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ACA Implementation: What Comes Next?

2016 CALPELRA Annual Training Conference
Monterey, November 2, 2016
1:30 p.m. – 3:00 p.m

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Employee Benefits

Primary Purposes of the ACA

- To make coverage more affordable
- To improve access to health care
- To generate revenues to cover costs associated foregoing purposes

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ACA Implementation for Employers: The Story So Far

- Market Reforms
  - No pre-existing condition exclusions
  - Adult dependent coverage to age 26
  - No-cost preventive care
  - No lifetime or annual limits
  - Flexible spending account limits
  - HRA integration
  - 90-day waiting period

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ACA Implementation for Employers: The Story So Far

- Individual mandate
  - Premium subsidies
  - Health insurance exchanges
- Fees
  - PCORI fee
  - Transitional reinsurance fee
- W-2 reporting
- Medical loss ratio rebates
- Employer mandate
- Employer Reporting

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Refresher: Employer Mandate ("Pay or Play")

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Employer Mandate

- Beginning in 2015, applicable large employers (ALE) must offer affordable minimum essential coverage to full-time employees (FTEs) and their dependents (not including spouses)
- "Applicable large employer" means an employer with, on average, at least 50 FTEs during the preceding calendar year
  - Includes full-time equivalent employees
    - Determine by dividing the number of hours of service of non-full-time employees by 120
    - This only applies for determining whether an employer is an ALE

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Employer Mandate: Penalties

- Two potential penalties will apply to ALE that do not offer medical coverage to FTEs (and their dependents) that meets certain minimum standards
  - No Coverage: Must offer minimum essential coverage (MEC) to substantially all FTEs (and their dependents) or "No Coverage" penalty applies ($2,000/FTE/year, based on all FTEs minus 30)
    - "Substantially all" means 70% for 2015 and 95% thereafter
    - Determine number of FTEs for 2015 by subtracting 80 instead of 30

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Employer Mandate: Penalties

- Insufficient Coverage: Must offer affordable coverage that provides minimum value or "Insufficient Coverage" penalty applies ($3,000/FTE/year, based on FTEs who actually receive premium tax credit or other subsidy)
  - Minimum Value: Plan's share of total costs of benefits provided must be at least 60% of such costs
  - Affordable Coverage: Employee's required contribution for lowest cost option (single coverage) cannot exceed 9.5% of household income

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Employer Mandate: How to Avoid Penalties

- To avoid "no coverage" penalty: Offer MEC to FTEs (and their dependents)
  - Must offer coverage even if employees are eligible for coverage from another source – but they may not be eligible for subsidies if they have other MEC (and therefore no penalty applies)
- To avoid "insufficient coverage" penalty: offer coverage that is affordable and provides minimum value
- Penalties apply only if at least one FTE purchases coverage through a Marketplace (i.e., Covered California) and receives a premium tax credit or other subsidy
  - Not subject to penalty if only a dependent of a FTE receives a premium credit or subsidy and not the FTE

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Transition Relief for 2015

- Employers with 50-99 FTEs are not subject to penalties for 2015
- Offers of Coverage to at Least 70% of FTEs
  - Instead of being required to offer coverage to at least 95% of FTEs, for 2015, employers will not be subject to penalties if they offered coverage to 70% of FTEs
- Calculating "no coverage" penalty
  - For 2015, employers subject to the no coverage penalty can subtract 80 from the number of FTEs (instead of 30)

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Transition Relief for 2015

- Non-calendar year plans
  - Transition relief from penalties is available for the period before the first day of the 2015 plan year with respect to employees who are eligible and offered affordable, minimum value coverage as of the first day of the 2015 plan year

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Transition Relief for 2015

- Coverage for Dependents
  - If an employer did not cover dependents in 2013 and 2014 but is taking steps to extend coverage to dependents, it will not be subject to penalties for failure to offer coverage to dependents in 2015
  - Dependents do not include foster children or stepchildren for purposes of employer mandate
  - Spouses are not dependents

