Affordable Care Act – Practical Application

Since passage of the health care reform bill, the *Patient Protection and Affordable Care Act* (ACA), in March, 2010, there has been a great deal of confusion for NAIFA members, business owners, employees, and consumers as to what the law means to them. With new regulations and provisions of the law coming into effect continually, including many critical portions having come into effect in January, 2014, this practical application guide seeks to address some of those new roles, expectations, and requirements. While many portions are already in effect, and some temporary provisions have already phased in or out, this guide largely addresses important topics set to take effect in the coming months.

Topics addressed in this practical application guide are as follows:

- Insurance Market Reforms
- Temporary Programs
- HSAs, FSA, HRAs & MSAs
- Essential Health Benefits
- Exchanges (Marketplaces)
- Guaranteed Coverage
- Personal Coverage Requirement
- Medical Loss Ratio
- Medicare and Medicare Advantage
- Employers Roles and Requirements
- Taxes and Fees

Insurance Market Reforms

1. **Q: IS IT TRUE THAT PLANS ARE PROHIBITED FROM RESCINDING POLICIES?**

A: Yes–group health plans and individual health policy rescissions (the retroactive cancellation or discontinuation of coverage) are prohibited, except in cases involving fraud or intentional misrepresentation of a material fact, effective for plan years which began on or after September 23, 2010.

2. **Q: IS NON-PAYMENT A RESCISSION?**

A: A cancellation or discontinuance of coverage is not a rescission if the cancellation or discontinuance of coverage has only a prospective effect; or if effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage. While non-payment is not a rescission, it is an allowable reason for retroactive cancellation.

3. **Q: WHAT TYPE OF RESCISSION NOTICE IS REQUIRED?**

A: In situations in which rescission would be allowed, group health plans or insurers would have to notify participants 30 days in advance.

4. **Q: ARE THERE RULES REGARDING HIGHLY COMPENSATED EMPLOYEES?**

A: Yes—the ACA requires all group health plans to comply with the Internal Revenue Code (IRC) section 105(h) rules (self-insurance plans) that prohibit discrimination in favor of highly compensated employees (HCE). However, the implementation of this provision has been delayed until regulatory guidance is released. An HCE is defined as one of the five highest paid officers of a company, is a shareholder of more than 10% of a

company's stock (with the application of attribution under section 318), or is one of the highest paid 25% of all of a company's employees. Discrimination in favor of a company's HCEs is prohibited under insured plans.

5. Q: WHAT ARE THE PENALTIES FOR NON-COMPLIANCE WITH HCE RULES?

A: Upon final implementation, plans found to be discriminating in favor of HCEs can lose tax-exempt status, face fines of $100 per day for time of non-compliance, and face additional civil penalties.

6. Q: WHAT ARE THE NEW RATING RULES?

A: Effective in 2014, no rating based on health or gender will be permitted. There is a 3:1 rating (pricing) ratio for age, and 1.5:1 for tobacco use.

7. Q: ARE WAITING PERIODS FOR COVERAGE ALLOWED?

A: The ACA eliminates waiting periods greater than 90 days beginning in 2014.

8. Q: WHAT IS A GRANDFATHERED PLAN?

A: To be a grandfathered health plan, a group health plan or an individual coverage must have been in effect on March 23, 2010, the date of enactment. In general, the ACA allows a grandfathered plan to continue its normal operations without losing its grandfathered status. New employees may enroll in a grandfathered plan, and current participants may reenroll or change coverage to add dependents to the health plan.

There are additional rules governing grandfathered plans that can be found at http://www.healthcare.gov/law/features/rights/grandfathered-plans/.

9. Q: WHAT IS THE CO-OP?

A: The ACA provided for the creation of the Consumer Operated and Oriented Plan (CO-OP) Program to enable nonprofit, member-run health insurance companies. There originally was $6 billion set to be allocated in federal loans to finance the program awarded by 2013. However, that number was cut to $3.4 billion in 2011 during Congressional budget negotiations. Moreover, further negotiations in January, 2013 have prevented the approval of further co-ops beyond the 24 that were already approved in some states. The CO-OP must meet state solvency and consumer protection standards.

10. Q: ARE THERE CHANGES TO THE LIMITS ON DEDUCTIBLES OR COST-SHARING?

A: Yes–for small employer plans, individuals will be limited to $2,000 annually on deductibles, and family plans will be limited to $4,000. There will be out-of-pocket total cost-sharing maximums for non-grandfathered plans, capped at HSA-qualified high-deductible health plan (HDHP) levels – or $6,350 for individuals and $12,700 for families. This provision was supposed to have begun in January, 2014, but has now been delayed until 2015.

11. Q: DO DEDUCTIBLE AND OUT-OF-POCKET COST SHARING LIMITS ALSO HAVE TO APPLY TO OUT-OF-NETWORK BENEFITS?

A: No–the values paid by enrollees for out-of-network services do not count toward deductible and out-of-pocket limits.

12. Q: I HEARD THE PRESIDENT TOLD INSURERS NOT TO CANCEL PLANS. DOES THAT MEAN I CAN KEEP MY POLICY AFTER ALL?

A: Maybe–the Administration announced that insurers had the option to renew existing plans, even those expiring sometime in calendar year 2014, for one more year. And the Administration told state regulators they had the option to allow plans to take that step. It's entirely at the discretion of the insurers and the state authorities. Some plans, like Florida Blue, have announced they will be offering customers the right to renew expiring policies. Others might not. Some commissioners will renew the expiring plans, but the state insurance commissioner of some states – including Washington, New York, Massachusetts, Minnesota, Arkansas, and Rhode Island – have already said insurers can't renew plans expiring after December unless those plans qualify for the law's original "grandfather" clause.

Temporary Programs

13. Q: WHAT IS THE PRE-EXISTING CONDITION INSURANCE PLAN (PCIP)?

A: The ACA prohibits denying coverage for individuals due to pre-existing conditions. However, since that provision does not take effect until January, 2014, the ACA established PCIP, a temporary public option plan, administered by the federal government and some states, that began covering individuals with pre-existing conditions beginning in August, 2010. In February, 2013, PCIP stopped accepting new applicants, and will begin migrating state enrollees to the federal program in July, 2013. PCIP was slated to end in January, 2014, once the permanent pre-existing condition provision took effect, however that phase out was delayed until March, 2014.

14. Q: WHAT IS THE EARLY RETIREE REINSURANCE PROGRAM (ERRP)?

A: Like PCIP, ERRP is a temporary program designed to fulfill the ACA's goals prior to the exchanges offering coverage in January, 2014. ERRP offers partial premium reimbursement to employers who continue to cover early retirees between the ages of 55-64 who are not yet eligible for Medicare. Although the $5 billion authorized for ERRP was dispersed by December, 2011, the program officially ended January, 2014.

HSAs, FSA, HRAs & MSAs

15. Q: ARE THERE CHANGES TO HEALTH SAVINGS ACCOUNT (HSA) DISTRIBUTIONS?

A: Account holders can no longer use Flexible Spending Account (FSA), HSA, Health Reimbursement Arrangements (HRA), and Archer Medical Savings Account (MSA) distributions for over the counter (non-prescription) medicines.

