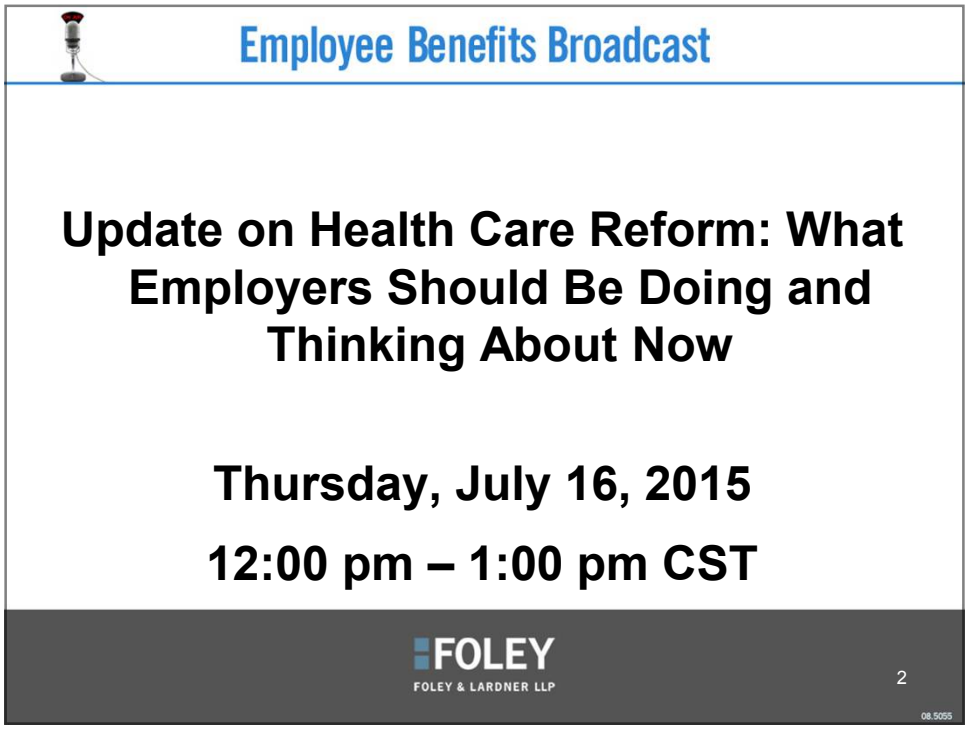

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Today's Speakers

Leigh C. Riley

Belinda S. Morgan

Katherine L. Aizawa

Lauren M. Shuster

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Agenda

- Employer Shared Responsibility Rules – Getting Ready for 2016
- Health Plan Reporting
- Changes to Preventive Care & Cost-Sharing Requirements
- Cadillac Tax

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Employer Shared Responsibility Rules – Getting Ready for 2016

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Right Now….

- Rules apply to an employer that employed 100+ FTEs (employees & equivalents) during 2014
- "BIG PENALTY": In a month, if fail to offer health plan coverage to at least 70% full-time employees:
  - Pay $167 per full-time employee, minus 80 "freebies"

  Only if one full-time employee obtains subsidized Marketplace coverage in that month
- "PER PERSON PENALTY": In a month, with respect to each full-time employee for whom offer of coverage not made, or for whom coverage is not for minimum value coverage or is not affordable:
  - Pay $250 per the particular full-time employee who obtains subsidized Marketplace coverage in that month

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2016- Which employers are subject to the rules?

- Rules apply to an employer that employed 50 or more full-time employees & equivalents during 2015
- Remember that controlled group rules apply
- Connected through 80% ownership
- Affiliated service group members
- Do you know who your controlled group members are for 2015?

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2016 – Which employers are subject to the rules?

When determining whether you employed 50+ FTEs in 2015:

- EXPIRED: You can select a 6-month time period to measure your # of full-time employees and equivalents
- IN EFFECT: If seasonal employees cause you to go above 50 (for 4 months or less), then you can ignore seasonals

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2016-Which employers are subject to the rules?

- Non-calendar year plans (as of 2/9/14) eligible for delay
- Do not move to new 100+ FTE rule until first month of 2016 plan year if:
  - No reduction in workforce/hours during 2/9/14-12/31/14
  - Health coverage offered on 2/9/14 not eliminated or reduced through end of plan year beginning in 2015

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2016- Who has to be offered coverage?

