ADP Lunch & Learn
Course Materials

This Year's Reporting of Your Health Care Expenditures

NASBA INFORMATION

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ADP has partnered with SmartPros (a Kaplan Company) to provide this program and SmartPros has prepared the material within.
### 2. This Year’s Reporting of Your Health Care Expenditures

**Learning Objectives:**
Upon successful completion of this segment, you should be able to:

- Recognize how the “play-or-pay” rules could result in an employer shared responsibility payment;
- Identify what health care forms are required to be filed by organizations this year;
- Determine the potential impact on employers of the upcoming Cadillac tax;
- Distinguish between those organizations that sponsor and fund wellness programs, and those that avoid them.

**Segment Overview:**
Health care benefits have long been a core component of the rewards that companies use to attract and retain talent. However, your health care reporting obligations will undergo major changes in 2015, reflecting your new compliance responsibilities under the Affordable Care Act. **Dorian Smith,** an attorney with Mercer, makes it clear that “this is the month” when you must pay close attention to your organization’s immediate information reporting requirements, as well as to your looming exposure to the so-called “Cadillac tax.”

**Field of Study:**
Taxes

**Expiration Date:**
August 31, 2017

**Course Level:**
Update

**Course Prerequisites:**
Work experience in tax planning or tax compliance, or an introductory course in taxation

**Advance Preparation:**
None

**Recommended Reading (Self-Study):**
- 1 hour group live
- 2 hours self-study

- “2015 ACA Compliance Checklist”
  By Jim O’Connell, of Ceridian Corporation
  For additional info, go to: [www.ceridian.com](http://www.ceridian.com)

- “Top 10 Issues for 2016 Health Benefit Planning”
  By Barbara McGeoch, Leslie Anderson, Cheryl Risley Hughes, and Dorian Smith, of Mercer

- “Additional Guidance on the Looming Cadillac Tax”
  By Jeffrey Arnold and Amy M. Gordon, of McDermott Will & Emery
  For additional info, go to: [www.mwe.com](http://www.mwe.com)

- “HSAs Surge, Leaving HRAs in a Niche”
  By Jan Greene, Reprinted with permission from Managed Care
  For additional info, go to: [www.managedcaremag.com](http://www.managedcaremag.com)

See page 2–13.

**Video Transcript:**
See page 2–21

**Running Time:**
35 minutes
I. New Responsibilities Under Affordable Care Act

A. Interrelated Considerations
   1. American health insurance system will continue to undergo changes this year
      a. Reflecting new compliance responsibilities under Affordable Care Act
   2. Accountants and financial executives will face wider range of interrelated considerations
      a. Should business continue to offer employee health insurance?
      b. Should active employees or retirees be “transitioned” to private health insurance exchanges?
      c. How much should be invested in health improvement and wellness programs?
      d. What is the risk from the 40% excise tax – Cadillac tax?

B. Effective This Year: 2015
   1. Large employers need to offer their full-time employees a certain level of coverage
      a. At an affordable value
      b. Or potentially pay penalties to the government
   2. Employers are going to be required to start tracking employee hours
      a. Voluminous reporting will be due to employees and the IRS early in 2016
         i. Based on 2015 data, 2015 health plans, 2015 employees’ hours

II. Pay or Play

A. Transition Relief for Companies
   1. For businesses that employed between 50 and 100 full-time equivalent employees during 2014
   2. To be eligible for relief the employer:
      a. Cannot have reduced the size of its workforce or the overall hours of service of its employees
      b. Cannot have eliminated or materially reduced the health coverage it offers
      c. Must have employed, on average, at least 50 full-time employees
         i. But fewer than 100 full-time employees during 2014

B. Employers Subject to Shared Responsibility Payments
   1. Applicable large employer will be subject to a shared responsibility payment
      a. Once at least one full-time employee receives a premium tax credit
   2. Employer also subject if:
      a. Offers health insurance coverage that is not affordable or does not meet minimum value standards
         i. $3,000 penalty for each employee who opts out of the employer’s coverage
      b. Employer does not offer health insurance coverage to at least 70% of employees
         i. $2,000 per employee
II. Pay or Play (continued)

C. Mechanics of “Play-or-Pay”
1. Employers with 50 or more full time employees in the prior year
   a. Includes full-time equivalent employees
      i. Need to offer their full-time employees affordable, minimum value coverage
2. If they do not do that they are exposed to potential assessments
   a. That is the “pay” part of the “play-or-pay”

D. Penalties for not Playing
1. If you do not offer employees affordable minimum-value coverage
   a. And they go to a public exchange and receive a subsidy or federal monies
   b. Could trigger a $3,000 or pro-rata share of the $3,000 penalty
2. Employers who decide that they do not want to offer health coverage anymore
   a. Could potentially be on the hook for a $2,000 penalty for each full time employee

III. Legal and Reporting Details

A. Employers with 50-99 Employees Get a Pass
1. Do not have to offer affordable minimum value coverage to their full time employees in 2015
   a. Get a pass until 2016
2. Employers with 50 to 99 employees still are responsible for reporting
   a. Have to calculate employee hours
   b. Have to issue reports to the IRS and to the employees early in 2016

B. Controlled Groups of Companies
1. IRS concept of a controlled group of corporations
   a. Parent company that may own 80% of a subsidiary
      i. So they are part of a controlled group
2. To determine whether or not you are a large employer
   a. Take a look at all of the different employers within controlled group
3. If all employees aggregate to over 50 full-time or full-time equivalents
   a. Every employer within that controlled group is subject to “play-or-pay” and to reporting
      i. Even those with fewer than 50 employees

C. Form 1094-C and 1095-C
1. Required to complete and send to their full-time employees
   a. And to any employees covered under a self-insured health plan
      i. By February 1st 2016 based on the 2015 calendar year
2. Employers required to send these reports to the IRS
   a. Along with information regarding their play-or-pay compliance
      i. Generally by March 31st, 2016
      ii. By February 29th if employer files by paper

D. Responsibility for Reporting
1. More of a benefits issue
   a. Information about people’s coverage
   b. Also involves counting hours
2. A lot of departments need to work together to complete the new forms
3. There is no more time to delay on this one
Outline (continued)

IV. Forms Needed for 2015

A. 1095-C
   1. Two most relevant forms for employers are the 1094-C and the 1095-C
   2. Employees who get a 1095-C fall into two buckets:
      a. Anyone who was a full time-employee, under ACA rules, for at least one month in 2015
      b. Any employee covered under an employer’s self-insured health plan for at least one month of the year
         i. Even if they were not a full time employee

B. 1094-C
   1. Transmittal report due to the IRS generally by March 31st for electronic filers
      a. February 29th for paper filers
      b. Attaches a copy of all of the 1095-Cs sent to employees
   2. Provides IRS with additional information regarding employer’s “play-or-pay” compliance

C. Self-Funded Insurance
   1. Reporting rules are the same
   2. Self-funded employers may have more reports to do than fully insured counterparts
      a. Have to report on coverage for any individual employee, retiree, or spouse covered for at least one month in 2015

D. New Increased Penalties
   1. Increased penalties for incorrect or incomplete information returns
      a. Went from $100 to $250 per form
      b. Caps went from $1.5 million to $3 million dollars
         “For this first year, as long as employers make a good faith, reasonable effort to comply with reporting, and they file in a timely manner, there will not be assessments for any errors or omissions of these reports.”
         - Dorian Smith

