Healthcare Reform-Patient Protection and Affordable Care Act (PPACA)

The IMS staff will be working closely this year to assist our clients in maintaining compliance with PPACA. Below is a list of the major issues that will impact your plan in 2013 and 2014:

- Major reforms impacting employers in 2013:
  - W-2 Reporting
  - Summary of Benefits and Coverage (SBC)
  - Patient-Centered Outcomes Research Institute Fee (PCORI) Tax
  - Exchange notices will be released to plan participants and their dependents. Final guidance on the due date for this notice is still pending.

- Major reforms impacting employers in 2014:
  - Employer Mandate "Play or Pay". Information detailed on subsequent notice.
  - 90-Day Limitation on Waiting Periods
  - Transitional Reinsurance Program (TRPA) Tax

W-2 Reporting Requirements

Employers that will file 250 or more W-2 forms for 2012 will be responsible for reporting to employees the total cost of their group health benefit plan coverage on their W-2 forms in January 2013. This requirement is informational only and does not mean that employer-provided coverage will be subject to income tax. Employers that will file less than 250 W-2 forms in 2012 will not be required to report the cost of health coverage on W-2 forms in January 2013, but will be in January 2014 for 2013.

The cost of coverage generally includes both the portion of the cost paid by the employer and the portion of the cost paid by the employee, regardless of whether the employee paid for that cost through pre-tax or after-tax contributions. Employers are not required to report the cost of health benefit coverage on any W-2 forms furnished to employees prior to January 2013.

Only covered employees that elect the coverage and pay the premiums or contribution amounts receive cost of coverage information on their W-2 forms. Beneficiaries and dependents will not receive the cost of coverage.

HIPAA "excepted benefits" plans are not subject to the W-2 reporting requirements (accident, disability income, supplemental liability, workers' compensation insurance). Stand-alone dental and vision plans are also not subject to the requirements. Coverage under an HRA, amounts contributed to an HSA or an Archer MSA, as well as salary reduction contributions to a health FSA, is not reportable. In addition, employee assistance programs (EAP), wellness programs, or on-site medical clinics, if the employer does not charge a premium for this type of coverage, are not reportable on the W-2.

Ultimately, it is the employer's responsibility to accurately determine which employees should receive cost of coverage information.

If elected by the client, IMS will provide the necessary W-2 Reporting as part of our PPACA Compliance Services.

Summary of Benefits and Coverage (SBC)

SBCs for group health plans are designed to provide information for consumers to better understand the coverage they have and allow them to compare their coverage options with different types of plans. The

final regulations regarding the SBC require this information to be presented in clear language and in a uniform format.

The final regulations also state that the SBC must be distributed to members of group plans with open enrollment periods, effective the first day of the first open enrollment period beginning on or after Sept. 23, 2012; and for delivery to members that enroll other than through an open enrollment period (including special enrollees), effective the first day of the first plan year on or after Sept. 23, 2012.

An SBC must be provided in writing and free of charge upon application for coverage, upon renewal or reissuance, and upon request, as soon as practicable, but in no event later than seven business days. The SBC must be provided to both participants and beneficiaries; however, a single SBC may be provided to a family unless any beneficiaries are known to reside at a different address. PPACA places responsibility to provide an SBC on the group health plan or designated administrator of the plan.

If elected by the client, IMS will provide a camera ready copy to the employer as part of our PPACA Compliance Services.

Patient Centered Outcome Research Institute (PCORI) Tax

The IRS has recently issued the final regulations describing how the fees for funding the PCORI Tax should be calculated and paid. This fee was set up to conduct research evaluating and comparing health outcomes and to assess the clinical effectiveness, risks and benefits of medical treatments.

Who will be affected?

- These regulations apply to policy and plan years ending on or after October 1, 2012, and before October 1, 2019.

- Those who will be required to report and remit these fees will consist of employer group health plans, whether they are fully-insured or self-insured and whether they are grandfathered or non-grandfathered. The fees also apply to group health plans of private sector employers and governmental employers, as well as, to plans offered by profit and nonprofit employers and church plans. In addition, the fees apply to HRAs, COBRA coverage and retiree plans, including retiree-only plans and premium-only HRAs, such as those for Medicare-eligible individuals. Those not subject to these fees, include all dental and vision plans that are "excepted benefits", wellness programs, disease management programs…

How and when will plans need to report and pay the fees?