- If fail to offer coverage to at least 95% of full-time employees in a particular month, then penalty of $167 per each full-time employee (minus 30) applies
- Non-calendar year plans get delay until first month of 2016 plan year
  - Provided you did not modify plan year after 2/9/14

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2016- Who has to be offered coverage?

- Who are you not making an offer of coverage to that needs to be added to get to 95%?
- Take hard look at:
  - Independent contractors
  - Staffing agency employees = if staffing agency offers coverage and you pay more money for each enrolled individual, can treat as **your** offer of coverage
  - Union employees = if employer contributes towards multiemployer coverage, can treat as **your** offer of coverage

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What should you be doing now?

- Finalize rules for 2015 if have not already done so
- Remember that penalties apply on monthly basis, so even if not yet compliant, never too late
- Updating SPDs or issuing SMMs to reflect whatever eligibility rules you have selected for 2015
- Start planning for 2016 now!

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ACA Health Plan Reporting for Individual and ALE Mandates

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ACA's 2 shared responsibility mandates:

- **Employer**: An "applicable large employer" (**ALE**) may be subject to a penalty if it fails to (i) offer minimum essential coverage (**MEC**) to 95% (70% for 2015 only) of full time employees and their dependents, or (ii) offers an unaffordable medical plan or a plan that does not offer minimum value. Penalty applies only if a full-time employee buys coverage from the Exchange and receives a tax subsidy.
- **Individual**: A taxpayer is liable for a penalty for any months in which he, or his spouse or dependents do not have MEC

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Who is an ALE?

- An employer that during the prior calendar year employed at least 50 full-time employees (**FTEs**) (or full-time equivalent employees)
- Controlled group rules apply to determine ALE status

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Reporting Purposes

- ALE reporting: to determine if (i) ALE is subject to penalties, (ii) whether an employee is eligible for a premium tax credit to help buy coverage from the Exchange, and (iii) to help an employee understand if he may be eligible for a premium tax credit
- Individual reporting: to determine if an individual must pay a penalty
- Reports are to both the IRS and employees

FORMS

IRC Sections	Transmittal Form to IRS	Employee Statements
6055 Individual Mandate	1094-B (to transmit Forms 1095-B)	1095-B to Responsible Individual
6056 ALE Mandate	1094-C (to transmit Forms 1095-C) Used only by ALEs	1095-C to each FTE Used only by ALEs ALEs sponsoring self-insured plans must use 1095-C for both Individual and ALE Mandates reporting

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Reporting Deadlines

- Fiscal year plans subject to **same** deadlines
- Form 1094-B to IRS: February 28 (March 31 if filed electronically)
- Form 1095-C
  - Individual statements to FTEs: January 31 (like W-2 deadline)
  - IRS: February 28 (March 31 if filed electronically)
- Next business day if deadline falls on a federal holiday or weekend
  - 2015 Individual statements to employees: February 1, 2016
  - 2015 Info to IRS: February 29, 2016 (March 31 if filed electronically)

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TPAs to Facilitate Reporting and Employer Reporting Liability

- Employer can contract in writing with a TPA to do the reporting, but reporting liability remains with Employer
- Exception - Gov't employers can contract with another entity to do reporting and reporting liability transfers to other entity
- Instructions unclear about how TPA will file on behalf of Employer

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How to File

- To IRS: electronic filing encouraged and required if more than 250 individual employee statements
- To Employees: generally by mail or hand delivery. Electronic allowed if notice, consent, hard and software requirements satisfied; probably of limited value
- 2015 Forms not yet available. Use 2014 Forms to report 2015 information until further guidance

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Plans Covering Controlled Group Members – Both Mandates

- Each controlled group member (**CGM**) required to report for its own employees, using its own EIN
- One CGM can file forms for other CGMs
- If employee works for multiple CGMs/month, CGM with greatest number of hours counts employee for that month

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Filers for Individual Mandate

- Grandfathered plans must report
- All Employers (ALE and non-ALE) that offer self-insured MEC
- Insurance carriers for insured plans, including SHOP plans sold on Exchange
- Sponsor of self-insured multiemployer plan, i.e., joint board, association, committee, etc.
- Government employer for self-insured plan

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What MEC Must Be Reported for Individual Mandate?

- Employer sponsored plans for active employees
- Retiree plans including stand-alone retiree only HRAs
- COBRA coverage

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What MEC Is Not Subject to Individual Mandate Reporting?

- Excepted benefits
- On-site medical clinics
- Employee assistance programs that do not provide significant medical benefits
- Coverage that supplements Employer's primary plan
- HRAs or wellness programs integrated with health plan
- Coverage supplementing Medicare or other gov't sponsored coverage

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What Individuals Are Included in Individual Mandate Reporting?