Full-Time Employees

- Identifying FTEs to determine potential 4980H(a) or (b) liability
  - Average of 30 hours/week or 130 hours/month
- Methods to determine full-time status
  - Month-by-month determination
    - Count an employee's hours of service for each month
  - Look back measurement safe harbor
    - Determine FTE status during a future stability period based on hours of service in a prior measurement period of 3-12 months

Look-Back Measurement Method

Example –

- **Measurement Period**: Nov. 2 – Nov. 1 (yellow)
- **Administrative Period** – Nov. 2 – Dec. 31 (green)
- **Stability Period** – Jan. 1 – Dec. 31 (blue)

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Employer Reporting

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Types of Employer Reporting

- MEC reporting
  - Assists the IRS and individuals to determine whether they are covered by MEC for purposes of the individual mandate penalty
- ALE reporting
  - Assists the IRS in administering the employer mandate penalties and premium subsidies
  - Each ALE must file a statement for each FTE

Employer Reporting in 2016

- First reporting period was in early 2016 for the 2015 plan year
- So far employers have not heard anything from the IRS

Reporting Issues in 2016

- Filing correctly and on time
  - No penalties for incorrect or incomplete 2015 returns if employer can demonstrate good faith effort to comply
  - No relief if employers fail to file returns, unless due to reasonable cause
- Determining ALE status
  - Part-time and temporary employees may push an employer over the 50 FTE limit because of counting FT equivalent hours

Reporting Issues in 2016

- Information needed to complete forms
  - Names, addresses, SSNs, dates of birth
- Determining employee share of lowest cost monthly premium for employee-only coverage
  - Consider new guidance on impact of HRA contributions, cafeteria plan flex credits, and opt-out payments on affordability (discussed later)
- Deciding which codes to use for different FTEs, retirees, and COBRA beneficiaries

Reporting Issues in 2016

- Reporting on HRA coverage
  - HRAs are self-insured health plans, so employers may be required to report on them even if major medical coverage is fully-insured
  - MEC reporting is not required if employees covered by an HRA are also covered by a group health plan (GHP) sponsored by the same employer
  - MEC reporting is required if employees are enrolled in other GHP coverage not offered by the same employer
  - Report coverage for retirees too – for each month in which the retiree was covered by the HRA for at least one day
  - Report coverage for each individual for whom medical expenses were reimbursable by the HRA (i.e., spouse and dependents) and who were not covered by the employer's GHP

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Preparing for Reporting in 2017

- Gather information
  - Obtain SSNs for employees and dependents
- Update HR systems if necessary
- Coordinate with a consultant or TPA
- IRS has issued draft 2016 forms and instructions for filing in 2017
- Be aware of deadlines for filing
  - January 31 for individual statements
  - February 28 (March 31 if filing electronically) for IRS returns

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The "Cadillac Plan" Excise Tax

Developing IRS Guidance

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What is the Cadillac Plan Excise Tax?

- In 2020, a 40% nondeductible excise tax on high-cost health coverage to be imposed on coverage provider
- Tax applies to an employee's "excess benefit" – the amount that the cost of applicable coverage exceeds a statutory threshold
  - Cost of applicable coverage expected to be calculated similarly to COBRA
- The threshold begins at $10,200 for individuals and $27,500 for families and will be adjusted
- Surveys indicate that as many as 82% of employers are expected to trigger the excise tax by 2023

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3 Step Approach to Understanding this Excise Tax

Step One – Determine Applicable Coverage

- Generally, “applicable coverage” means coverage provided to an employee under a GHP offered by the employer

What is Applicable Employer-Sponsored Coverage?

- Coverage under a GHP, made available by an employer which is excludable from gross income
  - Insured & self-funded
  - Employer-paid and employee-paid (including self-employed individuals)
  - Medical (including retiree medical)
  - HRAs, FSAs, executive physicals
  - Employer contributions (including pre-tax salary reduction contributions) to HSAs and Archer MSAs [NOTE: employee after-tax contributions DO NOT count]

What is NOT Applicable Employer-Sponsored Coverage?

