ACA Regulatory Update

January 29, 2015

Assurex GLOBAL

ACA Regulatory Update

January 29, 2015

Assurex Global Shareholders:

- Ahmann-Martin
- Catto & Catto
- Celedinas Insurance Group
- Cragin & Pike, Inc.
- The Crichton Group
- The Daniel & Henry Co.
- Engle-Hambright & Davies
- Frenkel Benefits
- Gillis, Ellis & Baker, Inc.
- Haylor, Freyer & Coon, Inc.
- The HDH Group
- The Horton Group
- INSURICA
- Kapnick Insurance Group
- Kinney Pike Insurance
- Lipscomb & Pitts Insurance
- LMC Insurance & Risk Management
- Lyons Companies
- The Mahoney Group
- Parker, Smith & Feek, Inc.
- PayneWest Insurance
- R&R/The Knowledge Brokers
- RCM&D
- Roach Howard Smith & Barton
- The Rowley Agency
- Starkweather & Shepley Insurance Brokerage
- Woodruff-Sawyer & Co.
- Wortham Insurance & Risk Management

Assurex GLOBAL

Agenda

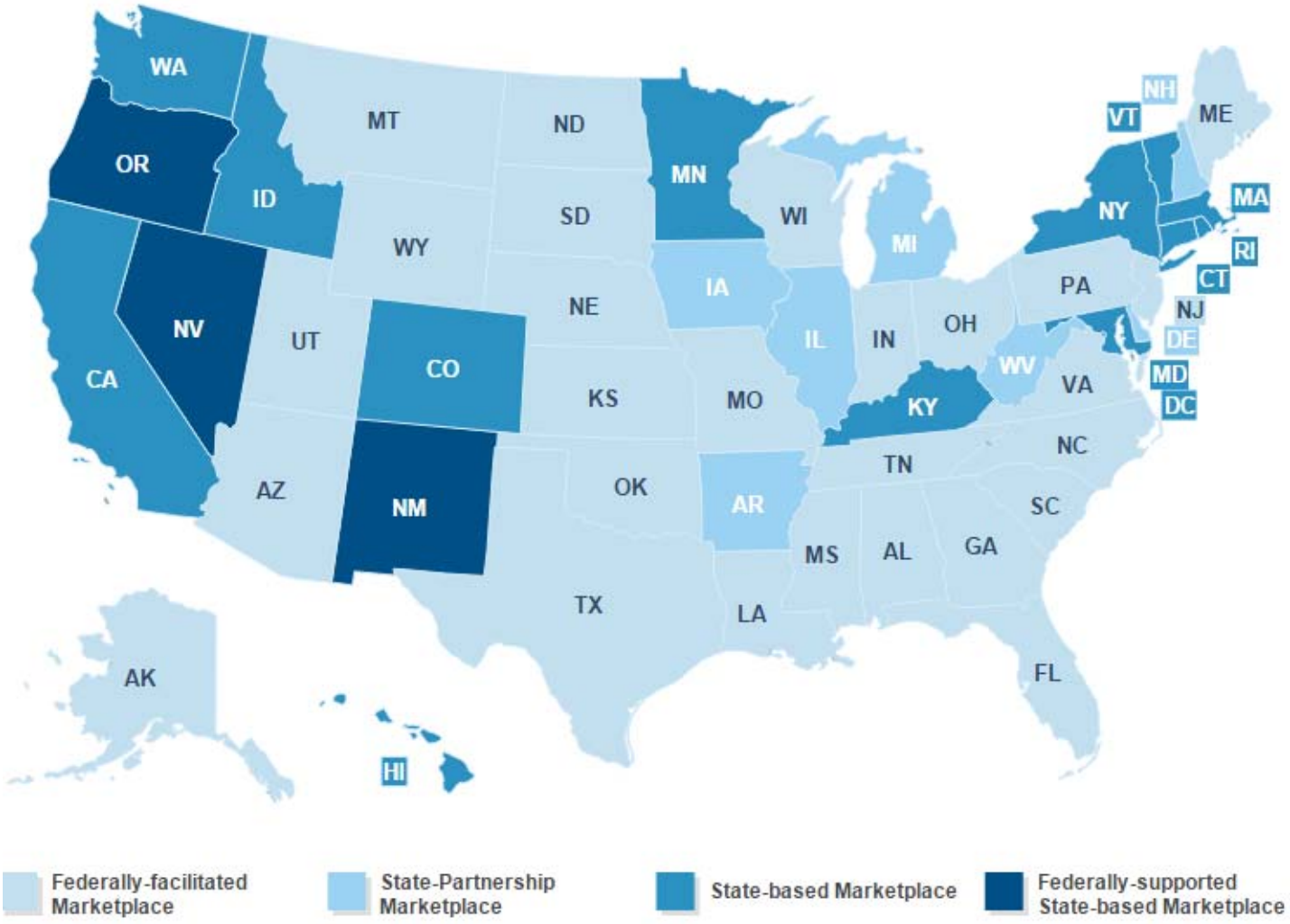
- **2015 Calendar**
- **SHOP and Small Business Tax Credit**
- **Guidance on Excepted Benefits**
- **Changing Limits and Fees**
- **Guidance on Cost-Sharing**
- **Guidance on SBCs**
- **Employer Reporting**
- **Guidance on Affordability**
- **Cracking Down on Creative Strategies**
- **Guidance on Expatriate Plans**

