Commonwealth Benefits Group
2 Barlo Circle
Suite C
Dillsburg, Pennsylvania 17019
(717) 432-1010
http://www.commonwealthbenefitsgroup.com

HEALTHCARE REFORM UPDATE 2014-13

Preparing for 2015 - Key PPACA Requirements

As we approach 2015, employers should be taking steps to ensure they are prepared to meet the Patient Protection and Affordable Care Act (PPACA) requirements that begin in 2015 and those which must be completed in 2014. The most significant upcoming requirements and options for an employer include the following.

Section 125 Plans

The maximum employee contribution to a health flexible spending account (HFSA) has been increased to $2,550 for the 2015 plan year.

The plan may be amended to consider either or both of the following events as a change in status event that allows a mid-year change to the pre-taxed contribution for medical coverage:

- Moving to Marketplace coverage, either during open enrollment for Marketplace coverage or as a result of a special enrollment event.
- A reduction in hours that does not affect eligibility for coverage under the group medical plan because the employee is in a stability period.

An HFSA may now offer employees an opportunity to carry over up to $500 in unused funds, instead of offering a three-month grace period.

Employers need to remember that, starting in 2014, HFSAs must meet the "excepted benefits" requirements. This means that:

- The employee must also be eligible for group medical coverage through the employer, and
- The employer contribution may not exceed the greater of $500

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and two times the employee contribution to the HFSA.

Plan Design Issues

An employer may not reimburse an employee, on either a pre-tax or an after-tax basis, for the cost of individual medical coverage. The prohibition applies both to coverage purchased through the Marketplace and directly from the carrier. An employee may not purchase individual medical coverage through a Section 125 plan or a health reimbursement arrangement (HRA).

In most cases a plan must include coverage for inpatient hospital and physician services and have an actuarial value of at least 60% to be considered "minimum value."

The out-of-pocket maximum for the 2015 plan year for most plans will be capped at $6,600 for single coverage and $13,200 for family coverage. The out-of-pocket maximum generally includes deductibles, coinsurance and copays for in-network coverage. A plan may have separate out-of-pocket maximums for medical and prescription drug expenses, but the combined maximums cannot exceed the limits.

Employer-Shared Responsibility Requirements

The employer-shared responsibility ("play or pay") requirements go into effect in 2015 for large employers only. However, mid-size employers will need to report on the coverage they offered for 2015, even though they generally will not be liable for penalties until 2016. To avoid penalties, beginning in 2015 large employers (those with 100 or more full-time or full-time equivalent employees) must offer health benefits to employees who work an average of 30 or more hours per week, or 130 hours per month. If an employer has a non-calendar year plan and can meet certain transitional rules, it can delay offering health benefits until the start date of its 2015 plan year.

Mid-size employers (those with 50 to 99 full-time or full-time equivalent employees) do not have to meet the play or pay requirements until 2016, as long as they keep their head count, eligibility requirements, benefit levels, and employer contribution amount or percentage at essentially the same level it was on February 9, 2014. Employers taking advantage of this delay must certify to the IRS that they have met these requirements.

To avoid all penalties, a large employer's plan must meet these requirements for 2015:

- Coverage must be offered to full-time employees working an average of 30 or more hours per week. Existing coverage for dependent children must be maintained. Coverage does not have to be offered to spouses.
- The plan must provide minimum essential coverage and it must be offered to at least 70% of full-time employees. Minimum essential coverage is basic medical coverage - most plans will satisfy this requirement.
- The plan must meet minimum value. This means that the plan is expected to pay, on average, at least 60% of the cost of medical claims.
- The plan must be affordable to employees. Affordability is based on the cost for single-only coverage under the lowest-cost plan that provides minimum value, regardless of the coverage the employee actually has. Affordability may be met under any of these criteria:
    - The W-2 test, which requires that the employee's cost not exceed 9.5% of the employee's income as reported in Box 1 of the W-2.

    - The rate of pay method, which requires that the employee's cost not exceed 9.5% of the lowest hourly rate paid to the employee, multiplied by 130 hours per month.
    - The federal poverty line test, which requires that the employee's cost not exceed 9.5% of the federal poverty rate (or about $92/month for 2014).

