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CAB 13-9

Milliman

CLIENT ACTION Bulletin
Employee Benefits

Recent Guidance on the Affordable Care Act's Implementation

SUMMARY **The federal agencies with regulatory authority under the Affordable Care Act (ACA) have published numerous regulations and related guidance since April to help employers that sponsor group health plans navigate implementation of the healthcare reform law. (For a summary of prior pronouncements, see Milliman's *Client Action Bulletins 13-2* and *12-11*.) This *CAB* briefly describes key guidance from the Departments of Treasury (IRS), Labor (DOL), and Health and Human Services (DHHS) released since Apr. 1 through Sept. 30, and applicable to group health plans and insurance in plan/policy years that begin in 2014.**

DISCUSSION

Large Employer Mandate Delay and Information Reporting

On July 2, the White House announced a one-year delay of the ACA requirement that employers provide healthcare coverage if they employ 50 or more full-time equivalent workers. The postponement of the "employer shared responsibility" (also known as the "employer mandate") provision delays the penalties (as much as $3,000 per employee) for not offering affordable coverage until 2015 and was aimed at giving employers more time to comply with the rules, particularly the reporting requirements. To administer the employer mandate, the ACA requires employers and insurers that provide minimum essential health coverage to provide certain information to the IRS and to employees. (See also, "Employer Mandate Delay: Key Considerations for Employers," a Milliman *Healthcare Reform Briefing Paper*.)

The IRS followed up on the announcement with *Notice 2013-45,* confirming that the agency will not impose the penalties during 2014 for the employer and insurer reporting requirements. By doing so, the IRS acknowledged that employers will be unable to determine if they owe shared responsibility payments and, accordingly, extended the transition relief to such payments for 2014.

Subsequently, the IRS published two *proposed rules* on Sept. 9 on the information reporting requirements, one on coverage information that employers or insurers (or other entity, such as a joint board of trustees or a labor union) must report if they provide minimum essential coverage, and the other on the additional detailed information that employers – regardless of whether they provide coverage – must report if they have at least 50 full-time employees. Both proposed rules require reporting to the IRS by Feb. 28 (or March 31, if filed electronically) and would cover the prior year's information, applying to noncalendar-year plans as well as calendar-year plans. Thus, first returns must be filed with the IRS in 2016, reporting information for 2015. Employers, insurers, and other entities must furnish the information on minimum essential coverage by Jan. 31 to individuals enrolled in coverage, and the additional detailed information relating to the offer of coverage to all full-time employees and to all employees who are offered coverage.

In general, the coverage information requires an affected entity to report such basic information as: the name, address, and employer/taxpayer identification number (EIN or TIN) of the employer/insurer; the name, address, and TIN of each employee or retiree and each covered spouse/dependent; the months of the year for which coverage was provided; and contact phone number and/or insurance policy number. For the additional reporting by employers, information required includes: whether, for each month of the calendar year, they offered minimum essential coverage; the number of full-time employees each month, along with their TINs; the months coverage was available and the months that coverage was provided for each full-time employee; and the employee's share of the monthly premium for self-only coverage under the lowest-cost option that provides minimum value. The IRS may require reporting of additional information. In addition, the proposed rules lay out "simplified" methods of reporting under certain circumstances and the IRS invited comments on them.

Separately, the DOL issued *Technical Release 2013-02* on May 8, providing temporary guidance on the notices to employees. The Technical Release also announced the availability of two model notices – one for employers that offer health coverage to some or all of their employees and one for employers

that do not – that a plan sponsor may use to notify employees about the Exchanges, as well as an updated COBRA model election notice that includes information about coverage available through the Exchanges. (See also, ***Client Action Bulletin 13-3***.)

Small Employers and the SHOP Program

The DHHS published a final rule on the Small Business Health Options Program (SHOP) on June 4, the state or federally facilitated program designed to permit small businesses to offer their employees a choice of health insurance coverage beginning in 2014. The final rule amended existing regulations on triggering events and special enrollment periods for qualified employees and their dependents. It also included a transitional policy for plan years during 2014 that allows a state's SHOP to permit employers to offer their qualified employees a choice of qualified health plans (QHPs) at a single level of coverage; federally facilitated SHOPs will not exercise this option but instead will allow employers to choose a single QHP from the choices available.

The IRS also released a proposed rule on the tax credit available for small employers (i.e., those with 25 or fewer employees and average annual wages of less than $50,000) that offer health insurance coverage to their employees. The proposed rule modifies the credit amount, requires employers to obtain the insurance coverage through a Small Business Health Options Program (SHOP) exchange, and limits the credit to two years.

Guidance for HRAs, Health FSAs, and EAPs

On Sept. 13, the IRS, DOL, and DHHS jointly released guidance on how the ACA's prohibition on annual dollar limits on benefits and the law's requirement to cover preventive services apply to health reimbursement arrangements (HRAs), health flexible spending arrangements (FSAs), and similar arrangements in which employers provide a fixed dollar amount to employees to pay for healthcare premiums and other eligible medical expenses. The guidance (DOL's *Technical Release 2013-03*, the IRS's *Notice 2013-54*, and the DHHS's *Memorandum*) generally apply to plan years beginning on or after Jan. 1, 2014, but may be relied upon for prior periods. A later application date applies for governmental plans that require legislative action to bring the plans into compliance.