16. Q: DOES THE RESTRICTION ON ANNUAL DOLLAR CONTRIBUTION LIMITS APPLY TO HEALTH FLEXIBLE SPENDING ARRANGEMENTS (FSAS)?

A: The annual limit rules do not apply to health FSAs. FSAs are specifically limited to $2500 (indexed for inflation) per year beginning with taxable years in 2013.

17. Q: DOES THE RESTRICTION ON ANNUAL DOLLAR LIMITS APPLY TO MEDICAL SAVINGS ACCOUNTS (MSAS) OR HEALTH SAVINGS ACCOUNTS (HSAS)?

A: The annual limit rules do not apply to MSAs or HSAs. Both MSAs and HSAs generally are not treated as group health plans because the amounts available under the plans are available for both medical and non-medical expenses. Also, annual contributions to these accounts are subject to specific statutory provisions that require that the contributions be limited.

18. Q: DOES THE RESTRICTION ON ANNUAL DOLLAR LIMITS APPLY TO HEALTH REIMBURSEMENT ARRANGEMENTS (HRAS)?

A: When HRAs are integrated with other qualified coverage as part of a group health plan and the other coverage alone would comply with the requirements, the fact that benefits under the HRA by itself are limited does not violate the restriction on annual limits because the combined benefit satisfies the requirement.

19. Q: IF AN EMPLOYER OFFERS EMPLOYEES AN HRA THAT ALLOWS THEM TO PURCHASE COVERAGE IN THE INDIVIDUAL EXCHANGE, WILL THE HRA BE CONSIDERED INTEGRATED WITH THAT INDIVIDUAL EXCHANGE COVERAGE, AND THUS SATISFY ANNUAL LIMIT REQUIREMENTS?

A: No–employer-sponsored HRAs cannot be integrated with individual exchange plans or other individual coverage plans without violating the prohibition on annual dollar limits.

20. Q: ARE THERE NEW PENALTIES FOR NON-QUALIFIED HSA DISTRIBUTIONS?

A: Yes–penalties for nonqualified HSA and Archer MSA distributions have doubled (to 20%).

Essential Health Benefits

21. Q: WHAT ARE ESSENTIAL HEALTH BENEFITS?

A: The ACA establishes ten required categorical areas of coverage. The Department of Health and Human Services (HHS) recently released guidance fleshing out these required coverage areas as well as other qualified health plan (QHP) requirements, such as minimum actuarial value and cost-sharing provisions, that establish the essential health benefits (EHB). The ten categorical areas are as follows:

- Ambulatory patient services;
- Emergency services;
- Hospitalization;
- Maternity and newborn care;
- Mental health and substance use disorder; services including behavioral health treatment;
- Prescription drugs;
- Rehabilitative and habilitative services and devices;
- Laboratory services;
- Preventative and wellness services and chronic disease management;
- Pediatric services including oral and vision care.

22. Q: ARE THERE ANY EXEMPTIONS FOR PROVIDING ESSENTIAL HEALTH BENEFITS?

A: Yes–in February, 2013, HHS issued regulations declaring that grandfathered plans, self-funded plans, and large group plans (100 individuals or larger) are exempt from meeting EHB requirements. Also, in November, 2013, President Obama allowed state regulators and insurers the option of continuing individual plans that do not meet EHB requirements for up to one year after January, 2014. Moreover, in February, 2014, a limited extension on allowing some small business plans to avoid penalties for not meeting EHBs was extended until January, 2016.

23. Q: WHAT ARE THE MINIMUM ACTUARIAL VALUE CATEGORIES?

A: There will be four benefit categories of plans plus a separate catastrophic plan to be offered through the exchange, and in the individual and small group markets. The out-of-pocket limit provisions on these plans have been delayed until 2015:

- The Bronze Plan is minimum creditable (qualifying) coverage. It must provide the essential health benefits laid out in the statute and further developed by regulations issued by HHS and the Department of Labor (DOL). It must cover 60% of the benefit costs of the plan, with an out-of-pocket limit equal to the Health Savings Account (HSA) current law limit ($6,350 for individuals and $12,700 for families).
- The Silver Plan must provide the essential health benefits, and cover 70% of the benefit costs of the plan, with the HSA out-of-pocket limits.
- The Gold Plan must provide the essential health benefits, and cover 80% of the benefit costs of the plan, with the HSA out-of-pocket limits.
- The Platinum Plan must provide the essential health benefits, and cover 90% of the benefit costs of the plan, with the HSA out-of-pocket limits.
- There is a catastrophic-only plan, called the “young invincibles” plan, available only to those up to age 30, or to those who are exempt from the mandate to purchase coverage. The young invincibles plan provides catastrophic coverage only with the coverage level set at the HSA current law levels except that prevention benefits and coverage for three primary care visits would be exempt from the deductible. This plan is only available in the individual market.

24. Q: HOW DO I DETERMINE IF MY PLAN MEETS THE MINIMUM VALUE (MV) OF AT LEAST 60%?

A: The IRS has allowed three possible ways to ensure that a plan meets MV, including:

- A MV Calculator for employers or self-funded plans, which can be found at: http://cciio.cms.gov/resources/regulations/index.html#pm;

- A straightforward safe harbor checklist that has yet to be released by the IRS. Plans that meet or exceed the safe harbors will be deemed to meet MV; and
- Obtaining actuarial certification.

Values that employers contribute to an employee's HSA are included in fulfilling a MV. Values made available for HRAs can also be used to fulfill MV requirements, so long as these values are used to cost-sharing purposes and do not pay down premiums. Most wellness plan incentives do not satisfy MV, except in the case of tobacco use reduction and prevention.

25. Q: HOW WILL STATE MANDATES FIGURE INTO COVERAGE IN THE ESSENTIAL BENEFIT PACKAGES? A: States will continue to be able to mandate additional benefits, but will not be permitted to reduce the benefits called for in the essential benefit package.

26. Q: ARE THERE ANNUAL AND LIFETIME BENEFIT LIMITS?

A: The ACA restricts annual and lifetime benefit limits for plan years which began on or after September 23, 2010, and prohibits them starting in 2015.

27. Q: WHEN DOES FREE PREVENTIVE CARE (CARE NOT SUBJECT TO COST-SHARING REQUIREMENTS) START, AND WILL IT AFFECT MY PLAN?

A: As of September 23, 2010, all new group health plans and new plans in the individual market must provide coverage for preventive services. Recommended prevention and vaccination services will be covered without any deductibles or copayments. Seniors enrolled in Medicare will also no longer have to pay for proven preventive services.

28. Q: WHAT SERVICES ARE CONSIDERED PREVENTIVE OR WELLNESS BENEFITS THAT MUST BE COVERED WITHOUT DEDUCTIBLES OR COPAYS?

A: Group and individual health insurance plans will cover at no additional cost to policy holders:

- Evidence based items or services that have in effect a rating of 'A' or 'B' in the current recommendations of the US Preventive Services Task Force (USPSTF).
- Immunizations that have in effect a recommendation from the Advisory Committee on Immunization practices of the CDC with respect to the individual involved.
- With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).
- With respect to women, additional preventive care and screenings as provided for in comprehensive guidelines supported by HRSA.

