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# HEALTH CARE REFORM FOR EMPLOYERS: NEWS YOU CAN USE TO NAVIGATE THROUGH UNCERTAIN TIMES

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## **What We Will Cover**

- The Individual Mandate
- The Employer Mandate
- Other Employer Obligations
- The Exchanges

## **The Individual Mandate: What does it mean to employees?**

- Beginning in 2014, taxpayers (with certain limited exceptions) will be assessed a “shared responsibility” penalty for months during which they or their spouse or dependents lack “minimum essential coverage”

## The Individual Mandate: What does it mean to employees?

- “Minimum essential coverage” includes coverage under any one of the following:
  - A government-sponsored program, including Medicare Part A, Medicaid, CHIP, and TRICARE
  - An eligible employer-sponsored plan
  - A health plan offered in the individual market
  - A grandfathered health plan
  - Other health benefits coverage recognized by HHS (such as a State health benefits risk pool)
  - Medicare Advantage plans
  - Self-funded student health insurance plans
  - Foreign health coverage
  - AmeriCorps coverage

## **The Individual Mandate: What does it mean to employees?**

- The penalty assessed for the failure to maintain minimum essential coverage is the greater of a flat dollar amount and an excess income amount
- The greater of these two amounts is divided by 12 to determine the penalty due for each month for which the penalty is applicable
- The shared responsibility payment is capped at the national average of the annual cost of a bronze level health insurance plan

## The Individual Mandate: What does it mean to employees?

- The annual flat dollar is assessed for each individual, spouse and dependent without coverage and is phased in over three years (\$95 for 2014, \$325 for 2015, and \$695 for 2016 and thereafter, as indexed for cost-of-living adjustments)
  - The amount for individuals younger than 18 is half the otherwise applicable amount
  - The fixed amount for any taxpayer is capped at three times the annual flat dollar amount per year, regardless of the number of individuals in the taxpayer's household who lack minimum essential coverage

## **The Individual Mandate: What does it mean to employees?**

- The excess income amount is determined by
  - subtracting the taxpayers exemption(s) and standard deduction(s) from the taxpayer's household income; and
  - multiplying that amount by the applicable percentage, which is phased in over three years (1% for 2014, 2% for 2015, and 2.5% for years after 2015)

## The Individual Mandate: What does it mean to employees?

**EXAMPLE:** Ashley and Scott are married and have two children ages 3 and 8. Their combined household income (after exemptions and standard deductions) is \$100,000. They do not have health insurance coverage for 2014 and do not qualify for any exceptions to the shared responsibility payment. Their shared responsibility payment would be \$1,000, calculated as the greater of the flat dollar amount and the excess income amount as follows:

- FLAT DOLLAR AMOUNT:
  - $\$95 + \$95 + \$47.50 + \$47.50 = \$285$
- EXCESS INCOME AMOUNT:
  - $\$100,000 \times 1\% = \$1,000$

## **The Individual Mandate: What does it mean to employees?**

### **Exemptions from Shared Responsibility Payment**

- Individuals who cannot afford coverage (those for whom a required contribution would cost more than 8% of household income)
- Individuals whose household income does not exceed threshold for filing a federal income tax return
- Members of certain Indian tribes
- Individuals who have a gap in coverage for less than three months
- Individuals who are extended a hardship exemption

## **The Individual Mandate: What does it mean to employees?**

### **Premium Tax Credit**

- Premium tax credit will be available to help pay for coverage purchased through an exchange. To qualify, taxpayers must:
  - have income between 100% and 400% of the federal poverty line and purchase coverage through an exchange
    - for a single individual, this means that income is between \$11,490 and \$45,960, and for a household of four, this means that income is between \$23,550 and \$94,200
  - not be eligible for coverage through a government-sponsored program like Medicaid or CHIP
  - not be enrolled in coverage offered by an employer, and not be eligible for coverage offered by an employer that is affordable and provides minimum value

