s group size.

* These requirements do not apply to “excepted benefits” or grandfathered plans.

What Insurance Mandates Apply? (cont'd)

Tip: Prior to Jan. 1, 2014, HIPAA's guaranteed-availability rules permitted insurers to impose ER contribution and minimum group participation requirements. ACA removed this provision. **Final regs allow issuers in "small group" market to apply minimum participation rules other than during the annual open enrollment period from Nov. 15 thru Dec. 15 of each year.** Thus, during that one-month annual open enrollment period, insurers must accept ERs in "small group" market, even if ER cannot satisfy the insurer's contribution and minimum participation requirements. **Insurers in the "large group" market may not impose minimum contribution or participation rules because large ERs generally do not present the same adverse selection risk as small ERs.**

What Insurance Mandates Apply? (cont'd)

- **Guaranteed-renewability rules applicable to all insurance:***
 - Guaranteed-renewability rules apply to both “small group” and “*large group*” market pre-ACA.
 - Health insurance issuers must renew or continue enforce insurance coverage at the option of the plan sponsor, subject only to certain exceptions.

Tip: ER switching between small group and large group market segments. According to HHS, the law guarantees an ER the right to continue to enforce the coverage it purchased in the small (or large) group market even if the ER ceases to be a small (or large) ER by reason of an increase (or decrease) in its number of EEs. *Q: If ER able to renew in original market segment despite increases or decreases in size, which insurance market reform rules apply to the ER? Need further guidance.*

* Insurance coverage that qualifies as a grandfather plan are not required to comply.

What Insurance Mandates Apply? (cont'd)

- **Exceptions to guaranteed-renewability:**
 - Non-payment of premium;
 - Fraud or material misrepresentations;
 - ER's failure to meet minimum contribution and participation requirements;
 - Insurer's discontinuance of a particular product or all coverage in that market;
 - No enrollees in the service area; and
 - Uniform modification of small group market coverage.

Recent guidance attempts to resolve conflict between guaranteed-availability and guaranteed-renewability for “small group” coverage purchased thru the FF-SHOP. FF-SHOP will not impose (and insurers offering QHPs thru the FF-SHOP may not enforce) minimum participation requirements for renewals occurring during the Nov. 15 thru Dec. 15 annual enrollment period.

Medical Loss Ratio Reporting and Disclosure Requirements

- **Rebates.** Insurer must provide rebates for GHP (whether grandfathered or not) to policyholder (typically ER*) if it fails to spend at least:
 - <85% of annual premiums in large group market; and
 - <80% of annual premiums in small group and individual markets; on incurred claims and quality improvement expenses.
- * Insurer generally provides rebate to the policyholder with two exceptions, in which case the rebate is provided to the participant EE covered by the plan during the calendar year for which the rebate is based.
 - Church plans, if insurer does not obtain written assurance from the policyholder that the rebate will be used to benefit members; or
 - If the plan has terminated and the insurer is unable to locate the policyholder.

Medical Loss Ratio Reporting and Disclosure Requirements (cont'd)

- *“Incurred claims”*:
 - Direct **claims paid** (including capitation fees) for clinical services or supplies;
 - **Claims reserves** (including contingent benefits and claims portion of lawsuits); and
 - **Experience rating refunds**.
- Annual rebates must be distributed by Aug. 1 of the following year.
- Policyholder requirements for use of rebate varies depending on whether plan is an ERISA, non-federal governmental, or church plan.

Claims and Appeal Procedures

- Detailed requirements pertaining to **internal claims, appeals, and independent external reviews of “adverse benefit determination”** applies to non-grandfathered GHPs.*
 - Generally must comply with DOL’s pre-ACA claims and appeal regs applicable to ERISA GHPs (with some modifications).
- * These requirements do not apply to grandfathered plans.

Summary of Benefits & Coverage

- GHPs (whether grandfathered or not) must provide a **Summary of Benefits and Coverage** (“SBC”) to applicants and enrollees (participants and beneficiaries) before enrollment or re-enrollment:
 - At initial enrollment;
 - Subsequent years with each year’s open enrollment period; and
 - Material modification of coverage requires 60-day notice to enrollees if occurs other than at renewal (e.g., mid-year changes).
- Overlapping insurer and Plan Administrator responsibility to provide SBC:
 - If insurer provides, that satisfies Plan Administrator’s obligation.
 - Plan Administrator of self-insured GHP responsible to provide.

Tip: SBC requirements apply in addition to ERISA’s SPD and SMM requirements.

- Templates, instructions, and related guidance are available on the DOL and HHS websites.
- Final regs, revised template, and other guidance make changes to SBC requirements for PYs beginning the 1st open enrollment period that begins on or after 1/1/21.
- **Consequences of failing to provide SBC**-civil penalty of up to \$1,000 per failure (adjusted for inflation). Max penalty assessed after 1/15/20 (for violations occurring after 11/2/15) is **\$1,176 per participant/beneficiary**. Fine cannot be paid from plan or trust assets.





Part 3

Shared Responsibility for ERs

(ER “Pay or Play”
Penalty Tax)

ER “Pay or Play” Penalty Tax



Are you going to
pay or play?

➤ Beginning in 2015, the shared responsibility provisions impose a non-deductible excise tax penalty, (also called the “pay or play” penalty tax) under IRC § 4980H on ALEs with 50 or > FTEs/FTEEs if they:

- Do not offer “*minimum essential health care coverage*” (“MEC”) under an “eligible ER-sponsored plan” to substantially all of its FTEs [the subsection (a) \$2,000 (as indexed)* “no-offer penalty”]; or
- Offer MEC to their FTEs, but it is either “*non-affordable*” or does not provide “*minimum value*” [the subsection (b) \$3,000 (as indexed)** “under-offer penalty”].

*For 2020- \$214.17/\$2,570/year; (estimated based on premium adjustment percentage in the 2020 Notice of Benefit and Payment Parameters.

NEW

NEW

**For 2020- \$321.67/\$3,860/year.

ER “Pay or Play” Penalty Tax (cont’ d)

Tax trigger. Pay or play penalty tax is due ONLY if any FTE is “*certified*” to ER as having purchased health coverage thru an Exchange AND for which the “*federal premium tax credit*” was paid.

➤ 2015 Transition relief:

- Most mid-size ERs (50-99 FTEs/FTEEs) are fully exempted;
- ALEs (100 or > FTEs/FTEEs):
 - Must offer coverage to at least 70% of its FTEs, instead of 95%; and
 - Pay or play penalty tax “*no-offer penalty*” calculated after excluding 80 FTEs, instead of 30 for each month in 2015 (and portion of 2015 PY that ends in 2016 for non-CY plan).

ER “Pay or Play” Penalty Tax (cont’ d)

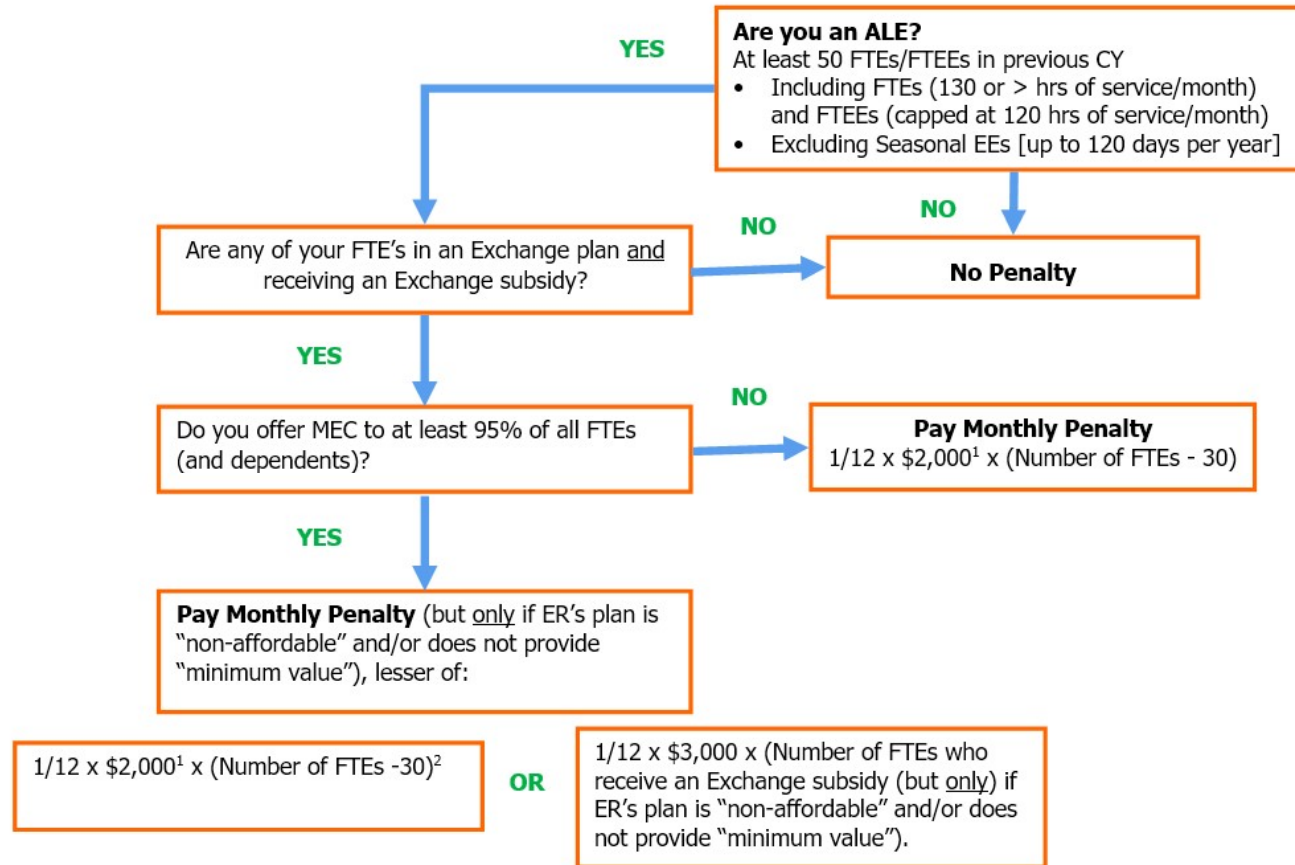
➤ **Clarification of periods during which § 4980H liability does not apply – “limited non-assessment periods”:**

ER will not be subject to a penalty under § 4980H(a), and in certain cases § 4980H(b) with respect to a FTE:

- Transition rule for ER’s 1st year as an ALE;
- For the 3 full calendar month period beginning with the 1st full calendar month in which EE is 1st eligible under “*monthly*” measurement method;
- During initial 3 full calendar months of employment for an EE reasonably expected to be FTE at start date under “*look-back*” measurement method;
- During “*initial measurement period*” to new variable-hour EE, seasonal EE, or part-time EE determined to be employed on average at least 30 hours of service per week, under “*look-back*” measurement method.
- Following EE’s change in employment status to FTE during “*initial measurement period*” under “*look-back*” measurement method; and
- Calendar month in which EE’s start date occurs on a day other than 1st day of calendar month.

