

Beyond the Employer Mandate: Other health-care regulations and best practices for implementation

EDITOR'S NOTE: On May 14, 2013, WorldatWork hosted the third and final webinar of a three-part town-hall series event aimed to educate benefits practitioners on key elements of the Patient Protection and Affordable Care Act of 2010 (PPACA). Following are the questions asked and submitted during the third town hall, "Beyond the Employer Mandate: Other Health-Care Regulations and Best Practices for Implementation." These FAQs are for educational purposes only and are not intended, and should not be relied upon, as legal or accounting advice. FAQs are also available from the March 20, 2013 town hall, "Large or Small: How Is Your Company Defined Under the Affordable Care Act?" and the April, 17 2013 town hall "Employer Mandate: Deciding Whether Your Organization Should Pay or Play?"

<http://www.worldatwork.org/waw/townhallseries/FAQsACA3-20-13TownHall.pdf>

<http://www.worldatwork.org/waw/townhallseries/FAQ-HealthCare.pdf>

PCORI Fees

PPACA established the Patient-Centered Outcomes Research Institute (PCORI), an independent, nonprofit organization. Its mission is to fund research that will provide patients, their caregivers and clinicians with the evidence-based information needed to make better-informed health-care decisions. PCORI is funded via a fee per covered life on health insurers and sponsors of self-insured group health plans (PCORI Fee) for the years 2012-2018.

■ \$1 for plan/policy years ending before October 1, 2013, \$2 as indexed thereafter.

[IRS Final Regulations on Fees on Health Insurance Policies and Self-Insured Plans for the Patient-Centered Outcomes Institute PCORI Research Trust Fund](#)

Q For 2012 through 2018, is there a date when the updated IRS Form 720 will be released to report and pay the PCORI Fee?

Sponsors of self-insured health plans must report and pay the PCORI fee to the IRS on Form 720 – Quarterly Federal Excise Tax Return. The PCORI regulations directly prohibit using "third-party reporting" arrangements, as is otherwise permitted in the context of the payment of payroll taxes. However, sponsors of self-insured health plans should not delay compliance preparations until IRS Form 720 is revised to accommodate the PCORI fee. It is unlikely that the fee deadline will be delayed for lack of a revised form.

Q Are there any group health plans that are not subject to the PCORI fees?

The only plans excluded from PCORI fees are:

1. Health Insurance Portability and Accountability Act (HIPAA) excepted benefits (e.g., accident only, disability insurance, liability, limited scope dental/vision, Medicare supplemental), most FSA and HSA
2. Exempt governmental programs (e.g., Medicare, Medicaid, Children's Health Insurance Program (CHIP) and certain Indian tribal programs) not including where a government entity is acting as the employer plan sponsor
3. Expatriate plans, if specifically designed and issued to cover primarily employees who are working and residing outside the United States
4. Stop loss and indemnity reinsurance
5. Employee Assistance Plans (EAPs), Wellness programs, disease-management programs (if they do not provide significant benefits in the nature of medical care or treatment)

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Reinsurance Fees

PPACA requires the Health and Human Services (HHS) secretary to implement standards enabling states to establish and maintain a three-year “Transitional Reinsurance Program” during the implementation of health reform. The transitional reinsurance program is intended to help stabilize premiums in the individual market during the first three years that the state-based exchanges are in effect (2014–2016), due to the fact that the exchanges cover those with pre-existing conditions. Insured and self-funded plans are ultimately responsible for reporting enrollment counts and making reinsurance contributions to HHS.

- \$63 annually per covered life for 2014.

[HHS Notice of Benefit and Payment Parameters for 2014](#)

[Amendments to the HHS Notice of Benefit and Payment Parameters for 2014](#)

Q Do you have to use the same count method for the PCORI Fee and the Reinsurance Fee?

You can. Just like with PCORI, the reinsurance fee is to be calculated on the basis of “covered lives.” This would include not only the employees or retirees who are covered as participants, but also their dependents. The proposed regulations describe the following three safe-harbor methods by which a self-funded plan may determine its number of covered lives:

- **Actual Count Method** – the actual number of lives covered under the plan for each day of the plan year, divided by the number of days in that plan year.
- **Snapshot Method** – the average number of lives covered under the plan, determined on a quarterly (or more frequent) basis
- **Form 5500 Method** – for plans that file a Form 5500, the average of (i) the number of participants reported for the first day of the plan year and (ii) the number of participants reported for the last day of the plan year (subject to the adjustment described below, if the plan offers dependent coverage).

Q We are self-insured and have employees in most states ... how do we handle the filing of the reinsurance fee in 2014?