- Does not apply to most HIPAA excepted benefits, but note:
  - Self-funded limited scope dental and vision plans and EAPs *may* be included
  - Certain "supplemental" coverage (e.g., specified disease or illness policies and hospital indemnity or other fixed indemnity) excluded only if premium paid with after-tax dollars
  - On-site medical clinics are included (if more than "de minimis" care provided)
- Anticipate IRS guidance on scope of exclusions/inclusions
  - *Employer comment suggestion*: self-funded limited scope dental and vision should be afforded the same status as insured benefits

Step Two – Determine Total Cost of the Applicable Coverage

- Includes full cost (employer and employee paid)
- General rule: use rules "similar to" COBRA rules for determining COBRA rate (look at similarly situated individuals)
- IRS indicates COBRA rules will likely be revised to align with future Cadillac tax guidance

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Step Three – See if Total Cost Is Greater than IRS Limit

- If so, 40% penalty applies on excess amount
- Penalty is calculated by employer (but others may have to pay a portion)
- Penalty applies on monthly basis
- Future Adjustments to $10,200 and $27,500 Thresholds:
  - Health cost average percentage (2020 only)
  - COLA (calendar years after 2020 only)

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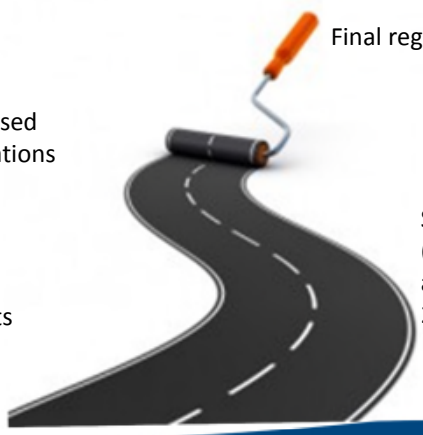
Example

- Calculating 40% Excise Tax
  - Employee has self only coverage in an employer-sponsored health plan and total monthly cost is $1,000
  - Projected 2020 IRS monthly limit is $850 ($10,200/12)
  - Since $1,000 total cost exceeds $850 monthly limit – the excess of $150 is subject to 40% excise tax
  - Excise tax for that employee for that month is $60 (40% of $150 excess)

Who is the Coverage Provider?

- For insured coverage, the coverage provider is the insurer
- For self-insured coverage, the coverage provider is generally the plan administrator (typically the employer, not the TPA)

The Road to 2020



New IRS Guidance on ACA Implementation

IRS Notice 2015-87

- Issued December 16, 2015 and addresses:
  - ACA market reform requirements for various employer health care arrangements
  - Impact of contributions to HRAs, flex credits, or opt-out payments on affordability
  - Adjustment of base amounts for affordability and pay-or-play penalties
  - Determination of an employee's full-time status
  - ALE controlled groups for governmental entities
  - COBRA continuation coverage rules for health FSAs that include carryover provisions
  - Transition relief from penalties for incorrect or incomplete employer reporting in 2016

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Notice 2015-87: Guidance on HRAs

- Retiree HRAs are not subject to the ACA market reforms
- A participant in an HRA with funds available will not be eligible for a premium tax credit because HRAs are considered MEC
- An HRA (other than a retiree-only HRA) fails to satisfy the market reform and integration requirements if it permits employees to use HRA funds to purchase individual market coverage

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Notice 2015-87: Guidance on HRAs

- The IRS appears to be taking the position that an HRA cannot be integrated with GHP other than the GHP sponsored by the employer offering the HRA
  - Previously, the IRS stated that an HRA could be integrated with any other GHP, so the HRA and the coverage with which it is integrated do not need to share the same plan sponsor
  - Now, an HRA will not meet the integration requirements if the covered individuals under the HRA do not match the individuals enrolled in the same employer's GHP
  - The IRS suggests tying coverage under the HRA to the GHP, (i.e., eligibility for HRA would automatically match the employee's level of coverage under the GHP