E. Repeal of Automatic Enrollment
   1. Latest Budget Act repealed the never-implemented automatic enrollment provision under the ACA
   2. Required employers with 200 or more employees to automatically enroll their employees in a health plan
      a. Or continue the enrollment of current enrollees
   3. There still is automatic enrollment in 401(k) and other retirement plans
V. New Parameters for Company Size and Costs

A. Redefining Large and Small Group Employers
   1. Protecting Affordable Coverage for Employees Act signed
   2. PACE Act allowed states to keep the definition of small group to 50 employees
      a. Allows those employers with more than 50 to be in the large group
      b. That is a state option

B. Employee Reimbursement Plans
   1. No longer can provide active employees with money to purchase individual coverage
   2. An employer cannot give active employees money to purchase public exchange health coverage
   3. Employer could set up a retiree-only HRA
      a. Which can reimburse pre-65 retirees for the cost of their health coverage

C. Out-of-Pocket Maximum Provision
   1. New rules and cost-sharing limits for the annual out-of-pocket maximum amount under a group health plan
   2. For family coverage
      a. Embedded individual out-of-pocket maximum cannot exceed $6,850
   3. ACA has not replaced COBRA or ERISA

VI. Cadillac Tax

A. 40% Excise Tax
   1. Certain employer-sponsored coverage will incur non-deductible 40% excise tax
      a. On the cost of employer-sponsored coverage over a threshold amount
      b. Starting in 2018
         i. Thresholds likely to be $10,200 for single coverage and $27,500 for family coverage
   2. Employers should be reviewing their plan designs
      a. In order to limit their exposure

B. Avoiding the Cadillac Tax
   1. Some businesses might consider redesigning their benefit packages in order to delay incurring the tax
   2. Doing whatever they can today to make sure plans do not trigger excise tax

C. Employer and Employee Contributions Accumulate to Excise Tax
   1. In certain instances monies in an HSA will accumulate toward the excise tax
      a. Any employer contributions
      b. Any employee pre-tax contributions
   2. Could be that some legislation or changes to the law will exclude the employee pre-tax contributions
VII. Other Cost Considerations

A. Pre-65 Retirees
1. Some employers may decide that there is a viable individual marketplace
   a. Where pre-65s can go get individual coverage
2. Some employers may want to continue offering their pre-65 retirees health coverage
   a. Because they feel it is the right thing to do
3. Some employers have decided to send their employee pre-65s to the exchange
   a. But they give them money to do that
   b. They seed retiree HRAs
      i. May jeopardize retiree’s ability to also get subsidized coverage from the government

B. Spousal Coverage
1. Employers are looking at whether or not to continue offering spousal coverage
   a. And whether they will impose a spousal surcharge
2. Under the “play-or-pay” rules employers required to offer minimum essential coverage to the employee and their children
   a. No requirement to offer coverage to spouses

C. Wellness Programs
1. Pros and cons to wellness programs
2. Cons
   a. Upfront cost – new investment
   b. Figuring out what you want to offer – incentives, etc.
3. Pros
   a. Potential for a nice return on investment
   b. Healthier employee population
      i. Ultimately reduces the cost of medical plan coverage

D. Going Forward
1. Probably not in for any relief – compliance is here to stay
2. Figuring out excise tax exposure is going to be a big deal over the next 2-3 years
3. Non-discrimination rules are in the pipeline
   “…compliance obstacles should not get in the way of an employer’s decision to continue to offer benefits to employees because…employers reap a benefit from that and employees reap a benefit from that.”
   - Dorian Smith
Group Live Option

Instructions for Segment

For additional information concerning CPE requirements, see page vi of this guide.

- As the Discussion Leader, you should introduce this video segment with words similar to the following:
  “In this segment, Dorian Smith explains that now is the time for you to pay close attention to your organization’s information reporting requirements, as well as to your looming exposure to the so-called ‘Cadillac tax.’”
- Show Segment 2. The transcript of this video starts on page 2–21 of this guide.
- After playing the video, use the questions provided or ones you have developed to generate discussion. The answers to our discussion questions are on pages 2–9 and 2–10. Additional objective questions are on pages 2–11 and 2–12.
- After the discussion, complete the evaluation form on page A–1.

Discussion Questions

2. This Year’s Reporting of Your Health Care Expenditures

You may want to assign these discussion questions to individual participants before viewing the video segment.

1. Why are so many employers rethinking their employee health benefit plans? How are their decisions likely to change between now and 2018? What financial modeling are your clients doing (or asking you to do) to assess their strategy and decisions vis-à-vis pay-or-play?

2. According to many experts, employer health benefit costs are projected to rise at a rate of 5 – 7% annually. To what extent are your clients’ health benefit costs increasing this year? Are they above or below the average? Why? How can you aid your clients in mitigating the increase in health benefit costs?

3. Why can lower health care costs be considered a competitive advantage, as well as a potential disadvantage, for an organization? How effective would you say that your clients are – and that your own organization is – at controlling health care costs?

4. Dorian Smith cites several examples of how organizations are increasing their bottom line, while increasing employee wellness. To what extent are your clients involved in any of these initiatives, such as bringing a health care clinician onsite? To what extent are your clients interested in wellness and prevention programs? Why or why not?
Discussion Questions (continued)

5. According to Dorian Smith, many employers are rethinking how they provide retiree health coverage, particularly for pre-65 retirees. To what extent do your clients currently provide pre-65 retiree health coverage? To what extent are you assisting them in considering opportunities for reevaluating and redefining those responsibilities?

6. Dorian Smith urges accountants to be more involved in planning and decision making for their clients’ health care benefits as well as for health care issues in general. To what extent are you assisting clients in health care planning? Are clients concerned about the health of the company, the health of the workforce, or both?

7. We have previously provided coverage of employer health care in the context of major events, such as the enactment of health care reform and the Supreme Court's "endorsement" of the Affordable Care Act. At a time of increased health care costs, how often should we revisit the issue in the future? To what extent should we provide continued coverage of this issue on an ongoing basis?
Suggested Answers to Discussion Questions

2. This Year's Reporting of Your Health Care Expenditures

1. Why are so many employers rethinking their employee health benefit plans? How are their decisions likely to change between now and 2018? What financial modeling are your clients doing (or asking you to do) to assess their strategy and decisions vis-à-vis pay-or-play?
   - Participant response is based on your clients (their workforce, their benefit programs, their financial condition, and their leadership), as well as on your perspective and experience.

2. According to many experts, employer health benefit costs are projected to rise at a rate of 5 – 7% annually. To what extent are your clients’ health benefit costs increasing this year? Are they above or below the average? Why? How can you aid your clients in mitigating the increase in health benefit costs?
   - Participant response is based on your clients (their workforce, their benefit programs, their financial condition, and their leadership), as well as on your perspective and experience.

3. Why can lower health care costs be considered a competitive advantage, as well as a potential disadvantage, for an organization? How effective would you say that your clients are – and that your own organization is – at controlling health care costs?
   - Lower health care "spend" is a competitive advantage for an organization when it results from doing a better job of managing and controlling costs. However, lower rates that result from offering less coverage often result in being unable to attract or retain a quality workforce.
   - Participant response is based on your clients (their workforce, their benefit programs, their financial condition, and their leadership), as well as on your perspective and experience.

4. Dorian Smith cites several examples of how organizations are increasing their bottom line, while increasing employee wellness. To what extent are your clients involved in any of these initiatives, such as bringing a health care clinician onsite? To what extent are your clients interested in wellness and prevention programs? Why or why not?
   - Participant response is based on your clients (their workforce, their benefit programs, their financial condition, and their leadership), as well as on your perspective and experience.