ER “Pay or Play” Penalty Tax (cont’ d)

Will ER Pay A Penalty?



¹ As indexed: 2020- § 4980H(a) penalty \$2,570/yr. (increased \$70)
§ 4980H(b) penalty \$3,860/yr. (increased \$110)

ER “Pay or Play” Penalty Tax (cont’ d)



Key action steps for ERS to determine potential penalties and strategic options:

1. Identify **ownership and control group** of ER (IRC § 414(b),(c), (m), and (o));
2. Determine **ER size** (e.g., whether ER meets the 50 **FTEs/FTEEs** threshold for ALE status);
3. Identify current **FTEs**;
4. Determine whether **coverage is offered** to substantially all **FTEs** (and dependents);
5. Determine whether **coverage offered is “affordable”**; and
6. Determine whether **coverage offered provides “MV”**.

ER “Pay or Play” Penalty Tax (cont’ d)

➤ Key definitions:

■ Dependent:

- Child of an EE to age 26;
- Includes **biological and adopted** children;
- Does not include stepchildren or foster children;
- Does not include spouse.

Tip: Beginning 2015 plan year, health insurers offering non-grandfathered health coverage for opposite-sex spouses must also offer coverage for same-sex spouses (legally married in a domestic or foreign jurisdiction that authorizes same-sex marriage).*

* Does not apply to grandfathered plans or self-insured plans.

ER “Pay or Play” Penalty Tax (cont’ d)

- **EE:**
 - An individual under the “*common law*” standard.
 - An **employment relationship exists** when person for whom services are performed has the right to control and direct the individual who performs the service.
 - **Does not include** leased EEs* [defined under IRC § 414(n)(2)], sole proprietor, partner in a partnership, 2% or > SH in S-Corp., EEs employed outside the U.S., or IRC § 3580 EEs (e.g., qualified real estate agents and direct sellers).
- **ER** means all “*common law*” ERs, including profit, non-profit, and governmental entities (e.g., federal, state, local, or Indian tribal government).

* IRC § 414(n), which treats “leased EEs” as EEs of the service recipient for various purposes, does not cross-reference § 4980H and accordingly would not apply to § 4980H.

ER “Pay or Play” Penalty Tax (cont’ d)

- **FTE** means, with respect to a calendar month, an EE who is employed on average of at least 30 “*hours of service*” per week (130 hours of service in a calendar month is treated as the monthly equivalent of at least 30 hours of service per week).
- **Hours of service** means each hour for which an EE is paid for performance of duties and each hour for which EE is paid during which no duties are performed due to vacation, holiday, illness, disability, layoff, jury duty, military duty, or other paid leave of absence:

Excluded hours of service for determining ALE status: An hour of service does not include hours performed by: (i) “bona fide volunteers” at governmental or tax exempt organizations; (ii) student EE work-study hours; (iii) hours of certain members of religious orders; (iv) hours of non-U.S. income; and (v) hours of EE that has TRICARE or coverage under federal program thru the Department of Veteran Affairs.

Special rules for certain groups (*e.g.*, adjunct faculty, lay-over hours for airline industry, and on-call hours).

ER “Pay or Play” Penalty Tax (cont’ d)

- **PY** must be **12 consecutive** months unless short PY of < 12 consecutive months is permitted for a **valid business purpose**. A change in PY is not permitted if a principal purpose of the change is to circumvent IRC § 4980H.
- **Seasonal EE** means an EE who is hired into a position for which the **customary annual employment is 6-months or less**:
 - Period of employment should generally begin in approx. the same part of the year (e.g. summer or winter);
 - Can still be seasonal EE if employment extended beyond customary period.
- **Variable hour EE** means an EE if, **based on the facts and circumstances at the EE’s start date**, the ER cannot determine whether EE is reasonably expected to be employed on average at least “30 hours of service/ week” during “initial measurement period” because EE’s hours are variable or otherwise uncertain. Factors to consider include, but not limited to, replacing a variable hour EE, similar positions, or how communicated to EE.

ER “Pay or Play” Penalty Tax (cont’ d)

- **Controlled group of ERs** – Code § 4980H applies the controlled group test, meaning that all entities treated as a single ER under Code § 414(b),(c),(m), or (o) are treated as a single ER for purposes of § 4980H. Thus, EEs of all the ERs within the controlled group are taken into account in determining whether any member of the controlled group is an ALE (e.g., all EEs and all hours of service are aggregated for all members of the controlled group). Thus, a controlled group member with < than 50 EEs will be deemed to be an ALE if the controlled group as a whole has 50 or more **FTEs/FTEEs**. With respect to any pay or play penalties, each member of the controlled group will be held liable only for the coverage it provides (or fails to provide) its own EEs. 30 EE (80 EE for 2015) reduction under no-offer penalty (§ 4980H(a)) is allocated among control group on the basis of **FTE**’s employed by each company.
- **Successor ERs** - Companies must include the EEs of companies they acquired during the prior year to the extent they are successor ERs under the rules used for employment taxes and may have successor liabilities for any penalty incurred by the predecessor ER.
- **New ERs** - ERs that were not in existence for all of the prior calendar year are still subject to these rules if it is **reasonably expected that they will employ an average of at least 50 FTEs during the current calendar year**.
- **Transition relief for 1st time ALEs**. ERs that qualify as ALEs for the 1st time have until April 1 of the 1st ALE year to offer coverage to a **FTE** who was not offered coverage in the prior year.

ER “Pay or Play” Penalty Tax (cont’ d)

- **Counting hours of service general rule** - The hours to be counted are “*hours of service*,” not “*hours worked*.” Hours of service include all hours for which the EE is paid or is entitled to payment for duties performed, and hours for which the EE is entitled to payment where no duties are performed such as for vacations, holidays, illness, incapacity (including disability), layoff, jury duty, military duty or a leave of absence. There is no limit on the number of hours that may be credited for paid leave:
 - **Counting hours of service for hourly EEs** - Hours of service for hourly EEs must be determined by counting the actual hours recorded by the company;
 - **Counting hours of service for non-hourly (salaried) EEs** - Hours of service for non-hourly workers can be calculated by: (i) counting actual hours from company records; (ii) using a days-worked equivalency based on 8 hours for each day with an hour of service; or (iii) using a weeks-worked equivalency based on crediting 40 hours for each week with an hour of service. The equivalency options cannot be used, however, if the result would be to substantially understate the EE’s hours of service to deny him or her treatment as a **FTE**. The same method need not be used for all non-hourly EEs so long as the distinguishing classifications used are reasonable and consistently applied. An ER may, however, change the method for calculating non-hourly EEs’ hours of service for each calendar year.

ER “Pay or Play” Penalty Tax (cont’ d)

- **Counting hours of service in special employment situations-** For EEs on commission, adjunct faculty,* transportation EEs, and similar special employment situations, ERs must use a reasonable method of crediting hours of service consistent with the purpose of the statute, pending further guidance. Any method that counts only some, but not all of an EE’s hours, or that would classify an obviously FTE as part-time, would not be considered reasonable.
- **General anti-abuse rule -** The proposed regs provide that any credited hours of service will be disregarded if done to circumvent these play-or-pay rules, or if the underlying service was requested or required of the EE for that same reason.

*

Colleges seeking a reasonable rule may credit adjunct faculty with $2 \frac{1}{4}$ hours of service/per week for each credit hour of teaching or classroom time (e.g., 3 hour class \times 2.25 = 6.75 hours of service per week).

ER “Pay or Play” Penalty Tax (cont’ d)

- **Temporary staffing agencies/PEO anti-abuse rule** - An offer of coverage to an EE performing services for an ER client (where staffing firm is not the “common law” ER) on behalf of the ER client under a plan established or maintained by the staffing firm, **is treated as an offer of coverage by the client ER** for purposes of IRC § 4980H pay or play penalties, provided the fee the ER client would otherwise pay to the staffing firm for such EE is **higher** if such EE enrolls in the staffing firm’s health coverage.

ER “Pay or Play” Penalty Tax (cont’ d)



➤ What ERs are subject to a Pay or Play Penalty Tax?

- Applies to “*applicable large ERs.*”
- “ALE” for a calendar year is an ER who employed on average of **at least 50 FTEs and/or FTEEs** on business days during the preceding calendar year, but excluding EEs who work outside the U.S.
- This determination is made **retrospectively** (e.g., ERs must count EEs for all 12 months in 2019 to determine ALE status for 2020).*



*2015 Transition relief that allowed ERs to choose any 6 consecutive month period in 2014 (rather than the entire calendar year), to determine their status for 2015 did not carry forward to 2016. Beginning in 2016 ER must use all 12 months in the previous CY to determine ALE status in the current year.

➤ Exemption for Seasonal EEs.

An ER employing seasonal workers may be exempt, if:

- the ER’s workforce **only exceeds the 50 EE threshold for 120 days (or <)** (does not have to be consecutive) during the previous calendar year; and
- the EEs in excess of 50 who were employed during that 120-day (or <) period **were seasonal workers.**

ER “Pay or Play” Penalty Tax (cont’ d)

➤ Steps to determine applicable large ER status:

1. Calculate the number of **FTEs** (including seasonal) for each calendar month during the preceding calendar year (those who average **30 or more hours of service per week** during the month– use 130 hours of service per month as an equivalency);
2. Calculate the number of **FTEEs** (including seasonal) for each calendar month in the preceding calendar year **by totaling the hours of service for all non-FTEs** for the month (capped at **120 hours of service** for any one EE) and **dividing by 120** (include fractions);
3. **Total the number of FTEs and FTEEs** calculated in steps 1 and 2 for **each** of the 12 months in the previous calendar year (include fractions);
4. **Add the monthly totals and then divide by 12** (rounded down). If the total is **50 or >**, the ER is an applicable large ER for the current calendar year and subject to the ER shared responsibility.*

* If ER exceeds the 50-EE threshold for 120 days or < (4 calendar months or less, whether or not consecutive) during the preceding year, and the excess is attributable to seasonal EEs, the ER will not be considered an ALE for the current calendar year.