29. Q: ARE THERE WELLNESS PLAN INCENTIVES IN THE INDIVIDUAL MARKET?

A: The new law establishes a 10-state pilot program to apply HIPAA bona fide wellness program rules to the individual market. (The pilot program will operate between 2014 and 2017.)

30. Q: CAN SELF-FUNDED, NON-FEDERAL GOVERNMENTAL PLANS STILL OPT OUT OF HIPAA REQUIREMENTS, INCLUDING MENTAL HEALTH PARITY?

A: Self-funded, non-federal governmental plans can still opt out of certain requirements, although the ACA amended the *Public Health Service Act* to prevent opting out of other provisions. These plans used to be able to opt out of all seven requirements below; now they are prohibited from opting out requirements (1) through (3):

(1) Limitations on preexisting condition exclusion periods;
(2) Requirements for special enrollment periods;
(3) Prohibitions against discriminating against individual participants and beneficiaries based on health status (but not including provisions added by the *Genetic Information Nondiscrimination Act of 2008);*
(4) Standards relating to benefits provided to newborns and mothers;

(5) Parity in the application of certain limits to mental health and substance abuse use disorder benefits (including requirements of the *Mental Health Parity and Addiction Equity Act of 2008);*
(6) Required coverage for reconstructive surgery following mastectomies; and
(7) Coverage of dependent students on medically necessary leave of absence.

Exchanges (Marketplaces)

31. Q: WHAT IS AN EXCHANGE?

A: An exchange (often referred to as a marketplace) is the primary organizational structure established by the ACA. The law grants states the opportunity to choose from three governance models–those federally-facilitated, those run in state-federal partnerships, that those that are state-operated, pending federal approval.

There will be two types of exchanges for every state–the individual exchange, where individuals can go to purchase QHPs, and the Small Business Health Options Program (SHOP) exchanges, where businesses will go to purchase QHPs for their employees. Access to the online portal for the SHOP has been delayed until November, 2014.

32. Q: IS THERE A NATIONAL EXCHANGE?

A: No–the exchanges are all state-based. The exchanges will be operational by October, 2013, and will be open to individuals without access to affordable health insurance and to small businesses. However, if a state is unable to establish an operational exchange by 2014, the federal government will intercede with a federal-facilitated exchange (FFE).

Additional information about the FFE is available at http://www.marketplace.cms.gov/.

33. Q: WHICH STATES HAVE CHOSEN TO OPERATE THEIR OWN EXCHANGES?

A: The majority of states have elected to default to the federally-facilitated model. Below are a list of the states, the model of exchange they have selected, and a link to the website of their respective exchange:

State-Operated Exchanges		State-Federal Partnerships	
California	http://www.coveredca.com/	Arkansas	http://www.healthcare.gov/
Colorado	http://www.connectforhealthco.com/	Delaware	
Connecticut	http://www.accesshealthct.com/	Illinois	
District of Columbia	http://hbx.dc.gov/	Iowa	
Hawaii	http://www.hawaiihealthconnector.com/	Michigan	
Idaho	http://www.healthexchange.idaho.gov/	New Hampshire	
Kentucky	http://kynect.ky.gov/	West Virginia	
Maryland	http://www.marylandhealthconnection.gov/		
Massachusetts	http://www.mahealthconnector.org/		
Minnesota	http://www.mnsure.org/		
Nevada	http://exchange.nv.gov/		
New Mexico	http://www.nmhia.com/		
New York	http://healthbenefitexchange.ny.gov/		
Oregon	http://coveroregon.com/		
Rhode Island	http://www.governor.ri.gov/healthcare/message/		
Vermont	http://healthconnect.vermont.gov/		
Washington	http://www.wahealthplanfinder.org/		

Federally-Facilitated Exchanges			
Alabama	http://www.healthcare.gov/	North Carolina	http://www.healthcare.gov/
Alaska		North Dakota	
Arizona		Ohio	
Florida		Oklahoma	
Georgia		Pennsylvania	
Indiana		South Carolina	
Kansas		South Dakota	
Louisiana		Tennessee	
Maine		Texas	
Mississippi		Utah	
Missouri		Virginia	
Montana		Wisconsin	
Nebraska		Wyoming	
New Jersey			

34. Q: WHAT TYPES OF PLANS WILL BE AVAILABLE?

A: Product options will vary from state to state depending upon providers registered to sell within exchanges. All plans will be required to meet minimum EHB requirements established by the ACA. The ACA also specifies that employer plans are to be defined by a "typical employer plan" for that state.

In April, 2013, HHS released criteria for employer based benchmark plans for states, which included:

- The largest plan by enrollment in any of the three largest products in the state's small group market;
- Any of the largest three state employee health benefit plans options by enrollment;
- Any of the largest three national Federal Employees Health Benefits Program (FEHBP) plan options by enrollment; or
- The largest insured commercial HMO in the state.

35. Q: IS THERE A GOVERNMENT-RUN PLAN IN THE EXCHANGES?

A: No–there will be no government-underwritten health insurance plan offered through the exchanges. All the insurance sold through the exchanges will be private insurance. All plans sold in exchanges must comply, by statute, with extensive rules regarding benefits that must be included in the policies, and with restrictions on cost-sharing (deductibles and copays).

36. Q: ARE INSURANCE ADVISORS ALLOWED TO PARTICIPATE IN THE STATE-BASED EXCHANGES?

A: Yes–agents are specifically authorized to help individuals and small businesses buy their insurance through exchanges.

37. Q: CAN LARGE EMPLOYERS PURCHASE COVERAGE IN THE EXCHANGE?

A: Beginning in 2017, states may allow large employers (greater than 100 employees) and multi-employer health plans to purchase coverage in the exchange.

38. Q: HOW DO AGENTS AND BROKERS INTERACT WITH THE EXCHANGE?

A: According to guidance issues by the Centers for Consumer Information and Insurance Oversight (CCIIO), for federally facilitated and partnership exchanges, there will be two main ways agents interact with exchanges. A training program will be made available to agents and brokers during summer, 2013. After completion of the training program, agents can be registered and sell products via the exchange.

Insurer websites will have portals that link to the exchange which agents and brokers can assist customers to purchase products through. They can also assist customers directly on the exchange website. State based exchanges may have different methods and protocols which agents can use to interact with the exchange.

39. Q: HOW ARE AGENTS AND BROKERS COMPENSATED IN REGARDS TO EXCHANGES?

A: Agents and brokers will be compensated through traditional means by their affiliated insurer. And, the Centers for Medicare and Medicaid Services (CMS) issues rules preventing compensation discrepancies for similar products sold inside and outside exchanges.

40. Q: WHAT IS A NAVIGATOR?

A: Navigators are individuals that exchanges make available to assist individuals and businesses in attaining coverage through the exchange. The Centers for Medicare & Medicaid Services specified that navigators cannot have conflicts of interest, particularly in working for or associating with insurers. They must also undergo training and certification to operate within both the SHOP and individual exchanges, and have a solid understanding of premium subsidies, Medicaid, Medicare, CHIP, and other coverage programs, though they will not be licensed. CMS has made clear that navigators will not replace the traditional role of agents and brokers in assisting consumers with the purchase of insurance.

