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The healthcare reform survival guide

Checklists and explanations to help
you meet changing health benefits
compliance mandates

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Staying compliant with healthcare reform

The Patient Protection and Affordable Care Act (PPACA), signed into law by President Obama on March 23, 2010, and the amendments made by the Healthcare and Reconciliation Act of 2010 (together, known as the Affordable Care Act), have had significant employment tax and information reporting implications.

The ramifications of healthcare reform in general, and its impact on employers specifically, have created confusion and complications for human resource professionals. As the requirements of the Affordable Care Act (ACA) are implemented in phases now through 2020, this guide will help you understand what you need to be doing already as well as what you need to prepare for in the future.

What does the ACA mean for you?

By now, you've probably heard about many of the provisions in the Affordable Care Act. Of particular note are a number of new healthcare reporting requirements that are needed to assist in the enforcement of the various health coverage required of individuals, employers, and insurers, with staggered effective dates.

There are also some hidden surprises. This survival guide will address the changes facing employers. You'll find explanations of compliance issues, checklists of what your company should be doing, and a calendar of important effective dates.

A word of caution: Additional guidance about healthcare reform is frequently released by the Internal Revenue Service (IRS), the Department of Labor (DOL), and the Department of Health and Human Services (HHS). The National Association of Insurance Commissioners (NAIC) is also weighing in. There are still more questions than answers. A good overview can be found at: www.healthcare.gov

Keep up with changes on dynamic HR resource sites such as SHRM. Access the latest healthcare reform guidance on the appropriate agency websites. And speak with your company's employment law specialists as you craft necessary changes to your benefits plans.

Big question— to insure or not?

Are you weighing the pros and cons of continuing to provide healthcare benefits to your workforce? Here's what you need to know.

It's the question on everyone's mind—employers, employees, benefits managers, health insurers, and government officials. Will businesses continue to provide private health insurance benefits to employees? Or will it be less expensive for them to pay the penalties and send employees to the insurance exchanges?

Is your company exempt from penalties?

The first question your CEO may ask you about healthcare reform is whether your company should offer health insurance benefits in the first place. The answer mainly depends on whether your business employs 50 or more full-time or full-time equivalent (FTE) employees.

Calculate FTE employees:

Divide each part-time employee's monthly hours by 120. Add all part-time employees' numbers together. Combine that number with the number of full-time employees (work 30+ hours per week).

Example: You have 47 full-time employees and seven employees who each work 93 hours per month.

Part-time=

7 x (93 hours/120) = 5.425

Full-time= 47

Total FT/FTE employees=

52.425 rounded down to 52

If you have fewer than 50 full-time or FTE employees, your company isn't required to provide healthcare benefits and will not be subject to penalties.

In companies with 50 or more full-time or FTE employees, you may choose to offer benefits that conform to provisions in the Affordable Care Act, such as affordability and minimum value coverage, or face penalties if a full-time employee receives subsidized coverage through an exchange.