## **The Individual Mandate: What does it mean to employees?**

### **Amount of Premium Tax Credit**

- Computed based on premium for second lowest cost silver plan in rating area where taxpayer resides and offered by exchange where taxpayer enrolls in a qualified health plan (the “applicable benchmark plan”)
- Monthly premium tax credit is the lesser of:
  - Monthly premium for qualified health plan in which the taxpayer enrolls, or
  - The excess of the adjusted monthly premium for the applicable benchmark plan over 1/12 of the product of a taxpayer's household income and the applicable percentage for the taxable year

## The Individual Mandate: What does it mean to employees?

### Amount of Premium Tax Credit (cont' d)

- The “adjusted monthly premium” is the premium an issuer would charge for the applicable benchmark plan to cover all members of the taxpayer's coverage family, adjusted only for age
- The “applicable percentage” is as follows:

Household income percentage of Federal poverty line	Initial %	Final %
Less than 133%	2.0	2.0
At least 133% but less than 150%	3.0	4.0
At least 150% but less than 200%	4.0	6.3
At least 200% but less than 250%	6.3	8.05
At least 250% but less than 300%	8.05	9.5
At least 300% but less than 400%	9.5	9.5

## **The Individual Mandate: What does it mean to employees?**

### **Cost-Sharing Reduction Subsidy**

- In addition to the premium tax credit, certain individuals and families will be eligible for cost-sharing reduction subsidies to assist with deductibles and co-payments
- When an individual receives covered essential health benefits, the provider will collect only the amount of cost-sharing specified in the silver plan variation in which the individual is enrolled
- The government will pay in advance to insurers the amounts estimated to cover the cost-sharing reductions related to the silver plan variation on a monthly basis
- The government will reconcile the advance payments to the actual cost-sharing reduction amounts annually

## **The Individual Mandate: What does it mean to employees?**

### **Reporting and Payment**

- Individual shared responsibility payment is reported annually by the individual on the individual's federal income tax return
- Individual and spouse filing a joint return are jointly liable for the penalties that apply to either or both of them
- For a dependent, the individual eligible to claim that dependent on the individual's income tax return is responsible for reporting and paying the penalty

## **The Individual Mandate: How does an employee's action affect the employer?**

### **The employer will be subject to penalties if:**

- It fails to offer minimum essential coverage to at least 95% of full-time employees and their dependent children and at least one full-time employee enrolls in a QHP through an exchange for which federal assistance is allowed (*i.e.*, premium tax credit or cost-sharing reduction)

OR

- It offers minimum essential coverage but the coverage is either unaffordable or fails to provide minimum value, and at least one full-time employee enrolls in a QHP through an exchange for which federal assistance is allowed (*i.e.*, premium tax credit or cost-sharing reduction)

## The Employer Mandate

- Beginning in 2014, “applicable large employers” may be subject to penalty tax for:
  1. failing to offer “minimum essential coverage” for at least 95% of “full-time employees” and their “dependents”;
  2. offering “minimum essential coverage” that is “unaffordable”; or
  3. offering “minimum essential coverage” that does not provide “minimum value.”

## **The Employer Mandate: A New Vocabulary**

### **Applicable Large Employer**

- An applicable large employer is an employer who employed an average of at least 50 full-time employees on business days during the preceding calendar year
- Applicable large employer status is determined on a controlled group basis, meaning that employees of all employers within a controlled group are taken into account in determining whether any member of the controlled group is an applicable large employer
- For purposes of determining applicable large employer status, the term employer also includes a predecessor employer and a successor employer

## **The Employer Mandate: A New Vocabulary**

### **Applicable Large Employer (cont' d)**

- A full-time employee for any month is an employee employed on average at least 30 hours per week (or 130 hours per month)
- An “employee” for this purpose is an individual who is a common law employee
- In determining whether it is an applicable large employer, an employer must include not only full-time employees but also full-time equivalents for employees who work part-time
  - Employer must add all hours of service in a month for all employees (including seasonal workers) who are not full-time and divide that aggregate number by 120
  - The result of that calculation is added to the number of full-time employees during that month