Guaranteed Coverage

41. Q: DOES THE ACA AFFECT INDIVIDUALS WITH PREEXISTING CONDITIONS?

A: Yes–for children enrolled in the plan who are under 19 years old, insurance can no longer base coverage (availability or price) on preexisting conditions effective for plan years which began on or after September 23, 2010 (plan years beginning on or after six months after date of enactment). Beginning on January 1, 2014, availability of coverage can no longer be limited based on preexisting coverage.

42. Q: ARE THERE ANNUAL AND LIFETIME BENEFIT LIMITS?

A: The ACA restricts annual and lifetime benefit limits for plan years which began on or after September 23, 2010, and prohibits them starting in 2015.

43. Q: HOW IS DEPENDENT COVERAGE EXTENDED?

A: Insurance policies are now required to allow coverage for adult children up to age 26 under their parents' policies.

44. Q: WHEN ARE PLANS PROHIBITED FROM RESCINDING POLICIES?

A: Group health plans and individual health policy rescissions are prohibited, except in cases involving fraud or intentional misrepresentation of a material fact, effective for plan years which began on or after September 23, 2010.

45. Q: IS NON-PAYMENT A RESCISSION?

A: A cancellation or discontinuance of coverage is not a rescission if the cancellation or discontinuance of coverage has only a prospective effect; or if effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage. While non-payment is not a rescission, it is an allowable reason for retroactive cancellation.

46. Q: WHAT TYPE OF RESCISSION NOTICE IS REQUIRED?

A: In situations in which rescission would be allowed, group health plans or insurers would have to notify participants 30 days in advance.

Personal Coverage Requirement

47. Q: WHAT DOES THE ACA MEAN FOR INDIVIDUALS WHO DO NOT CURRENTLY HAVE HEALTH INSURANCE?

A: The ACA mandates that starting in January, 2014, any individual who is not exempt (due to financial hardship or religious beliefs) is required to obtain minimum essential coverage (MEC) or pay a penalty (tax). Individuals

who can demonstrate they had policies cancelled at the end of 2013 and faced difficulties enrolling in a new plan may also be exempt from penalties for 2014.

48. Q: WHAT IS THE TAX FOR INDIVIDUALS WHO DO NOT OBTAIN INSURANCE?

A: The ACA will fine those who fail to carry MEC, and whose income exceeds the amount needed to be required to file federal income tax returns, as follows:

- 2014: $95/adult, or $47.50/child under 18 (max $285/family), or 1% of income over the tax-filing threshold
- 2015: $325/adult, or $162.50/child under 18 (max $975/family), or 2% of income over the tax-filing threshold
- 2016: $695/adult, or $347.50/child under 18 (max $2,085/family), or 2.5% of income over the tax-filing threshold

There is a family cap on the dollar amount fine of $2,085. Individuals and families lacking qualified coverage for only a portion of the year will only be assessed a fine that is 1/12 of the annual fee for each month they lack qualified coverage.

49. Q: WHAT HAPPENS TO INDIVIDUALS WHO CANNOT AFFORD COVERAGE?

A: The Supreme Court ruled the ACA provision that required states to expand their Medicaid programs to 133% of the federal poverty level (FPL) in order to receive Medicaid funding was unconstitutional, and that states could instead participate in this expansion optionally. Since then, 15 states have opted not to participate in the expansion, 30 have indicated they will participate, and the remaining six still have not indicated if they will participate.

In states that are participating in the expansion, if your household income falls below 133% of the FPL, you will be eligible for Medicaid coverage. This level will be 100% of the FPL for states that have opted not to expand. If an individual does not qualify for Medicaid but still cannot afford coverage, they may be eligible for a tax credit to help pay for private insurance sold through the exchanges. These premium tax credits will be available for individuals and families who do not qualify for Medicaid with incomes below 400% of the FPL.

50. Q: WHAT IS THE HEALTH PREMIUM TAX CREDIT?

A: The health premium tax credit is an advanceable, refundable tax credit for families to reduce the out-of-pocket cost of their health premiums. Individuals and families who do not qualify for Medicaid, Medicare, or other coverage programs, and do not receive coverage through employers, with incomes below 400% of the FPL may apply through the exchange to have their premiums reduced on a sliding income scale.

51. Q: HOW IS THE PREMIUM TAX CREDIT AWARDED?

A: Starting on January 1, 2013, individuals and families applying through the exchange can receive either an advanceable, refundable or combination tax credit. Once it is determined that an applicant qualifies for the credit, they can elect to receive either the whole or partial value immediately to reduce their premiums, or they can receive it as a refundable credit when they file their taxes. The advanceable credit will be paid directly to the exchange and will result in an automatic reduction of the customers' premiums.

More information about the premium tax credit and how it is awarded can be found here: https://sites.google.com/a/consumer.org/tax-credit-brochure/.

52. Q: IF I QUALIFY FOR A PREMIUM TAX CREDIT, CAN I USE THAT ON ANY HEALTH PLAN?

A: No–the plan that your credit applies to must be a QHP purchased through an exchange. However, in November, 2013, the Administration gave insurers the option to enroll subsidy-eligible consumers directly through insurers while still maintaining their tax credits. Details on this option are still being developed.

53. Q: WILL VETERANS WITHOUT HEALTH INSURANCE WHO RECEIVE MEDICAL CARE THROUGH THE VA BE REQUIRED TO PURCHASE HEALTH INSURANCE?

A: No–health care provided through government health insurance, including the VA, is qualifying health insurance.

Medical Loss Ratio

54. Q: ARE THERE MEDICAL LOSS RATIOS THAT MUST BE MET?

A: Yes–health plans are required to spend a minimum of 85% in the large group market and 80% in the individual and small group market of premiums on medical claims – and rebate any excessive overhead to enrollees. Agent compensation is included in the limited medical loss ratio.

55. Q: HOW WILL THE NEW MEDICAL LOSS RATIO REBATES BE DISTRIBUTED?

A: Rebates in the group market will generally be provided to employers. Some individuals may receive an actual rebate check. Insurers must send notices to consumers informing them of the rebates and how they will be paid.

56. Q: ARE THERE GUIDELINES OR LIMITS ON HOW EMPLOYERS CAN SPEND REBATES?

A: Limitations on how rebates may be used depend on the type of plan offered:

- ERISA Plans – Plan sponsors will have to determine if rebates are plan assets and to what extent the rebate is attributable to participant contributions. The Department of Labor has issued Technical Release 2011-04 to cover employer responsibilities under ERISA.
- Nonfederal Governmental Plans – Employers must use the rebate to either, (a) reduce an employee's portion of that year's premiums for the policy receiving a rebate, (b) reduce an employee's premiums for the subsequent year's premiums for the policy receiving a rebate, or (c) issue a cash rebate to employees covered by the policy receiving a rebate.
- Church Plans – The insurer must receive a written assurance from the employer that the rebate will be awarded in one the approved methods for nonfederal governmental plans. Otherwise the insurer must distribute the rebate directly to the participants of the policy.

Medicare and Medicare Advantage

57. Q: MY PRESCRIPTION DRUG SPENDING WILL PUSH ME INTO THE DONUT HOLE THIS YEAR. WHAT RELIEF WILL I GET?

A: Seniors who hit the gap in Medicare prescription drug coverage known as the donut hole were provided with a $250 rebate in 2010.