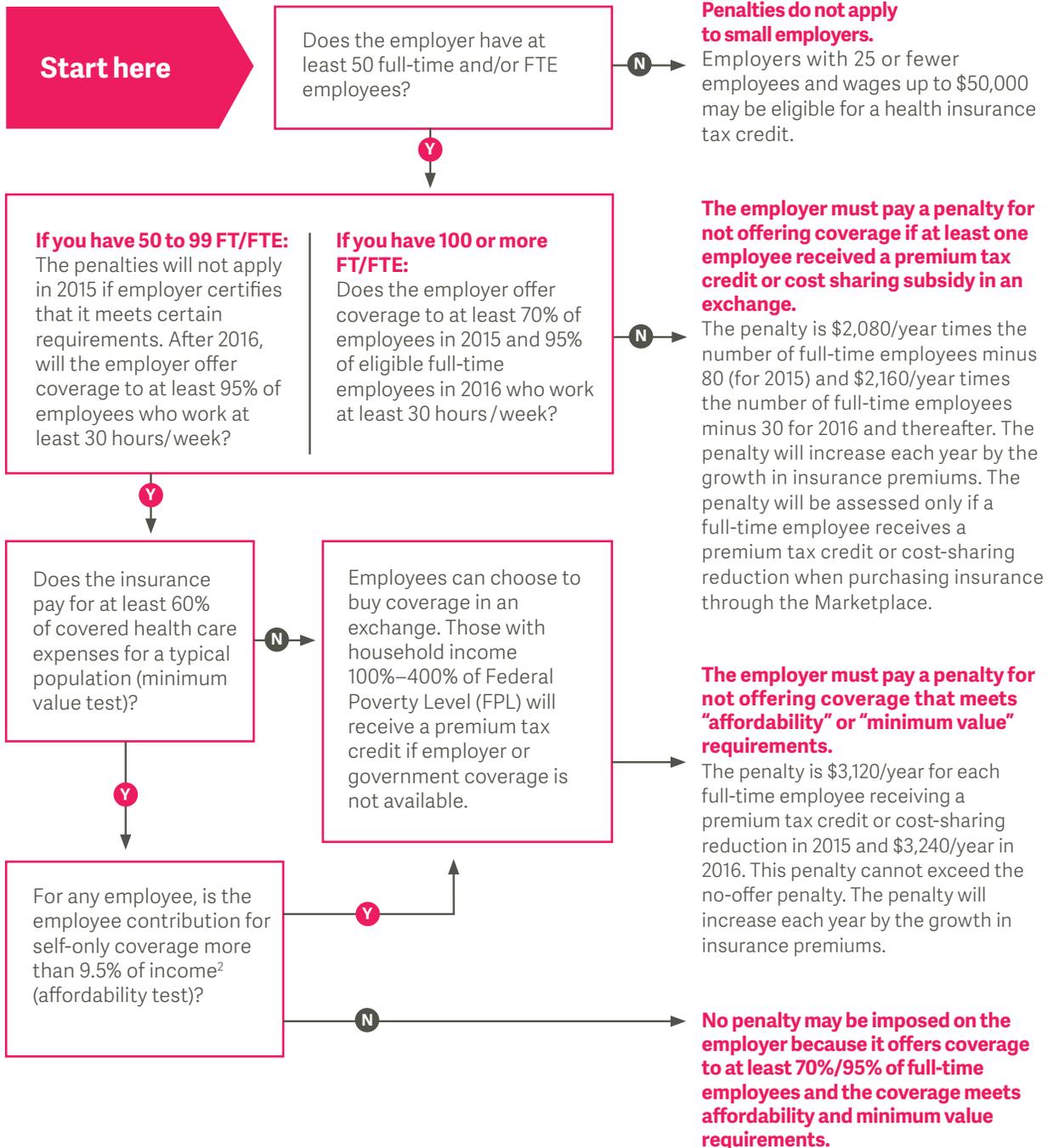
Certain transitional rules are currently in place (through 2015) for companies with 50-99 full-time or FTE employees and also for those with 100 or more full-time or FTE employees.

What's less expensive—penalties or healthcare coverage?

If your company employs 50 or more full-time or FTE employees, you'll need to analyze the costs and benefits of providing an employer-sponsored health plan. Starting in 2015, companies that fail to offer affordable, quality healthcare will pay an "Employer Shared Responsibility Assessment," which is commonly referred to as a pay-or-play penalty.

How to determine if you should pay or play

Please see the flow chart below to help decide which options are right for your company.



Please note: To ease compliance with final requirements, some transition rules, generally for 2015, have been provided.

¹ A full-time equivalent (FTE) is defined as part-time employees whose combined hours add up to 120/month. For example, two part-time employees who each work 60 hours/month = 1 FTE.

² There are also two other "safe harbors" definitions of income: rate of pay x 130 hours or 100% of FPL for an individual.

Although the final regulations assess a penalty if coverage is not offered to at least 95% of the employer's full-time employees—for the year 2015 only—the threshold for assessing the penalty will be 70% instead of 95%, meaning that employers who offer coverage to at least 70% of their full-time employees in 2015 will not be subject to the a penalty.

Also in 2015, the number of exempt employees necessary to avoid a penalty increased to the first 80 full-time employees. The exempt employee number reverts to 30 for 2016.