Notice 2015-87: Guidance on HRAs

- Transition guidance: reimbursement for family members not enrolled in the same employer's GHP is permitted for:
  - Plan years beginning before January 1, 2016, and
  - If the plan and HRA would otherwise be integrated based on the terms of the plan as of December 16, 2015, for plan years beginning before January 1, 2017
    - Employers whose HRAs met the prior integration rules as of December 15, 2016 have until the end of 2016 to update their arrangement

Notice 2015-87: Employer Payment Plans

- "Employer payment plan" means a GHP that reimburses an employee or directly pays for individual health insurance policy premiums (i.e., through Covered California)
- Employer payment plans are no longer permitted because they violate the market reforms for GHPs
  - Employer payment plans provided through a cafeteria plan are also prohibited
- Employer payment plans may reimburse premiums for individual market coverage for excepted benefits only
- IRS Chief Counsel ruled that cash-in-lieu arrangements are not employer payment plans because cash-in-lieu is unrelated to the cost of other coverage

Notice 2015-87: Affordability Calculations

- Employer contributions to HRA
  - Reduce an employee's share of the cost of employee-only health coverage only if:
    - The HRA is integrated with the employer's GHP
    - The employee can only use the contribution to pay:
      - premiums for an employer-sponsored health plan, or
      - premiums for an employer-sponsored health plan and for cost-sharing or other health benefits in addition to premiums
    - The employer's contribution is required under the terms of the HRA or is otherwise determinable within a reasonable time before the employee decides whether or not to enroll

Example

- Employer contributions to HRA:
  - Employee's self-only contribution under the employer's health plan is $200/month
  - The employer contributes $100/month to an integrated HRA to be used for premiums for health coverage, cost-sharing, or the cost of dental and vision coverage
  - Because the contribution satisfies the requirements listed above, the employer contribution of $100/month would reduce the employee's required contribution to $100/month ($200-$100)
  - The employer reports $100 as the monthly cost of coverage offered on Form 1095-C, Line 15

Notice 2015-87: Affordability Calculations

- Employer flex credits under Section 125 cafeteria plan
  - Employer flex credits (e.g., employer allowance) contributed to a 125 plan reduces the employee's share of the cost of employee-only health coverage if:
    - employee cannot opt to receive the flex credit as a taxable benefit;
    - employee may use the flex credit to pay for MEC; and
    - employee can only use the flex credit to pay for medical care, within the meaning of Section 213.
  - If a flex credit may be used for non-health benefits (i.e., dependent care), or if a flex credit can be used for health care or alternatively received as cash, it will not affect the employee's share of the cost of employee-only health coverage (i.e., will not be added or subtracted)

Notice 2015-87: Affordability Calculations

- Transition guidance for plan years beginning before January 1, 2017:
  - If a flex credit may be used for non-health benefits, it will be treated as reducing the employee's share of the cost of employee-only health coverage and the employer may report it as such on Form 1095-C
  - Transition relief is not available for plans adopted after December 16, 2015 or that substantially increase the available flex credit after December 16, 2015

Example

- Employer flex credits under Section 125 cafeteria plan:
  - Employee's self-only contribution under the employer's health plan is $200/month
  - The employer contributes $50/month of flex credits to a cafeteria plan, to be used for premiums for health coverage or contributed to a health FSA
  - Because the contribution satisfies the conditions listed above, the flex credit would reduce the employee's required contribution to $150/month ($200-$50)
  - The employer reports $150 as the monthly cost of coverage offered on Form 1095-C, Line 15

Notice 2015-87: Other Guidance

- Calculation of affordability based on an employee's household income will be adjusted to 9.66% for 2016
- Employer mandate penalty amounts increased
  - Base penalty amounts under Section 4980H are $2,000 per FTE in excess of 30 if the employer does not offer health coverage, and $3,000 per FTE who actually receives a premium tax credit based on insufficient employer coverage
  - For 2015, increased to $2,080 and $3,120
  - For 2016, increased to $2,160 and $3,240