Fractions (*e.g.*, .5, .9) are taken into account for monthly totals, however, after dividing by 12 all fractions are disregarded (*e.g.*, annual average of 49.9 **FTEs/ FTEEs** is rounded down to 49, thus ER is not ALE for the current calendar year). Optional rounding rule to nearest 1/100th for monthly calculation (*e.g.*, 30.544= 30.54).

ER “Pay or Play” Penalty Tax (cont’ d)

EXAMPLE-Calculating Number of FTEs/FTEEs



Illustration of calculating number of FTEs/FTEEs. ER A has 40 FTEs from January thru December 2019. ER A also has 30 additional EEs who assist during the busiest time of the year, a 5-month period from May thru September. 10 of the 30 EEs work 100 hours per month during those 5 months, while 20 of the 30 EEs work 125 hours per month during those 5 months. Q. How many FTEs/FTEEs does ER A have in 2019? Q. Is ER A subject to the Pay or Play Tax in 2020? ER A would calculate its FTEs/FTEEs as follows:

- 1) Calculate the number of FTEs. For each of the 12 months (40 FTEs/month).
- 2) Calculate aggregate hours for additional EEs. The aggregate hours for each of the 5 months will equal: $[(10 \text{ EEs} \times 100) + (20 \text{ EEs} \times 120)] = 1,000 + 2,400 = 3,400$ aggregate hours per month. Note that the maximum number of hours is capped at 120, even though 20 EEs actually worked more (here, 125 hours). The extra 5 hours (120-125) are ignored.
- 3) Divide aggregate hours for additional EEs by 120. Divide the aggregate hours for additional EEs for each of the 5 months (3,400) by 120. The result is 28.33, which is the FTEE number for each of the 5 months.
- 4) Add FTEs and FTEEs. Now add the number of FTEEs (28.33) and the number of FTEs (40) for each of the 5 months. For May thru September, ER A has 68.33 EEs who are counted (FTEs plus FTEEs).

ER “Pay or Play” Penalty Tax (cont’ d)

EXAMPLE-Calculating Number of FTEs/FTEEs (cont’ d)

5) Each Month. Now add up the numbers for each month.

Month	FTEs + FTEEs	Month	FTEs + FTEEs
January	40	July*	40+28.33=68.33
February	40	August*	40+28.33=68.33
March	40	September*	40+28.33=68.33
April	40	October	40
May*	40+28.33=68.33	November	40
June*	40+28.33=68.33	December	40
Total for Year			621.65

6) Divide by 12. Now divide the yearly total by 12. $621.65/12 = 51.80$, rounded down to **51**. ER A is subject to the Pay or Play tax because it has at least 50 FTEs/FTEEs.

* Seasonal EE exception N/A as were employed > 120 days. If employed 120 days or >, ER A would not have been subject to Pay or Play tax.

ER “Pay or Play” Penalty Tax (cont’ d)

➤ **IRC § 4980H(a)** pay or play penalty tax on ALEs when coverage not offered to enough FTEs:

- Beginning 2015, an ALE will pay a penalty tax (*i.e.*, make assessable payment) **for any month** that:
 - ER fails to offer at least 95%* of its **FTEs (and their dependents)** opportunity to enroll in “*MEC*” under an “*ER-sponsored*” plan for that month;
 - At least **1 FTE** has been certified to ER by an Exchange as having **enrolled in the Exchange** for that month in a qualified health plan (QHP) for which a federal **premium tax credit** or cost-sharing reduction is allowed or paid.


ER will not be treated as having made an **offer of coverage to a FTE for a PY** if EE does not have effective opportunity to elect to enroll (or decline to enroll if not MV coverage) in coverage no less than once a year (e.g., must have annual open enrollment).

* **2015 transition relief for certain ALEs**- ER must offer coverage to at least 70% of its **FTEs (and their dependents)** did not carry forward to 2016.

Tip: Most ER-provided group health coverages will meet the very broad definition of “minimum essential coverage.” Compare “essential health benefits” which is the term used by health care reform to describe the benefits the QHPs are required to cover.

ER “Pay or Play” Penalty Tax (cont’ d)

➤ Amount of § 4980H(a) Penalty Tax on large ER when NOT offering coverage to enough FTEs is equal to the “applicable payment amount” (as indexed) Xs the total # of FTEs employed by the ER (less a 30* FTE reduction) during the month:

- The applicable payment amount for 2014 was \$166.67/month (1/12 of \$2,000); for 2016-\$180/month (1/12 of \$2,160); for 2017-\$188.33/month (1/12 of \$2,260); for 2018-\$193.33/month (1/12 of \$2,320); for 2019-\$208.33/month (1/12 of \$2,500); and for 2020-\$214.17/month (1/12 of \$2,570). 
- 30 FTE Reduction.** The # of FTEs for any month is reduced by 30 for purposes of calculating the penalty tax for ERs when not offering coverage to enough FTEs.**

* Allocated to member ERs in a control group based on pro rata share of FTEs.

** 2015 transition relief for ALEs with 100 or > FTE/FTEEs was 70% (less an 80 FTE reduction) did not carry forward to 2016.⁸³

ER “Pay or Play” Penalty Tax (cont’ d)



Example: Calculation of § 4980H(a) Play or Pay Penalty for 2020. ER does not offer health coverage and has 51 **FTEs** and 50 **FTEEs** = 101 **FTEs/FTEEs**.


One **FTE** enrolls in the Exchange and receives a federal tax credit for the entire year.

ER A owes **\$214.17/month** (i.e., 1/12 of \$2,570) for each **FTE**; reduced by 1st 30 **FTEs**, so ER A owes a 2020 play or pay penalty tax of \$4,508.91/month or \$53,970/annually (**51 FTEs – 30 FTEs = 21 FTEs X \$214.17 = \$4,508.91/month X 12 = \$53,970/annually**).

ER “Pay or Play” Penalty Tax (cont’ d)

- IRC § 4980H(b) pay or play penalty tax on large ERs who offer coverage that does not meet the “*affordability*” or “*MV*” standards:
 - Beginning 2015, an “*ALE*” will pay penalty tax (*i.e.*, make accessible payment) for any month that:
 - ER offers to its **FTEs** (and their dependents) the opportunity to enroll in “*MEC*” under an eligible ER-sponsored plan for that month; but
 - At least **1 FTE** has been certified to ER by an Exchange as having **enrolled** for that month in a QHP for which a federal premium **tax credit** or **cost-sharing reduction** is allowed or paid (generally because ER’s coverage is either “*not affordable*” or **does not provide “MV”**).

ER “Pay or Play” Penalty Tax (cont’ d)

- Coverage under ER-sponsored plan is deemed “*affordable*” for an EE if the EE’s required contribution (whether by salary reduction or otherwise) **does not exceed a specified percentage (as indexed)** of the EE’s household income* for the taxable year (9.5% for 2014; 9.56% for 2015; 9.66% for 2016; 9.69% for 2017; 9.56% for 2018; 9.86% for 2019; and **9.78% for 2020**). 
- Coverage under ER-sponsored plan provides “*MV*” if the Plan’s share of the “total allowed costs of benefits” provided under the plan is **60% or >** of those costs.

* **Three “affordability” safe harbors** are available for ERs to determine whether the EE’s contribution amount is < the specified percentage. Beginning in 2015, ERs may use either: (i) the 9.5% threshold as provided in the original safe harbor regs; or (ii) the new increased safe harbors (e.g., 9.56% for 2015; 9.66% for 2016; 9.69% for 2017; 9.56% for 2018; 9.86% for 2019; and **9.78% for 2020**) until such time as IRS amends the regs (see IRS Notice 2015-87).

 NEW

ER “Pay or Play” Penalty Tax (cont’ d)

- Affordability safe harbors available only if ER offers MV coverage.
- Safe harbors based on EE’ s portion of self-only coverage premium for the ER’ s lowest cost coverage that provides a least 60% MV. Dependent coverage does not have to be affordable.

Tip: Wellness incentives affect affordability (*e.g.*, if affect premiums for tobacco use, treated as earned [reduce EE contribution by amount of incentive]; if not related to tobacco use, treated as unearned [N/A in calculating EE contribution amount]).

- **Effect of ER “opt-out” payments on affordability:**
 - Transition relief- IRS Notice 2015-87 provides ERs are not required to treat “opt-out” payments (other than payments under arrangements adopted after 12/16/15) as increasing EE’s required contribution for affordability purposes or for information reporting under IRC § 6056.*
 - EEs, on the other hand, can treat opt-out payments as increasing their required EE contributions when they calculate affordability for purposes of eligibility for premium tax credits under IRC § 36B.

* Except for “eligible opt-out arrangements” under which EE provides reasonable evidence that they (and family, if applicable) will have MEC other than individual Marketplace coverage during PY or other period covered by the opt-out arrangement.

ER “Pay or Play” Penalty Tax (cont’ d)

➤ Form W-2 safe harbor:

- EE’ s premium shall not be > than 9.5% (as indexed) of the EE’ s wages as reported in Box 1 of Form W-2 (e.g., net wages after pre-tax contributions to 401(k) and cafeteria plan);
- Determined after the end of the calendar year (e.g., retrospectively);* and
- On an EE by EE basis.

Example: For 2020, EE’ s contribution is \$100/month and W-2 wages are \$24,000. Because EE’ s contribution is < 9.78% of EE’ s W-2 comp, coverage is affordable ($\$24,000 \times 9.78\% = \$2,347.20/12 = \underline{\$195.60/month}$).



- * ER could use W-2 safe harbor prospectively at the beginning of the 2019 CY to set EE contribution (e.g., automatically deducting 9.78% or lower %) from EE’ s Form W-2 wages for each pay period.

ER “Pay or Play” Penalty Tax (cont’ d)


- **Rate of pay safe harbor:**
 - Hourly EE’s premium share for the month not > 9.5% (as indexed) of the EE’s applicable hourly rate of pay as of the 1st day of the coverage period (e.g., 1st day of the PY) or the EEs lowest hourly rate of pay during the month **Xs 130 hours;**
 - For **salaried EEs**, monthly salary would be used;
- Rate of pay for hourly EEs may be reduced during the year, however rate of pay for salaried EEs may not be reduced even due to reduction in work hours;
- **Determined at the beginning of the coverage period** (prospectively) without need to continually analyze EE’s wages or hours.

Example: For 2020, EE’s contribution is \$85/month and rate of pay is \$7.25/hr. ER may assume EE will earn \$942.50/month ($\$7.25 \times 130 = \942.50). Because EE’s contribution is < 9.78% of EE’s assumed income, coverage is affordable ($\$942.50 \times 9.78\% = \underline{\$92.18/month}$).