2015 Calendar

	2015 Calendar
JAN	W-2 reporting of cost of health insurance coverage to employees by Jan. 31 (employers filing 250 or more W-2s in the previous calendar year)
	Employer shared responsibility rules (Section 4980H) go into effect; also employers subject to reporting requirements must begin tracking applicable data
	1st installment of reinsurance contributions for 2014 due by Jan. 15
FEB	Annual open enrollment for Public Marketplaces ends Feb. 15
JUL	PCORI fees due by Jul. 31 for employers with a self-funded plan year ending in 2014
AUG	Handle MLR rebates within 90 days to avoid having to hold them in trust
NOV	Annual open enrollment for small group market Nov. 15 – Dec. 15 (no participation/contribution requirements)
	Annual open enrollment for public Marketplace Nov. 15 – Feb. 15
	Employers with self-funded plans must report enrollment counts for reinsurance fees by Nov. 15
OTHER	If adopting Section 125 change in status events related to individual coverage, must make plan amendments no later than the end of the 2015 plan year
	Provide Exchange Notice to all new hires within 14 days of hire

SHOP and Small Business Tax Credit

SHOP



SHOP

- Small Business Health Options Program (SHOP)
  - Group plans on the SHOP available to small employers
    - 2014 & 2015 small employer is 50 employees or less
    - Beginning in 2016 small employer is 100 employees in all states
    - In 2017 states have the option to open SHOP to large employers
  - SHOP enrollment very limited in most states
    - 16 state-based with varying success
    - 34 federally-based with limited success
  - Online enrollment available for 2015
    - SHOP enrollment in 2014 often required paper application or working through a broker offering QHPs
    - Some state-based SHOPs already had online enrollment in 2014

Small Business Tax Credit

- Eligible small employers may receive a tax credit of up to 50% of premiums paid
- To qualify, employers must generally:
  - Have fewer than 25 employees;
  - Pay average annual wages of less than $50,000 (indexed for inflation - $50,800 for 2014 and $51,600 for 2015);
  - Contribute a uniform percentage of at least 50% of the premium costs for employees; and
  - Coverage must be purchased through a SHOP, unless employer is in certain Washington or Wisconsin counties
- Tax credit is available for up to 2 consecutive years

Guidance on Excepted Benefits

Excepted Benefits

- Excepted benefits are generally exempt from HIPAA and ACA requirements (i.e. annual limits, waiting period, cost-sharing, preventive coverage) and will not cause an individual to lose eligibility for subsidies for coverage obtained through the public Marketplace/Exchange because the are not considered to be minimum essential coverage (MEC)
- Final rules released Oct. 2014 regarding limited scope dental and vision as well as employee assistance programs (EAPs)
- Proposed rules released Dec. 2014 regarding limited wraparound coverage