Employers may still incur a penalty if full-time employees were not offered coverage in 2015 and obtained subsidized coverage on a public exchange or if employees were offered coverage but it was either not adequate (covering 60 percent or more of medical costs on average) or unaffordable (costs no more than 9.5 percent of an employee's household gross income) and received subsidized coverage on an exchange.

Under the Affordable Care Act, employer-provided coverage is considered "affordable" if it meets one of the three IRS safe harbors for determining that the employee's contribution for self-only coverage doesn't exceed 9.5% of the employee's household income.

Note: Any penalty paid under the Employer Mandate is not deductible from corporate taxes.

Additional transition rules in 2015 for employers with at least 100 FT/FTEs

- For certain noncalendar year plans, an extension of the penalty provisions' effective date to the first day of the 2015 plan year was granted.
- For employers that did not previously offer dependent coverage but are taking steps to arrange for such coverage, a one-year delay in the requirement was granted until 2016.
- The ability to use a six-month measurement period for 2014 to determine full-time status for the 2015 plan year, as long as the measurement period begins by July 1, 2014, was granted.
- The ability to determine whether the employer is a "large employer" (for example, has 100 or more FT/FTEs) by using six consecutive months during 2014 (rather than the entire year) was granted.

Note: These are only applicable if the employer meets the requirements for the particular transition rule.

Midsized employers granted a delay

Under the final regulations an applicable large employer subject to the employer shared responsibility rule is defined as an employer with at least 50 full-time or full-time equivalent employees.

Transition rule for midsized employers

For 2015 only, employers with fewer than 100 full-time and full-time equivalent employees during 2014 were not subject to the employer shared responsibility penalties, giving these midsized employers additional time to comply.

Note: Employers must meet several requirements and certify these to the IRS in order for this transition rule to apply.

There are other important considerations. If you provide healthcare now but later stop, how will it affect employee morale? Will you have trouble retaining good employees and suffer increased turnover costs?

Employer checklist

Pay careful attention to the items on the next several pages, as these provisions are already in effect. If your company is not in compliance—take action now!

Past due: Are you compliant?

- Determine if your health plan is “grandfathered.”
- Implement mandated healthcare plan design changes.
- Submit transparency disclosures to Secretary of HHS and make information public. (See Compliance in this guide.)
- Establish a private space and breaks for nursing mothers.
- Determine if your company qualifies for a tax credit.

Quick check: Does your business qualify for a tax credit?

If your company employs fewer than 25 people and pays less than \$50,000 in average annual wages, you can receive a tax credit of up to 35% of the cost of employer premiums. Nonprofit organizations can receive a credit of up to 25%. The credit provides relief retroactively, as of January 2010. In 2014, the amount of the credit increased to up to 50% of your cost for healthcare plan premiums (35% for nonprofits).

Key provisions

Existing health plans can be “grandfathered” and temporarily avoid some, but not all, of the restrictions of the Affordable Care Act.

Fair Labor Standards Act (FLSA) mandates space for nursing mothers. As of March 2010, employers must provide nursing mothers with “reasonable” unpaid breaks for pumping breast milk. Employers must also provide a space for these breaks that is private and is not a bathroom. Companies with fewer than 50 employees may be exempt if providing such a space imposes undue hardship.

Will kids ever leave home?

Don't count on it! The Affordable Care Act is very generous to adult children. To remain covered by a parent's plan, adult kids (younger than 27):

- Can be married or unmarried.
- Can be students, workers, or unemployed.
- Do not have to live with the employee or in the same state.
- Do not have to qualify as a dependent on a parent's tax return.
- Can be eligible for their own health benefits through an employer but remain on your plan (as of 2014).

Plan coverage is available tax-free to children younger than 27 whose parents belong to an employer-sponsored health plan.

Mandatory plan design changes taking effect for future plan years impact all employer-sponsored healthcare plans, including new plans, grandfathered plans, and retiree plans.

These changes include the following:³

- Most children under 27 can be insured by parents (exception for grandfathered plans).
- Insurance cannot be canceled retroactively, except in limited circumstances such as fraud.
- There are lifetime limits.
- There is a ban on preexisting conditions for children under 19.

*More changes are required for retiree health plans but are outside the scope of this guide.