In question-and-answer format and examples, the guidance addresses:

- *The application of the ACA's market reforms to HRAs and other employer healthcare arrangements* – In general, HRAs, health FSAs, and employer payment plans are group health plans that must comply with the ACA's annual dollar limit prohibition and the preventive care requirements unless they are integrated with other group health plan coverage that complies. These arrangements also qualify as "minimum essential coverage," unless the coverage consists solely of excepted benefits.
- *HRA integration methods* – Two tests are available to determine if an HRA is properly integrated with another group health plan, a "minimum value" test (consisting of three requirements) and a "minimum value not required" test (with five requirements). Under both tests: the employee covered by the HRA must actually enroll in a group health plan; the HRA must be available only to employees who are actually enrolled in non-HRA group coverage; and the terms of the HRA must at least annually permit participants to permanently opt out of and waive future reimbursements from the HRA. Employers sponsoring the HRA may rely on employees' attestations that they are enrolled in their spouse's or other third-party group health plan.
- *The application of the ACA's market reforms to health FSAs* – Health FSAs that provide only excepted benefits are not subject to the ACA's preventive services requirement. These health FSAs require the employer to offer group health coverage that is not limited to excepted benefits and must limit the maximum benefit payable to twice the participant's salary reduction election. Even if they do not qualify as excepted benefits, health FSAs are exempt from the annual dollar limit prohibition, but only if they are offered through a cafeteria plan under tax code section 125 as of Sept. 13, 2013 (i.e., they must limit annual salary reduction contributions to $2,500).
- *Guidance on employee assistance programs (EAPs)* – The agencies will amend regulations so that EAPs that do not provide "significant" medical care or treatment will be excepted benefits, and thus, at least through 2014, employees covered by the EAP will be eligible for premium subsidies. Employers may use a reasonable, good-faith interpretation of whether their EAPs provide "significant" medical care or treatment.
- *HRAs for retirees* – Retirees covered by a stand-alone HRA for any month will not be eligible for a premium tax credit to purchase subsidized coverage through an Exchange. "Retiree-only" HRAs

are excepted benefits and thus are exempt from the annual dollar limit prohibition and the preventive care rules.

Other Regulations and Guidance Issued

Other guidance from the federal agencies issued from Apr. 1 through Sept. 30 include:

- **IRS *Notice 2013-57*,** clarifying that a health savings account plan will qualify as a high-deductible health plan (HDHP) even if it provides preventive health services without a deductible.
- **Three sets of frequently asked questions (*FAQs, Parts, XIV, XV, and XVI*)** from the IRS, DOL, and DHHS covering, respectively: the summary of benefits and coverage (SBC) required of group health plans to be used after Jan. 1, 2014, and before Jan. 1, 2015 (i.e., the second year of applicability); the annual limit waiver expiration date based on a change to a plan or policy year, provider nondiscrimination, coverage for individuals participating in clinical trials, and transparency in reporting coverage; and permitted notification about the health insurance exchanges by other entities, such as third-party administrators and multiemployer plans, on an employer's behalf, and allowing employers "at least through 2014" to rely on the agencies' March 2013 proposed rule on the 90-day waiting period limitation. Subsequently, the DOL issued a FAQ (unnumbered) stating that no employer penalty applies for failing to issue the notice on the Exchanges by Oct. 1, 2013.
- **A final DHHS regulation on the Exchanges' income and subsidy determination processes** that encourage, but not require, employers to provide employees the information about enrollment in, affordability of, and satisfaction of the minimum value standard by, the employers' plan.
- **A tri-agency final rule, along with DHHS guidance,** on the ACA's contraceptive coverage exemption for "religious employers" and the accommodations available to certain nongrandfathered insured or self-insured organizations with religious objections to providing such coverage.
- **IRS Chief Counsel Advice Memorandum (*AM 2013-002*),** which states that the fees paid by self-insured plan sponsors (and insurance companies) to fund the Patient-Centered Outcomes Research Institute (PCORI) are tax deductible as ordinary and necessary business expenses. The IRS also published an updated Form 720, which will be used to pay the PCORI fee.
- **A tri-agency final rule** on incentives for nondiscriminatory wellness programs (see ***CAB 13-5***).
- **IRS proposed rules on the minimum value** of employer-sponsored health plans and other requirements relating to the premium assistance available for qualifying individuals who purchase insurance on the Exchanges (see ***CAB 13-3***).

ACTION Group health plan sponsors should review the new regulations and guidance and consider the effects on their healthcare coverage and insurance. By moving forward with careful planning and implementation, plan sponsors can address timing issues that may arise without the risk of penalties. For example, the one-year delay of the reporting requirements will provide breathing room for employers to work through compliance issues before the requirements apply in 2015. Similarly, plan sponsors should assess how their health FSAs and HRAs may be affected and take steps to ensure compliance with the ACA and the agencies' regulations. Employee communications materials should be developed to address key issues that are likely to be raised as 2014 approaches.

For additional information about any of the recent releases from the DOL, DHHS, and/or the IRS, or for assistance with analyses or compliance, please contact your Milliman consultant.