## The Employer Mandate: A New Vocabulary

### Minimum Essential Coverage

- Minimum essential coverage includes coverage under any one of the following:
  - A government-sponsored program, including Medicare Part A, Medicaid, CHIP, and TRICARE
  - An eligible employer-sponsored plan
  - A health plan offered in the individual market
  - A grandfathered health plan
  - Other health benefits coverage (such as a State health benefits risk pool) recognized by HHS
- Most employer-sponsored major medical coverage is likely to meet the very broad definition of minimum essential coverage, including self-insured employer coverage, retiree coverage and COBRA coverage

## The Employer Mandate: A New Vocabulary

### Affordable Coverage

- Coverage for which the self-only premium paid by the employee does not exceed 9.5% of the employee's household income
- Proposed regulations provide three safe harbors that can be used to determine affordability
  - Form W-2 Safe Harbor
  - Rate of Pay Safe Harbor
  - Federal Poverty Line Safe Harbor
- The safe harbors can be used only if the employer offers its full-time employees and their dependent children the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan and the coverage provides minimum value

## The Employer Mandate: A New Vocabulary

### Minimum Value

- Coverage provides “minimum value” if the plan’s share of the total allowed cost of benefits is at least 60%
- IRS and HHS proposed several approaches for determining if a plan provides minimum value:
  - Minimum Value Calculator
  - Design-Based Safe Harbor Checklists
  - Actuarial Certification

## The Employer Mandate: A New Vocabulary

### Full-Time Employees

- The penalty tax under the employer mandate is based on whether affordable minimum essential coverage that provides minimum value is offered to full-time employees
- Employers need to be able to classify their employees for purposes of the employer mandate
  - Full-time
  - Part-time
  - Temporary/variable hour/seasonal

## **The Employer Mandate: A New Vocabulary**

### **Full-Time Employees**

- A full-time employee for any month is a common law employee who is employed on average at least 30 hours per week
- Proposed regulations provide that 130 hours of service per month is treated as the monthly equivalent of 30 hours of service per week
- The IRS has announced the adoption of voluntary safe harbor methods employers may use to determine which employees will be treated as full-time employees for purposes of the employer mandate

## **The Employer Mandate: A New Vocabulary**

### **Full-Time Employees**

- **Three Key Periods**

- Measurement Period
- Stability Period
- Administrative Period

- **General Rules**

- Full-time during the measurement period = full-time during the next stability period
- Not full-time during the measurement period = not full-time during the next stability period
- Administrative period to make determination and conduct enrollment

- **New Employees v. Ongoing Employees**

## The Employer Mandate: A New Vocabulary

### Full-Time Employees

- **Example:**
  - Stability period = plan year = 2015 calendar year
  - Measurement period = Oct 2013 through Sept 2014
  - Administrative period = Oct 2014 through Dec 2014

## The Employer Mandate: A New Vocabulary

### Dependents

- Does not include an employee's spouse or domestic partner
- Does include an employee's child (as defined in Code Section 152(f)(1)) who is under age 26
  - Biological child, adopted child, step child and eligible foster child
- Review of dependent definition is critical to avoid inadvertent failures

## The Employer Mandate: The Penalties

### Penalty Tax on Employers Not Offering Coverage

- Applicable large employer member will pay penalty tax for any month that:
  - at least 95% of that member's full-time employees and their dependent children do not have the opportunity to enroll in minimum essential coverage; AND
  - at least one full-time employee of that member is certified to the applicable large employer member as having enrolled for that month in a QHP through an exchange for which federal assistance is allowed or paid (*i.e.*, premium tax credit or cost-sharing reduction)

## The Employer Mandate: The Penalties

### Penalty Tax on Employers Not Offering Coverage (cont'd)

- The amount of the tax is \$166.67 per month (\$2,000 per year) times the total number of full-time employees employed by the applicable large employer member (minus the member's pro-rata share of a 30 employee reduction)