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- Participant response is based on your practice – its client needs as well as its own management needs – as well as on your perspective, experience and job responsibilities.
Objective Questions

2. This Year’s Reporting of Your Health Care Expenditures

You may want to use these objective questions to test knowledge and/or to generate further discussion; these questions are only for group live purposes. Most of these questions are based on the video segment, a few may be based on the required reading for self-study that starts on page 2–13.

1. Under the ACA employees are considered full time for a calendar month if they average at least _______ hours of service per week.
   a) 50
   b) 40
   c) 35
   d) 30

2. Employers will be subject to a shared responsibility payment if:
   a) at least 100 full time employees receive a premium tax credit
   b) the employer does not offer health insurance coverage to at least 80% of employees
   c) the employer offers health insurance coverage that is not affordable or does not meet the minimum value standards
   d) employers will no longer be subject to a shared responsibility payment under the ACA

3. Play or pay rules require employers with more than ____ full-time employees to provide minimum value coverage or they are subject to a _____ penalty.
   a) 30, $3,000
   b) 40, $5,000
   c) 50, $3,000
   d) 100, $5,000

4. Two forms most relevant for employers with respect to reporting under play or pay rules are:
   a) 1094C and 1095C
   b) 1099 and 1040
   c) 1098 and 1099
   d) none of the above

5. With respect to the definition of large versus small employee groups:
   a) the PACE Act requires states to use the definition of large versus small groups as defined by the ACA
   b) being placed in a large group market will be more advantageous from a premium perspective
   c) by 2016 the ACA will define small groups as any employer with less than 50 employees
   d) ACA rules for large and small groups are the same

6. As of 2015 employers _______ provide _______ with reimbursement for health care coverage.
   a) can, retirees
   b) can, active employees
   c) cannot, retirees
   d) cannot, active employees or retirees

7. The ACA Cadillac tax provisions impose a _____% excise tax on employers offering employees coverage over a certain amount.
   a) 10.2%
   b) 40%
   c) 27.5%
   d) 6.8%

8. The costs of compliance with the ACA are expected to _______ in future years.
   a) increase
   b) decrease
   c) remain the same
   d) the costs of compliance cannot be determined at this time
Objective Questions (continued)

9. Under the ACA’s definition of affordable health care coverage the employer’s share of the premium for the employer’s lowest costs, self only coverage option is not more than ___ of the employee’s wages.
   a) 3%
   b) 7.5%
   c) 9.5%
   d) 10%

10. Issues employers should address in 2016 health benefit planning include all of the following except:
   a) employer shared-responsibility (ESR) strategy
   b) preventive care
   c) same-sex marriages and domestic partnerships
   d) proposed changes to Medicare eligibility rules
Self-Study Option

Instructions for Segment

When taking a CPA Report segment on a self-study basis, an individual earns CPE credit by doing the following:

1. Viewing the video (approximately 30–35 minutes). The transcript of this video starts on page 2–21 of this guide.
2. Completing the Required Reading (approximately 25–30 minutes). The Required Reading for this segment starts below.

3. Completing the online steps (approximately 35–45 minutes). Please see pages iii to v at the beginning of this guide for instructions on completing these steps.

Required Reading (Self-Study)

2015 ACA COMPLIANCE CHECKLIST

By Jim O’Connell, of Ceridian Corporation
For additional info, go to: www.ceridian.com

The January 1, 2016 effective date for new Affordable Care Act (ACA) compliance requirements is less than 90 days away. And with finance, HR and payroll gearing up for year-end, you should be prepared with an ACA compliance checklist.

Employer Shared Responsibility:
ACA Sec. 4980H

For employers with 100 or more full-time employees, the so-called “play-or-pay” mandate is effective for plan years beginning on or after January 1, 2015. To avoid compliance penalties employers subject to 4980H must offer “minimum essential coverage” to full-time employees and their dependents that is both “affordable” and provides “minimum value.”

Employers generally face two “play-or-pay” penalty scenarios:

(1) Greater Penalty: Employer does not offer minimum essential coverage to full-time employees (or offers coverage to fewer than 70%) and at least one full-time employee qualifies for a premium tax credit to help pay for exchange-based coverage. Liability is $2,000 times the number of full-time employees, minus up to 80 employees for 2015;

(2) Lesser Penalty: Employer does offer coverage to at least 70% of full-time employees but for particular employees the coverage proves unaffordable or fails to provide minimum value. Liability is $3,000 for each full-time employee that qualifies for a premium tax credit to help pay for exchange-based coverage.

It’s worth noting the specific ACA definition of “affordable” health coverage: the employee’s share of the premium for the employer’s lowest-cost, self-only coverage...
option is not more than 9.5% of the employee’s Box 1 W-2 wages, assuming the employer elects the W-2 affordability “safe harbor.”

**Employer Health Coverage Reporting**

Employer health coverage reporting is the fulcrum of the health reform law. Indeed, it is the way IRS will enforce both the individual mandate to have insurance and the employer shared responsibility mandate to offer coverage to full-time employees.

Similar to W-2 reporting, Code sections 6055 and 6056 require employer plan sponsors annually to file forms with the IRS reporting health coverage information. Depending on whether health plans are fully insured or self-insured, employers will file Forms 1094-B and 1095-B or Forms 1094-C and 1095-C.

An important 2015 ACA compliance priority, therefore, is to ensure that your systems are able to collect, verify and provide the data needed to report health coverage information to the IRS and furnish statements to employees.

Health coverage data will be collected during 2015 so the required forms can be filed with IRS and furnished to employees early in 2016. Best practice employers will build a systematic reporting process on a platform with electronic documentation capabilities that will reflect employment and benefits decisions and when they were made to comply with Internal Revenue Service reporting requirements.

**Determination of Full-Time Employee Status**

Perhaps no 2015 ACA employer compliance mandate is more onerous than tracking hours worked to determine employees’ full- or part-time status. Since the law requires most employers to offer health coverage to full-time employees starting in plan year 2015, employers must document who is a “full-time” employee under the Affordable Care Act definition.

Employers will document hours worked because when coverage is not offered to an employee, an employer must be able to demonstrate that coverage was not offered specifically because the employee did not work a full-time schedule.

Most employers will adopt a “Look-Back” Measurement Method of 3-12 months to determine whether ongoing employees averaged 30 or more hours a week. Employers will then use a corresponding “Stability Period” during which qualifying health coverage will be offered. For 2015 only, employers may use a 6-month 2014 look-back period and a 12-month 2015 stability period.

Managing full-time status determinations with look-back and stability periods likely will be straightforward for most “ongoing employees.” But issues will no doubt arise for “ongoing variable hour employees” and for new employees not expected to work full-time. Employers will also face challenges in correctly categorizing seasonal employees, short-term employees and breaks in service.

Clearly managers will need a single application design that enables precise tracking of hours worked and determinations of eligibility for offers of coverage. To categorize employees, verify benefits eligibility and document timelines for offers of coverage, employers will want to reflect changes in hours worked in payroll, time and attendance and benefits – with all information available in real-time.

**Ready to Comply?**

This ACA checklist illustrates that the year 2015 demands a new standard for Affordable Care Act compliance. The ACA Compliance Trifecta – “play-or-pay,” health coverage information reporting and full-time status determinations – will put enormous pressure on employers of all sizes.