Excepted Benefits

- Health Flexible Spending Account (FSA)
  - IRS has indicated that a health FSA must maintain "excepted benefit" status so that it doesn't violate the health care reform rules by failing to provide preventive coverage
  - In order for a health FSA to retain its excepted benefit status (and therefore be allowed under the health care reform rules), it must satisfy 2 conditions:
    - *Maximum Benefit Condition.* Maximum benefit payable to any participant in the class for a year cannot exceed two times the participant's salary reduction election (or, if greater, the amount of the participant's salary reduction election plus $500)
    - *Availability Condition.* Other non-excepted group health plan coverage (e.g., major medical coverage) must be made available for the year to the class of participants by reason of their employment. NOTE – this requirement is that the individuals are eligible for both, not that they have to be enrolled in both

Excepted Benefits

- Limited Scope Dental and Vision
  - Dental and vision benefits are excepted if they are limited in scope (described as benefits, substantially all of which are for treatment of the eyes or mouth) and are either:

    (1) provided under a separate policy, certificate, or contract of insurance (only possibly for fully-insured plans); or

    (2) otherwise not an integral part of a group health plan
  - Not Integral…to satisfy this test, participants must be able to decline coverage
    - Original requirement was that participants must have the right to decline coverage AND if participants elect coverage, be required to pay an additional contribution; additional contribution requirement was eliminated

Excepted Benefits

- Employee Assistance Program (EAP)
  - Must meet 4 requirements to be excepted:
    1. Cannot provide significant benefits in the nature of medical care (amount, scope, and duration are considered)
       - Not significant – limited, short-term outpatient counseling for substance use disorder services (no inpatient, residential, partial residential, or intensive outpatient care) without requiring prior authorization or review for medical necessity
       - Significant - disease management services (such as laboratory testing, counseling, and prescription drugs) for individuals with chronic conditions such as diabetes
    2. The EAP cannot be coordinated with benefits under another group health plan
       - Must not be required to use and exhaust benefits under the EAP before being eligible for benefits under the other group health plan
       - Eligibility for benefits under the EAP must not be dependent on participation in another group health plan

Excepted Benefits

- Employee Assistance Program (EAP)
  - Must meet 4 requirements to be excepted (continued):
    3. Employees cannot be required to make a contribution to participate in the EAP
    4. There can be no participant cost-sharing (such as a co-pay) under the EAP

Excepted Benefits

- Limited Wraparound Coverage
  - Limited health coverage designed to wrap around individual health insurance coverage offered by the employer to part-time employees or retirees
    - Intention was to allow employers to offer a less costly alternative to part-time and retirees who would generally not afford the employer's coverage for full-time employees and would likely obtain Exchange/Marketplace coverage
  - Effective for limited wraparound plans offered no later than Dec. 31, 2017 and would remain effective for three years
  - Not expected that many employers will take advantage of this option

Excepted Benefits

- Limited Wraparound Coverage
  - Five requirements:
    1. Available only to part-time employees or retirees or employees (part-time or full-time) enrolled in a Multi-State Plan;
    2. Must be designed to provide "meaningful benefits beyond coverage of cost sharing under eligible individual health insurance;"
    3. Total cost of the wraparound coverage (both employer and employee contribution) must not exceed maximum annual contribution for health flexible spending accounts (i.e., $2550 in 2015);
    4. Must not impose any pre-existing condition exclusions, discriminate based on any health factor or discriminate in favor of highly compensated employees; and
    5. Reporting requirement must be satisfied by the employer sponsor (and health insurance issuer)

Changing Limits and Fees

2015 Plan Limits

- Health Flexible Spending Accounts (FSAs)
  - Maximum pre-tax payroll reduction $2,550 (up from $2,500) per 12-month plan year
  - Employer could make an additional contribution above $2550, but to avoid losing excepted benefit plan status, employer should (a) limit contributions to $500 or less; or (b) do a matching contribution
- Cost-sharing for essential health benefits (EHBs)
  - Out-of-pocket (OOP) maximum: $6,600 self-only/$13,200 self-plus
  - Plans can have a separate RX and medical OOP, but the total of the two cannot exceed the limit
- High deductible health plans (HDHPs)
  - Minimum deductible: $1,300 self-only/$2,600 self-plus
  - Maximum out-of-pocket: $6,450 self only/$12,900 self-plus
- Health savings accounts (HSAs)
  - Maximum contribution: $3,350 self-only/$6,650 self-plus