ER “Pay or Play” Penalty Tax (cont’ d)

➤ Federal poverty line safe harbor:

- Design based safe harbor using 9.5% (as indexed) of Federal poverty line for a single individual divided by 12;
- Determined at the beginning of the calendar year (prospectively) regardless of EE’s actual wages or hourly rate/salary using prior year’s FPL. ERs may use FPL guidelines that were in effect 6 months prior to the beginning of the PY (\$11,880 for 2016; \$12,060 for 2017; \$12,060 for 2018; \$12,140 for 2019; and \$12,490 for 2020 coverage). 



Example: For 2020, the maximum monthly contribution that meets the FPL safe harbor will be 9.78% of the prior year’s FPL (\$12,490 in most states for 2019 CY plans)/12 = \$101.79/month/\$1,221.52/year.

NOTE: Affordability safe harbors would not affect an EE’s eligibility for a premium tax credit thru the Exchange which is based on EE’s household income. Thus, safe harbors would apply only for purposes of determining whether an ER’s coverage satisfies the 9.5% (as indexed) “affordability” test for purposes of the § 4980(b) accessibility payment.

ER “Pay or Play” Penalty Tax (cont’ d)

- **Determining Minimum Value: 3 potential approaches** discussed in IRS Notice 2012-31 and new final regs for determining “minimum value” for ER sponsored plans (further guidance expected):
 - **Minimum Value Calculator**
 - HHS and IRS developed an “MV calculator” for use by insured large group plans and self-insured plans.
 - Plans with standard cost-sharing features (e.g., deductibles, co-insurance and maximum out-of-pocket costs) will be able to enter information about “four core categories” of benefits (physician, mid-level practitioner care, hospital and emergency room services, pharmacy benefits, lab, and imaging services) into the calculator based on claims data of typical plan.
 - <http://cciio.cms.gov/resources/regulations/index.html>

ER “Pay or Play” Penalty Tax (cont’ d)

- **Design Based Safe Harbor Checklists***
 - Array of safe harbor checklists that plans can compare to their own coverage.
 - Each safe harbor checklist would **describe the cost-sharing attributes of the plan** (e.g., deductibles, co-payments, co-insurance, and maximum out-of-pocket costs) that apply to the same four core categories of benefits and services.

*Certain categories of benefits must be covered to use the design-based safe harbor. Although ER-sponsored plans are not required to cover four core benefit categories, the agencies anticipate that a plan will not satisfy any design-based safe harbor if it fails to do so.

ER “Pay or Play” Penalty Tax (cont’ d)

- **Actuarial Certification**
 - Available for plans with non-standard features (e.g., limits on days or numbers of visits).
 - **Certified actuary** determines the plan’s actuarial value without use of a MV calculator.

ER “Pay or Play” Penalty Tax (cont’ d)

- **Amount of § 4980H(b) Penalty Tax** on large ER offering coverage that is either: (i) non-affordable; or (ii) doesn’t provide MV is calculated monthly (as indexed). For 2016-\$270/month (1/12 of \$3,240); for 2017-\$282.50/month (1/12 of \$3,390); for 2018-\$290/month (1/12 of \$3,480); for 2019-\$312.50/month (1/12 of \$3,750); and **for 2020-\$321.17/month (1/12 of \$3,860)** Xs the # of **FTEs** for any month who actually enroll in an Exchange and receive federal premium tax credits or cost sharing assistance [minus those **FTEs** in a limited non-assessment period (e.g., waiting period), and those **FTEs** who were offered (but declined) MV coverage that otherwise met the affordability safe harbors].
- **This penalty tax is capped** at an overall limit equal to the amount the ER would have otherwise had to pay under § 4980H(a) for not offering coverage to enough FTEs (e.g. the “applicable payment amount” Xs the ER’s total # of **FTEs** less the 30 **FTE** reduction during that month).

NEW

ER “Pay or Play” Penalty Tax (cont’ d)

NEW

Example 1: Calculation of § 4980H(b) Pay or Play Penalty. For 2020, ER B offers MV coverage, but makes no ER contribution towards the cost; and has 51 FTEs and 50 FTEEs=101 FTEs/FTEEs. 20 FTEs enroll in an Exchange, however only 5 FTEs receive a federal tax credit for the year because the cost of ER B’s coverage is not affordable based on their household income. ER B owes \$321.67/month (i.e. $1/12 \times \$3,860$) ONLY for each FTE receiving a federal tax credit,* so ER B owes a pay or play penalty tax of **\$1,608.35/month or \$19,300/annually (5 FTEs X \$321.67 = \$1,608.35/month X 12 = \$19,300/annually).**

*Minus any of those FTEs who were either in a “non-assessment period” or were offered MV coverage that met one of the “affordability safe harbors” in which case ER not liable for that month.

ER “Pay or Play” Penalty Tax (cont’ d)

NEW

Example 2: Calculation of § 4980H(b) Pay or Play Penalty. Same as previous example, except all 20 FTEs receive a federal tax credit for the year for enrolling in an Exchange because ER B’s coverage is not affordable based on their household income. ER B owes \$321.67/month i.e., $1/12 \times \$3,860$ for each FTE receiving a federal tax credit, so ER B owes a pay or play penalty tax of **\$6,433.40/month or \$77,200/annually** ($20 \text{ FTEs} \times \$321.67 = \$6,433.40/\text{month} \times 12 = \$77,200/\text{annually}$). However, the penalty for ER B is capped at an amount of the § 4980H(a) penalty it would have been assessed for not offering coverage (i.e. \$4,508.91/month or \$53,970/annually). **Since the calculated penalty of \$6,433.40/month or \$77,200/annually is more than the maximum “capped” amount, ER B pays the capped penalty of \$4,508.91/month or \$53,970/annually.**

ER “Pay or Play” Penalty Tax (cont’ d)

➤ Process for Paying Penalties:

- Penalties are payable upon notice and demand by IRS;
- IRS to adopt procedures to ensure the ER receives certification (called § 1411 Certification) under which an EE is certified to the ER as having enrolled for a calendar month in a QHP thru an Exchange and received premium tax credit or cost-sharing reduction;
- IRS to contact ERs re: potential liability and provide ER opportunity to respond before any liability assessed or notice and demand for payment made;
- Beginning in 2016, Exchange to notify ERs within a “reasonable” time following any month EE enrolls in Exchange and qualifies for subsidy.

ER “Pay or Play” Penalty Tax (cont’ d)

- **Determining FTE status in current year for purposes of offers of coverage and ER reporting requirements (Forms 1094-C and 1095-C):**
 - FTE with respect to any month is an EE who is employed on average at least 30 “hours of service” per week (130-hr monthly equivalency);
 - Two methods for determining FTE status:
 - Monthly measurement method; and
 - Look-back measurement method.
 - ER may apply either monthly or look-back measurement method based on permitted categories:
 - Salaried/Hourly;
 - Union/Non-Union
 - EEs covered by different collective bargaining agreements; and
 - EEs of different states.
 - ER must choose one method for each permissible category of EEs (e.g., no sub-classes permitted).
 - Detailed rules for determining FTE status when EEs transfer from one measurement method to the other.

ER “Pay or Play” Penalty Tax (cont’ d)

➤ Monthly measurement method:

- Used to identify **FTEs** by ERs who do not use the look-back measurement method;
- EEs are identified based **hours of service** for each calendar month;
- If ER using optional weekly rule, will have to divide the year into 4 and 5-week periods and EEs averaging at least 30 hrs/week during those periods will be treated as a FTE (e.g., 4-week periods = 120 hrs of service/month; 5-week periods = 150 hrs of service/month); and
- **FTEs** must be offered coverage no later than the **1st day of the month following 3 full months of employment** to avoid penalty*.

Example: FTE is hired on 1/15/20 in an eligible class. ER must offer coverage to FTE no later than 5/1/20 (1st day of the month following 3 full months of employment) to avoid “pay or play” penalty.



* ACA prohibition on excessive waiting periods of more than 90 days for EE’s coverage to become effective, subject to certain other permissible conditions for eligibility.

ER “Pay or Play” Penalty Tax (cont’ d)

➤ Look-back measurement method:

- May be used for ongoing EEs, new “*variable hour*” EEs, and “*seasonal EEs*”;
- Hours of service measured for a period of time (measurement period of 3-12 months) to lock-in full-time status during a subsequent stability period (at least 6 months, but not > the measurement period) regardless if reduction in hours of service during stability period as long as remains an EE;
- Specific rules apply for ongoing and new EEs;
- Transition measurement periods were allowed for 2015 only.

Tip: Rules for look-back measurement method are complex and technical - may not be used for purposes of determining ALE 50 FTEs/FTEEs threshold.

ER “Pay or Play” Penalty Tax (cont’ d)

- **New (*non-seasonal*) FTEs** (reasonably expected to work full-time):
 - Must be offered coverage by **1st day of the month following 3 full months of employment***;
 - Reasonable expectation based on facts and circumstances;
 - Factors may include:
 - Status of EE being replaced;
 - Status of EE’ s in a comparable position;
 - Whether job advertised as requiring 30 hrs./week on average
- **Variable hour, seasonal, and ongoing EEs:**
 - **Look-back measurement method**- ER establishes a “*measurement period*” of **3-12 months** to determine the average hours worked (must be consistent for all EEs in same category);
 - If EE averaged at least **30 hours of service per week** during **measurement period**, the ER treats EE as a **FTE** during a subsequent “*stability period*” established by the ER regardless of EE’ s hours of service during the stability period;
 - **Stability period** must be at least **6 calendar months** but not < than the “*measurement period*”.

* ACA prohibition on excessive waiting periods of more than 90 days for EE’s coverage to become effective, subject to certain other permissible conditions for eligibility.

ER “Pay or Play” Penalty Tax (cont’ d)

- **Optional “administrative period”** – ER can use up to a **90-day administrative period** following the measurement period to provide time for ER to determine EE’s eligibility:
 - **Ongoing EEs-** administrative period will **overlap the EEs prior stability period** so no gap in coverage;
 - **New variable hour and seasonal EEs-** if EE is determined to be a **FTE**, coverage must not be delayed for more than **13 months** (e.g., coverage must be effective no later than the 1st day of the month following 13 months of employment).

Tip: See IRS “Pay or Play” Examples for Determining Full-time status from IRS Notice 2012-58.