As a self-insured plan, the employer would presumably need to make the reinsurance payment directly to HHS. In states that choose to operate their own transitional reinsurance program, the PPACA also permits a state to

collect a supplemental assessment (beyond the \$63 per capita paid to HHS) on **insured** products in the state to cover administrative expenses of the state transitional reinsurance program. States may not assess self-insured plans for these additional state administrative expenses. HHS will administer the three-year reinsurance program for insurers in the individual market in states that choose not to operate their own transitional reinsurance program. Therefore, for self-insured plans, the fee is fixed across the states and due directly to the HHS.

Q Are there any group health plans that are not subject to the reinsurance fees?

The only plans excluded from the reinsurance fees are:

1. HIPAA-exceptions coverages
2. In the case of health insurance, coverage that is not considered to be part of the issuer’s “commercial book of business”
3. In the case of health insurance, coverage that is not issued on a form filed and approved with a state insurance department
4. Self-funded group health plans or health insurance that do not provide major medical benefits
5. Health Savings Accounts (HSAs), Health Reimbursement Accounts and Flexible Spending Accounts (FSAs), EAPs, Tricare, stop-loss, tribal coverage

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Small Employers

Q Do small employers (less than 50 employees) have to pay these fees even though the other provisions are not applicable?

It depends on whether or not your insurance offerings are fully funded by an insurer or if your company is self-insured and only uses an insurance company to administer your plan. Most small employers are not self-insured and purchase fully-insured products. In these plans the insurance company will be responsible for the fees. However, small employers should expect and prepare for insurers to pass down the fees in the form of higher premiums.

[IRS Final Regulations on Fees on Health Insurance Policies and Self-Insured Plans for the Patient-Centered Outcomes Institute \(PCORD\) Research Trust Fund](#)

[HHS Notice of Benefit and Payment Parameters for 2014](#)

[Amendments to the HHS Notice of Benefit and Payment Parameters for 2014](#)

Cadillac Tax or Excise Tax

Q What is the 'Cadillac' tax?

The Cadillac tax is a tax on high-cost health plans. A high-cost health plan is defined as having annual premiums of more than \$10,200 for an individual or \$27,500 for a family, including worker and employer contributions to flexible spending or HSAs. Beginning in 2018, PPACA imposes a tax levied on insurers at 40% on the amount of premiums above these thresholds.

■ Example: Individual premium is \$11,000 in 2018; the plan will owe $.4 \times (\$11,000 - \$10,200 = \$800) = \320 .

The agencies have not released guidance or frequently asked questions on the Cadillac tax.

Q If an employee contributes the max individual HSA at \$3,250, does that mean that the plan value can't be more than \$6,950?

Yes that is correct. The definition for what is considered a high-cost health plan includes contributions made to an FSA or HSA. In this example, the individual's \$3,250 contributions to his/her HSA would be subtracted from the \$10,200 threshold, so the plan value would need to stay under \$6,950 for annual premiums to avoid paying the Cadillac tax in 2018.

Q Is the 40% excise tax calculated on a per-employee or per-covered life basis?

The tax is on health-plans that exceed the \$10,200 for an individual policy or \$27,500 for a family plan, so it is not on a per-covered life basis, nor is it per employee. The tax is tied directly to the annual premiums for a plan.

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Exchanges

PPACA helps create a competitive private health insurance market through the creation of Health Insurance Marketplaces. These state-based, competitive marketplaces, which launch in 2014, are to provide millions of Americans and small businesses with “one-stop shopping” for affordable coverage.

[The Center for Consumer Information & Insurance Oversight Resource Page On The Health Insurance Marketplaces](#)

Q If I won't know my 2014 insurance premiums before 10/1/2013, what info do I provide for comparison on the required Marketplace (Exchange) notice to employees?

You do not need to provide any detailed information specific to your plan in the notice such as premium or cost-sharing.

PPACA requires employers that are subject to the Fair Labor Standards Act of 1938 (FLSA) to provide to each of their employees, and to all new employees at the time of hiring, a written notice. The notice must inform employees of the following:

- The existence of the government-run healthcare exchanges/the Marketplace, including a description of the services provided and the manner in which employees may contact an exchange to request assistance.
- If the employer plan's share of the total allowed costs of benefits provided under the plan is less than 60% of such costs, employees may be eligible for a premium tax credit under section 36B of the Internal Revenue Code if they purchase a qualified health plan through an exchange.
- If employees purchase a qualified health plan through an exchange, they may lose the employer contribution (if any) to any health benefits plan the employer offers. All or a portion of this contribution may be excluded from income for federal income tax purposes.

To satisfy these content requirements, model language is available on the DOL's PPACA website. There is one Model Notice for employers that offer a health plan to some or all employees and another Model Notice for those that do not offer a health plan.

Employers may use one of these models or a modified version, provided the notice meets the content requirements described above. It must be provided to each employee, regardless of plan-enrollment status or part-time or full-time status. Employers are not required to provide a separate notice to dependents or other

individuals who are or may become eligible for coverage under the plan but who are not employees.

Q Employer group plan medical premiums are pre-tax for Federal, Social Security and Medicare taxes. Will public exchange premiums have the same tax status?