2015 Fees

- Patient-Centered Outcomes Research Institute (PCORI) Fee
  - If plan year ended on a date between Jan. 1, 2014 and Sep. 30, 2014: fee is $2.00 per covered life no later than Jul. 31, 2015
  - If plan year ended on a date between Oct. 1, 2014 and Dec. 31, 2014: fee is $2.08 per covered life no later than Jul. 31, 2015
- Transitional Reinsurance Contribution
  - $44 per covered individual (decreased from $63 in 2014)

2016 Proposed Limits and Fees

- Cost-sharing for essential health benefits (EHBs)
  - Out-of-pocket (OOP) maximum: $6,850 self-only/$13,700 self-plus
- Transitional Reinsurance Contribution
  - $27 per covered individual (decreased from $63 in 2014 and $44 in 2015)
- 4980H penalties
  - 4980H(a) - $173.33/mo. ($2080/yr)
  - 4980H(b) - $260.00/mo. ($3120/yr)

Guidance on Cost-Sharing

Cost-Sharing

- Out-of-Pocket (OOP) Maximum - limit on an individual's spending for covered essential health benefits under non-grandfathered group health plans (i.e. co-pays, coinsurance and deductibles)
- Reference-based pricing - plan pays a fixed amount for a particular procedure, which certain providers accept as payment in full
  - May exclude amounts above the reference-based pricing if employers use a reasonable method of establishing to ensure access to quality providers
    - Treat providers that accept the reference price as the only network providers for only those services where consumers have time to make an informed choice of provider
    - Ensure the availability of an adequate number of providers that accept the reference price and meet reasonable quality standards
    - Offer an exceptions process when access to a provider that accepts the reference price is unavailable or compromises quality of services
    - Provide information about pricing structure, including services to which it applies and the exceptions process (and providers lists upon request)

Guidance on SBCs

Guidance on SBCs

- Summary of Benefits (SBC) and Uniform Glossary
  - Background
    - "…to help plans and individuals better understand their health coverage, as well as to gain a better understanding of other coverage options for comparison"
    - Generally, all group health plans (but not excepted benefits) are required to distribute the SBC upon certain events
      - Insurance carrier (issuer) will generally provide the SBC on behalf of fully insured plans, but the plan administrator should ensure that is the case as the plan administrator is jointly responsible
      - For self-funded plans, the plan administrator (typically the employer) must provide the SBC

Guidance on SBCs

- Summary of Benefits (SBC) and Uniform Glossary
  - Timing and Method of Delivery
    - Must be provided to participants and beneficiaries (including COBRA-qualified beneficiaries) at open enrollment or renewal, upon initial enrollment and special enrollment, and also upon request (within 7 business days)
      - As long as the SBC is provided to the employee, the distribution requirement is met for all dependents living at the same address
    - May be provided in either paper or electronic form
      - For current participants who actually enroll online, the SBC may be provided electronically in conjunction with and at the same time as other online enrollment material (prior consent not required);
      - For current participants who enroll using any other means, the SBC may be provided electronically to those individuals who satisfy the DOL's safe harbor for electronic distribution; and
      - For individuals not currently enrolled, the SBC may be provided electronically if the individuals are notified (either in paper form or by email) that the documents are available on the Internet

Guidance on SBCs

- Summary of Benefits (SBC) and Uniform Glossary
  - Proposed rules effective for plan years beginning on or after Sep. 1, 2015
  - Notable changes:
    - Template shortened from 4 to 2½ pages (double-sided)
      - New template eliminates some information not required by statute to make it easier to include all of the required information while satisfying the statutory page limit
    - Added a few provisions to prevent duplication of effort between insurer (carrier) and plan administrator
    - Clarification that statements regarding whether the plan meets minimum essential coverage (MEC) or minimum value (MV) standards are required and no longer allowed via cover letter
    - A 3rd coverage example now required – simple foot fracture requiring an emergency room visit
    - Updated uniform glossary