ER “Pay or Play” Penalty Tax (cont’ d)

- **Transition Rules for 2015 were not carried forward for 2016:**
 - **Stability period rule** - ERs intending to use a 12-month stability period beginning in 2015, may use a **measurement period that is shorter than 12 months, but not less than 6 months**, and that begins no later than July 1, 2014, and ends no earlier than 90 days before the 1st day of the PY beginning on or after January 1, 2015.
 - **Variable EE rule** - The status of variable hour EEs must be **based on facts and circumstances specific to the new EE at EE’s start date**, and cannot be based on ER’s general expectations or projections about turnover rates. ERs must assume that variable hour EEs will be employed during the entire initial measurement period.

ER “Pay or Play” Penalty Tax (cont’ d)

- **Nonpayment or late payment of premiums:**
 - ALE will not be treated as failing to offer to a **FTE** the opportunity to enroll in MEC under an ER-sponsored plan whose coverage under the plan is terminated solely due to EE **failing to make timely payment** of the EE portion of the premium thru the end of the coverage period (typically the PY).
 - Rules in IRC Reg § 54.4980B-8, Q&A-5(a)(c),(d), and (e) apply to payment for coverage with respect to **FTE in same manner that they apply to payment of COBRA continuation coverage** (e.g., 30-day grace period, insufficient amount and payment made on date sent to the plan).

ER “Pay or Play” Penalty Tax (cont’ d)

- **Change in employment status** for ERs using the look-back method- If a new variable or seasonal EE changes employment status **during the initial measurement period** so that, had EE begun in that new status, they would have reasonably been expected to average at least 30 hours of service per week, that individual will be **treated as a FTE on the first day of the 4th month** following the change in employment status (or, if earlier, and the individual averaged 30 hours of service during the initial measurement period, the 1st day following the end of the initial measurement period and any applicable administrative period). This change of status rule **applies only to new EEs, not ongoing EEs.**

- **Rehired EEs and Those Returning from Leaves of Absence:**
 - EEs who are credited with **0 hours of service for at least 13 consecutive weeks** and then return to employment may be treated as **new hires.**
 - If the period of “no service” is < than **13 consecutive weeks**, an ER may apply an optional rule of parity and treat the returning EE as a **new hire** if the period of “no service” is **at least 4 but less than 13 weeks**, and is longer than the EE’ s immediately prior period of employment.

ER “Pay or Play” Penalty Tax (cont’ d)

- Look back method: For an ongoing **EE who resumes work after an unpaid “special leave,”** (on account of the FMLA, USERRA, or jury duty), the ER must determine the average hours of service per week for that EE, **ignoring the period of unpaid leave,** and use that average for the entire measurement period. Averaging method does not apply to the monthly method.
- **Special rule for educational institutions** - For periods of 0 hours of service for at least **26 consecutive weeks that are not unpaid special leaves** (e.g., summer breaks, sabbatical periods), an educational organization must either: (i) calculate average weekly hours ignoring the break period; or (ii) credit EEs with the average number of hours for the weeks of the break that were the average credited for the weeks without the break, but the number of hours that can be credited for any **EE break period is capped at 501 hours a calendar year** (not including hours credited for special unpaid leave).
- **Use of payroll periods** - ERs can adjust **measurement and stability periods to comport with its payroll periods.** For payroll periods of 1 week, 2 weeks, or semi-monthly, ER can treat as a measurement period a period that begins on the 1st day of the payroll period that includes the date that would otherwise be the 1st day of the measurement period and ends on the last day of the payroll period preceding the payroll period that includes the date that would otherwise be the last day of the measurement period.



Part 4

Administration

Automatic Enrollment for EEs of Large ERs (with Notice and Opt-Out)

- Requires certain large ERs (> than 200 FTEs) to **automatically enroll** new FTEs in one of the ER's health plans, and provide notice and opportunity for EE to opt out.

NOTE: Repealed Nov. 2, 2015.


Reporting Cost of ER-Sponsored Health Coverage on Form W-2s

- **Cost of ER-sponsored health coverage.** ERs must report the aggregate cost of ER-sponsored health benefits on EE's Form W-2 for informational purposes only (excludes all contributions to HSAs, Archer MSAs, salary reduction contributions to FSAs, EAPs, and wellness programs.)
 - Transition relief until further notice for any calendar year if the ER was required to file < 250 Form W-2s for the preceding calendar year; and
 - Use of “*controlled group*” rules not required under transition relief for filing < 250 Form W-2s.

Tip: Refer to the [Form W-2 Reporting of ER-Sponsored Health Coverage](#) chart at www.irs.gov, and detailed information can be found in the instructions for Form W-2.

Information Reporting of MEC and ER-Sponsored Coverage

➤ **ER reporting requirements.** ALEs, small self-insured ERs and all health insurers must begin collecting monthly info on 1/1/15, to report to IRS and covered individuals beginning in 2016:

- Reporting requirements under **IRC § 6055** intended for enforcement of the individual mandate – verifies the months in which covered individuals have maintained MEC (e.g., insurer and self-insured ER annual information reporting to IRS and provide a statement to each individual who is covered by MEC);
- Reporting requirements under **IRC § 6056** intended for administration of ER “pay or play” penalty tax and premium tax credits (e.g., ALE annual information reporting to IRS and provide a statement to each FTE with info re ALE’s offer of MEC);
- EE statements due annually by 1/31 (IRS extended deadline to 3/2/20 for 2019 ACA reporting to individuals). May be furnished electronically if requirements are met; 
- Due to IRS annually on or before 2/28 (3/31 if filed electronically); and
- **Penalty** of \$100/per return/statement up to \$1.5 million.

Information Reporting of MEC and ER-Sponsored Coverage (cont' d)

Tip: Electronic filing of IRS returns REQUIRED if filing 250+ EE statements (Form 1095-C).* NOTE: Fully-insured non-ALEs (<50 FTEs/FTEEs) will have no reporting responsibilities:

- **Forms 1094-B, 1095-B:**

Used by insurers/self-insured non-ALEs (<50 FTEs/FTEEs) to report individuals covered by MEC;

- **Forms 1094-C, 1095-C:**

Used by ALEs (50 or > FT/FTEEs) to report offers of MEC coverage to its FTEs; and for self-insured ALEs to report individuals covered by ER-sponsored MEC; and

- **Form 1095-A:**

Used by insurers to report enrollment in QHPs thru Marketplace.

*IRS released 2019 final Forms 1094-C and 1095-C (and related instructions) - available on the IRS website: www.irs.gov/pub/irs-pdf. No substantive changes from 2018.

NEW

Health Care Reform Fees and Taxes



- **Patient-Centered Outcome Research Institute (“PCORI”) extended for another 10 years (12/20/19).** The 2019 continuing spending resolution reinstated PCORI fees for the 2020-2029 fiscal years. Now, temporary fees on fully-insured and self-insured group health plans continue thru 2029 or 2030 depending on the PY. (\$2.17 for PYs ending on or after 10/1/15 and before 10/1/16; \$2.26 for PYs ending on or after 10/1/16 and before 10/1/17; \$2.39 for PYs ending on or after 10/1/17 and before 10/1/18; \$2.45 for PYs ending on or after 10/1/18 and before 10/1/19; and \$2.54 for PYs ending on or after 10/1/19 and before 10/1/20) Xs the average # of lives covered on the policy or plan (e.g. 2020 family of 5 X \$2.54 = \$12.70 fee):
 - For insured health plans, the issuer pays the fee;
 - For self-insured plans, the plan sponsor pays the fee;
 - Special counting rules for HRAs;
 - PCORI fees are due by 7/31 of the year following. (2019 Form 720 is due 7/31/20).
- **Medicare payroll tax rate** increases 0.9% (from 1.45% to 2.35%) on wages over \$200,000 for individual taxpayer and \$250,000 for married couples filing jointly.
- **Medical expense tax deduction** threshold for itemized deductions for unreimbursed medical expenses increased from 7.5% of AGI to 10% of AGI (waived if age 65 or older thru 2016).

Health Care Reform Fees and Taxes (cont' d)



Health Insurance Providers Fee Tax REPEALED beginning in 2021 (12/20/19). The 2019 continuing spending resolution fully repeals the annual Fee on health insurance providers that took effect 2014.

- Based on insurers/HMOs proportionate market share of the aggregate fee for that fee year as set by statute;
- Can be passed directly down to fully-insured consumers;
- Does not apply to self-insured plans, nonprofit insurers that receive over 80% of their gross revenues from government programs (*i.e.*, Medicare, Medicaid and CHIP) and VEBA's established by non-ERs; and
- Total assessed tax on industry started at \$8 billion in 2014; \$11.3 billion for 2015 and 2016; \$13.9 billion for 2017; and \$14.3 billion for 2018 (after 2018, fee indexed).
- ERs not directly subject to this fee. However, providers of insured plans have been passing the cost of the fee to ERs sponsoring the coverage. As a result, the repeal may result in savings (2-3%) for fully-insured ERs on their health insurance rates.

Health Care Reform Fees and Taxes (cont' d)

- **Reinsurance program fees on health insurers and self-funded health plans for the 3-year period from 2014 thru 2016 (NOTE: 2016 was last year for reinsurance program fees):**
 - Fees used to pay for early retiree reinsurance program and for state reinsurance program available to insurers who offer coverage in the individual market (fully insured plan sponsors do not pay the fee directly);
 - Fees will be based on national contribution rate (“NCR”) announced annually by HHS;
 - For 2015, \$44 per enrollee, and for 2016, \$27 per enrollee;
 - Calculated by multiplying **average # of lives x NCR** (e.g., family of 5 x \$63 = \$315/yr);
 - **Enrollment data** must be provided to HHS by Nov. 15th of the benefit year;
 - Payments may be paid either: (i) in **lump sum** by Jan. 15th of the following calendar year; or (ii) in **two separate payments**, with the 1st payment due by Jan. 15th for the actual reinsurance contribution (plus HHS admin. cost), and by Nov. 15th for payments allocated to the U.S. Treasury, of following calendar year. *For example, for 2014 benefit year, HHS invoiced on 12/15/14 and may be paid by either: (i) lump sum on 1/15/15; or (ii) two separate payments- \$52.50 x # of average lives due by 1/15/15, and \$10.50 x # of average lives due by 11/15/15;*
 - **Must complete all required steps online** using government portal (Pay.gov) no later than Nov. 15. The form will automatically calculate contribution amount, and entity must submit payment info and schedule payment date(s). For more info go see: https://www.regap.info/faq_view.php?i=3338 (as visited Sept. 15, 2014).
- Tip:** Self-insured self-administered GHPs (e.g. do not use a TPA), and retiree-only HRAs are exempt; and reinsurance contributions do not need to be made on ER-sponsored coverage for EEs with Medicare primary coverage.