Employers are advised first, to establish an ACA 4980H compliance strategy with clear lines of responsibility and C-level buy-in; and second, to put in place the kind of single solution, best-in-class HCM system that will allow seamless management of ACA compliance requirements.
TOP 10 ISSUES for 2016 HEALTH BENEFIT PLANNING

By Barbara McGeoch, Leslie Anderson, Cheryl Risley Hughes, and Dorian Smith, of Mercer
For info, go to: http://www.mercer.com/about-mercer/lines-of-business/health-and-benefits.html

In finalizing 2016 health benefit designs, contribution strategies, vendor terms, and employee communications, employers need to keep pace with the latest Affordable Care Act (ACA) and other developments impacting health plans. This article discusses the top 10 issues employers should address in health benefit planning for the upcoming year. For clear-cut 2016 priorities already recognized by most employers, this offers reminders of actions to take or consider in addressing these matters.

1. **Employer shared-responsibility (ESR) strategy.** Ensure intended goal of avoiding or paying ESR assessments for 2016 coverage is supported by coverage offers, administrative and recordkeeping processes, and benefit documents.

2. **ESR reporting.** Arrange data sources, systems, and administrative processes to collect all information about enrollees with minimum essential coverage (MEC), full-time employees, and coverage offers that will be needed for reporting on 2016 coverage. Create a process for correcting any erroneous IRS filings and personal statements.

3. **Preventive care.** Ensure non-grandfathered group health plans comply with final ACA rules and recent guidance on cost-free preventive services.

4. **Other ACA reporting and disclosure.** Review delivery operations for summaries of benefits and coverage (SBCs) and watch for revised SBC templates. Prepare for round two of online submission and payment of ACA’s reinsurance fee.

5. **Midyear changes to cafeteria plan elections.** Decide whether to permit midyear changes to cafeteria plan elections for either or both of the change-of-status events added by IRS Notice 2014-55.

6. **ACA’s out-of-pocket maximum.** Verify that self-only and other (e.g., family) coverage tiers in non-grandfathered plans meet ACA’s 2016 out-of-pocket (OOP) limits for in-network care. Confirm that family coverage also satisfies ACA’s self-only OOP limit for each enrollee.

7. **Same-sex marriages and domestic partnerships.** Assess how the US Supreme Court’s Obergefell v. Hodges ruling legalizing same-sex marriage nationwide affects your benefit programs and employment policies. Also consider the decision’s indirect implications for domestic partner coverage.

8. **Mental health parity.** Check that plan designs and operations provide parity between medical/surgical and mental health/substance use disorder (MH/SUD) coverage. Federal audits of health plans now evaluate compliance with the final Mental Health Parity and Addiction Equity Act (MHPAEA) rules that took effect in 2015. In addition, litigation and state legislative activity around parity issues continue.

9. **Wellness.** Review employee wellness programs against the proposed Equal Employment Opportunity Commission (EEOC) rules requiring voluntary participation and restricting incentives for completing health risk assessments and/or biomedical screenings. Be prepared to make changes after EEOC finalizes these rules for nondiscriminatory wellness plans under the Americans with Disabilities Act (ADA).

10. **Fixed-indemnity and supplemental health insurance.** Review fixed-indemnity and supplemental health insurance policies to ensure they qualify as excepted benefits under the ACA and the Health Insurance Portability and Accountability Act (HIPAA).
The Affordable Care Act (ACA) added Code Section 4980I to the Internal Revenue Code. Effective for tax years beginning on or after January 1, 2018, an excise tax of 40 percent will be imposed on the cost of employer-sponsored health coverage that exceeds an annual limit. This tax is informally known as the “Cadillac Tax” and will impose a penalty on employers, health insurers and “persons who administer plan benefits” with regard to high-cost health care coverage.

On July 30, 2015, the Internal Revenue Service (IRS) issued guidance on the Cadillac Tax in Notice 2015-52, supplementing Notice 2015-16, which was released on February 23, 2015.

Who Must Pay the Cadillac Tax?

The Code defines the “coverage provider” as the taxpayer liable for paying the Cadillac Tax. For purposes of an insured group health plan, the coverage provider is the health insurance issuer. For purposes of a Health Savings Account (HSA) or an Archer medical savings account (MSA), the coverage provider is the employer. For all other types of applicable coverage, the coverage provider is defined as “the person who administers the plan benefits.” The term “person who administers the plan benefits” is not used elsewhere in the Code or the ACA. As a result, the IRS is considering two approaches to defining this term. Notice 2015-52 outlines these approaches.

First Approach: Under the first approach, the “person who administers the plan benefits” would be the person responsible for performing the day-to-day functions that constitute the administration of plan benefits, such as receiving and processing claims for benefits, responding to inquiries or providing a technology platform for benefits information. The IRS anticipates that this person generally would be a third-party administrator for self-insured benefits.

Second Approach: Under the second approach, the “person who administers the plan benefits” would be the person who has the ultimate authority or responsibility under the plan or arrangement with respect to the administration of the plan benefits. The IRS anticipates that this person would be identified in the applicable plan documents and would not likely be the person who performs the routine administrative functions of the plan. This would likely be the “Plan Administrator” or its delegate for ERISA-covered plans.

How Are Employers Aggregated for Purposes of the Cadillac Tax?

Employers aggregated under the Internal Revenue Code’s controlled group and affiliated service group rules – Code Section 414(b), (c), (m) or (o) – are treated as a single employer for purposes of the Cadillac Tax. In addition, there is a special rule for multi-employer plans. The plan sponsor of a multi-employer plan (as defined in Section 414(f)) is responsible for making the calculations and for providing the notice.

The IRS requests comments on the application of these aggregation rules to the following:

- Identification of the applicable coverage taken into account as made available by an employer
- Identification of the employees taken into account for the age and gender adjustment, and the adjustment for employees in high-risk professions, such as employees who repair and install electrical or telecommunication lines
- Identification of the taxpayer responsible for calculating and reporting the excess benefit
Identification of the employer liable for any penalty for failure to properly calculate the Cadillac Tax

**Taxable Period**

The Cadillac Tax imposes a 40 percent penalty on any “excess benefit” provided to an employee for any taxable period. An “excess benefit” is defined as the excess of the aggregate cost of applicable coverage over the annual applicable dollar limit for an employee. The applicable dollar limit for high-cost plans is currently $10,200 for individual coverage and $27,500 for family coverage. These dollar limits will be updated for 2018 when final regulations are issued and thereafter indexed for inflation in future years. The IRS anticipates that the “taxable period” will be the calendar year for all taxpayers; however, the regulations provide that the “taxable period” can be a shorter period as prescribed by the Secretary, and permit the Secretary to prescribe different taxable periods for employers of varying sizes.

In order to determine the amount of tax owed for a taxable period, the employer must determine the extent any applicable coverage exceeded the dollar limit in a given month. The employer then must notify both the IRS and the coverage provider, and the coverage provider then must pay the tax. As a result, employers will need to determine the amount of tax soon after the close of the taxable year so that coverage providers may pay the tax in a reasonably timely manner.

The IRS anticipates a host of timing issues to arise for different fully insured and self-insured plan structures, and requests comments on any such issues.

**Calculating the Cost**

The cost of the applicable coverage is to be determined using rules “similar to the rules of section 4980B(f)(4)” regarding the determination of the COBRA applicable premium. The IRS has invited comments on potential approaches to determine the cost of applicable coverage. The U.S. Department of the Treasury and the IRS also have asked for comments on any issues raised by the anticipated need to determine the cost of applicable coverage for a taxable period reasonably soon after the end of that taxable period.