Guidance on SBCs

- Summary of Benefits (SBC) and Uniform Glossary
  - In specified counties, those in which at least 10% of the population residing in the county is literate only in the same non-English language, plans and issuers must provide interpretive services and written translations upon request (Spanish, Chinese, Tagalog, and Navajo)
    - SBCs sent to addresses in an applicable county must include a one-sentence statement clearly indicating how to access the language services provided by the plan (or insurer)
      - *Example – If you can't read this, contact _____*
    - HHS has provided written translations of the SBC template, sample language, and the uniform glossary in Chinese, Navajo, Spanish, and Tagalog
    - CMS provided an updated list of applicable counties in Dec. 2014 - http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/2009-13-CLAS-County-Data_12-05-14_clean_508.pdf

Employer Reporting

Employer Reporting

- Who must report?
  - All employers offering a self-funded group health plan providing minimum essential coverage (MEC)
  - All "applicable large employers" – those with 50 or more full-time equivalents
- Timeframe
  - First required in 2016 for the 2015 calendar year
    - Annual employer returns must be filed with the IRS by Feb. 28 (Mar. 31, if filed electronically)
    - Corresponding employee statements must be provided annually to employees by Jan. 31
- Method of reporting
  - Employers will use Forms 1094 and 1095
    - Both will be submitted to the IRS and a copy of the 1095 will be provided to applicable employees
    - Only draft forms and instructions currently available

Employer Reporting

- Employers with less than 50 full-time equivalents offering a fully-insured plan or not offering coverage
  - NO REPORTING REQUIRED
- Employers with less than 50 full-time equivalents offering a self-funded plan
  - Use Forms 1094-B and 1095-B
  - Form 1094-B
    - Complete the whole form
  - Form 1095-B must be completed for individual that is actually covered under the self-funded plan
    - Complete Parts I, II and IV of the form
  - Information required:
    - Name, address and SSN of each covered individual
    - Months for which the individual was covered under the plan

Employer Reporting

- Applicable large employers offering a fully-insured group health plan
  - Use Forms 1094-C and 1095-C
  - Form 1094-C is the employer summary information
    - Complete Parts I, II, and III of the form (and IV if part of a controlled group or affiliated service group)
  - Form 1095-C must be completed for any employee that works full-time (as defined by Section 4980H) for at least 1 calendar month
    - Complete Parts I and II of the form
  - Information required:
    - Status as a single employer or part a controlled group
    - Total employee count each month
    - Total full-time employee count each month
    - For each full-time employee:
      - Which months coverage was offered
      - If minimum value (MV), employee contribution for lowest cost option

Employer Reporting

- Applicable large employers offering a self-funded group health plan
  - Use Forms 1094-C and 1095-C
    - Forms 1094-B and 1095-B as well for non-employees covered under the self-funded plan (i.e. COBRA participants, retiree, owners, etc.)
  - Form 1094-C
    - Complete Parts I, II, III (and IV if part of a controlled group or affiliated service group)
  - Form 1095-C must be completed for any employee that works full-time (as defined by Section 4980H) for at least 1 calendar month and for each additional employee that is actually covered under the self-funded plan
    - Complete Parts I, II and III of the form

Employer Reporting

- Applicable large employers offering a self-funded group health plan (continued)
  - Information required:
    - Status as a single employer or part a controlled group
    - Total employee count each month
    - Total full-time employee count each month
    - For each full-time employee:
      - Which months coverage was offered
      - If minimum value (MV), employee contribution for lowest cost option
    - For each covered individual:
      - Name, address and SSN
      - Months for which the individual was covered under the plan

Individual Mandate Reporting

- Generally, the individual will simply check a box indicating whether or not they had coverage during 2014
  - Individuals without coverage for all or part of 2014 and want to file for an exemption may need to file Form 8965 and attach it to Form 1040
  - Otherwise, those who mark “no” may pay a penalty
- Individuals should be able to file their tax returns without a 1095 or any other form showing proof of creditable coverage
- Employers are not under any obligation to provide a 1095 this year
  - Employer obligations to report (Form 1094 and 1095) are not required until early 2016 for the 2015 calendar year. But note, employers and/or carriers may choose to voluntarily file this year
  - If the individual received coverage through a public Exchange/Marketplace, the individual will receive a 1095-A

