2014 PPACA Overview

57 Million People younger than 65 do not have access to affordable healthcare benefits. Sixty-seven (67%) percent of the population financially resides between 100%-400% federal poverty level. TML IEBP political subdivision business is experiences about a seventy-eight (70.8%) percent population between 100%-400% federal poverty level. Insurance Marketplace Timetable Enrollment began 10.1.13 through 12.1.13. Extension has been applied due to technical difficulties. Extension exists through March 31, 2014 with the possibility of application for exemption due to documented enrollment problems. Federal Government stating website should be updated by the end of November 2013. More than two (2) million Texans will be eligible for tax credits. Texas has more eligible for tax credits than any other state Kaiser Study released 11.5.2013. Medicaid Expansion (average 2.3% rate load) includes age 19-65 who have incomes below 138% of FPL (income determined by modified adjusted gross income (MAGI) from most recent federal income tax filing rules and, pregnant women, families (parents/caretaker relatives). HHS awards Affordable Care Act funds to expand access to care in 236 communities to serve more that 1.25 million.

Patient Protection Affordable Care Act	Employer Size		Funding	
Patient Protection Affordable Care Act Administrative Costs March 23, 2010	**< 50 employees**	**>50 employees**	**Fully Funded Compliance Required**	**Self Funded Compliance Required**
Calendar Year 2012 W-2 Form reporting required to be furnished to employees in January 2013 for employers that were required to file 250 W-2 Forms. Notice 2012-9 includes information on how to report, what coverage to include and how to determine the cost of coverage. September 2013 CBO Budget Outlook Report did not reflect W-2 benefit reporting as a revenue line item.	N/A IRS publishes guidance giving at least 6 months of advance notice of change to the transition.		X	X
Medical Loss Ratio Payment: Employer subsidy vs. employee risk	Return Premium/Contribution excess if loss ratio is <80	Return Premium/Contribution excess if loss ratio is <85	Return Premium/Contribution excess if loss ratio is <85	N/A
Grandfather Status Loss: Plan Years after January 2014 will be mandated to be PPACA Compliant. November 14, 2013: Obama states individuals may keep insurance for another year with appropriate price comparison transparency to the Insurance Marketplace Current Grandfather Groups lose status if they increase in a benefit percentage cost-sharing requirement, regardless of the status: an increase in deductible if out of pocket amount excess medical inflation plus 15%, increase in copayment if the increase exceeds $5 (adjusted for medical inflation) or medical inflation plus 15%. Medical Inflation means the increase since March 2010 in the overall medical care component of the Consumer Price Index for all Urban Consumers (CPI-U) (unadjusted). A decrease in the employer's contribution rate by more than 5% measured by each tier of coverage. Elimination of all or substantially all benefits to diagnose or treat a particular condition. Adding a new overall annual dollar limit or decreasing the overall annual dollar limit in effect on March 2010. Any change must be measured relative to the plan in effect on March 23, 2010. Any of the following plan changes may also trigger the loss of grandfathered status. The addition of a new prescription drug tier with new cost-sharing, an increase in cost-sharing related to wellness incentives or penalties, an increase in retiree self-pay rates, transfer of employees into a less generous plan or plan option where the transfer is not due to bona fide employment-based reason, and certain changes made in response to the Mental Health Parity and Addiction Equity Act such as increasing cost sharing for medical/surgical benefits instead of lowering cost sharing for mental health and or substance use disorder benefits. Changes that do not trigger grandfather status loss: signing a new insurance contract, switching from insured to self-insured coverage, changing third party administrators, pharmacy benefit managers and changing the plan's network or switching PPO networks. Effective Plan Years after 2014 patient protection affordable care act compliance will be required for: attained age twenty-six benefits, no cost-share Phase I-III preventive benefits, network benefit deductible and out of pocket cost shares for emergent and immediate care, appeal procedure, direct access to primary care physicians, pediatricians, and OB-GYNs, compliance with non discrimination rules to prevent favoring highly compensated participants, measurement of provider performance based outcomes. Appropriate disclosure regarding affordability and minimum essential benefits must be disclosed.	Grandfathered Employers Only	Grandfathered Employers Only	Grandfathered Employers Only	Grandfathered Employers Only