Additional changes required for new plans and existing plans that lose grandfathered status:

- Plans must provide 100% employer coverage of preventative care.
- Plan must have an internal process for claims appeals. DOL issued a grace period for enforcement until July 1, 2011.⁴

As of January 2011, over-the-counter drugs are no longer reimbursable from Flexible Spending Accounts (FSA) and Health Savings Accounts (HSA). Only prescription drugs and insulin will qualify for reimbursement—this is a major change for employees.

The penalty for unqualified reimbursements from an employee's HSA increases to 20%. That penalty is on top of paying tax at the employee's regular U.S. income tax rate.

Quick check: Is your plan grandfathered?

To retain grandfathered status, you may only add or delete employees and make minor changes to plan design. According to a [DOL fact sheet](#), plans with grandfathered status may not:⁵

- Significantly cut or reduce benefits.
- Raise coinsurance rates.
- Significantly raise deductibles.
- Significantly lower employer contributions.
- Add or tighten an annual limit on what the insurer pays.
- Change insurance companies. This last rule is especially challenging for smaller businesses, which often shop around to limit runaway premium increases.

3 U.S. Government, "Fact Sheet: Keeping the Health Plan You Have: [The Affordable Care Act and Grandfathered Health Plans](#)," 2010.

4 Seyfarth Shaw, "An Employer's Guide to Healthcare Reform," April 15, 2010.

5 U.S. Department of Labor, "[Technical Release No. 2010-02](#)," September 20, 2010.

Mandates to meet

- A **fee to fund Patient Center Outcomes Research** is assessed on health insurers and sponsors of self-insured health plans. The fee generally was \$1 per covered life with respect to the 2012 plan year and is currently \$2 per covered life. The fee must be paid annually on IRS Form 720, which is due July 31 of the following year.
- Forms W-2** must include information about the value of employer-provided healthcare.
- Flexible spending account (FSA) capped** at \$2,550 of employee contributions.
- The Affordable Care Act added an **additional employee 0.9% Medicare Tax** beginning in 2013 for individuals with income above a specified threshold amount.
- Tax on retiree drug subsidy** eliminates the ability for employers to take a deduction equal to the amount of subsidy a retiree receives.
- State-based exchanges** are open for business.
- The **individual mandate** requiring all persons to have health insurance coverage is now being enforced.
- No preexisting condition exclusions** allowed for any person.
- Employers offer coverage for **clinical trials for life-threatening diseases**.
- For plan years beginning on or after January 1, 2014, group health plans and health insurance issuers are **prohibited from imposing annual limits on the dollar value of essential health benefits**. Under the Affordable Care Act, essential health benefits are defined to include the following general categories: 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, preventive and wellness services, and pediatric services (including oral and vision care).
- Employee out-of-pocket** expenses cannot be greater than the current limits for high-deductible health plans (\$6,850 for individuals, \$13,700 for families).⁶
- Incorporate the 2015 transition rules** to determine pay-or-play penalty, which could be assessed in 2016. Penalties may be incurred in 2015 but not assessed until 2016 based on the reporting.
- Employers must provide **healthcare coverage certification** for full-time employees. Any applicable large employer will be subject to pay-or-play penalties (the no-offer or the unaffordable/inadequate coverage penalty) if at least one full-time employee purchases federally subsidized health insurance through an exchange.
- Waiting periods** for eligibility cannot exceed 90 days.
- The limit on the **flexible spending account** voluntary employee contribution has increased to \$2,550.
- Comply with ACA reporting** to the IRS under section 6055 and/or 6056, using forms 1094/1095-B and/or 1094/1095-C, which are first due in 2016 (see details under the section "New W-2s and reporting requirements").

⁶ IRS limits are lower than ACA out-of-pocket limits.

2016 and beyond

Effective dates are spread out through 2020 as healthcare reform is implemented in phases. The following is a brief overview of the next few years. If a specific effective date is not noted, all items take effect on January 1 of the respective year.

2016

- Be aware that **transition rules expire** as noted earlier.
- Comply with ACA reporting** to the IRS under section 6055 and/or 6056, using forms 1094/1095-B and/or 1094/1095-C, which are first due in 2016 (see details under the section “New W-2s and reporting requirements”).