Health Care Reform Fees and Taxes (cont' d)

- **Individual shared responsibility provisions** began (e.g., individual mandate) in 2014.
NOTE: 2017 tax act effectively repealed these provisions beginning in 2019.
- **ER shared responsibility provisions** (“*pay or play*” tax) were to begin in 2014:
 - Delayed implementation of “pay or play” tax for certain medium sized ERs (50-99 FTEs/FTEEs) for yet another year, until 2016;
 - For larger ERs (100 or > FTEs/FTEEs), requirement to offer coverage to 95% of FTEs will be phased in over 2 years (70% with an 80 FTE reduction for 2015, then 95% with a 30 FTE reduction for 2016 and after).
- **Exchange user fee** beginning in 2014 for health insurers that offer plans on the federal Exchange. This fee will help offset operations of an exchange in these states.

Health Care Reform Fees and Taxes (cont' d)



- **Cadillac Tax- REPEALED (12/20/19).** The 2019 continuing spending resolution fully repeals the non-deductible excise tax on high cost group health coverage that was to go into effect for tax years beginning in 2018 (extended until 2022), for all GHPs, including self-insured plans. Paid by insurer (fully-insured) or TPA (self-insured). As a result, GHPs will never have to pay this 40% excise tax.

ER Marketplace Notice Requirement

- **Exchange Notice.** ERs must provide **written notice** to all **new hire EEs** within **14 days** of hire date informing them about health coverage options available thru the state-based Marketplace and some of the consequences if the EE decides to purchase a QHP thru the Exchange in lieu of the ER-sponsored GHP.
 - DOL FAQ issued 9/11/13 - ER should issue the notice, but no fine or penalty under the law (FLSA) for ER failing to provide the notice.
 - **Model Notice:** New Health Insurance Coverage Options and Your Health Coverage, available at:
www.dol.gov/ebsa/pdf/FSLAwithoutplans.pdf and
<http://www.dol.gov/ebsa/pdf/FSLAwithplans.pdf> .
- Tip:* New optional model COBRA notices and forms are available on the DOL website that include updated information and explanation of alternative coverage available to a COBRA QB (e.g., Marketplace and other coverage thru spouse or parent under HIPAA special enrollment provisions).

Administrative Simplification: Standards and Operating Rules for Electronic Transactions; Health Plan Identifiers (HPIDs)



- **Elimination of HPID requirements (RESCINDED 10/19).** All HIPAA “covered entities” (including group health plans) were required to obtain and use a standard unique health plan identifier (“HPID”) (a 10-digit number) whenever they identify a health plan in a “standard transaction” (related to eligibility, claims; electronic fund transfers, and payment).
- The deadline for a GHP to obtain a HPID was originally Nov. 5, 2014 (or Nov. 5, 2015 for a small health plan, including a health insurance issuer with annual receipts of \$5 mil or <). This was delayed until further notice.

Cafeteria Plan Change Rules

- Cafeteria plans may allow revocations of health plan elections for additional reasons. IRS Notice 2014-55, effective Sept. 18, 2014, allows ERs to expand permitted change rules to revoke election of coverage under group health plan (that is not health FSA) and that provides MEC, and purchase QHP thru an Exchange:
 - Conditions for revocation due to reduction in hours of service:
 - EE whose hours of service are reduced to average < 30 hours of service per week, even if that reduction *does not* affect eligibility for coverage under ER's group health plan; and
 - Revocation corresponds to intended enrollment in MEC effective no later than the first day of the second month following the month that includes the date the original coverage is revoked.
 - Conditions for revocation due to enrollment in a QHP:
 - EE is eligible for SEP to enroll in QHP thru an Exchange; or
 - EE seeks to enroll in QHP thru an Exchange during Exchange's annual open enrollment period; and
 - Revocation corresponds to intended enrollment in QHP effective beginning no later than the day immediately following the last day of the original coverage that is revoked.
 - ER may rely on the reasonable representation of EE that the EE and related individuals have enrolled or intend to enroll in such other coverage effective on dates above.

Tip: Cafeteria plan must be amended on or before the last day of the PY in which elections are allowed, and may be retroactive to the first day of the PY. However, in no event may an election to revoke coverage on a retroactive basis be allowed.



Tip: The dollar limit on EE salary reduction contributions for 2020 is \$2,750 (up from \$2,700).



Part 5

Shared Responsibility for Individuals (Individual Mandate)

Individual Shared Responsibility Penalties

- **Shared responsibility for individuals (Individual Mandate) requirement applies in 2018, but discontinued for 2019 and beyond.** Beginning in 2014, taxpayers (with certain exceptions) were assessed a “shared responsibility” penalty (**TAX**) for any months during which they (including spouse and dependents) lack “minimum essential coverage.”
 - **Minimum essential coverage (“MEC”) means:**
 - **Government-sponsored program**, including Medicare Part A, Medicaid, CHIP program, and TRICARE;
 - **Eligible ER-sponsored plan**;
 - **Health plan offered in the individual market**;
 - **Grandfathered health plan**; or
 - **Other health benefits coverage** (e.g., state high risk pool) as HHS recognizes.
 - Tip:** Most ER-sponsored plans will meet the very broad definition of “MEC.” However, does not include excepted benefits (e.g., dental, vision, cancer, limited indemnity plans).
 - Starting in 2016, individuals began receiving a Form 1095-B or Form 1095-C from coverage provider if enrolled in MEC during the previous CY.

Individual Shared Responsibility Penalties (cont' d)

- **Exceptions** for certain individuals:
 - Religious conscience objectors;
 - Members of a healthcare sharing ministry;
 - Individuals who are not citizens, nationals, or aliens lawfully present in the U.S.; and
 - Incarcerated individuals.

- In addition, **certain individuals (even if they qualify as “*applicable individuals*”)** are exempt from the tax:
 - Individuals who cannot afford coverage (*i.e.*, required contribution for coverage would cost more than 8% (as indexed) of their household income);
 - Individuals whose household income does not exceed the threshold for filing a federal income tax return;
 - **Members of certain federally recognized Indian tribes or individuals eligible to receive services from an Indian health provider;**

Individual Shared Responsibility Penalties (cont' d)

- Individuals who have < 3-month gap in coverage (limited to one period without coverage in a year); and
 - Individuals who are extended a hardship exemption as determined by the Secretary of HHS.
- **Amount of penalty tax:**
- Phased-in **excise tax** for noncompliance;
 - Penalty tax is:
 - **2014-** > of **\$95 or 1%** of income;
 - **2015-** > of **\$395 or 2%** of income; and
 - **2016- 2018-** > of **\$695 or 2.5%** of income.
 - **2019-** and thereafter- **\$0** per 2017 tax act.
 - For individuals under age 18, penalty capped at 50% of individual penalty tax;
 - For family, penalty capped at 300% of individual penalty rule.


Individual Shared Responsibility Penalties (cont' d)

- **Reporting, collection, and enforcement:**
 - Tax reported annually on **individual's federal income tax return**;
 - If individual and spouse file joint return, they are jointly liable for tax that applies to either; and
 - If applicable individual is a dependent, the individual eligible to claim that dependent on the individual's tax return is responsible for reporting and paying the tax.
- **IRS collects and enforces tax.** However, ACA imposes limitation or levies and liens.

Tip: However, appears that no restriction has been placed on IRS's ability to use the refund offset as a means of collecting the amount due.

Individual Shared Responsibility Penalties (cont' d)

▶ Refundable premium tax credit for low income individuals:

- Marketplace determines eligibility for premium tax credit and cost-sharing reductions;
- Assist individuals and families who do not qualify for Medicare or Medicaid and are not offered “affordable minimum value coverage” thru an ER (e.g., EE’s cost for self-only coverage under ER’s plan > a specified percentage (9.5% indexed) of the EE’s household income (9.5% in 2014; 9.56% in 2015; 9.66% in 2016; 9.69% for 2017; 9.56% for 2018; 9.86% for 2019; and 9.78% for 2020) or ER’s plan does not meet the 60% MV standard; 
- Generally, taxpayers with household income between 100% and 400% of the federal poverty line (FPL) who purchase insurance thru an Exchange will qualify;

Individual Shared Responsibility Penalties (cont' d)

- For purposes of calculating modified adjusted gross income (MAGI) to determine eligibility for the premium tax credit, **social security benefits are included** even if not included in gross income for the taxable year;
- In addition, some individuals and families who qualify for premium tax credits may also qualify for **cost-sharing reduction subsidy** to help with deductibles and co-payments; and
- **IRS will notify ER and identify the EE** if individual enrolls in a QHP thru an Exchange and receives a premium tax credit or cost-sharing reduction. NOTE: ER may not be subject to a tax penalty if ER's MV coverage meets one of the three 9.5% (as indexed) "affordability" safe harbors even if EE qualifies for premium tax credit as tax credit is based on EE's household income.

Tip: Premium tax credits thru federal exchanges. IRS confirmed nothing has changed at this time for individuals receiving advance payment of premium tax credits despite recent conflicting court rulings. Dispute arises from language in the IRC providing that the amount of premium tax credits is based on the cost of coverage obtained thru an exchange established "by a state".

Individual Shared Responsibility Penalties (cont' d)



Federal Poverty Guidelines (Coverage year 2020)

# in Household	100% FPL	200% FPL	300% FPL	400% FPL
1	\$14,380	\$28,760	\$43,140	\$57,520
2	\$19,460	\$38,920	\$58,380	\$77,840
3	\$24,540	\$49,080	\$73,620	\$98,160
4	\$29,620	\$59,240	\$88,860	\$118,480
5 or more add \$5,080 for each additional person				

Note: Eligibility for premium tax credits in coverage year 2020 is passed on poverty guidelines for 2019.
Source (plus Hawaii and Alaska guidelines): aspe.hhs.gov/poverty-guidelines

Individual Shared Responsibility Penalties (cont' d)

➤ Subsidies for individuals in Marketplace:



Expected Premium Contribution (Coverage Year 2020)

Annual Household Income (% of FPL)	Less than 133% FPL	133 % FPL	138% FPL	150% FPL	200% FPL	250% FPL	300-400% FPL	More than 400% FPL
Expected Premium Contribution (% of income)	2.08%	3.11%	3.42%	4.15%	6.54%	8.36%	9.78%	n/a

Source: <https://www.irs.gov/pbu/irs-drop/rp-18-34.pdf>



* **Example:** In 2020, 4-person household with MAGI of \$75,000, using the 2020 base 100% FPL \$29,620 ($\$75,000 / \$29,620 = \underline{253.2\% \text{ of FPL}}$). Max % of household income required to be paid toward health insurance coverage is 8.36% ($\$75,000 \times .0836 = \underline{\$6,270 \text{ per year}/\$522.50 \text{ per month}}$). Based on 2nd lowest cost silver plan offered in the applicable Marketplace.