As of 2011, seniors in the donut hole began receiving a 50% discount on prescription drugs. In addition, the Medicare share of costs will increase so that the donut hole will be completely closed by 2020.

58. Q: WHAT ARE THE MEDICARE ADVANTAGE CHANGES?

A: The new law modifies Medicare Advantage (MA) plan rules as follows:

- Freezes MA payments in 2011;
- In 2012, MA benchmarks were reduced from 95% of Medicare spending in high cost areas to 115% of Medicare spending in low-cost areas. The benchmark reductions will be phased in over three, five or seven years, depending on the extent of the resulting payment reductions;
- Authorizes the Centers for Medicare and Medicaid Services (CMS) to adjust MA risk scores for observed differences in coding patterns relative to fee-for-service;
- Requires MA plans spend at least 85% of their revenue on medical costs or activities that improve quality of care.

The cuts to MA are set to total $202 billion from 2012-2019.

59. Q: WHEN DOES MY FREE PREVENTIVE CARE START AND WHAT DOES IT COVER?

A: Effective January 1, 2011, proven preventive services are free. In addition, Medicare will provide a new annual wellness visit that provides personalized prevention plan services, including a health risk assessment.

60. Q: IS THERE A MEDICARE PART D SURCHARGE FOR WEALTHY SENIORS?

A: The health reform law does impose a surcharge on the premiums charged for Medicare Part D coverage for seniors earning more than $85,000/year (individual) or $170,000/year (married filing jointly). Those income levels are frozen (i.e. will not adjust for inflation) at 2010 levels until 2019. Plus, Part D premium prices are not protected by the "hold harmless" provisions that specify that for seniors with incomes below the threshold amounts ($85,000/$170,000), their Part B premiums cannot rise more than the inflation adjustment for Social Security.

Employers Roles & Requirements

61. Q: I OWN A SMALL BUSINESS—DOES THIS MEAN THAT I WILL NEED TO PURCHASE INSURANCE FOR MY WORKERS?

A: No–the ACA does not require any business of any size to provide health insurance for its workers. However, it does impose assessments on employers that do not provide affordable, qualified health insurance coverage beginning January, 2015. In February, 2014, the Administration delayed penalties for businesses meeting certain criteria until January, 2016. Whether a small business will be subject to these assessments depends on the size of the business, and on whether any of its workers qualify for federal subsidies with which to purchase their own health insurance.

If your business employs fewer than 50 full-time (including full-time equivalents) workers, it will not face any penalties for not offering insurance. Small employers with fewer than 25 employees and average wages of less than $50,000 (per full-time and full-time equivalent worker) will qualify for a health coverage tax credit.

Businesses with 50 or more full-time (including full-time equivalents) employees that do not offer coverage will have to pay a fee of $2,000 per full-time employee if any of their workers qualify for the premium tax credit, a government subsidy used to purchase health insurance coverage through the exchange. The employer's first 30 employees are not counted in calculating the assessment. Employees in the waiting period between date of hire and eligibility for the employer's health plan are not counted. The waiting period cannot exceed 90 days. Only full-time employees are counted for purposes of calculating the assessment, although "full-time equivalents" are used to determine whether the employer is subject to the rule.

62. Q: HOW DO I DETERMINE THE NUMBER OF FULL-TIME EQUIVALENT EMPLOYEES?

A: Full-time employees are defined as employees on average working at least 30 hours per week. Full-time equivalents are determined by counting all part-time hours worked in a month, and then dividing by 120. Measurements are done on a monthly basis. The employer responsibility rules take effect in 2015.

The IRS has issued alternative safe harbor guidance on calculating full-time equivalents, designed to aid employers with employees who work variable hours. Employers can track employees' hours worked for a "measurement period" ranging from three months to one year, and if it is found that, on average, an employee is working 30 hours or more per week, than the employee is found to be a full-time equivalent. If the employer is offering coverage under the ACA mandate, than they must also offer coverage to that employee during a "stability period" that is equal to the length of the "measurement period," though not less than six months. Employers must use the same "measurement period" for the same type of employees, but may use varying "measurement periods" for different types.

63. Q: OUR WORKFORCE VARIES THROUGHOUT THE YEAR. HOW DO I DETERMINE IF I AM REQUIRED TO PROVIDE COVERAGE?

A: You must determine the number of full-time and full-time equivalent employees for each month of the preceding calendar. Add the number for all 12 months together and divide by 12. If that value is greater than 50, an employer is obligated to provide coverage.

64. Q: DOES THE EMPLOYER MANDATE APPLY ON THE PLAN DATE, OR ON JANUARY 1, 2015?

A: Originally, the employer mandate applied on January 1, 2014 with some exemptions if an employer offered an affordable QHP based on a fiscal year (not calendar year) to all full-time employees on or before December 27, 2012. If these criteria are met, an employer would be exempt from penalties for the months in 2014 prior to the first day in 2014 of the plans FY 2014 calendar year for:

- Any employee who is eligible for the employer's plan up to the plan's first day of its new fiscal year; and;
- Any other employee if, (a) all of the employer's eligible fiscal year plans were offered to at least one-third of their employees (full and part-time) at the most recent open season; or (b) your fiscal year plan covered at least one quarter of your employees.

On July 2, 2013, the Administration announced it would delay until 2015 the ACA's requirement that businesses with more than 50 employees offer qualified insurance or face penalty. On February 10, 2014, the Administration pushed that date back further to 2016 for businesses between 50-100 employees meeting certain criteria.

65. Q: HOW DOES A SUBSIDIARY DETERMINE IF THE EMPLOYER MANDATE APPLIES?

A: If all of the combined subsidiaries of a parent company employ at least 50 full-time or equivalent employees, then each subsidiary is responsible to fulfill the employer mandate. This applies even if an individual subsidiary employs less than 50 full-time or equivalent employees.

66. Q: OUR COMPANY'S HEALTH PLAN IS SELF-FUNDED. HOW DOES THE LAW AFFECT US?

A: Self-funded plans will be treated the same under the law as fully-insured plans. It is important that self-funded employers are aware of the law's impacts.

67. Q: IS OUR NON-FEDERAL GOVERNMENTAL OR CHURCH PLAN AFFECTED BY THIS LAW?

A: Yes–there are no exceptions for non-federal governmental or church plans in the ACA.

68. Q: WHAT IS THE SMALL BUSINESS TAX CREDIT AND HOW DO I KNOW IF I AM ELIGIBLE?

A: As of January 1, 2010, tax credits are available to qualifying small businesses that offer health insurance to their employees. The tax credit is worth up to 35% of the premiums your business pays to cover its workers – 25% for nonprofit firms. In 2014, the value of the credit will increase to 50% – 35% for nonprofits.

Your business qualifies for the credit if you cover at least 50% of the cost of health care coverage for your workers, pay average annual wages below $50,000, and have less than the equivalent of 25 full-time workers (for example, a firm with fewer than 50 half-time workers would be eligible).

The size of the credit depends on your average wages and the number of employees you have. The full credit is available to firms with average wages below $25,000 and less than 10 full-time equivalent workers. It phases out gradually for firms with average wages between $25,000 and $50,000 and for firms with the equivalent of between 10 and 25 full-time workers.