While the coverage provider will pay the Cadillac Tax for fully insured coverage, the IRS anticipates that the cost of the tax will be passed through to the employer. Additionally, because the Cadillac Tax is not deductible, any reimbursement received by the coverage provider from the employer will be additional taxable income to the coverage provider. As a result, it is likely that a coverage provider will pass along both the Cadillac Tax reimbursement and the additional income tax (the “income tax reimbursement”) to the employer. While the Cadillac Tax reimbursement will be excluded for purposes of determining the cost of applicable coverage, the Code is not clear on whether to recognize the income tax reimbursement. The IRS is still considering whether this reimbursement should be excluded as well. However, Treasury and IRS are concerned that a methodology for excluding an income tax reimbursement may not be administrable, given the potential variability of tax rates and other factors among different coverage providers, as well as potential difficulties in determining and excluding the reimbursement amount. Nonetheless, comments are requested on administrable methods for exclusion of the income tax reimbursement.

**Contributions to HSAs, Archer MSAs, FSAs and HRAs**

Account-based plans, such as HSAs, Archer MSAs, Flexible Spending Accounts (FSAs) and Health Reimbursement Arrangements (HRAs), pose a unique problem because contributions to such accounts may be difficult to track. The IRS is considering an approach under which contributions to account-based plans would be allocated on a pro rata basis over the period to which the contribution relates (generally the plan year), regardless of the timing of the contributions.
Age and Gender Adjustment to the Dollar Limit

As described previously, the dollar limit that determines the onset of the Cadillac Tax for 2018 is $10,200 for self-only coverage and $27,500 for anything other than self-only coverage. However, these limits may be increased based on the age and gender characteristics of a particular workforce. The IRS is considering using the Current Population Survey (Table A-8a), Employed Persons and Employment-Population Ratios by Age and Sex, Seasonally Adjusted (Table A-8a), published annually by the U.S. Department of Labor Bureau of Labor Statistics.

In order to determine the age and gender characteristics of an employer’s population, the IRS is considering requiring an employer to determine the age and gender of each employee as of the first day of the plan year for purposes of determining the population for the entirety of the year.

Notice and Payment of the Tax

In addition to calculating the tax, employers must notify the IRS and each coverage provider of the amount. The IRS is considering the form and deadline of this notice. The IRS is also considering how calculation errors may affect both notice and payment of the tax.

HSAs SURGE, LEAVING HRAs IN A NICHE

By Jan Greene
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Health reimbursement arrangements (HRAs) have fewer rules, but health savings accounts (HSAs) create more of an incentive to shop for health care.

The increasing popularity of account-based health plans poses a problem for anyone in the position of having to explain what they are and how they differ. The two main versions, the health savings account (HSA) and health reimbursement arrangement (HRA), have similar acronyms and get lumped together in surveys. But they are really quite different.

Jay Savan, a consultant for Mercer, runs into this problem all the time. So he’s taken to using a breakfast-related analogy to explain the difference: “They are like bagels and donuts. They may appear outwardly similar, but when you bite into them they are different.”

Employers – particularly the larger ones – are snacking on HSAs and HRAs as never before – especially HSAs. Mercer’s 2014 employer survey showed 41% of employers offering an account-based plan to their employees, up from 32% the year before. The preference among large employers is even stronger: 85% of the large companies surveyed by the National Business Group on Health earlier this year are offering HSAs (the savings account is provided along with a high-deductible health plan).

The trend is expected to continue in the next few years as employers seek to keep a lid on health care spending by turning to account-based plans (the term “consumer-directed health plan” is also used). They cost employers 18% less than a PPO and 20% less than an HMO, according to Mercer’s 2014 numbers.

An HRA is funded completely by the employer; the money it sets aside can be withdrawn to cover deductibles, copays, and other out-of-pocket expenses. Employees don’t contribute to their HRAs, and typically they don’t take any of the money with them if they leave the company. In the Mercer
survey, the median employer contribution to an HRA was $750 for an individual plan and the average in-network deductible was $1,500. Because the money can be rolled over, employees can accumulate enough money in their HRAs to cover their entire deductible. That possibility tends to operate as a disincentive to run through money that comes from the employer.

The HSA is used to cover similar expenses, but it is funded largely by the employee, to whom it belongs. Some employers make arrangements for their employees to fund their HSAs through payroll deductions. It’s a tax-free account that can be maintained throughout life. Some people even use their HSA as part of retirement planning.

Because HSAs are tax-free, the IRS regulates the design of the health plans that go along with them, so there’s minimum deductibles and out-of-pocket limits. (For 2015, the minimum deductible is $1,300 for an individual and $2,600 for a family; the maximum out-of-pocket is $6,450 individual and $12,900 family; and the contribution limit is $3,350 individual and $6,650 family.)

Health plans packaged with HRAs are not subject to the same rules, so there’s much more flexibility. They needn’t have a high deductible, and employers are free to add some bells and whistles to make them attractive alternatives to more expensive HMO or PPO plans.

The HRA concept was in use by big employers for decades before the IRS formally recognized it in 2002. Employers used HRAs to shield their employees from medical costs not covered by their health insurance. HRAs, never hugely popular, were more so in the aughts, but stalled out by the end of the decade. According to the Kaiser Family Foundation Employer Benefits Survey, just 4% of companies offered HRAs in 2014, compared with 7% three years earlier.

The HSA, on the other hand, has seen the number of companies offering the accounts more than double to 30 million by 2017. The bump gets its bounce, in part, from employers turning to the combination of high-deductible health plans and HSAs to avoid triggering the ACA’s excise tax on expensive health plans (the so-called Cadillac tax), scheduled to go into effect in 2018. The less employers spend on an employee’s health benefits, the less likely they’ll pay the tax, and high-deductible plans are cheaper.

Very few employers – about 4% of large employers, according to the Mercer survey – offer both an HRA and an HSA. The number is small mostly because it’s too difficult to educate employees about the differences between HRAs and HSAs, says Mercer’s Savan. His advice is to pick one and, perhaps, add the other variety once participants are grounded in the concept, he says. “Getting people to understand the subtle differences between the two can be a real challenge – particularly when introduced simultaneously.”

HRAs are also losing out to HSAs as part of a larger trend of employers offering their employees fewer health benefit choices. Yesterday’s benefit smorgasbords often had an HMO, PPO, an indemnity plan and perhaps an HSA or an HRA. They’re being replaced by offerings of just one or two plan options and, most likely, an HSA not an HRA.

Meanwhile, the HRA isn’t likely to go away. Julie Stone, a senior consultant for Towers Watson, sees the HRA continuing to offer value as HMOs and point of service plans lose market share, at least in the near term. “There’s often a transition stage to an HRA on the way to an HSA,” she says. “They will be around and add value in the short- to medium-term, but we see more movement to other plan options.”

Paul Fronstin, PhD, a top official at EBRI, sees the HRA continuing to fill a niche for employers that want to use it for flexibility in plan design. “I don’t think it will disappear, but it may decline,” he says. “At this point, employers have had 10 years to switch from HRA plans to HSAs, and for the most part they haven’t.” Employers that want flexibility in plan design will likely
continue to use the HRA, benefits advisers say.

“The HRA plans tend to be more costly, but very accommodating from a plan perspective,” says Savan. “They allow you to do things HSA-compatible plans don’t.”
2. This Year’s Reporting of Your Health Care Expenditures

QUINLAN: For nearly seven decades, employer-based coverage has been a cornerstone of the United States health care system. At the same time, health care benefits have long been a core component of the total rewards that companies use to attract and retain talent. But the American health insurance system – and, probably, your own company’s health care – will continue to undergo changes this year, reflecting the new compliance responsibilities under the Affordable Care Act.