Guidance on Affordability

Affordability

- General rule
  - Employee contribution for employee-only (single) coverage cannot exceed 9.56% of employee's household income
- Considering employer contributions
  - HRA Contributions
    - Amounts that can be used only for cost-sharing will count for minimum value (MV) purposes, while amounts that can be used only for premiums (or premiums and cost-sharing) will count for affordability
  - Cafeteria (Section 125) Contributions
    - Employee's required contribution is reduced by any employer contributions that (1) may not be taken as a taxable benefit, (2) may be used to pay for MEC, and (3) may be used only to pay for Code §213 medical care
      - Where use of the employer's contribution is not limited to medical expenses, "it cannot be assumed that the employee will use the contribution for purchasing [MEC]"

Affordability

- Considering employer contributions
  - Wellness Incentives
    - Affordability for wellness incentives should be determined assuming that each employee fails to satisfy the requirements of the wellness program, except for the requirements of a nondiscriminatory wellness program related to tobacco use.
    - Example:
      - Required employee contribution is $150/mo. and potential wellness incentive (not tobacco-related) reduces cost to $120
      - *The coverage is "affordable" so long as $150 (not $120) does not exceed 9.56% of the employee's household income*

Cracking Down on Creative Strategies

Cracking Down on Creative Strategies

- IRS Notice regarding Minimum Value (MV)
  - Group health plans that exclude substantial coverage for inpatient hospitalization services or physician services (or both) will not satisfy MV standards
  - Transition relief for plan years beginning before Mar. 1, 2015 that, in reliance on the MV Calculator entered into a binding written commitment to adopt, or began enrolling employees in such a plan prior to Nov. 4, 2014
- DOL FAQs regarding reimbursement of individual health insurance premiums
  - Reimbursing individual premiums creates a group health plan subject to health care reform requirements (i.e. annual/lifetime limits, coverage for preventive services, etc.) and will not be able to satisfy such requirements
  - Providing cash incentives to high risk employees to encourage them to waive coverage on the employer's plan, and instead purchase individual health insurance is a violation of the HIPAA rules that prohibit discrimination against individuals based on their health status

Guidance on Expatriate Plans

Expatriate Plans

- Generally exempt from health care reform requirements
- In most cases, will satisfy an individuals requirement to obtain minimum essential coverage (MEC)

Expatriate Plans

- Definition - to be an expatriate health plan, substantially all of the primary enrollees must be “qualified expatriates ” fitting into one of the following categories:
  - *Workers in the U.S.:* Individuals whose skills and expertise caused the employer to temporarily transfer or assign them to the U.S., who are reasonably determined to require access to health insurance in multiple countries, and to whom the employer periodically offers “other multinational benefits”
  - *Workers Outside the U.S.:* Individuals working outside the U.S. for at least 180 days in a consecutive 12-month period that overlaps with the plan year
  - *Charitable Workers:* Members of groups formed for traveling or relocating internationally to do certain nonprofit work (and not formed primarily for the sale of health insurance), if determined by HHS to require access to health insurance in multiple countries

ACA Regulatory Update

January 29, 2015

Assurex Global Shareholders:

- Ahmann-Martin
- Catto & Catto
- Celedinas Insurance Group
- Cragin & Pike, Inc.
- The Crichton Group
- The Daniel & Henry Co.
- Engle-Hambright & Davies
- Frenkel Benefits
- Gillis, Ellis & Baker, Inc.
- Haylor, Freyer & Coon, Inc.
- The HDH Group
- The Horton Group
- INSURICA
- Kapnick Insurance Group
- Kinney Pike Insurance
- Lipscomb & Pitts Insurance
- LMC Insurance & Risk Management
- Lyons Companies
- The Mahoney Group
- Parker, Smith & Feek, Inc.
- PayneWest Insurance
- R&R/The Knowledge Brokers
- RCM&D
- Roach Howard Smith & Barton
- The Rowley Agency
- Starkweather & Shepley Insurance Brokerage
- Woodruff-Sawyer & Co.
- Wortham Insurance & Risk Management

Thank you!

Assurex GLOBAL

ACA Regulatory Update

January 29, 2015

Assurex GLOBAL