## The Employer Mandate: The Penalties

### Penalty Tax on Employers Who Offer Coverage

- Applicable large employer member will pay a penalty tax for any month that:
  - at least 95% of its full-time employees and their dependent children have the opportunity to enroll in minimum essential coverage; AND
  - that minimum essential coverage is not affordable or does not provide minimum value; AND
  - at least one full-time employee of that member is certified to the applicable large employer member as having enrolled for that month in a QHP through an exchange for which federal assistance is allowed or paid (*i.e.*, premium tax credit or cost-sharing reduction)

## The Employer Mandate: The Penalties

### Penalty Tax on Employers Who Offer Coverage (cont'd)

- The amount of the tax is \$250 per month (\$3,000 per year) multiplied only by the number of the applicable large employer member's full-time employees who enroll for that month in a QHP through an exchange for which federal assistance is allowed or paid (*i.e.*, premium tax credit or cost-sharing reduction)
  - The number of full-time employees in this calculation is not reduced by 30
- The penalty tax is capped at an overall limitation per month equal to the penalty that the applicable large employer member would have had to pay if it had not offered minimum essential coverage to at least 95% of its full-time employees and their dependent children

## **The Employer Mandate: The Penalties**

### **Penalty Tax Within a Controlled Group**

- Any penalty tax is determined and paid within a controlled group of companies on a member-by-member basis
  - Liability for and amount of any penalty tax is computed and assessed separately for each applicable large employer member, taking into account that member's offer of coverage (or lack thereof) and, if applicable, based on that member's number of full-time employees (minus that member's share of the first 30)

## The Employer Mandate: The Penalties

### **EXAMPLE: Coverage not offered to at least 95% of full-time employees**

- Employer with 100 full-time employees does not offer coverage to 10 employees who are full-time because of their classification
- One excluded employee receives exchange coverage with federal assistance (*i.e.*, a premium tax credit or cost-sharing reduction)
- Employer pays \$140,000 penalty tax in 2014 (\$2,000 x 70 (100-30))
- If under these same facts, an employer has 10,000 full-time employees, the employer would pay nearly \$20 million in penalties (\$2,000 x 9,970 (10,000-30))

## The Employer Mandate: The Penalties

### EXAMPLE: Coverage is not affordable

- Employer with 100 full-time employees offers minimum essential coverage to all full-time employees, but the coverage is unaffordable to 10 full-time employees
- 2 full-time employees receive exchange coverage with federal assistance (*i.e.*, a premium tax credit or cost-sharing reduction)
- The other 8 employees participate in the employer's plan, even though it is not affordable
- The employer would pay \$6,000 in penalties for 2014 (\$3,000 x 2)

## **The Employer Mandate: New Reporting**

### **Code Section 6056 Reporting**

- Beginning for 2014, applicable large employers must report to the IRS whether they offer their full-time employees and their dependent children the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan and to provide certain other information
- Reporting employers must also provide a related written statement to their full-time employees
- The IRS will use the information that employers report to verify employer-sponsored coverage and to administer the employer play or pay mandate

## Other Employer Obligations

- Exchange Notice
- New Fees and Payments
- Patient Protection in Plan Design

## Exchange Notice

- Employers must provide all new hires and current employees with a written notice about the exchanges and the consequences of purchasing coverage through an exchange instead of employer-provided coverage
- The disclosure requirement was scheduled to be effective March 1, 2013
- Recent guidance confirms that the notice requirement did not take effect on March 1, 2013
- Anticipated that required timing for distribution of notices will be this fall

## Comparative Effectiveness Fees

- PPACA created the Patient-Centered Outcomes Research Institute (PCORI), a nonprofit corporation intended to support clinical effectiveness research
- PCORI will be funded in part by fees paid by certain health insurers and self-insured health plan sponsors
- The fees are payable for policy/plan years ending after September 30, 2012, but cease to apply for policy/plan years ending after September 30, 2019
  - For calendar year policies/plans, this means that the fees apply for policy/plan years 2012 through 2018
- The amount of the fees is based on the average number of lives covered by the policy or plan