Not only will accountants and financial executives be concerned with their information reporting requirements, but they will also face a wider range of interrelated considerations: should the business continue to offer employee health insurance at all; should active employees or retirees be “transitioned” to private health insurance exchanges; how much should be invested in health improvement and wellness programs; and what is the risk from the forty-percent excise tax, known as the Cadillac tax?

SURRAN: Of course, in recent years, the impact of legislative and regulatory developments on employer-sponsored health care plans and compliance has been never-ending. Bringing us up-to-date is Dorian Smith, an attorney and partner with Mercer, who monitors and analyzes the ongoing effects of health care-related developments for their Washington Resource Group. Thanks for joining us this month, Dorian.

SMITH: My pleasure, Becky.

SURRAN: We’ve heard, every year since the enactment of the Affordable Care Act, that “this is the year” when employers must pay attention to – and must implement – health care reform. From your perspective, Dorian, is this really the year that everything is ready to be put into effect?

SMITH: This is definitely a big year. This is the year that, effective 1/1/2015, the Employer Shared Responsibility Mandate came into play, which means that large employers need to offer their full-time employees a certain level of coverage at an affordable value or potentially pay penalties to the government.

Also, this is the year that employers are going to be required to start tracking the hours of their employees because there is this voluminous reporting, Becky, that you may have heard of, that is going to be first due to employees and the IRS early in 2016, based on the 2015 data, the 2015 health plans and the 2015 employees’ hours.

SURRAN: Thanks, Dorian. We’ll return to your commentary in a minute.

QUINLAN: The good news is that the Affordable Care Act does not require businesses to provide health benefits to their workers. But the not-so-good news is that large employers may face penalties, if they don’t make affordable health coverage available to their workforce. Specifically, the employer shared responsibility provision of the Affordable Care Act penalizes so-called “applicable large employers” who either do not offer coverage to their employees or who do not offer health coverage that meets minimum value and affordability standards.

You may recall that, for 2015, there is transition relief from the penalty for those businesses that employed between fifty and 100 full-time equivalent employees during 2014. However, to be eligible for relief, the employer:
One, cannot have reduced the size of its workforce or the overall hours of service of its employees;

Two, cannot have eliminated or materially reduced the health coverage it offers; and

Three, must have employed, on average, at least fifty full-time employees, but fewer than 100 full-time employees, during 2014.

You may recall that employees are considered full-time for a calendar month if they average at least thirty hours of service per week or 130 hours of service per month.

QUINLAN: Generally, in 2015, an applicable large employer will be subject to a shared responsibility payment once at least one full-time employee receives a premium tax credit and: A) the employer offers health insurance coverage that is not affordable or does not meet the minimum value standards. In this case, the penalty is three thousand dollars for each employee who opts out of the employer’s coverage and obtains their health insurance through an exchange, where they are eligible for a premium tax credit.

B) the employer does not offer health insurance coverage to at least seventy percent of their employees. Here, the penalty is essentially calculated at two thousand dollars per employee.

SURRAN: Since the Supreme Court’s decision earlier this year, there really isn’t any doubt that the so-called employer-shared responsibilities will be in effect. Since I’ve heard that mandate is also called “play-or-pay,” how do we play and when do we pay?

SMITH: That is a good question, Becky. What “play-or-pay” means is that large employers – and when I say large employers, I mean employers with 50 or more full time employees in the prior year, which includes full-time equivalent employees – need to, or have an interest in offering, their full-time employees affordable, minimum value coverage, and that would be playing. If they do not do that, they are exposed to potential assessments, and that is the pay part of the “play-or-pay.”

There are obviously a lot of rules and details behind all of what I have just said. But that is the very basic high-level of what a “play-or-pay” is.

SURRAN: What you said makes sense, Dorian. Even to me. But remind me: isn’t there also an additional penalty when a full-time employee is offered coverage that is not affordable? What happens when that employee then decides to purchase coverage through an exchange, where he or she qualifies for a premium tax credit?

SMITH: That is a good question, Becky. The first thing you have to understand is that the employees that we really care about for this purpose are full-time employees. That is an employee who works, on average, 30 hours per week or 130 hours per month. There are a variety of different ways on how you measure employees’ hours.

Your full time employees are those who, if you do not offer them affordable minimum-value coverage and they go to a public exchange and receive a subsidy or federal monies to help them pay for that individual coverage, could trigger a $3,000, or pro-rata share of the $3,000 penalty, for the employer.

SURRAN: Okay, but what about those employers who choose not to “play.” How much will they be expected to pay for the “privilege” of not offering health insurance to seventy percent of their employees?
SMITH: Becky, that is a choice. Employers can decide that they do not want to be in the game of health coverage anymore, that there are other options out there. If a large employer decides that it no longer wants to offer health coverage to its employees, or specifically, does not offer coverage to a requisite percentage of its full time employees, then that employer could potentially be on the hook for a $2,000 penalty times all of its full time employees, minus a handful. This is at a high level, Becky, but there are a lot of rules behind what I just said.

SURRAN: Let’s make sure I understand, Dorian. Isn’t there a difference – at least, for 2015 – between those companies with one hundred or more full-time employees and those with between fifty and ninety-nine full-time equivalents?

SMITH: You have been doing your homework, Becky. There is. For this first year in 2015, from a substantive perspective, employers with 50 to 99 full time employees get a pass from any penalties. So, those employers do not have to offer affordable minimum value coverage to their full time employees in 2015. They get a pass until 2016. However, those employers – with 50 to 99 employees – still are responsible for reporting. So, those employers still have work to do.

They have to measure the hours of their employees. They have to issue reports to the IRS and to the employees early in 2016. So, they are not out of the soup. They are just out of the penalty.

SURRAN: I know that, at one time you served as an attorney at the Department of Labor. Wasn’t there an expression – from ERISA – involving “controlled and affiliated service groups”? So, what happens – in the health care world – when you’ve got a number of businesses with fifty employees, but they’ve all got some degree of common ownership?

SMITH: Well, Becky, this is actually a pretty complicated question that you are asking me. To try and boil it down, this is really an IRS rule. There is an IRS concept of a controlled group of corporations. What that means, from a very high level, is that you have a parent company that may own 80% of a subsidiary, so they are part of a controlled group. There are other concepts of brother-sister corporations. What I think you are getting at is that, to determine whether or not you are a large employer – again, whether you have 50 or more full-time or full-time equivalents or 100 full-time or full-time equivalents – you take a look at all of the different employers within that controlled group.

You add up the employees, and if they aggregate to over 50 – either full-time or full-time equivalents – then every single employer within that controlled group is subject to “play-or-pay” and to reporting, even the ones that have less than 50 full-time employees.

SURRAN: For many businesses, it is not just meeting the new “pay-or-play” requirement that’s so difficult. It’s also the information reporting that’s now required. As you mentioned, the first reports for the 2015 calendar year are due in early 2016, aren’t they?

SMITH: They are, and this is something that employers are really struggling with. These reports are form 1095-C and form 1094-C that employers are required to complete and send to their full-time employees, and to any employees covered under a self-insured health plan, by February 1st, 2016, based on the 2015 calendar year. In addition, employers are required to send these reports to the IRS, along with another report that tells the IRS about information regarding their play-or-pay compliance or
lack thereof, generally by March 31st, 2016, or by February 29th if that employer happens to file by paper.

**SURRAN:** You know our viewers: corporate financial executives. They work closely with – and sometimes supervise – the payroll function, the tax group and the HR staff. How do you decide who’s responsible for issuing Forms 1094 and 1095?