- All employees – FTEs and non-FTEs
- Other enrolled individuals, whether or not an employee, i.e., dependents
- COBRA beneficiaries

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Who Receives a Return for Individual Mandate?

- **Responsible Individual** who is the primary insured

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Filers for ALE Mandate

- ALE sponsoring insured or self-insured plan
- Government employer sponsoring plan

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What MEC Must Be Reported for ALE Mandate?

- Employer sponsored plans for active employees, whether insured or self-insured

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Who Receives an Individual Return for ALE Mandate?

- FTEs
- Must be only one return for each FTE for each CGM

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What Individuals Are Included in ALE Mandate Reporting?

- FTEs, regardless if they were offered MEC
- If employee was a FTE for one or more months/year, employee must be reported for the full calendar year, including pre- and post-employment

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Transmittal Forms to IRS

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Form 1095-C – ALEs with Self-Insured Plans

- Dual Purpose: Individual and ALE reporting by filing the Form 1095-C with the IRS and providing a copy to each full-time employee, even if coverage was not offered
- Dual reporting eliminates filing of Form 1094-B with IRS and 1095-B to employees
- Multiemployer plans bifurcated reporting: (i) administrator reports on employees eligible for multiemployer plan, and (ii) individual employer reports on its employees not eligible for multiemployer plan

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Information Needed

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Tips

- Individuals' SSNs
  - Can be truncated to last 4 digits for individual returns but not on returns filed with IRS
  - Alternative: Can use date of birth
- Deemed One Month Rule: An individual is deemed to have coverage for a month if he was covered for at least 1 day

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ALE Mandate Form 1095-C to IRS and FTEs – Dual Reporting for ALE with Self-Insured Plan

- Complete Parts I, II and III for any employee enrolled in Employer plan, whether or not an FTE, for any month in calendar year
- ALE's name, address and EIN
- Name and telephone number of ALE's contact person
- Calendar year for which info is being reported
- Certification by month that ALE offered its FTEs (and their dependents) the opportunity to enroll in MEC

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ALE Mandate Form 1095-C to IRS and FTEs – Dual Reporting for ALE with Self-Insured Plan (continued)

- Months for which MEC was available
- Each FTE's share of the lowest cost monthly premium for self-only coverage providing minimum value offered to that FTE by calendar month
- What affordability safe harbor the Employer's plan satisfied each month
- The number of FTEs for each month during the year
- For each FTE: employee's name, address and SSN and what months the employee was covered by an eligible employer medical plan

Form 1095-C transmittal to IRS for ALE Mandate – ALE Self-Insured Plan with Insured Options

- Complete Part III of Form 1095-C only for employees and dependents enrolled in self-insured option
- Do not complete Part III b/c covered by Form 1095-B

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ALE Mandate Form 1095-C to Employees – Fully Insured Plan or Multiemployer Plan

- Complete Parts I and II only
- Do not complete Part II b/c covered by Form 1095-B

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Form 1094-C transmittal to IRS for ALE Mandate

- ALE's name, address and EIN
- Name and telephone number of ALE's contact person
- Calendar year for which info is being reported
- Whether Form 1094-C is the authoritative transmittal to IRS for CGM
- If authoritative transmittal: total number of Forms 1095-C filed with this Form by CGM, complete Part IV with the names and EINs of each CGM

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Form 1094-C transmittal to IRS for ALE Mandate (continued)

- Eligibility for certain transition relief
  - No 2015 penalties if medium size ALEs with 50 to 99 FTEs and FTE equivalents; but still must provide individual returns
  - Reduction in §4980H(a) penalty by 80 employees (30 employees after 2015)
- By month indicate if CGM offered MEC to at least 70% of its FTEs and dependents (95% after 2015)
- Number of FTEs each month
- Total FTEs and part-time employee counts for each month

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Form 1095-B Employee Return for Individual Mandate

- **Responsible Individual** is the employee who can enroll himself and his dependents
- Employee's name, address, last 4 digits of SSN or date of birth
- Employer's name, EIN and address
- Insured or gov't plans: name, EIN and address of the insurance carrier or gov't agency
- For each covered individual: name, last 4 digits of SSN or date of birth, and each month in which was enrolled. Deemed 1 month rule applies.