2020

- Excise tax on high-cost coverage (Cadillac Tax).** Beginning in 2018, a 40 percent excise tax will be imposed on the value of health insurance benefits exceeding a certain threshold. The thresholds are \$10,200 for individual coverage and \$27,500 for family coverage (indexed to inflation). The thresholds increase for individuals in high-risk professions and for employers that have a disproportionately older population.

Compliance, reporting, and employee communications

Notification checklist:

Here is a summary of the annual participant notice requirements that apply to group health plans:⁷

Women's Health and Cancer Rights Act (WHCRA)

Each year participants must receive a summary plan description (SPD) of a health plan's coverage for mastectomies and breast reconstructive services. If the SPD is reissued each year, the notice can be included in the SPD. Otherwise, a separate notice should be included in the plan's annual enrollment materials.

Medicare Part D Notice of Creditable or Non-Creditable Coverage

This annual notice must be provided to any participant (employee or dependent) who has coverage under Medicare Part A or coverage under Medicare Part B and who lives in the service area of a Medicare Part D prescription drug plan. While employers usually know whether an employee is eligible for Medicare, employers often do not have this information regarding dependents. As a result, providing the notice to all participants ensures compliance. Notice should be provided by October 15. Again, if the SPD is reissued each year, the notice can be included in the SPD. Otherwise, a separate notice should be included in the plan's annual enrollment materials.

HIPAA Notice of Privacy Practices

Participants must be notified at least once every three years that they may receive a copy of the HIPAA notice of privacy practices. Alternatively, the notice can be reissued at least once every three years. An easy way to comply with this requirement is to notify participants annually, at open enrollment, that they may request a new copy of the notice. Further, the notice should have been updated for the 2013 HHS regulations regarding HITECH. Specifically, the notice must include an explanation of a covered entity's obligation to notify affected individuals following the breach of unsecured protected health information.

Children's Health Insurance Program Reauthorization Act (CHIPRA)

Since 2009, special enrollment rights to immediately enroll in an employer's health plan arise if an individual becomes eligible for a state premium assistance subsidy under Medicaid or CHIP. The subsidy helps low income individuals pay for employer coverage, transferring them from government-sponsored health programs to employer health plans. The notice must be provided annually to all employees residing in each premium assistance subsidy state, including employees not enrolled in the plan. Model notice language, which is periodically updated, is available on the DOL website and includes contact information for each state offering a premium assistance subsidy. Before distributing the notice each year you should check the DOL website for any updates to the model.

⁷ Jennifer Benz, "[Key notification and communication requirements in health care reform](#)," Employee Benefit News, October 1, 2010

⁸ Internal Revenue Service, "IRS Releases Draft W-2 Form for 2011; Announces Relief for Employers," October 12, 2010.

Summary of Benefits and Coverage

Health care reform added a new participant notice requirement known as the Summary of Benefits and Coverage (SBC). The purpose of the SBC is to provide certain information in a prescribed format to participants in an employer's medical plan so they can easily compare the information to other plans which they may be eligible for, including the coverages which will be offered on the Health Insurance Marketplaces. In addition, beginning with the 2014 plan year, the SBC must indicate if the plan constitutes "minimum essential coverage" and whether the plan provides "minimum value." The notice should be provided annually to participants, as well as in other prescribed circumstances. If a plan makes a material modification in any of the plan terms that would affect the content of the SBC, the plan must provide notice of such change no later than 60 days prior to the date on which the modification will become effective. This does not apply to changes that occur in connection with a renewal or reissuance.

Notice of Exchange Availability

By no later than October 1, 2013, employers were required to issue employees a Notice of Exchange Availability. The notice provided certain basic information about the employer's group health coverage so the employee could share that information with the Health Insurance Marketplace in the event the individual applied to enroll in exchange coverage and obtain a premium credit. The notice was a one-time requirement to existing employees and is not required to be reissued annually. However, any new hires after October 1, 2013, should be provided a copy of the notice within 14 days of their start date.