A large employer needs to decide how it will determine which of its employees are "full-time" under PPACA. Under the rules, an employer may use one of two methods to determine whether an employee is full-time.

- Under the monthly method, the employer will simply look at the hours the employee works each calendar month, and either offer coverage for employees who worked an average of 30 or more hours per week during that month, or be prepared to pay a penalty if any employee receives subsidized coverage through the Marketplace.
- Under the look-back method, the employer will use hours worked during a "measurement period" to determine whether the employee will be considered full-time during the following "stability period." Employers may find it simplest to use a stability period that is the same as their coverage period and a measurement period that ends shortly before their open enrollment period. So, for instance, a calendar year plan may want to use a measurement period of October 16 through October 15, an administrative period of October 16 through December 31, and a stability period of January 1 through December 31.

Employers should maintain records of head count and any calculations they made to support their approach in the event of an audit.

If a large employer does not offer minimum essential coverage (basic medical) to at least 70% of its full-time employees in 2015, the employer will owe a penalty of $166.67 per month ($2,000 per year) on all of its full-time employees if any full-time employee receives subsidized coverage through a public Marketplace. If a large employer does not offer affordable, minimum value coverage to its full-time employees, the employer will owe a penalty of $250 per month ($3,000 per year) for each full-time employee who receives subsidized coverage through a public Marketplace. Any penalty will be due in mid-2016.

Reporting

As in prior years, employers that issued more than 250 W-2s in the prior year must include information about the cost of health coverage on their employees' W-2s. The exemption for smaller employers and for multiemployer coverage remains in effect for this year's reporting.

Beginning in 2016, employers with 50 or more full-time or full-time equivalent employees must provide detailed reporting on the coverage offered to all employees during the prior calendar year. Reporting will be made using IRS Forms 1094 and 1095. Final reporting forms and instructions have not been issued yet, but because reporting will be based on coverage offered during 2015, large and mid-size employers should begin to consider how they will gather data needed for this reporting.

Plan Amendments

Many group health plans will need to be amended -- regardless of the employer's size -- to reflect the required changes to benefits and waiting periods. Employers also should consider whether eligibility language will need to be updated to reduce waiting periods, lower the number of hours

an employee must work to be eligible, address measurement and stability periods, or use actual hours worked instead of the "regularly scheduled to work" language that is common now. Same-sex marriages are now recognized in many states, and the plan's definitions and eligibility rules may need to be changed accordingly.

Section 125 plans have until December 31, 2014, (regardless of the plan year) to amend the plan to cap an employee's contribution to an HFSA at $2,500 (indexed). Section 125 plans have until the end of the 2014 plan year to complete amendments needed if a carryover provision is adopted under its HFSA (and any available grace period is eliminated) during 2013 or 2014.

Section 125 plans also may need to be amended to remove pre-taxation of individual medical premiums, including premiums for individual coverage purchased through the Marketplace, or to make changes in eligibility to mirror changes to the group health plan.

An employer that chooses to recognize the newly available changes in status described at the beginning of this article may wait until the last day of the 2015 plan year to adopt the needed plan amendment, but if the plan is being amended for other reasons, this change also should be addressed.

HRAs must be amended to allow an employee, or a former employee, to permanently opt out of and waive future reimbursements from the HRA -- at least annually -- and to provide that upon termination of employment, either the remaining amounts in the HRA will be forfeited or the employee will be permitted to permanently opt out of and waive future reimbursements from the HRA.

The HRA also may need to be amended to meet the requirement that, beginning in 2014, the HRA be integrated with a group medical plan, unless the HRA only reimburses "excepted benefits" like dental and vision expenses, or it only covers retirees. In order for an HRA to be integrated:

- The HRA must only be available to employees who are actually enrolled in group medical coverage (either through the employee's or a family member's employer); and
- The employee receiving the HRA must actually be enrolled in a group medical plan (either through the employee's or a family member's employer).

An employer may wish to amend the HRA so that its eligibility will mirror that in the group health plan.

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