Individual Shared Responsibility Penalties (cont' d)

Tip: Example of eligible EE who declines ER's minimum essential coverage. Jim is a FTE of ER A that offers its EEs MEC. Jim does not enroll in ER A's plan and now wants to enroll in the Marketplace and apply for the premium tax credit. Jim can enroll in the Marketplace, however unless ER A's plan is "non-affordable" or does not provide "minimum value," Jim is not eligible for any premium tax credit or cost-sharing reductions.

NOTE: If EE actually enrolls in an eligible ER-sponsored plan, the tax credit is not available-even if the plan does not meet the affordability and MV standards. Nor is the ER responsible to pay any "pay or play" penalty tax with respect to that EE.

Tip: "Related individuals" (e.g., spouse and dependent children claimed on EE's federal income tax return) of EE who are eligible to enroll in ER's plan, can enroll in the Marketplace, however unless ER's plan is "non-affordable" with regard to EE-only premium cost to Jim, or does not provide "minimum value," related individuals, are likewise not eligible for any premium tax credit or cost-sharing reductions. "Married-filing separate" spouse is not considered a related individual, nor is a child of the EE if the EE doesn't claim as a dependent on EE's federal income tax return. **ACA generally requires married individuals to file joint return to qualify for premium tax credit, subject to certain exceptions.**

Individual Shared Responsibility Penalties (cont' d)

- **Excess advance premium tax credits must be repaid.** If an individual tax payer's advance credit payments exceed the premium tax credit allowed for the CY, tax payer owes the excess as an additional tax, subject to limitations.
- For taxable years beginning in 2018:

If the household income (expressed as a percent of FPL) is:*	The limitation amount for unmarried individuals (other than surviving spouses and head of household) is:	The limitation amount for all other taxpayers is:
< than 200%	\$300	\$600
At least 200% but < 300%	\$775	\$1,550
At least 300% but < 400%	\$1,300	\$2,600

* If 400% or > full amount

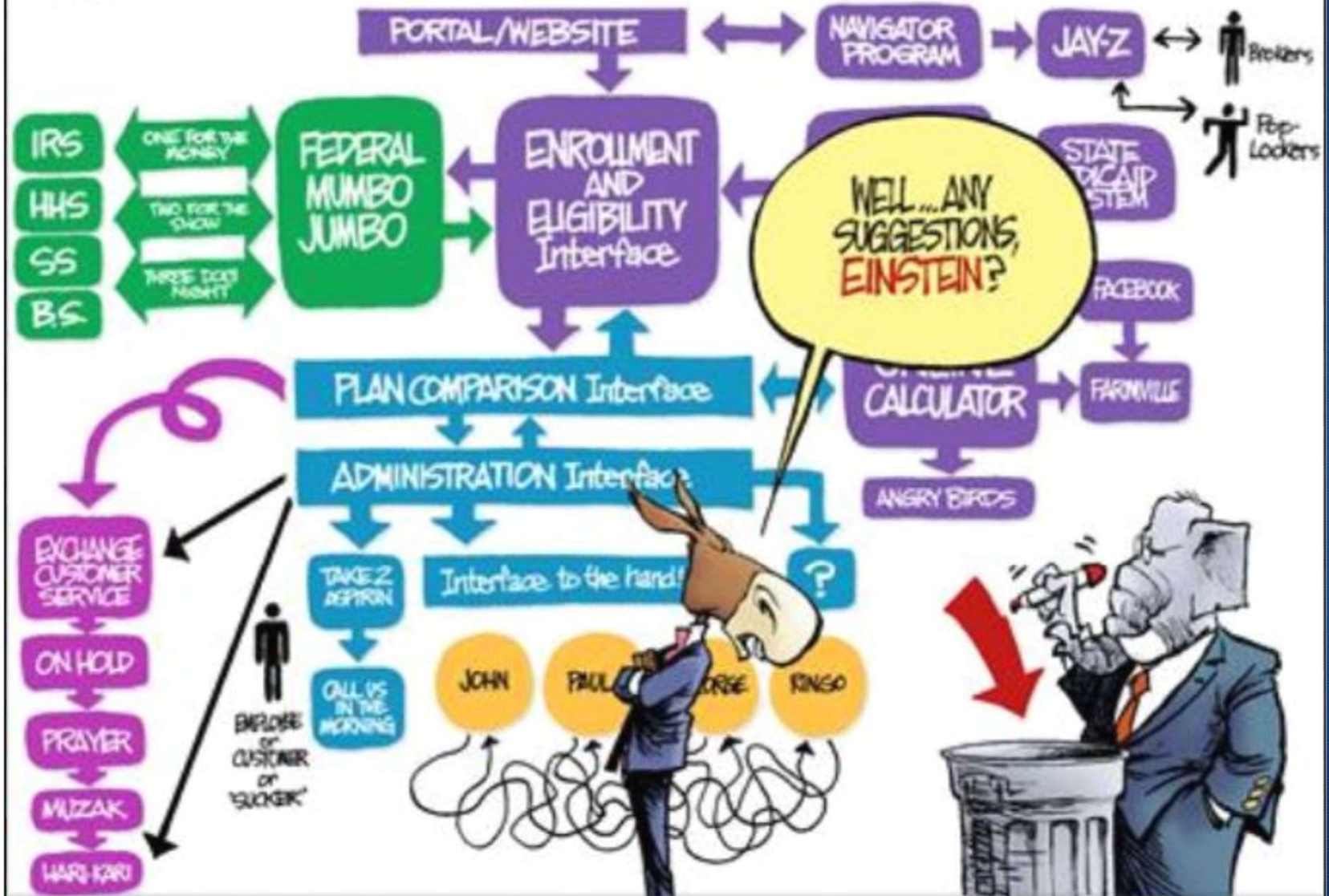


Part 6

Marketplace (Exchange)

Obamacare Flowchart

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2014-Ready to SHOP Marketplace (Exchange)

- **What are Marketplaces?** Under HCR, a health insurance Marketplace is an electronic marketplace where consumers can shop for health coverage. They are intended to help enhance competition and give small businesses the same purchasing clout as large ERs. The Marketplaces will perform a variety of functions required by ACA, including: (i) certifying QHPs; (ii) determining eligibility for enrollments in QHPs; and (iii) determining eligibility for insurance affordability programs (e.g. Medicaid, federal premium tax credits, and federal cost-sharing reductions).
- **Health Insurance Marketplace Application for Health Coverage & Help Paying Costs.** Includes an “Employer Coverage Tool” form for individual to give to ER to fill out to help answer questions on the Application about any ER health coverage that the individual is eligible for (even if it’s from another person’s job, like a parent or spouse).

Marketplace (Exchanges) (cont' d)

- Press Release 11/19/12- Governor Fallin notified U.S. Secretary of Health that Oklahoma will not pursue the creation of a state-based Marketplace or participate in the Medicaid expansion program.

According to the Governor, “Any exchange that is PPACA compliant will necessarily be ‘state-run’ in name only and would require Oklahoma resources, staff, and tax dollars to implement. It does not benefit Oklahoma taxpayers... Furthermore,... Oklahoma will not be participating in the Obama Administration’s proposed expansion of Medicaid. Such an expansion would be unaffordable, costing the State of Oklahoma up to \$475 million between now and 2020, with escalating annual expenses in subsequent years.”

- Although SoonerCare (OK Medicaid) was not expanded, **Insure OK has been extended thru 2020-** No changes in SoonerCare ER-Sponsored ESI plan (remains “at or below 200% FPL”); however change in SoonerCare individual IP plan to “at or below 100% FPL” beginning in 2017 (was 200% FPL) along with other benefit changes. Individuals above “100% FPL” may qualify for the Marketplace and related subsidies.

NEW

Marketplace (Exchanges) (cont' d)

- **Federal government** is responsible for running the Marketplace in the majority of states, including Oklahoma. Launch date began 10/1/13, but still working on the “glitches.”

You can reach the Marketplace:

Online: www.healthcare.gov;

Individuals-round-the-clock
operators: (800) 318-2596 or
TTY (855) 899-4325;

Businesses 8 am-4 pm, weekdays :
(800) 706-7893 or TTY (800)
706-7915.

Marketplace (Exchanges) (cont' d)



- Initial, special, and annual enrollment periods required for Marketplaces:
 - 2020 open enrollment period for Marketplaces ran from 11/1/19 thru 12/15/19;
 - Special enrollment period (“SEP”) for Marketplaces :
 - HHS regs allow “qualified individuals” and enrollees a SEP under a variety of circumstances during which they could enroll in QHPs or change enrollment from one QHP to another;
 - Each SEP will either be 30 or 60 days from the date of triggering event.
 - **SEP for non-calendar renewals.** 60-day SEP for individuals whose non-calendar year individual policies come up for renewal outside the FF Exchange open enrollment period.
 - Individuals will be permitted to select a QHP up to 60 days before and after a loss of MEC.

Tip: If you lose GHP coverage (for other than non-payment of premium or fraud) you have 60-day SEP (before or after window), however, coverage will not be effective until the later of 1st day of the month after (i) loss of coverage; or (ii) date of enrollment.

Marketplace (Exchanges) (cont' d)

- **Trump Administration Finalized Market Stability Rule**
 - 2018 OEP ran from **11/1/17 thru 12/15/17** which CMS specifically designed to overlap with Medicare and most ER plan enrollments. State-based exchanges that couldn't meet the new OEP were allowed to supplement with a special enrollment period as a transitional measure.
 - **Tighter restrictions** on special enrollment periods (SEPs) eligibility;
 - SEPs will require "*verified supporting documentation*" beginning in June 2017 - **100% of new consumers enrolling thru SEPs will need to complete pre-enrollment verification** (applications will be pended and not released to the issuer until eligibility is confirmed within 30 days);

Marketplace (Exchanges) (cont' d)

- Applies a more rigorous test for uses of the “*exceptional circumstances*” SEPs;
- **Actuarial value standard** to allow a variation from -4 to +2% points (except for bronze plans, which can vary -4 to +5 % points; and
- Finalizes the proposal to on states for **network adequacy** reviews (requires network include at least 20% as participating practitioners).
- Rule will NOT impose **continuous coverage requirements**, such as imposing a 90-day waiting period, late enrollment penalty, or requiring a 6-12 months of prior coverage; however, CMS will explore other policies to promote continuous coverage.
- Rule did NOT address whether the administration plans to fund the **cost-sharing reduction payment program**, and whether the administration will enforce the **individual mandate**.