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Extensions to Mail Statements to Responsible Individuals and FTEs

- Maximum 30 day extension
- Available for both mandates
- Before January 31 send a letter to IRS listing all the reasons for requesting extension
- Letter must be signed by applicant

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Reporting Penalties

- Generally, $250 per return
- Maximum $3M under IRC §§6721 and 6722
- Applies separately to Individual Mandate and ALE Mandate reporting
- If good faith effort, relief given if 2015 returns (due in 2016) have incorrect or incomplete reported information, including SSNs or dates of birth
- Hopefully, IRS will be lenient if good faith effort made because of lack of guidance on many questions

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Recent Changes to the Affordable Care Act's Preventive Care and Cost-Sharing Requirements

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The ACA Requires Plans to Provide Preventive Care Services

- Non-"grandfathered" group health plans and insurers must cover specified preventive care services without cost-sharing (*i.e.*, no copayments, deductibles, or coinsurance)

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Preventive Care Services Defined

- Preventive care services include:
  - Evidence-based screenings and services with USPSTF "A" or "B" ratings;
  - Routine immunizations;
  - Preventive care and screenings for infants and children (to age 21); and
  - Preventive care and screenings for women
    - Based on recommendations of the Health Resources and Services Administration (HRSA), an HHS agency

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Limits on the Provision of Preventive Care Services

- Regs describe certain exceptions to the $0 cost-sharing requirement for preventive care services
- If the frequency, method, treatment, or setting of preventive service has not been specified, plan sponsors can apply reasonable medical management techniques to control costs

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Where to Find Currently-Required Preventive Care Services

- Recommendations for preventive care services change periodically
  - Current USPSTF A- and B-rated recommendations can be found at:

    http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/
  - A current list of all required preventive care services can be found at:

    https://www.healthcare.gov/preventive-care-benefits/

Changes to Covered Preventive Care Services

- If a new preventive care recommendation is issued:
  - Plans must provide $0 coverage for it in plan years beginning one year after the date the new recommendation is issued
- If a preventive care recommendation is downgraded (to a C or D rating) or removed:
  - Plans need not cover it going forward, but should consider other laws before making changes (*i.e.*, required SBC changes/state law requirements)

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Preventive Care for Women

- Along with other services and screenings, HRSA's guidelines require all non-grandfathered plans (fully-insured/self-funded) to provide women with contraceptive coverage, counseling, and related services

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May 2015 FAQs

- May 2015 FAQs clarified a number of preventive care issues:
  - Prohibit plans/insurers from limiting the provision of sex-specific preventive services based on a participant's gender at birth, gender identity, or recorded gender
  - Provide guidelines for the provision of anesthesia services in connection with colonoscopies
- FAQs also discussed women's preventive care:
  - BCRA genetic testing (including for women who have previously had certain cancers)
  - Well-woman preventive care for dependents

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Required Coverage of Contraceptives

- The May 2015 FAQs also require plans/insurers to provide at least one form of each FDA-identified contraceptive method with $0 cost-sharing to the participant
  - Currently, 18 methods have been identified

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Required Contraceptive Coverage Categories

- Sterilization surgery
- Surgical sterilization implant
- Implantable rod
- IUD (copper)
- IUD (w/progestin)
- Shot/injection
- Patch
- Oral contraceptives
  - Combined pill
  - Progestin only
  - Extended use
- Contraceptive ring
- Diaphragm
- Sponge
- Cervical cap

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Required Contraceptive Coverage Categories, cont.

- Female condom
- Spermicide
- Emergency contraception:
  - Plan B/Plan B One Step/Next Choice
- Emergency contraception:
  - Ella

Coverage of Contraceptives

- Within each method, plans/insurers may use reasonable medical management techniques to encourage use of specific products
  - For example, a plan may impose cost-sharing on name-brand oral contraceptives in order to encourage the use of lower-priced, generic alternatives
- Must provide a medical necessity exception process (with deference to provider's opinion)

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Limits on Required Contraceptive Coverage

- The ACA's contraceptive mandate is limited by:
  - Exemption for "religious employers" (generally, churches, houses of worship);
  - Accommodations for eligible non-profit organizations with religious objections to providing contraceptives; and
  - Accommodations for eligible closely-held, for-profit organizations with religious objections to providing contraceptives (due to the Supreme Court's ruling in *Hobby Lobby* case)

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The Accommodation for Eligible Non-Profit Organizations

- 2013 regs defined an "eligible" non-profit organization as one that:
  - Opposes contraceptive coverage on religious grounds;
  - Is organized and operated as a non-profit entity;
  - Holds itself out as a religious organization; and
  - Self-certifies that it meets those requirements