## Comparative Effectiveness Fees

### Policies and Plans Subject to the Fees

- Major medical plans, both insured and self-insured
- Fees are payable by insurers of applicable insured health plans
- Fees are payable by sponsors of applicable self-insured health plans (can aggregate multiple self-insured plans)
- Final regulations confirm that fees apply to retiree coverage and COBRA coverage

## Comparative Effectiveness Fees

### Policies and Plans Not Subject to the Fees

- Policies issued to employers for purposes of covering primarily employees working and residing outside the U.S.
- Stop-loss and reinsurance policies
- HIPAA-excepted benefits (*e.g.*, limited scope dental and vision coverage and health flexible spending accounts)
- EAPs, disease management programs and wellness programs, as long as they do not provide significant benefits in the nature of medical care or treatment

## Comparative Effectiveness Fees

### Determination of Fees

- Guidance provides several different methodologies for calculating the average number of covered lives under the policy/plan
  - Actual Count Method, Snapshot Method, Form 5500 Method
- For policy/plan years ending before October 1, 2013, the fee is \$1.00 times the average number of covered lives under the policy/plan
- For later policy/plan years, the fee is \$2.00 times the average number of covered lives under the policy/plan, indexed based on the percentage increase in the projected per capita amount of National Health Expenditures (as published by Treasury)

## Comparative Effectiveness Fees

### Payment and Reporting of Fees

- Fees must be reported and paid once a year on IRS Form 720
- Reports and payments for policy and plan years that end in a calendar year are generally due by July 31 of the following year
- Final regulations confirm that TPAs of self-insured plans may not report and pay the fees on behalf of plan sponsors
- Final regulations confirm that the fees are imposed on the plan sponsor and are not permissible plan expenses

## Required Contributions towards Reinsurance Payments

- A temporary reinsurance program to which group health plans must contribute must be established in each state to help stabilize premiums for coverage in the individual market from 2014 through 2016
- Contributing entities are required to make the contributions toward reinsurance payments
  - Insured coverage – insurers are liable for making the contributions
  - Self-insured coverage – plan is liable for making the contributions, but third party administrator can be used to transfer the contribution payments

## Required Contributions towards Reinsurance Payments

- Contributions required with respect to “major medical products” – includes major medical coverage
- Contributions are not required for:
  - coverage offered by an insurer under a contract to provide Medicare, Medicaid or CHIP benefits
  - a health FSA, HSA or integrated HRA
  - an EAP, disease management program or wellness program that does not provide major medical coverage
  - stop loss policies
  - employer-provided coverage that is secondary to Medicare (*e.g.*, that is for Medicare-eligible retirees, COBRA participants or individuals on long-term disability)

## Required Contributions towards Reinsurance Payments

- Contributions must be made for all “reinsurance contribution enrollees”, which includes all individuals covered by a plan for which reinsurance contributions must be made
- The contribution is calculated by multiplying the average number of covered lives during the benefit year by the contribution rate for the benefit year (similar to the PCORI fees)
  - Contribution rate for 2014 is \$63 per covered life (\$5.25/month)
- First report due to HHS by November 15, 2014 and first payments due in late 2014 or early 2015

## Other Plan Design Requirements

- Prohibition on annual limits on essential health benefits
- Prohibition on excessive waiting periods (> 90 days)
- Prohibition on pre-existing condition exclusions
- Cost sharing limits

## Automatic Enrollment

- Certain large employers must automatically enroll new full-time employees in one of employer's group health plans
  - applies to employers who (1) are subject to FLSA, (2) have more than 200 full-time employees and (3) have one or more health benefit plans
- PPACA does not specify effective date for requirement
- DOL has indicated that employers do not have to comply until final regulations are issued, and that such regulations are not expected to be issued in time to implement automatic enrollment by 2014