Marketplace (Exchanges) (cont' d)

- **Individuals and small ERs eligible for the Marketplace began in 2014:**
 - All **individuals** are eligible to purchase coverage thru a Marketplace of the state where they reside;
 - Only “**small ERs**” are eligible to offer coverage to their EEs thru a Marketplace SHOP or FF-SHOP.
- **Guaranteed availability for SHOPS.** Insurers marketing plans thru a SHOP generally must accept every ER in that state that applies for coverage – even if the ER declines to enroll thru the SHOP or is eligible to do so. Thus, insurers must be prepared to make their SHOP plans available outside of the SHOP as well.

Tip: HHS regs adopt Code § 4980H(c)(2) counting method that applies to determining ALE status. “Small ER” is an ER that employed an average of at least 1, but not more than 50 FTEs/FTEEs, on business days during the preceding CY, and employs at least 1 EE on the 1st day of the PY. CAUTION: Some state-based SHOP Exchanges count SHOP FTEs differently.

Marketplace (Exchanges) (cont' d)

- In Oct. 2015, legislation amended the small ER definition restoring the pre-ACA cut-off of 50 EEs. States have the option to extend the cut-off to 100 EEs.
- Coverage offered to individuals thru a Marketplace will generally not constitute a “qualified benefit” under Code § 125 and therefore cannot be offered to EEs on a “pre-tax basis” under a cafeteria plan.
Exception for Marketplace - eligible ERs that offer EEs opportunity to enroll thru Marketplace in a QHP in a group market.

Tip: Marketplace SHOP not required for ERs. ERs are permitted, but not required to obtain coverage for their EEs thru a Marketplace SHOP. However, an ER who chooses to obtain coverage thru a Marketplace SHOP must elect to make all of its FTEs eligible for one or more QHPs offered thru the Marketplace. No minimum contribution rate for Marketplace SHOP, however ER must contribute same % for all EE classes.


Marketplace (Exchanges) (cont' d)

- Only QHPs are available thru a Marketplace.
- QHP is a Marketplace-certified “health plan” that offers an essential health benefits package (“EHBP”) that is offered by an “insurer” (e.g. full-insured).
 - Self-insured GHPs and multiple ER welfare arrangements (MEWAs) not subject to state insurance regulation under ERISA § 514 cannot qualify as QHPs.

Marketplace (Exchanges) (cont' d)

- HHS gave **states the opportunity to provide input on establishing requirements for essential health benefits packages (“EHBP”)***.
 - EHBP Includes:
 - Specific mandated benefits;
 - Ambulatory patient services;
 - Emergency services;
 - Hospitalization;
 - Maternity and newborn care;
 - Mental health and substance use disorder services, including behavioral health treatment;
 - Prescription drugs;
- * Self-insured and grandfathered health plans are not required to offer.

Marketplace (Exchanges) (cont' d)

- Rehabilitative and habilitative services and devices;
- Laboratory services;
- Preventative and wellness services and chronic disease management; and
- Pediatric services, including oral and vision care.
- **Cost-sharing requirements***:
 - **Deductible annual limits can't be higher than annual out-of-pocket max limits;**
 - **Out-of-pocket annual limits** for 2015- \$6,600 single/\$13,200 family; for 2016- \$6,850 single/\$13,700 family; for 2017-\$7,150 single/\$14,300 family; for 2018-\$7,350 single/\$14,700 family; for 2019-\$7,900 single/\$15,800 family; **and for 2020-\$8,150 single/\$16,500 family,**  including deductibles, coinsurance and co-pays);
 - * **HHS applies cost-sharing limits to in-network benefits only; Beginning in 2018, services provided by an out-of-network ancillary provider in an in-network facility will count towards in-network OOP max if issuer does not provide timely notice the provider is no longer in –network.**
- **Minimum actuarial value of either 60%, 70%, 80%, or 90%** (e.g., bronze, silver, gold, and platinum respectively); and
- Catastrophic-only policies for those age 30 and younger.

SHOP Marketplace

➤ **Small business health option program (SHOP):**

- SHOPs intended to allow small ERs to offer their EEs a choice of QHPs the way large ERs can (e.g. bigger risk pool and more choices);
- Each state Marketplace is required to create a SHOP;
- Participation is strictly voluntary for small ERs; and
- Small ERs must participate in the SHOP to qualify for tax credit.

Tip: **Certain SHOP functions may be eliminated in 2018.** HHS issued proposed regs in Nov. 2017 to eliminate the federal SHOP enrollment process starting in 2018. If this proposal is finalized, the federal SHOP services (e.g., premium aggregation functions) would also be eliminated.

SHOP Marketplace (cont'd)

- In states that do not establish a state-based Marketplace, HHS may implement a federally-facilitated SHOP (“FF-SHOP”);
- FF-SHOPs are expected to provide small ERs with tools and resources to evaluate coverage options;
- FF-SHOPs will collect a single premium aggregated payment for each ER and distribute payment to QHP insurers based on EE selections.*

* EE choice option delayed indefinitely in FF-SHOPs; however, from 2017 forward, HHS *may* provide opportunities for a “vertical option” where EEs pick carrier options regardless of actuarial value (e.g., EE can choose from any bronze, silver, gold or platinum coverage option offered by a single carrier).

SHOP Marketplace (cont' d)



- Who are “*qualified*” ERs eligible for a SHOP:
 - Small ER (e.g. 50 FTEs/FTEEs or < or at state’ s option 100 EEs or <);
 - Elects to offer, at a minimum, all “*full-time*” EEs (30 or more hours of service per week) coverage in a QHP thru a SHOP (can’ t class out EEs);* and
 - Either has its primary office in the Marketplace service area and offers all its EEs coverage thru that SHOP, or offers coverage to each eligible EE thru the SHOP servicing the EEs primary worksite.

* **Tip:** FF-SHOPs (including OK) will use the same 50 EE threshold test as used for “*pay or play*” (e.g. control group, common law EEs, FTEs/FTEEs, does not include leased EEs, sole proprietor, partner in a partnership, 2% or > SH in S-Corp & IRC § 3580 EEs).

Tip: SHOP coverage may be offered to former EEs and their dependents (e.g. retirees and COBRA QBs). Business owners may enroll in SHOP coverage so long as at least one EE enrolls (e.g. sole proprietors; > 2% owners in S-Corp; > 5% owners in C-Corp; > than 5% partners of partnership; > 5% members of LLC; or working spouses, domestic partners, or other family members of those individuals).

SHOP Marketplace (cont' d)

- OK FF-SHOP ER participation process:
 - ER may begin participating in the FF-SHOP at any time;
 - Guarantee issue;
 - No minimum ER contribution requirements;
 - Must offer coverage to all FTEs (30 or more hours of service/week);
 - Must provide new FTEs w/ 30-day enrollment period that begins on the date the ER notifies the SHOP about the newly qualified EE. ER required to notify SHOP about newly qualified EEs on or before the 30th day after the day that the EE becomes eligible for coverage. Waiting period in SHOPS must not exceed 60-days, calculated beginning on the date the EE becomes eligible.
 - No participation requirement at renewal to stay in FF-SHOP if enrolled during FF-SHOP's annual open enrollment 11/15-12/15; and
 - ER required to adhere to an annual ER election period during which it could change EE offerings.



Part 7


Outstanding Issues & Action Steps for ERs

Outstanding Issues

New proposed regs and delay announcements highlight a number of issues that Treasury and IRS continue to address in subsequent guidance, including:

- “*Eligible ER-sponsored plans*”, including self-insured “*preventive only plans*” or “*skinny*” plans qualifying as MEC;
- Staffing and leased EE arrangements; and
- Interaction of **90 day waiting period** and **one-month orientation period** with **ER pay or play** 1st day of the month following 3 full calendar months of eligibility (employment).

Action Steps for ERs

- Engage a knowledgeable agent/broker or consultant/attorney;
- Stay up-to-date on ACA changes, delays, special rules and regs, and IRS enforcement of “pay or play” penalty taxes;
- Begin NOW collecting information to comply with § 6055 and § 6056 annual ER reporting requirements to IRS and EEs for 2019;
- ERs with significant number of lower paid EEs may want to evaluate whether those positions can be performed by part-time EEs (e.g., 29 hrs/week or <) or if EEs would be better off purchasing coverage thru an Exchange and receiving federal premium tax credit;
- ERs will need to spend time (possibly considerable time) in 2020 to ensure compliance with play or pay rules. The 1st key action step will be to determine ALE status for 2020 (using 2019 payroll data), and if yes, determine effective date for compliance (e.g., 1/1/20 for CY plans; or 4/1/20 for new 1st time ALEs). 

Action Steps for ERs (cont' d)



- ALE's must decide **whether to pay or play** (e.g., to offer “affordable” “MV” coverage to its **FTEs** (and their dependents) or pay the penalty. If choose to **offer coverage**:
 - Determine whether coverage provides **MV**. If not, ER must take steps to re-design its coverage to avoid penalties;
 - Evaluate **EE contribution levels** and adjust them using safe harbors, if needed, to avoid penalties;
- ERs using **look-back method need** to determine FTEs need to re-evaluate beginning dates and duration periods for their **initial measuring, standard measuring and stability periods, and make any desired changes, including adjusting the administrative period (if needed)**.
- **Prepare EE communication materials** and amend plan/docs/SPDs/SBCs/SMMs to include any other changes needed to comply with ACA requirements for 2020.



Action Steps for ERs (cont' d)

- If ER's health plan is **insured**, the ER would likely need to consult its insurer and **insurance agent/broker** about any contemplated changes to the scope and/or costs of coverage.
- **Self-insured** ERs would likely need to consult its **TPAs, stop loss insurer, and consultant/attorney** about any contemplated changes to the scope and/or costs of coverage.
- ERs may wish to consider **cost-shifting current ER contributions** from dependent coverage towards additional ER contributions for EE coverage to offset any additional cost to make plan "affordable."
- If **ER has questions** about these play-or-pay provisions, any ACA compliance requirements, or any other EE benefit matters, **ER should contact its producer/agent/broker or consultant/attorney.**
- **And, we are really going to have some fun with all the proposed changes coming down the pike in 2020!!!!!!** ERs had expected that a Republican administration and a GOP majority congress would repeal the ER mandate, if not OBAMACARE itself. Those efforts have failed thus far, leaving in place the ACA's ER mandate and ER reporting obligations. Will Republicans continue to either fully repeal OBAMACARE, or at least simplify ER reporting, which would make the process less burdensome for ERs?
- **Hang in there.** Keep up with new guidance. **REMEMBER - ACA rules change as fast as the weather in Oklahoma!**



Any Questions?