69. Q: IS THE 35% TAX CREDIT REPLACING THE CURRENT BUSINESS DEDUCTION OF 100% OF WHAT EMPLOYERS PAY FOR EMPLOYEES' HEALTH INSURANCE, OR IS IT ON TOP OF THE NORMAL BUSINESS DEDUCTION?

A: It does not replace the deduction, but the deduction is reduced by the amount of the credit.

70. Q: IS THE CREDIT PAYABLE IN ADVANCE OR REFUNDABLE?

A: The credit is not payable in advance to the taxpayer nor is it refundable. The credit is only available to offset actual tax liability and is claimed on the employer's tax return.

71. Q: HOW DOES A SMALL EMPLOYER USE THE 35% TAX CREDIT THIS YEAR IF THEY DO NOT HAVE MUCH TAX TO PAY THIS YEAR? CAN THEY TAKE IT OUT OF THE 941 DEPOSITS?

A: The tax credit is not refundable or claimable in advance. It is taken against actual tax liability at the time the tax return is prepared. So, a qualifying employer with no tax liability (or tax liability below the tax credit amount) generally will not benefit from the tax credit. It is structured to be claimed on the employer's 2011 tax return on income and tax liability for 2010.

72. Q: WHAT IF MY SMALL BUSINESS DOES NOT OFFER INSURANCE TODAY, BUT I CHOOSE TO START OFFERING INSURANCE THIS YEAR? WILL I BE ELIGIBLE FOR THESE TAX CREDITS?

A: Yes–the tax credit is designed to both support those small businesses that provide coverage today as well as those that newly offer such coverage.

73. Q: DO EMPLOYERS HAVE NEW RESPONSIBILITIES REGARDING NURSING MOTHERS?

A: Employers shall provide a reasonable break time for an employee to express breast milk for one year after the employee's child's birth, and shall provide a private place for such purpose. This rule does not apply to employers with fewer than 50 employees, if such requirements would impose an undue hardship.

74. Q: WHAT IS A SIMPLE CAFETERIA PLAN?

A: A new employee benefit cafeteria plan known as a Simple Cafeteria Plan eases the participation restrictions so that small businesses (100 or fewer employees) can provide tax-free benefits to their employees and it includes self-employed individuals as qualified employees.

75. Q: WHAT HAPPENS IF A SMALL BUSINESS ESTABLISHES A SIMPLE CAFETERIA PLAN AND THEN GROWS?

A: If an employer has 100 or fewer employees for any year and establishes a simple cafeteria plan for that year, then it can be treated as meeting the requirement for any subsequent year even if the employer employs more than 100 employees in the subsequent year. However, this exception does not apply if the employer employs an average of 200 or more employees during the subsequent year.

76. Q: WHAT ARE THE CONTRIBUTION REQUIREMENTS?

A: Under the contribution requirements, a simple cafeteria plan must make a contribution to provide qualified benefits on behalf of each qualified employee, in an amount equal to:

(1) a uniform percentage (not less than 2%) of the employee's compensation for the year; or

(2) an amount not less than the lesser of:

(a) 6% of the employee's compensation for the plan year, or;

(b) twice the amount of the salary reduction contributions of each qualified employee.

If the employer bases the satisfaction of the contribution requirements on the second option, it will not be in compliance if the rate of contributions to any salary reduction contribution of a highly compensated or key employee is greater than the rate of contribution for any other employee.

For purposes of the contribution requirements, a salary reduction contribution is any amount contributed to the plan at the election of the employee and not includable in the employee's gross income under the Sec. 125 cafeteria plan provisions. The terms "highly compensated employee" and "key employee" retain their definitions under the classic cafeteria plan provisions. A "qualified employee" is any employee who is not a highly compensated or key employee.

77. Q: MUST A SIMPLE CAFETERIA PLAN SATISFY ELIGIBILITY AND PARTICIPATION REQUIREMENTS?

A: A simple cafeteria plan also must satisfy minimum eligibility and participation requirements. The requirements are met if all employees who had at least 1,000 hours of service for the preceding plan year are eligible to participate, and if all employees have the same election rights under the plan.

An employer may elect to exclude from the plan employees who have not attained the age of 21 before the close of the plan year, who have less than one year of service with the employer as of any day during the plan year, who are covered under a collective bargaining agreement if there is evidence that the benefits covered under the plan were the subject of good faith bargaining between employee representatives and the employer, or are nonresident aliens working outside the United States whose income did not come from a U.S. source.

78. Q: DO EMPLOYERS HAVE TO REPORT THE VALUE OF HEALTH BENEFITS?

A: Yes–employers are required to report the value of health benefits on W-2. The IRS issued guidance stating that beginning in taxable year 2012 (for W-2s issued in 2013), employers will be required to report the value of applicable employer sponsored coverage. To determine the value of employer-sponsored health insurance coverage, the employer calculates the applicable premiums for the taxable year for the employee under the rules for COBRA continuation coverage under section 4980B(f) (4) (and accompanying Treasury regulations), including the special rule for self-insured plans. The IRS specified that there are certain benefits that will not be allowed to be included in the aggregate value applicable coverage, including:

- Stand-alone dental or vision insurance;
- Contributions to MSA, HRA, and FSA accounts;
- The value of wellness programs, on-site care, or employee assistance program (EAP);
- Coverage for a specified disease;
- Long term care insurance;
- Hospital indemnity or other fixed indemnity insurance;
- Only accident insurance; and
- Contributions made to a multi-employer plan.

79. Q: DO EMPLOYERS HAVE OTHER REPORTING REQUIREMENTS?

A: Yes–employers with the equivalent of 50 or more full-time employees will be required to provide the following information when filing their annual taxes:

- A certification as to whether the employer has offered its employees the opportunity to enroll in an employer provided QHP providing minimum EHB;
- The length of any waiting period for enrollment;
- The months that coverage for employees was available;
- Monthly premiums for the lowest cost option;
- The employer's share of covered plan costs;
- The number of full-time (or equivalent) employees;
- The name, address, and tax ID for each of those employees; and
- Information about the plan for which the employer pays the largest portion of the costs.

80. Q: ARE THERE OTHER ASSESSMENTS ON EMPLOYERS?

A: Yes–for employers with the equivalent of 50 or more full-time employees not offering coverage, or coverage that meets actuarial or EHB requirements, the law requires those employers to pay an assessment of $2,000 per equivalent employee, minus the first 30 employees. For employers offering coverage, to avoid an assessment, the employer-offered insurance must be "affordable," cover a minimum value of at least 60%, and cover all other EHBs. To be "affordable", an employee cannot be required to pay more than 9.5% (and in some cases much less—as low as 2%) of their household income for insurance. If the employer offers an insurance plan that is "not affordable," and at least one employee qualifies for a health premium tax credit, then the employer is subject to a $3,000 per affected full-time worker assessment. This rule takes effect for some

businesses on January 1, 2015, and others January 1, 2016, contingent on criteria issued by the Administration on February 10, 2014.

81. Q: DOES "AFFORDABLE INSURANCE" INCLUDE ONLY INDIVIDUAL COVERAGE, OR DOES IT ALSO INCLUDE DEPENDENT COVERAGE?

A: The IRS issued guidance in January, 2013, announcing that only individual coverage would be subject to the affordability standard.