## Establishment of Exchanges

- Effective January 1, 2014
- Legislative requirement:
  - Facilitate the purchase of insurance coverage by qualified individuals through qualified health plans, and
  - Assist qualified employers in the enrollment of their employees in qualified health plans
  - Must cover the entire geography of the state through one or more exchanges

## Exchanges

- Each state must provide for exchange; a “marketplace” of qualified health plans for small businesses and individuals
- Purchase through an exchange is voluntary
- Three options
  - State governmental agency or nonprofit entity
  - State-federal partnership
  - In the absence of state action HHS must establish exchange

## What Exchanges Do

- Determine eligibility and facilitate enrollment
- Determine eligibility for premium tax credit and cost-sharing reductions
- Assess eligibility for Medicaid or CHIP
- Certify and assign ratings to QHPs
- Provide toll-free hotline for consumer assistance
- Establish internet web site that meets certain accessibility requirements
- Provide electronic calculator to compare QHPs
- Provide consumer assistance, including Navigator program
- Provide outreach and education

## Glossary

- **QHP:** an exchange-certified health program that offers an essential health benefits package. The insurer must:
  - Be licensed and in good standing to offer coverage in the state
  - Agree to offer at least one QHP in the silver level and at least one QHP in the gold level in each exchange
  - Agree to charge the same premium rate for each QHP, whether offered through the exchange, directly or through an agent
  - Comply with HHS regulations and exchange requirements

A self-insured group health plan cannot be a QHP

## Glossary (cont' d)

- **Essential health benefits package:** must provide essential health benefits, limit cost-sharing and provide one of five levels of coverage (catastrophic, bronze, silver, gold, platinum)
  - Essential health benefits must include:
    - 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
    - Pediatric services, including oral and vision care

**Note, this is a different concept than “minimum essential coverage”**

## Glossary (cont' d)

- **Small Employer:** employs an average of at least one but not more than 100 employees on business days during preceding calendar year and employs at least one employee on first day of the plan year; before 2016, a state may elect to define small employer by substituting 50 for 100
- **Large Employer:** employs an average of at least 101 employees on business days during preceding calendar year and employs at least one employee on first day of plan year; before 2016, a state may elect to define large employer by substituting 51 for 101
- **IAP:** Insurance Affordability Program. Programs that provide advance payments of premium tax credit, cost-sharing reductions, Medicaid, CHIP and any state-established basic health program.

## SHOPs for Small Employers

- Intended to allow small employers a choice of QHPs
- Each state exchange must create a SHOP
  - Federally assisted state exchanges may only be capable of offering one plan option in 2014
- Participation by small employers is voluntary; qualified employers can obtain small business health care tax credit
- Eligible employers
  - Small employer
  - Offers coverage at least to all full-time employees in a QHP through a SHOP
  - Either has primary office in exchange service area and offers all its employees coverage through that SHOP or offers coverage to each eligible employee through SHOP servicing employee's primary worksite

## Eligibility for QHP through Exchange

- 2014 – All lawful U.S. residents; must use exchange in state of residence
- 2014 – Small employers eligible
  - Before 2016 a state exchange may limit small employers to those with no more than 50 employees
- 2017 – Exchange may make large employers eligible

## Enrollment – Initial Open Enrollment

- October 1, 2013 – March 31, 2014
- Coverage is effective:
  - January 1, 2014 for individuals who make a QHP election by December 15, 2013
  - The first day of the next month, for elections made between the 1st and 15th day of any subsequent month during initial enrollment period
  - The first day of the second following month, for elections made between the 16th and last day of the month between December 16, 2013 and March 31, 2014

## Enrollment – Special Enrollment

- May enroll or change enrollment from one QHP to another
- Duration is 60 days from triggering event
- Coverage is effective:
  - As of first day of next month for elections made between the 1st day and 15th day of preceding month
  - As of 1st day of second following month for elections made between the 16th day and last day of month
  - For birth, adoption or placement for adoption, as of such event
  - For marriage or loss of minimum essential coverage, as of the 1st day of the following month
- Triggering events similar to current HIPAA special enrollment right events and Code Section 125 cafeteria plan mid-year election change events

