THE GROUP BENEFIT NEWS BULLETIN

Update on Health Care Reform

Patient-Centered Outcomes Research Institute Fee

Background:
PPACA created a new Patient-Centered Outcomes Research Institute to research and compare health outcomes and the effectiveness, benefits, and risks of various medical treatments/procedures. Fees are to be collected from both the fully-insured and self-funded markets. For fully-insured employers, the carriers hold responsibility for payment of the fee. For self-funded employers, the plan sponsor is responsible for the fee. For those on a calendar plan year the fee will be collected for years 2012-2018. For non-calendar plan years, the fee will be collected on plan years ending after September 30th, 2012 through September 30th, 2019. A Form 720 must be completed annually illustrating the fee amount due to the IRS.

Update: Per the IRS, the correct FORM 720 will be available the last week of May 2013.

PCORI fees are due by July 31st of the year immediately following the last day of the plan year. For 2013 (the first year), the fee is $1 per average covered life under the plan. The second year fee is set at $2 per covered life. For subsequent years, the fee is indexed based on the prior year's fee plus an adjustment for medical inflation. Fully-insured HRAs are to be counted individually while self-funded are only counted once. Retirees and those enrolled via COBRA or state benefits continuation programs are counted as well. Multiple methods exist on how to determine "average covered life" based on Fully-Insured or Self-Funded Status.

Fully Insured Plans
For fully-insured employers, the carriers are responsible for calculating the average number of covered lives, submitting the form 720 and paying the fee on behalf of the employer. Full-Insured employers should expect this fee to be rolled into their premiums.

Self-funded Plans
Self-funded plans may determine the average number of covered lives by using any of the following methods. Like fully insured plans, plan sponsors must use the same method consistently for the duration of any year and the same method for all policies subject to the fee.

- **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 Method-"Count Method"*** ** – 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.)
    - **Snapshot Method-"Factor Method"** – In the case of self-only coverage, determine the sum of: (1) the number of participants with self-only coverage, 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.

As of December 5th 2012, the IRS updated the first year requirement that the beginning date to be May 14th rather than actual beginning date of plan year for anyone whose plan year began before May 14th and will end after September 30th 2012. In addition with respect to the snapshot method, Each date used for the second, third, and fourth quarters must be within three days of the date in that quarter that corresponds to the date used for the first quarter, and all dates used must fall within the same policy year or plan year.

Fees do not apply to excepted benefits, such as stand-alone dental and vision plans, FSA, Expatriate, Stop Loss, Indemnity Reinsurance Policies, Medicare, Medicaid, SCHIP, Non-Insurance health programs for members of the Armed Forces or veterans, or Federally recognized Indian Health Services.

Notice to Employees of Exchanges

Early in 2013, the US Department of Labor (DOL) notified employers that the requirement to make employees aware of Exchanges was delayed from its original date of March 1st until further guidance was issued. On May 8th, 2013, DOL released temporary guidance requiring that all employers subject to the Fair Labor Standards Act (FLSA) notify their employees by October 1st, 2013 (to coincide with the marketplace Open Enrollment) that the Exchanges will be open January 1st, 2014.

The notice is a one-time requirement in October and must be supplied to all newly-hired associates thereafter. For new-hires, if the notice is provided within14 days of the employees' start date, then it is considered to be delivered at the time of hire. All full-time and part-time employees must be notified, regardless of whether the employee is enrolled in an employer-sponsored medical plan. Even if an employer does not offer medical coverage, the employee must be provided this notice. Employers are not required to supply the notice to employees' dependents.

The notice must include:

- Verbiage that the Exchange or Marketplace exists and the services provided within it, and direction for employees to visit Healthcare.gov for more information.
- Employees may be eligible for premium tax credits if their employer does not provide "affordable" coverage with "minimum value." Coverage is affordable if the employee-only rate does not exceed 9.5% of an employee's Box-1 income on their W-2. Coverage is deemed to be of minimum value if the plan pays at least 60% of allowed charges for covered services.
- Coverage through an Exchange or Marketplace is purchased with after-tax dollars.
- Information about medical coverage that is offered to the employee by the Employer.

COBRA notices are also to be updated to inform eligible employees and dependents of the alternatives available through the Health Insurance Marketplace.

Additionally, the notice may be delivered electronically if all ERISA standards for electronic transmission are met.

Affordability Determination: Wellness and Tobacco Credits

Background:

Beginning January 1, 2014 employers must offer affordable health insurance to employees. Employers with 50 or more full-time employees or equivalents will be required to pay a penalty if they don't offer health insurance coverage that covers minimum value (plan pays at least 60 percent of the cost of services) and the employee only rate of the employer's lowest cost coverage does not exceed 9.5 percent of an employee's W2 income***(Technically the 9.5 percent applies to household income, however, IRS has amended to allow a safer harbor to employers to use employees W2 income since most employers will not know an employees household income).*

Recent proposed guidance from the IRS states that when determining affordability (the 9.5% threshold) an employer may not include wellness incentives. However, transition relief is provided for plan years beginning before January 1, 2015. The transition relief allows employers to utilize wellness credits whereby the offer of coverage to the employee under the employer's group health plan would have been affordable, or satisfied Minimum Value if the employee met the requirements of the wellness program, including wellness programs with requirements unrelated to tobacco use.

The rule applies only (1) To the extent of the reward as of May 3, 2013, expressed as either a dollar amount or a fraction of the total required employee contribution to the premium (or the employee cost-sharing, as applicable), (2) under the terms of a wellness program as in effect on May 3, 2013, and (3) with respect to an employee who is in a category of employees eligible under the terms of the wellness program as in effect on May 3, 2013 (regardless of whether the employee was hired before or after that date).

The proposed guidance does however provide the use of tobacco credits when determining affordability. The comment period for these proposed regulations run through July 15th, 2013 at which time Final Regulations on these items is to be released.

As always, TBPG will continue to monitor all updates and keep you informed of any pertinent information. If you have any questions, please contact your TBPG representative.