82. Q: WHAT IS INCLUDED IN "HOUSEHOLD INCOME"?

A: Household income includes income from ALL those in the household (i.e., children) who can be covered under the insurance policy. It is not pegged to tax filing (e.g., kids file their own tax returns separately), and it does not include "mere roommates" (e.g., students sharing an apartment.)

83. Q: HOW DOES AN EMPLOYER KNOW WHAT AN INDIVIDUALS HOUSEHOLD INCOME IS?

A: Due to the difficulty of determining what an employee's household income is, for both an employee and employer, the IRS created three safe harbors employers can use to calculate "household income." Employers can use:

- The employee's taxable income, found in box one, on the employees W-2, as an annual benchmark;
- An employee's hourly wage, multiplied by 130 hours (the monthly minimum number of hours under the ACA to establish full-time status) as a monthly benchmark; or
- Using the FPL, since individuals below the FPL would otherwise qualify for Medicaid.

84. Q: IS THE EMPLOYER RESPONSIBLE FOR DETERMINING WORKERS' ELIGIBILITY FOR A PREMIUM TAX CREDIT?

A: No–eligibility for a premium tax credit (federal subsidy to pay for health insurance) is determined by the exchange, which notifies the employer (for purposes of assessments).

85. Q: HOW IS ELIGIBILITY FOR SUBSIDIES DETERMINED?

A: Eligibility for subsidies is based on "household income". If an employee's household income is between 133% and 400% of the federal poverty level, and is such that the employee's share of the cost of the health insurance (including dependent coverage) is greater than the prescribed percentage (a sliding scale based on income that tops out at 9.5%), then the employee qualifies for the federal subsidy.

86. Q: HOW DOES AN EMPLOYER DETERMINE WHETHER ANY OF ITS WORKERS QUALIFY FOR A PREMIUM CREDIT WITH WHICH TO BUY HEALTH INSURANCE (AND THUS TRIGGERS THE EMPLOYER ASSESSMENTS)?

A: There is no reliable way for an employer to know ahead of time whether any of its workers qualifies for a federal subsidy. The exchange is responsible for notifying the employer if any of its workers qualify for a federal subsidy. Premium credits (payable by the government to the insurance company) are available to families earning up to 400% of federal poverty.

An employer certainly can ask its workers for information on the worker's spouse's earnings, but there will surely be some workers who decline to share that information. There is nothing in the law that would compel a worker to tell his/her employer that information. Also note: other laws prohibit prospective employers from inquiring of job applicants about their family status.

87. Q: IF A PERSON ON MEDICARE IS AN EMPLOYEE, DOES THAT PERSON COUNT IN CALCULATING ASSESSMENTS?

A: No.

88. Q: WHEN WILL THE TAX CREDITS FOR EXCHANGE COVERAGE BEGIN?

A: In 2014, tax credits are made available for exchange-based coverage; amount varies by income up to 400% of FPL.

89. Q: ARE THERE NEW FORM 1099 REQUIREMENTS?

A: No–the ACA originally required employers to file a Form 1099 for all transactions over $600, including payments to corporations, beginning in 2012. This was an expansion of existing form 1099 reporting requirements. However, on April 14, 2011, President Obama signed into law a bipartisan repeal of this reporting requirement.

90. Q: DOES THE NEW LAW CHANGE THE EMPLOYER DEDUCTIBLE SUBSIDY UNDER MEDICARE PART D?

A: Yes–in 2013 the law eliminates the tax deduction for employer subsidies of Medicare Part D (prescription drug) premiums.

91. Q: ARE THERE FINANCIAL INCENTIVES FOR SMALL EMPLOYERS TO PROVIDE WELLNESS PROGRAMS?

A: Yes–the new law established a federal grant program for small employers providing wellness programs. $200 million has been made available for these programs. Rules regarding the establishment of qualifying wellness programs are expected to be released sometime in 2014.

92. Q: WHAT RESPONSIBILITIES DO EMPLOYERS HAVE REGARDING NOTIFYING EMPLOYEES ABOUT THE EXCHANGE?

A: The ACA requires all employers subject to the Fair Labor Standards Act to provide the written notice of health coverage options to each new employee at the time of hiring and to all current employees by October 1, 2013. A notice will be considered to have been provided at the date of hire so long as it is provided within 14 days of an employee's start date. All employees must receive this notice, regardless of plan enrollment status or of part-time or full-time status, and whether or not the employer will be providing coverage. Separate notices to dependents or other non-employees who may become eligible for coverage are not required.

Guidance issued by the Department of Labor recommends the following models that employers can use to fulfill notification requirements:

For employers providing coverage – http://www.dol.gov/ebsa/pdf/FLSAwithplans.pdf.
For employers not providing coverage – http://www.dol.gov/ebsa/pdf/FLSAwithoutplans.pdf.
Employer COBRA notification – www.dol.gov/ebsa/modelelectionnotice.doc.

93. Q: WHAT ARE FREE-CHOICE VOUCHERS?

A: Originally, beginning in 2014, employers that offer basic insurance coverage would have had to offer free-choice vouchers to their low-income employees, who can elect to purchase their health insurance through one of the exchanges created under the new law. However, the Free Choice Voucher Program was repealed on April 15, 2011.

94. Q: DO EMPLOYERS HAVE TO AUTOMATICALLY ENROLL FULL-TIME EMPLOYEES IN A HEALTH PLAN?

A: Employers with more than 200 full-time employees must automatically enroll full-time employees in their health plans (if they offer such plan). The automatic enrollment program must include adequate notice and opportunity for employees to opt out. Note: this is not a requirement to offer health insurance; it is a requirement only if the employer is offering health insurance.

95. Q: WHAT IS THE EMPLOYER'S ROLE IN DETERMINING THE HIGH-VALUE HEALTH INSURANCE TAX (NICKNAMED THE "CADILLAC" TAX)?

A: The "Cadillac" tax is a 40% tax, payable by "the insurer" (the insurance company or the employer or plan administrator in the case of self-insurance or other non-insurance company coverage, like flexible spending accounts), if the aggregate value of the employer-offered insurance exceeds $27,500 for dependent coverage or $10,200 for individual coverage. Stand-alone dental and vision coverage is exempt from the aggregation rules. The employer is responsible for doing the aggregation calculations. (There are higher threshold amounts for

those in high risk occupations, and adjustments will be permissible for employers with age and gender demographics that vary from national averages.) This tax takes effect beginning in 2018.

96. Q: DOES THE "CADILLAC" TAX REQUIRE INCLUSION OF FSA REIMBURSEMENTS?
A: Yes–the aggregate value of the health plan includes FSA reimbursements for medical expenses. It also includes reimbursements under health reimbursement arrangements (HRAs), employer contributions to a health savings account (HSA) and other supplementary health insurance. Stand-alone dental and vision coverage is not included in aggregating the value of coverage for Cadillac tax purposes.

97. Q: ARE EMPLOYEES NOW TAXED ON BENEFITS PROVIDED BY THEIR EMPLOYER?
A: The W-2 reporting is to effectuate the Cadillac tax provision (2018) and it will not subject the employees to any new tax obligations.