Premiums in the public exchanges will be on an after-tax basis.

Q If the employer is located in one state but the employee lives in a neighboring state ... which state exchange would the employee apply for?

Individuals will apply to the exchange in the state where they live. The exchanges will look at residency of the individual and will not factor in where the individual works.

Q If I provide my employees with the model exchange notices now, do I have to provide them with another notice in October?

The DOL likely will issue additional guidance and perhaps, revised model notices in the coming months, but has stated that any such future guidance “will provide adequate time to comply with additional or modified requirements.” Thus, the use of these model notices apparently will constitute compliance with this new notice requirement unless and until the DOL provides contrary, prospective guidance.

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Wellness Programs

PPACA created new incentives and it builds on existing wellness program policies to promote employer wellness programs and encourage opportunities to support healthier workplaces. The HHS, Department of Labor (DOL) and the Department of Treasury jointly released final rules on wellness programs to reflect the changes to existing wellness provisions made by PPACA and to encourage appropriately designed, consumer-protective wellness programs in group health coverage. These rules will be effective for plan years starting on or after January 1, 2014.

[DOL News Release](#)

[Final Regulations Addressing Wellness Programs](#)

[WorldatWork Press Statement on Final Wellness Rules](#)

Q We charge employees a \$20 wellness fee each month if they decide not to participate in a health risk assessment. When we calculate whether or not our plan is affordable and we use one of the safe harbors (W2, FPL or Rate of Pay), do we need to take into consideration this \$20 wellness fee?

The proposed regulations on minimum value and affordability provide guidance that addresses how wellness programs factor into an employer's determination of whether its plan provides minimum value and whether or not it is affordable. Under the proposed rule, when determining a plan's share of costs for minimum value purposes, any reduced cost sharing that is available under a nondiscriminatory wellness program is generally disregarded, with one exception. For wellness programs designed to prevent tobacco use, a plan's minimum value may be calculated assuming every eligible individual satisfies the terms of the program relating to prevention or reduction of tobacco use.

Similarly, the proposed regulations provide that for purposes of determining affordability of employer coverage, employers must assume that each employee fails to satisfy the requirements of a wellness program, except that an employer may assume that employees satisfy the requirements of a qualifying tobacco cessation program.

Q If the reward for participating in a wellness program is a reduced employee premium, does this need to be calculated in the cost of coverage?

Yes, currently, the HIPAA wellness rules limit the amount of health-based incentives or penalties to 20% of the cost of coverage. As mandated by PPACA, the proposed rule adopts a higher limit of 30%, beginning in 2014 and up to 50% if related to tobacco use.

Q Do I have to tell employees in advance that a reasonable alternative has to be provided for a health-contingent wellness program, or do I just wait for an employee to ask for a reasonable accommodation?

While the guidance does not require group health plans and issuers to establish a particular alternative standard in advance of an individual's specific request for one, it's advised that employers be transparent about the availability of reasonable alternatives. The guidance does require plans and issuers to disclose the availability of other means of qualifying for the reward or the possibility of waiver of the otherwise applicable standard in all plan materials describing the terms of a health-contingent wellness program. The rule provides sample statements that are intended to be simple for individuals to understand and to increase the likelihood that those who qualify for a different means of obtaining a reward will contact the plan or issuer to request it.

Q If an employee does not have a legitimate medical reason for failing to meet a biometric target, do I still have to provide them an alternative? If so, does the employee have to agree to the alternative or can I (the employer) decide? What happens if they fail to meet the target under the alternative?

The rule adds a new requirement that if the standard for obtaining a reward is based on a measurement, screening or test relating to a health factor, such as in a health risk assessment or biometric screening, the program must make available a reasonable alternative of qualifying for the reward for any individual who does not meet the original standard.

Aside from the 50% incentive limit for tobacco use, this is probably the most significant change from the original HIPAA rules. This new rule essentially expands the "reasonable alternative" requirement to all participants, regardless of their medical situation. As the final

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Wellness Programs (Continued)

guidance states, “if an individual does not meet a plan’s target biometrics (or other, similar initial standards), that individual must be provided with a reasonable alternative standard regardless of any medical condition or other health status, to ensure that outcome-based initial standards are not a subterfuge for discrimination or underwriting based on a health factor.”

Miscellaneous

Q We have recently heard that all co-pays will be required to go toward the out-of-pocket maximum. Are you familiar with that change in PPACA and have you scoped the impact? We estimate this will be a significant employer cost increase if we don’t change our Office of Personnel Management amounts.

Yes, complying with these maximums will be a challenge. All member cost sharing must accumulate toward that out-of-pocket maximum. The deductible, co-insurance and all co-pays (office visit, emergency room and prescription drug) must count toward the out-of-pocket maximum. Currently, most plans accumulate only co-insurance or the co-insurance and deductible toward the out-of-pocket maximum.



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