Notice Regarding Grandfathered Plan Status

Plans that were in effect prior to the enactment of the Affordable Care Act (ACA) are exempt from some of the insurance market reforms under ACA so long as they retain "grandfathered plan" status. One of the requirements to retain grandfathered plan status is including certain disclosures in SPDs and other plan materials (such as annual open enrollment materials) provided to participants describing the plan's benefits. The disclosure must state that the plan is grandfathered and must provide contact information for questions and complaints. Model notice language is available on the DOL website.

Follow these links to check for additional [DOL guidance and model notices](#) as well as [guidance from HHS](#).

W-2s and reporting requirements

The Affordable Care Act requires employers to report the cost of coverage under an employer-sponsored group health plan. Reporting the cost of health care coverage on the Form W-2 does not mean that the coverage is taxable. This reporting is for informational purposes only and will provide employees useful and comparable consumer information on the cost of their health care coverage.

Employers that provide "applicable employer-sponsored coverage" under a group health plan are subject to the reporting requirement. This includes businesses, tax-exempt organizations, and federal, state, and local government entities (except with respect to plans maintained primarily for members of the military and their families). However, federally recognized Indian tribal governments are not subject to this requirement.

For certain employers, types of coverage, and situations, there is transition relief from the requirement to report the value of coverage. This transition relief will continue to apply to future calendar years until the IRS publishes additional guidance.⁸

Until further regulations are issued by the IRS, employers that provide fewer than 250 W-2s are not required to report this information on the W-2.

Section 6055

Section 6055 requires insurers and self-insured employers that provide minimum essential coverage to submit annual information reports to the IRS each year identifying who is covered. If an employer offers a fully insured group health plan, the health insurance issuer is required to submit the returns. If the employer offers a self-insured group health plan, the employer is required to submit the returns. Note that the common-law employer, rather than the plan sponsor, is responsible for this reporting, although a third party may prepare the return.

Section 6056

Section 6056 requires all applicable large employers to report for each full-time employee information about the coverage (if any) offered to the employee, by month, including the lowest employee cost of self-only coverage offered.

The sections 6055 and 6056 reporting requirements were set to take effect in 2014. However, on July 2, 2013, the Treasury Department announced that it would provide employers with an additional year to comply with the reporting requirements. Thus, the first returns are due in 2016 for coverage provided in 2015.

Transparency disclosures

For plan years beginning after September 23, 2010, employers must send the Secretary of Health and Human Services (HHS) information about how claims are paid, how costs are shared with employees, how policies are rated, out-of-network coverage, and employees' participant rights. Further guidance may require additional information, too. These disclosures must also be made available to the public and employees.

How automation can help

Notification checklist:

Make no mistake, there's a lot of work ahead for HR professionals and benefits managers in order to comply fully with the Affordable Care Act. A Human Resources Management System (HRMS) is designed to centralize HR and benefits information so you can easily access the data you need for compliance and decision making. An HRMS can ease the burden of implementing the Affordable Care Act by helping you:

- Stay current with compliance requirements.** An HRMS customer receives regular software updates that keep the system updated for legislative changes, such as the Affordable Care Act, so you don't have to do the research to stay compliant. An HRMS solution includes employee notifications, revised forms, and more. It also helps keep your company in compliance with EEO-1, EEO-4, I-9 Citizenship Verification, Vets-100, Family and Medical Leave Act (FMLA), and OSHA recordkeeping requirements.
- Better track and manage benefits plans.** An HRMS allows you to define and set up unlimited benefit plans and carefully track the costs associated with each plan. You can also project future costs.
- Simplify recordkeeping and improve data accuracy.** With all of your data in one central location, it's easier to determine which of your employees participates in each benefit plan. An HRMS greatly reduces the risk of inaccurate data in your database.
- Communicate more effectively with employees.** An HRMS enables you to produce employee communications more easily. Distribute announcements in an online secure portal using employee self-service. Or easily use your employee database to create a letter or email and distribute it.
- Perform open enrollment more quickly and with less expense.** Online benefits enrollment functionality enables employees to choose the benefits packages they want on a secure website. An HRMS can track the status of enrollment and report on results.
- Calculate accurate payroll.** Integrated payroll software is also updated to reflect current tax rates and rules. It will be ready to produce the new W-2s with health coverage costs included when you are required to print and deliver them.

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