- The Form 720, "Quarterly Federal Excise Tax Return," had been amended to provide that plan sponsors will report and pay these fees once a year on Form 720. A Form 720 return will generally cover plan years that end during the preceding calendar year. The instructions for Form 720 require that the filer (the plan sponsor, or issuer) have an Employer Identification Number (EIN) to use in filing.

- The fee must be filed by July 31 of the calendar year following the last day of the plan year. For example, a return that reports liability for the fee imposed for the year ending on December 31, 2012 must be filed by July 31, 2013. A return that reports liability for the fee imposed for the plan year ending on October 31, 2012 must be filed by July 31, 2013. A return that reports liability for the fee imposed for the plan year ending on January 31, 2013 must be filed by July 31, 2014.

How will the fees be calculated?

The IRS has required that plan sponsors use one of the three below methods to calculate the average number of lives covered during a plan year.

- Actual Count – Count the total covered lives for each day of the plan year and divide by the number of days in the plan year.

- Snapshot Count – Count the total number of covered lives on a single day in a quarter (or more than one day) and divide the total by the number of dates on which a count was made. (The date or dates must be consistent for each quarter.)

  Or

  Snapshot Factor – Determine the sum of: (1) the number of participants with self-only coverage on the date(s) mentioned above, and (2) the number of participants with other than self-only coverage, multiplied by 2.35.

- Form 5500 Method – For self-only coverage, determine the average number of participants by combining the total number of participants at the beginning of the plan year with the total number of participants at the end of the plan year as reported on the Form 5500 and divide by 2. In the case of plans with self-only and other coverage, the average number of total lives is the sum of total participants covered at the beginning and the end of the plan year, as reported on the Form 5500.

If elected by the client, IMS will provide notification of the amount owed and due date as part of our PPACA Compliance Services. Each client will then be responsible for entering that amount on Form 720 for remittance to the IRS by the due date.

Guidance: **http://www.gpo.gov/fdsys/pkg/FR-2012-12-06/pdf/2012-29325.pdf**

IRS Form 720: **http://www.irs.gov/pub/irs-pdf/f720.pdf**

90-DAY WAITING PERIOD

A group health plan may not use a waiting period that exceeds 90 days. A waiting period is the period of time that must pass before coverage for an employee or dependent who is otherwise eligible to enroll under the terms of the plan can become effective. For this purpose, being eligible for coverage means having met the plan's substantive eligibility conditions (such as being in an eligible job classification or achieving job-related licensure requirements specified in the plan's terms).

The 90-day waiting period guidance sets forth a number of examples to demonstrate how the 90-day limitation will apply to plans. In particular, it provides guidance on the application of the 90-day rule to plans with eligibility conditioned on an employee regularly working a specified number of hours per period when it cannot be determined that a newly-hired employee is expected to regularly work that number of hours per period. The guidance permits the plan to take a reasonable period of time to determine whether the employee meets the plan's eligibility conditions, which may include a measurement period that is consistent with the timeframe permitted for determining full-time employee status.

The Agencies Guidance on 90-Day Waiting Period Limitation can be found at **http://www.dol.gov/ebsa/newsroom/tr12-02.html**

Transitional Reinsurance Program (TRPA) Tax

This fee will fund a three year reinsurance program designed to reimburse companies that insure high cost individuals within the individual health insurance market (the Exchanges). The assessment works on a fixed dollar schedule with the amounts decreasing over time, and it is time limited. The total amounts to be assessed are $12 billion in 2014, $8 billion in 2015 and $5 billion in 2016, which is scheduled to be the final year of the program.

- TRPA will be approximately $63 per member in 2014.
- Fees will be imposed for 2014, 2015, and 2016, which is scheduled to be the final year of the program.
- The same method for counting covered lives that is used for PCORI calculations can be used for TRPA.
- It is intended the fees will decrease each year.

If elected by the client, IMS will provide notification of the amount owed and due date as part of our PPACA Compliance Services.

Link to IRS FAQs

- **http://www.irs.gov/uac/Newsroom/ACA-Section-1341-Transitional-Reinsurance-Program-FAQs**