**SMITH:** That is a great question, Becky. When this rolled out, you saw a lot of different units in a corporation pointing at each other, saying, “You take control,” whether it was the tax department or the finance department or HR.

I view this as more of a benefits issue. Even though this is a tax form, it is reporting information about people’s coverage: about the affordability of coverage and about whether they were offered coverage.

But it also involves counting hours. Even if somebody was not offered coverage, you need to know if they were a full-time employee. That may not necessarily be in the benefits department. That may be in a separate HR department. You may need to take into account somebody’s FMLA hours. You need to know whether somebody was covered under a plan, and that will be in the benefits department or with an insurer.

There are a lot of departments that are going to need to work together in order to complete all of the necessary information on these new forms.

I have been telling my clients that, if they have not started this already, this is really the time that they need to accumulate that data, understand where that data is, and get a vendor if they have not already secured a vendor to help them with this. A lot of my clients are using third party vendors.

But really, there is no more time to delay on this one. The reports are due February 1st. While there may be an opportunity to get some sort of extension, it is certainly far from a certainty at this point in time.

**SURRAN:** I don’t want to get too far into the “weeds,” Dorian, but can you remind me: what are the forms that employers should be issuing, starting this year?

**SMITH:** So, the two forms that are most relevant for employers are the 1094-C and the 1095-C. The employees that get a 1095-C fall into two buckets.

It is, one, any employee who was a full-time employee, under ACA rules, for at least one month in 2015. Then two, any employee who is covered under an employer’s self-insured health plan for at least one month of the year, even if they were not a full time employee.

Those two groups of employees are going to intersect in many instances. But you could have some non-ACA full-time employees who are covered under a self-insured health plan who need to receive a 1095-C. Also you could have some full-time employees who are not covered under any plan, but also need to receive a 1095-C.

**SURRAN:** Besides Form 1095, you also mentioned Form 1094. How is that different?

**SMITH:** The Form 1094-C is a report that goes to the IRS, a transmittal report that is due to the IRS generally by March 31st for electronic filers or February 29th for paper filers. That report attaches a copy of all of those 1095-Cs that you sent to employees.
It sends a copy to the IRS, sort of like a batch W-2. It also provides the IRS with some additional information regarding the employer’s “play-or-pay” compliance, or lack thereof.

SURRAN: Okay, but what about those companies that self-fund their insurance as opposed to using a third-party? Are there special reporting rules for them?

SMITH: Well, Becky, as I mentioned, the reporting rules are the same, except for those who self-fund. They may actually have more reports to do than your fully insured counterparts because, like I said, they do have to report on the coverage for any individual employee, retiree, or spouse who is covered under their self-insured health plan for at least one month in 2015.

SURRAN: Did you happen to notice, Dorian, that recently enacted legislation significantly increased the penalties for incorrect or incomplete information returns? I assume these new penalty amounts apply to health care payee statements, too.

SMITH: They do. Earlier this year, as part of the legislation that was enacted, the government increased the penalties from $100 to $250 per form, with caps at $1.5 million now to $3 million dollars, for incorrect or missing forms. That includes the two new 1095-Cs and 1094-Cs.

But there is some good news here, Becky. For this first year, as long as employers make a good faith, reasonable effort to comply with reporting, and they file in a timely manner, there will not be assessments for any errors or omissions of these reports.

Again, importantly, employers cannot blow off this reporting. They have to do it, and have to do it on a timely basis. They just do not need to be so concerned about the one-off errors that might occur because penalties are waived for this first year.

SURRAN: Another provision that was included in the budget legislation was the repeal of the automatic enrollment provisions for health plans. Since I don’t know any companies that have installed these provisions, tell me: what impact, if any, will the repeal have on our viewers and their health plans?

SMITH: You are right, Becky. In fact, just recently, the Budget Act that was signed into law repealed the never-implemented automatic enrollment provision under the ACA. I like to call it the “we never got to know you” provision. That provision required employers with 200 or more employees to automatically enroll their employees in a health plan or continue the enrollment of current enrollees. Because that provision did not take effect until the regulators issued regulations, and because the regulations never issued regulations, it has been sitting dormant. Well, now it is just gone. It has been written out of the law, and so we do not have to worry about monitoring that going forward.

That said, there still is automatic enrollment in 401K and other retirement plans. So, not to be confused with the repeal of the automatic enrollment for health plans, automatic enrollment for other types of qualified retirement plans is alive and well.

SURRAN: Speaking of recently enacted legislation, I saw that Congress passed – and President Obama signed – the Protecting Affordable Coverage for Employees Act. How does this PACE Act amend the definition of “small employers”?
SMITH: When the ACA was enacted, it proposed to change the rules for what was defined as a “small group” or a “large group.” By 2016, any employer with 100 or fewer employees was supposed to be in the small group market. That had some negative consequences for employers, particularly for employers between 50 and 100 employees, who used to be in the large group, and now they were going to be placed in the small group and had different rules that their plans had to abide by. This was increasing the cost of coverage in many instances.

Hopefully, what this PACE Act did is it allowed states to keep the definition of small group at 50 employees, and allows those employers with more than 50 to be in the large group.

But that is a state option. Some states have decided to expand their large group market, and we do not know if they are going to change it, such as New York. While other states may in fact keep their definition of small group from 1 to 50 or from 2 to 50, and allow those companies with above 50 employees to remain in the large group market which, from what I understand in speaking to clients, is going to be advantageous from a premium perspective.

SURRAN: Many of those small employers have historically provided some of their workers with employee-reimbursement plans. Those are no longer allowed, are they?

SMITH: Right; ever since 2014, the IRS has said “You no longer can provide your active employees with money to go out and purchase individual coverage.” That has been a result of the ACA and various ACA mandates. There was a delay for smaller employers and S corporations until June 30th of 2015, and even for some until the end of 2015. However, now that we are at the end of 2015, those employers as well are not allowed to provide their active employees with money to go to a public exchange and purchase coverage. That is a violation of various ACA provisions.

An employer cannot give active employees money to go to purchase public exchange health coverage. On the other hand, for retirees, an employer could set up a retiree-only HRA, which can reimburse pre-65 retirees for the cost of their health coverage that they purchase in the individual marketplace.

There is an important distinction you have to realize. Retiree-only HRA is permissible under the ACA, but a standalone HRA – or monies to purchase individual coverage for active employees – is not.

SURRAN: Many companies are so overwhelmed by the employer mandate and by their information reporting responsibilities that they may not have looked at the fine print. For example, aren’t there also new rules – and cost-sharing limits – for the annual out-of-pocket maximum amount under a group health plan?

SMITH: There are, Becky. As part of the ACA, there is a provision that limited the out-of-pocket expenses that could be incurred by an individual. When I talk about out-of-pocket expenses, what I am referring to are deductibles, co-insurance, and co-pay on an in-network basis. The ACA set certain limits on that. Now, this has been in place since 2014, but there has been a tweak to this rule effective in 2016. To explain it, at a somewhat high level:
For family coverage, there may need to be an embedded individual out-of-pocket maximum that does not exceed the threshold for individual out of pocket max which, I believe, in 2016 is $6,850.

Plans that have family out-of-pocket maximums that exceed $6,850 for in-network coverage are going to need to make some decisions on how to rectify that, in order to comply with this new out-of-pocket maximum provision.

SURRAN: And presumably there is still the alphabet soup of so-called federal group health plan mandates – everything from COBRA and HIPAA to GINA and Michelle’s Law, right?

SMITH: The ACA has not replaced COBRA or ERISA or the Internal Revenue Code or that alphabet soup of regulatory or statutory mandates.