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The Accommodation for Eligible Non-Profit Organizations (Fully-Insured)

- An eligible organization with an insured plan must provide a copy of its self-certification to the plan's insurer
- The insurer will then provide separate payments for contraceptive services to be made to women in the organization's health plan at no cost to the women, or to the organization

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The Accommodation for Eligible Non-Profit Organizations (Self-Funded)

- An eligible organization with a self-funded plan must provide a copy of its self-certification to the plan's TPA
- The TPA will then provide or arrange for separate payments for contraceptive services to be made to women in the organization's health plan at no cost to the women, or to the organization

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The Accommodation for Eligible Closely-Held, For-Profit Organizations

- Regs issued on July 10 extend the non-profit accommodation process to eligible closely-held, for-profit organizations whose owners have sincerely-held religious objections to providing contraceptive coverage
- The regs also provide an alternate notification method for organizations requesting an accommodation
  - An eligible organization may notify HHS or DOL of its religious objections, rather than contacting its insurer/TPA directly

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The Accommodation for Eligible Closely-Held, For-Profit Organizations

- A for-profit organization is closely-held (for purposes of the accommodation) if it:
  - Is not a non-profit organization;
  - Is not publicly-traded; and
  - Five or fewer individuals hold more than 50% of the value of the organization's ownership interests
- To obtain the accommodation, the organization's board/owners must take corporate action establishing its owners' sincerely-held religious objections to providing contraceptive services to the organization's employees

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The ACA's Cost-Sharing Limits

- The ACA limits the level of cost-sharing non-grandfathered plans may impose on plan participants
- Rules limit the maximum out-of-pocket (OOP) cost participants must pay before the plan begins paying all covered costs
  - The ACA initially imposed deductible limits on small group plans, but these limits were eliminated by a law change enacted in 2014

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OOP Limits for 2015 and 2016

- 2015 OOP Limits:
  - $6,600 for self-only coverage
  - $13,200 for "family" coverage (*i.e.*, other than self-only coverage)
- 2016 OOP Limits:
  - $6,850 for self-only coverage
  - $13,700 for "family" coverage (*i.e.*, other than self-only coverage)

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Limits on Out-of-Pocket Costs and Essential Health Benefits

- The OOP limits apply to all non-grandfathered plans, regardless of size (small- or large-group) or funding type (fully-insured or self-funded)
- The OOP limits apply to in-network copays, deductibles, and coinsurance for "essential health benefits" (EHBs)
  - EHBs include: emergency services; hospitalization; lab services; maternity & pediatric care; mental health & substance abuse treatment; ambulatory care; prescription drugs; preventive care; rehab care & rehab services; vision and dental care for children

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EHBs and Self-Funded and Large Group Plans

- Non-grandfathered self-funded and large insured group plans are not required to provide EHBs
  - Such plans must use an authorized definition of EHBs (based on various benchmark plans) to apply the ACA's OOP limits
  - How a plan sponsor defines EHBs may affect the plan's design

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Changes to the Limits on Out-of-Pocket Costs

- May 2015 FAQs clarify that the self-only OOP limit applies to each plan participant, regardless of whether the participant is covered by self-only or family coverage
  - So, no individual participant can pay more than the single-only OOP limit, even if by covered by family coverage with a higher family OOP limit

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Changes to the Limits on Out-of-Pocket Costs – Effective Date

- The guidance contained in the May FAQs is effective for plan years beginning on or after Jan. 1, 2016
  - Applies to all non-grandfathered plans, whether fully-insured or self-funded and regardless of the number of plan participants

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Changes to the Limits on Out-of-Pocket Costs – Example

- In 2016, a family of 4 enrolls in family coverage with a $13,700 family OOP limit (not HSA-eligible HDHP coverage)
- Son incurs OOP costs of $9,850, while each of the three other family members incurs OOP costs of $4,000
- What is the impact on the plan?

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Changes to the Limits on Out-of-Pocket Costs – Example, cont.