## **Enrollment – Annual Enrollment Beginning for 2015**

- October 15 through December 7 of each year beginning in 2015
- Exchange must provide advance written notice of annual enrollment each September
- Coverage is effective January 1 of the following year
- HHS may decide to permit automatic enrollment

## Payment for QHP

- Individual QHP can not be purchased with pre-tax dollars (not a qualified benefit under IRC §125)
- Employers eligible to purchase group coverage through an exchange may offer a purchase option through the employer's cafeteria plan

## Employer Interaction with Exchanges

- Individual Enrollment Process:
  - Applicant to provide personal and family income information:
    - Employer name
    - Wages/tips (before taxes)
    - Average hours worked each week
    - Other income (*e.g.*, unemployment, alimony, retirement)
    - Deductions (*e.g.*, alimony, student loan interest, other)
  - Applicant to provide employer information
    - Employer name, EIN, phone number and employer contact (phone number and email address)
    - Name of lowest cost self-only health plan employee could enroll in (“only consider plans that meet the ‘minimum value standard’ set by ACA”)
    - “Do you think the employer’s coverage is affordable?”

## Employer Interaction with Exchanges (cont' d)

- Individual Enrollment Process (cont' d):
  - Applicant to provide family health insurance information:
    - Whether family member is enrolled, plans to enroll or is not enrolled in employer-provided coverage
    - “Check here if this job will no longer offer health coverage next year”
    - “Check here if you think this health insurance will not be affordable next year”
  - HHS is clearly struggling with the most efficient way to obtain employer health care coverage information

## Employer Interaction with Exchanges (cont' d)

- Eligibility Verification
  - Exchange will use HHS-approved electronic data sources
  - Exchange to select statistically significant random sample of applications where verification is not available
    - Exchange will inform applicant that it will contact employer identified on application
    - Exchange will make reasonable efforts to contact employer
    - Information provided by employer must be used if provided

## Employer Interaction with Exchanges (cont' d)

- Employer Appeal Rights
  - Employer will be notified by exchange of each employee eligible for premium tax credit or cost-sharing reductions
  - Employer may appeal exchange finding
    - Must appeal within 90 days of date notice is sent
    - Employer may appeal exchange finding that:
      - Employer's plan does not provide minimum essential coverage
      - Employer's plan is unaffordable
- This process is different from the IRS' procedure used in connection with imposition of employer mandate penalty

## State-Based Exchange

- California
- Colorado
- Connecticut
- District of Columbia
- Hawaii
- Idaho
- Kentucky
- Maryland
- Massachusetts
- Minnesota
- Nevada
- New Mexico
- New York
- Oregon
- Rhode Island
- Utah
- Vermont
- Washington

## Federal Exchange

- Alabama
- Alaska
- Arizona
- Florida
- Georgia
- Indiana
- Kansas
- Louisiana
- Maine
- Mississippi
- Missouri
- Montana
- Nebraska
- New Jersey
- North Carolina
- North Dakota
- Ohio
- Oklahoma
- Pennsylvania
- South Carolina
- South Dakota
- Tennessee
- Texas
- Virginia
- Wisconsin
- Wyoming

## State-Federal Partnership

- Arkansas
- Delaware
- Illinois
- Iowa
- Michigan
- New Hampshire
- West Virginia

## Issues to Consider

- Implementation of the substantial and complex requirements under health care reform will require input not only from human resources, but also from:
  - Senior leadership
  - Finance
  - Payroll
  - IT
  - Tax
- Putting together the appropriate interdisciplinary team, analyzing the impact of the mandates and compliance all will take time, so an early start to the effort in 2013 is critical

## Issues to Consider (cont' d)

- Whether and how to provide group health coverage
- How and when to communicate with exchanges
- How and when to communicate with employees
- What records to retain – and for how long
- Establishing new compliance protocols
  - Required communications
  - Required reports and tax returns
  - Plan document amendments
  - Document retention