Taxes and Fees

98. Q: WHAT IS THE PATIENT-CENTERED OUTCOMES RESEARCH INSTITUTE (PCORI) FEE?
A: PCORI is a trust fund established by the ACA to conduct comparative research on various health care programs, systems and delivery methods to determine the most effective and affordable systems. To fund PCORI, a fee is assessed on all health plans between October 1, 2012, and October 1, 2019.

The fee will be $1 per individual covered for plans ending before October 1, 2013, $2 per individual covered for plans ending before October 1, 2014, and is indexed annually thereafter. This fee is applicable even to non-ERISA plans.

99. Q: IF OUR MEDICAL PLAN IS INSURED, IS THERE ANYTHING WE HAVE TO DO?
A: No–for insured plans, the insurer will be responsible for fee payment and reporting. For self-funded plans, employers must download and file IRS Form 720 quarterly. The fee will only be due annually however, by July 31.

100. Q: FOR SELF-FUNDED PLANS, HOW DO WE DETERMINE THE AVERAGE NUMBER OF INDIVIDUALS COVERED UNDER OUR PLAN FOR THE PLAN YEAR?
A: For plan years that began before July 11, 2012, employers may use any reasonable method for determining the average number of individuals covered for that year. For subsequent plan years, you can choose one of three alternative methods:

- Actual Count Method – add the total number of individuals covered by the plan for each day of the year and divide by the number of days in the year.
- Snapshot Method – add the total number of individuals covered on one date in each quarter, or more dates if there are an equal number of dates in each quarter, and divide that value by the total number of days incorporated in the count. For this method, you must use the same day for each quarter (e.g. the first day of the quarter).
- The 5500 Method – add together the total number of individuals covered by at the beginning of the plan year, and at the end of the plan year, as required on Form 5500 filed for the applicable heath plan for that year, and divide by two.

101. Q: HOW WILL TAXES BE INCREASED TO PAY FOR THE ACA?
A: Industry and consumer relevant taxes and assessments to pay for the ACA are as follows:

- 10% tax on all indoor UV tanning;
- Wealthier seniors (individuals with modified adjusted gross income of $85,000/individual or $170,000/married filing jointly or more begin paying higher Part D premiums. (Income amounts are not indexed for inflation in Parts B/D);

- Impose new annual tax (based on annual sales) on brand name pharmaceutical companies;
- Penalties for nonqualified HSA and Archer MSA distributions double (to 20%);
- New tax ($2 per enrollee) on all private health insurance policies (including self-insured plans) to pay for comparative effectiveness research (plan years beginning 2012);
- Increase Medicare wage tax by 0.9% and impose a new 3.8% tax on investment income including annuities for high income taxpayers (those earning $200,000 (individual)/$250,000 (married filing jointly) or more. No indexing is provided;
- Impose $2,500 annual cap on FSA contributions (indexed to CPI);
- Generally, establishes that medical expenses are deductible only to the extent they exceed 10% of adjusted gross income (up from 7.5%).
- Eliminate the deduction for employers' Part D retiree drug subsidy;
- Impose 2.3% excise tax on medical devices;
- $500,000 deduction cap on compensation paid to insurance company employees and officers;
- Individuals without government-approved coverage are subject to a fine of the greater of $95 or 1.0% of income. The fine phases up to the greater of $325 or 2.0% of income in 2015 and to $695 or 2.5% of income in 2016;
- Employers who fail to offer "affordable" coverage would pay a $3,000 assessment for each employee who receives a federal subsidy (premium credit) with which to buy health insurance through the exchange;
- Employers that do not offer insurance must pay an assessment of $2,000 for every full-time employee — employers with fewer than 50 full-time (including full-time equivalent) employees are exempt from this assessment;
- Impose tax on nearly all private health insurance plans ($8 billion in 2014, $11.3 billion in 2015 and 2016, $13.9 billion in 2017, $14.3 billion in 2018, and indexed to medical cost growth thereafter); based upon firm's market share starting in 2013;
- Impose "Cadillac tax" on "high cost" plans— 40% tax on the aggregated benefit value above $10,200 for individual coverage, and $27,500 for family coverage, annually.

Timeline

102. Q: WHAT IS THE TIMELINE FOR ACA IMPLEMENTATION?

A: Portions of the ACA went into effect immediately after the bill became law in 2010. Since then, provisions have phased in each year, and will continue to do so through 2018, with the main portions of the law taking effect between late 2013 and January, 2015. Below is a specific timeline of when each of the major provisions of the ACA takes effect:

Effective Immediately	• Grandfathering • Part D rebate	• Small business tax credit

Beginning June-July, 2010	• Temporary early retiree reinsurance program begins • National high-risk pool established	• HHS web portal established
Plan Years Beginning On or After Sept. 23, 2010	• Adult children coverage to age 26 • No pre-existing conditions exclusion for children under age 19 • Restricted rescissions • Preventative care services with no cost sharing • No lifetime dollar limits on essential benefits • Restricted annual dollar limits on essential benefits	• Internal and external appeals process* *(grace period until 7/11)* • Transparency disclosures* • Emergency services (at in-network cost)* • Direct access to OB/Gyn • Choice of PCP/pediatrician • Non-discrimination rules extended to insured plans • Medical loss ratio (MLR) reporting
2011	• No reimbursement for OTC drugs on HSAs • Form W-2 reporting of value of benefits *(grace period)* • Increased penalty (20%) for non-qualified HSA withdrawals	• MLR rebate • SIMPLE Cafeteria Plans allowed (small employers under 100 lives) • ~~CLASS Act~~ (repealed)
2012	• Summary of coverage requirement • 60-day notice in advance of modifications	• ~~HHS to provide CLASS Act details~~ (repealed)
2013	• 3.8% investment income tax for high-earners • Medicare tax increase for high-earners • No deduction for retiree drug subsidy • $2,500 cap on health FSA contributions	• Employer notification regarding exchanges • Eligible medical expense deduction threshold increased (7.5% to 10%) • ~~CLASS premium payments and employer auto-enrollment~~ (repealed)
2014	• Rate reviews begin* • MLR based on three years of data begins • Individual mandate for minimum essential coverage • State-based insurance exchanges • Employer responsibilities/penalty (partially delayed until 2016) • ~~Free choice vouchers~~ (repealed) • No pre-existing condition exclusions • Limit on employee out-of-pocket expenses* (delayed until 2015) • Modified community rating*	• Increased wellness program incentives • Small employer tax credit increases to 50% • No annual dollar limits on essential benefits (delayed until 2015) • Required coverage for clinical trials for life-threatening diseases* • 90-day limit on waiting periods • Early retiree reinsurance program ends • National high-risk pool ends

2017	• States may permit large employers in exchanges
2018	• 40% excise tax on high-cost plans

*** Grandfathered plans exempt**

ABOUT NAIFA: Founded in 1890 as The National Association of Life Underwriters (NALU), NAIFA is one of the nation's oldest and largest financial services organizations representing the interests of insurance professionals from every Congressional district in the United States. NAIFA members assist consumers by focusing their practices on one or more of the following: life insurance and annuities, health insurance and employee benefits, multiline, and financial advising and investments. NAIFA's mission is to advocate for a positive legislative and regulatory environment, enhance business and professional skills, and promote the ethical conduct of its members.

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