- The plan must pay $3,000 towards the son's OOP costs (the amount by which he exceeded the $6,850 single-only OOP limit)
- The plan must also pay an additional $5,150 – the difference between the plan's family OOP costs ($18,850 – the son's $6,850, plus $4,000 for each of the others) and the plan's family OOP limit ($13,700)

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Impact on HSA-Eligible HDHPs

- The change to the ACA's OOP limits will impact HSA-eligible HDHPs that use a single, combined family deductible, without an embedded self-only deductible
  - HSA-eligible HDHPs have minimum deductible requirements, along with maximum OOP limits
    - Deductibles count toward the plan's OOP limits

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Impact on HSA-Eligible HDHPs

- Because the new guidance limits a participant's total OOP costs to $6,850, an HSA-eligible HDHP could not use a combined family deductible exceeding that amount
- If an HSA-eligible HDHP wants to use a family deductible in excess of $6,850, it will need to include an embedded self-only deductible of not more than $6,850 to comply with the ACA
- In addition, HSA-eligible HDHPs will also need to comply with the ACA's lower OOP limits (vs the IRS' higher HSA OOP limits)

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Next Steps

- The recent changes to the ACA's OOP limits may require changes to a plan's design – especially if the plan is an HSA-eligible HDHP
- Plan sponsors should review their plans' OOP and deductible limits and determine whether changes are needed
- In addition, plan sponsors should talk to their TPAs, insurers to confirm that they can administer embedded self-only OOP and deductible limits (for HSA-eligible HDHPs)

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Affordable Care Act Cadillac Tax Concerns

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Cadillac Tax Background

- Why?
  - Raise revenue
  - Control health care costs by reducing health care spending
- 40% non-deductible annual excise tax on cost of coverage above two thresholds
- Thresholds
  - $10,200 employee-only coverage
  - $27,500 family coverage
- Adjustments to Increase Thresholds
  - Retirees, age and gender characteristics
  - Rising U.S. health care costs from 2010 to 2018

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Employee Benefits Broadcast

Calculating the Tax

- Who calculates and pays the tax?
  - Fully-Insured Plans
    - Employers Calculate and Insurers Pay
  - Self-Insured Plans
    - Employers Calculate and Pay
  - Other Health Plans
    - Employers Calculate and Plan Administrators Pay
    - Employers Frequently Administer Plans
  - Multiemployer Plans
    - Plan Sponsors (Board of Trustees) Calculate and Pay

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Calculating the Tax

Included Benefits *	Excluded Benefits
• Fully-Insured and Self-Insured Group Health Coverage, including Prescription Drug Coverage • Wellness Programs that are Group Health Plans • Most On-Site Medical Clinics • Health Reimbursement Arrangements • Executive Physical Programs • Hospital Indemnity and Other Fixed Indemnity Insurance paid by paid by Pre-Tax Contributions • Specified Disease or Illness Insurance paid by Pre-Tax Contributions • Pre-Tax Contributions to Health Savings Accounts or Archer Medical Savings Accounts • Health Flexible Spending Accounts • Governmental Health Plans • Retiree Medical • Multiemployer Plans	• Vision Coverage • Dental Coverage • Employee Assistance Programs • Accident or Disability Income Insurance • Specified Disease or Illness Insurance paid by Employee After-Tax Contributions • Hospital Indemnity or Other Fixed Indemnity Insurance if paid by Employee After-Tax Contributions • Employee After-Tax Contributions to Health Savings Accounts or Archer Medical Savings Accounts • Long-Term Care • Supplemental Liability Insurance • General and Automobile Liability Insurance • Workers' Compensation Coverage • Automobile Medical Payment Insurance • Credit-Only Insurance • Insurance with Secondary or Incidental Medical Care • Expatriate Plans for Most Categories of Expatriates • Governmental Coverage for the Military

*Based on preliminary, non-binding guidance issued by the IRS

Calculating the Tax

- How to calculate the cost?
  - Cost of Coverage "determined under rules similar to the rules under COBRA"
  - Proposed Separate Groupings
    - Based on Health Benefit Package
    - Employee-Only or Family Coverage
  - IRS Proposed Approaches for Self-Insured Plans
    - Actuarial Basis Method
    - Past Cost Method

Employee Benefits Broadcast

Strategies and Legal Implications

- Debut in 2018
- Trimming Health Plans and Benefits
  - First dollar coverage
  - Removing High Cost Options
- Different Plan Options
  - High Deductible Health Plans
  - Private Exchanges
  - Multiemployer Plans
- Proactive Support
  - Wellness Programs
  - On-Site Clinics

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Thank You!

- A copy of the PowerPoint presentation and a multimedia recording will be available on the event Website early next week: **http://www.foley.com/employee-benefits-broadcast-summer-2015/**
- HRCI or CLE questions? Contact Ellie Kemmeter at **ekemmeter@foley.com**
- We welcome your feedback. Please take a few moments before you leave the Web conference today to provide us with your feedback

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