Notice 2015-87: Other Guidance

- Counting hours to determine FTE status:
  - "Hours of service" does not include:
    - Hours after the individual terminates employment; or
    - Hours for which an employee is directly or indirectly paid while not working due to workers' compensation, unemployment or disability laws
      - Individuals receiving payments for short-term or long-term disability who retain employee status will earn hours of service while still an employee, unless the payments are made from an arrangement to which the employer did not contribute (e.g., the employee paid with after-tax dollars)
  - No 501-hour limit on the hours of service required to be credited to an employee for a continuous period during which no services are performed

Notice 2015-87: Other Guidance

- Governmental ALE controlled groups
  - Rules for aggregating employers to determine whether an employer is an ALE do not specifically address their application to government entities
    - The IRS permits government entities to make a good faith interpretation of the aggregation rules under Code Sections 414(b), (c), (m), and (o)
    - Each separate employer entity needs its own EIN for purposes of ALE reporting

Notice 2015-87: Other Guidance

- Health FSAs
  - Health FSAs may condition the availability of a carryover to employees who have elected to participate in the health FSA for the following plan year
  - Health FSAs may limit ability to carry over unused amounts to a maximum period
  - COBRA not required for a health FSA if amount required to pay for COBRA exceeds amount available under the FSA for the remainder of the plan year
  - Any carryover amount is included in determining the benefit that a COBRA beneficiary can receive during the remainder of the plan year in which the qualifying event occurs
  - COBRA applicable premium for a health FSA only includes salary reductions and any employer contributions, not any unused amounts carried over from a previous year
  - If a health FSA permits carryovers for other similarly situated employees, it must also permit carryovers for COBRA qualified beneficiaries (limited to use during the COBRA continuation period), but is not required to permit new salary reduction elections or employer contributions for the next plan year

Opt-Out Payments

- Notice 2015-87 and Proposed Regulations
- Opt-out payment means a payment that is available only if an employee declines coverage, including waiving coverage, and that is not permitted to be used to pay for coverage under the plan
  - An employer contribution to a cafeteria plan that can be used by the employee to purchase MEC is not an opt-out payment, whether or not the employee may receive the amount as a taxable benefit (i.e., cash)

Opt-Out Payments

- Unconditional opt-out payments
  - A payment conditioned solely on an employee declining coverage under an employer's health plan (and not on other requirements, like showing proof of other group health coverage)
  - Unconditional opt-out payments will be added to the employee's share of the cost of employee-only health coverage
  - Taxpayers with opt-out arrangements adopted on or before December 16, 2015 may rely on the Notice before regulations are finalized and are not required to add unconditional opt-out payments to the employee's share of the cost of employee-only health coverage

Opt-Out Payments

- Eligible opt-out arrangements – Conditional opt-out payments that meet the following requirements:
  - Employees must provide reasonable evidence of other group coverage that is MEC for the employee and all other individuals for whom he or she reasonably expects to claim a personal exemption deduction for the tax year to which the opt out payment applies ("tax family")
  - Reasonable evidence must be provided annually, no earlier than regular open enrollment for the next plan year
  - The alternate coverage must be effective during the period of coverage of the employer's plan
  - The opt out payment will not be provided if the employer knows or has reason to know that the employee or other individual in the employee's tax family will not have the alternate coverage

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Opt-Out Payments

- Payments under an eligible opt-out arrangement will not be added to the employee's share of the cost of employee-only health coverage
- Guidance is proposed to be effective for plan years beginning after December 31, 2016
  - But unconditional opt-out arrangements adopted after December 16, 2015 must be added to the employee's required contribution for periods after December 16, 2015

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Example

- Opt-Out Payments:
  - Employee's self-only contribution is $200/month
  - Starting January 1, 2016, employer offers a $200 opt-out payment if the employee waives coverage. The employee does not need to show proof of other coverage in order to receive the payment
  - The opt-out payment is added to the employee's required contribution because it is an unconditional opt-out payment that is not eligible for transition relief
  - The employer reports $400 as the monthly cost of coverage offered on Form 1095-C, Line 15

Questions & Answers

Thank you for attending.

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