QUINLAN: Just when you thought it was “safe to go in the water,” there’s a looming threat to compliance with the Affordable Care Act when the so-called “Cadillac tax” goes into effect.

Under the ACA, certain employer-sponsored coverage will incur a non-deductible, forty percent excise tax – beginning in 2018 – on the cost of employer-sponsored coverage over a threshold amount. According to early indications, the thresholds for 2018 are likely to be $10,200 for single coverage and $27,500 for family coverage.

As you might expect, the Cadillac tax is most likely to be incurred by organizations with historically generous health benefits packages and by those businesses with less healthy or older populations, as well as companies with operations in geographic areas with high health care costs.

SURRAN: For years, Dorian, I’ve heard about an upcoming, forty percent nondeductible excise tax on high-cost health plans, known as the Cadillac tax. All of a sudden, 2018 is really right around the corner, isn’t it?

SMITH: Becky, you are absolutely right. Not only would financial executives consider this, they are doing this. There is no doubt that if an employer has modeled out their plans to 2018, and realized that their plans are going to hit or exceed the thresholds, the threshold being $10,200 dollars for single coverage and $27,500 dollars for other-than-self-only coverage, with certain additional adjustments.

If they have modeled that out to have their plans exceed, they are doing whatever they can today in order to make sure that those plans do not trigger any sort of excise tax.
SURRAN: For a couple of years, Dorian, advisers from your firm recommended that our viewers consider updating the health savings accounts that they offer. But isn’t it possible that a well-funded HSA plan could actually trigger the Cadillac tax?

SMITH: Becky, you are absolutely right. While the underlying health plan – the high-deductible health plan – is a good type of plan vis-à-vis the excise tax, because the underlying plan itself has a lower value than a rich PPO plan or a rich HMO plan, in certain instances the monies in the HSA will accumulate toward the excise tax. Which monies accumulate? Any employer contributions to that HSA, such as a seed contribution or a wellness incentive contribution or a matching contribution, will accumulate toward the excise tax, and, based on what we know today, any employee pre-tax contributions to that HSA will also accumulate. When I say that, I mean pre-tax being made through the employer’s cafeteria plan, those also will accumulate to the excise tax. Now, it could be that some legislation or changes to the law at least exclude the employee pre-tax contributions. But as of today, that is not the case. So, employers are really going to think about, “what are they going to do in the future,” to the extent that they offer these plans, but still want to make sure that monies in that HSA are not accumulating toward that excise tax calculation.

SURRAN: I guess cost considerations aren’t only about the Cadillac tax, is it? I’ve heard about employers who no longer offer medical coverage to their pre-65 retirees. In some cases, doesn’t it make sense to send those retirees to the exchanges, where they may qualify for premium subsidies without triggering penalties for the employer?

SMITH: That’s a great question, Becky, and that is really a matter of corporate culture. Some employers may decide that: “Yes, there is now a viable individual marketplace out there, where pre-65s can go get individual coverage, not be medically underwritten, may actually have subsidies available to them based on where they live and based on their household income. So, that may present a better opportunity than they’ve ever had.” On the other hand, some employers may feel that they want to stay in the game, and want to continue offering their pre-65 retirees health coverage, because they feel like it is the right thing to do. They are not comfortable yet sending out their pre-65 retirees to a marketplace that is still in its infancy stage. I mean, it has only been two or three years now that the exchanges are up and running, and there are some pitfalls with exchange coverage that we all know about, narrow networks. Some employers have not decided to completely pull the plug on their pre-65 retiree programs.

The third option is that some employers have decided that they are going to send their employee pre-65s to the exchange, but they are going to give them some money to do that. They are going to seed retiree HRAs, which will allow those retirees to take some employer money and purchase coverage in the exchange. But realize: doing that may jeopardize the retiree’s ability to also get subsidized coverage from the government.

SURRAN: I suppose if you’re “counting heads,” Dorian, for purposes of reinsurance and PCORI fees, then you’d also consider whether to offer coverage to spouses, wouldn’t you?

SMITH: Well, Becky that is an interesting way of looking at it. I would say that certainly employers are looking at whether or not to continue offering coverage to spouses. Or if they do continue to offer coverage, whether they will impose a spousal surcharge. So, that if that spouse has access to
coverage at their employer, if they want to join the employee’s plan it will cost extra.

I am not so sure that decision is necessarily driven by the PCORI fee or the transitional reinsurance fee, but it is definitely being driven by cost. Incidentally, getting back to something we were discussing earlier, Becky, under the “play-or-pay” rules, the requirement is that the employer offer minimum essential coverage to the employee and their children to the end of the year in which they turn age 26. There is no requirement to offer coverage to spouses.

So, if an employer decided to completely pull the plug on offering coverage to spouses, that does not present any exposure under the “play-or-pay” rules.

Surran: Since we’re discussing costs, I know – on the one hand – some companies are providing so-called wellness benefits to their employees. But on the other hand, there’s certainly a cost associated with providing those benefits, isn’t there?

Smith: There is. Wellness is a very hot topic. As I like to say, “If you’ve seen one wellness program, then you’ve seen one wellness program.” There are pros and cons to wellness programs. The cons, as you mentioned, is that there is an upfront cost to them: a new investment in them; figuring out what you want to offer; and, certainly, the incentives that you might want to offer. So, you’re putting in something upfront.

The benefit for these wellness programs, one, is that there is a potential for a nice return on investment. Some companies have seen this return on investment, while some are still waiting. But that is the goal that these wellness activities are going to get the employee population healthier which will ultimately reduce the cost of medical plan coverage. In addition, wellness is a nice thing to have.

Some employers may find that giving their employees access to a wellness program is just a nice thing to do, and it makes the employees feel like they are at a place they want to be.

Surran: As you’d expect, our viewers – as stewards of their companies’ assets – have been concerned for many years about the increased costs associated with compliance, as well as with coverage, in the health insurance sector. Since you brought your crystal ball with you, Dorian, tell me: are we in for any relief?

Smith: Becky, I wish I could tell you with some certainty. But my guess is that we are not in for any relief. I think that compliance is here to stay, while “play-or-pay” goes and becomes more of a rote activity and reporting comes and goes. I mean, it is not going to go away, but it will become like other things, like W-2 reporting, and employers will get used to it.

But it is sort of like “whack-a-mole.” We would knock that one down and what is going to pop up? Well, you know what might pop up? Figuring out excise tax exposure. That is going to be a big deal over the next two or three years. There are these non-discrimination rules that are in the pipeline, which may require employers to start taking a look at whether their fully-insured plans are compliant with non-discrimination rules.

To date, fully-insured plans have not needed to be compliant with non-discrimination rules in the same way that self-insured health plans do. There are cafeteria plan non-discrimination rules that have been sitting dormant since August 2007. Eventually, those are going to become finalized. While we think we are over most of the big humps from the
ACA perspective, I do know for certain that we have more compliance in the future.

SURRAN: Well, you’ve certainly covered a wide range of topics for us, Dorian. If our viewers could take one thought away from this discussion, what would you like that to be?

SMITH: I am glad you asked me that, Becky. I think the one thing I would want employers to take away is that, while there are a lot of compliance obstacles to overcome, compliance obstacles should not get in the way of an employer’s decision to continue to offer benefits to employees because, as we know, employers reap a benefit from that and employees reap a benefit from that.

SURRAN: Mercer’s Dorian Smith, thanks for bringing us up-to-date.

SMITH: Well, Becky, thank you for allowing me to be here.