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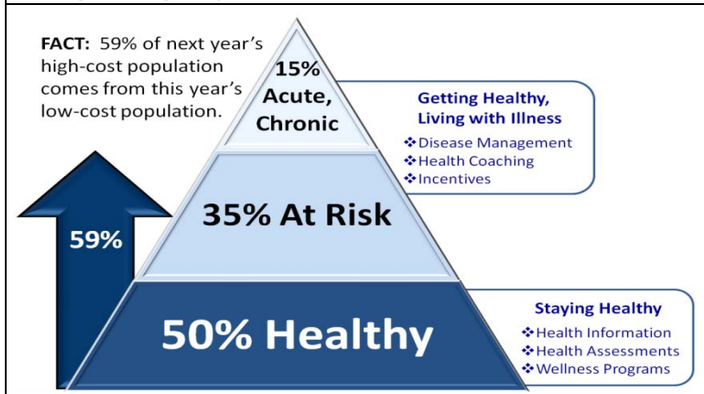
Patient Protection Affordable Care Act Administrative Costs March 23, 2010	**< 50 employees**	**>50 employees**	**Fully Funded Compliance Required**	**Self Funded Compliance Required**
Summary of Benefits and Coverage (SBC) uniform information about the plan and coverage, as well as a uniform glossary of terms commonly used in health coverage, at the time of enrollment and each subsequent year during annual enrollment and upon request. Both documents must comply with certain appearance and format requirements and must utilize terminology understandable by the average plan enrollee. Must be compliant on or after September 23, 2012. The summary must contain information regarding cost sharing, continuation of coverage, benefit limitations and details on where participants can obtain more information. This summary is required in addition to the ERISA summary plan description.. October 2013 update mandate to include reference regarding affordability of plan and compliance to minimum essential coverage. Failure to comply will result in a $1,000 fine per employee	Compliance Required	Compliance Required	Compliance Required	Compliance Required
Health Flexible Spending: In 2013 **PPACA** implemented maximum plan year dollar limit of $2,500 and made the requirement of a provider prescription order to purchase over the counter medication. IRS Notice 2005-42 incorporates a two month and fifteen day extension of section 125 funds. IRS Notice 2012-40 allows up to a $500.00 carryover of unused dollars (for unreimbursed health claims only) from one flex year to the next if not in excess of plan year capped dollar amount of $3,000.00. 2013 amendment or new contract will be required. Employer will have the option upon December 2013 Plan Year's thereafter to execute a Section 125 2 month 15 day grace period agreement or a up to $500.00 unreimbursed healthcare Carry Over Agreement.	Compliance Required	Compliance Required	Compliance Required	Compliance Required
Wellness Compliance: Currently 20% variance in review for 30% variance PHSA Section 2705 approved. Confirmation of Completion: Biometric Screening/Health Power Assessment. Tobacco use 50% variance PHSA Section 2705. Well Woman Act: Expanded Coverage of Preventive Services for Women without cost sharing expenses: Contraceptive benefits, breastfeeding support, domestic violence screening Over the Counter Prescriptions: Doctor Ordered: Aspirin, Folic Acid, Fluoride Chemoprevention Supplements, Iron Deficiency Supplements, and Vitamin D supplementation to prevent falls in community-dwelling adults age 65 years and older who are at an increased risk for falls.	Awaiting final Regulations	Awaiting final Regulations	Awaiting final Regulations	Awaiting final Regulations
	Awaiting final Regulations	Awaiting final regulations	Awaiting final regulations	Awaiting final regulations
Patient Centered Outcome Research Institute (PCORI): The "plan sponsor" (self-funded designated employer) fee is addressed under Section 4376 for applicable self-insured plan. The current regulations identify a fee structure for plan years 2012-2018. The annual filing will be identified on the revised IRS Form	$1.00 PPPY Compliance Required	$1.00 PPPY Compliance Required	Compliance Required	Compliance Required

Patient Protection Affordable Care Act	Employer Size		Funding	
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720. Fees must be paid by July 31, 2013 of the calendar year immediately following the last day of the plan years **ending after September 30, 2012 revised to Plan Years on or after October 1, 2012).** Fee is $1.00 per participant for 2012, **$2.00** per participant for 2013, and fee will be indexed for future payments. HRA and H.S.A. counts will be fee applicable if integrated with a health plan. HRA 's must be linked to group health care coverage in order to continue to offer benefits in 2014. Only exclusion is RRA's. If a retiree is accessing HRA dollars, the retiree will not be eligible for premium tax credits. Annually, an employer is mandated to allow opt in/out of HRA accounts which could assist in the spend down of the account. Eligibility audits and documentation requirements should be implemented Public Sector trend is 8% -10% error rates. Private Sector is 6%-8% error rate.				
Review and Revise your Notice of Privacy Practices and make necessary revisions by September 23, 2013, the compliance deadline for the new rules. If you maintain your Notice of Privacy Practices on your website, you must post the revised notice to the website as of the effective date of the new notice. Distribution of a paper copy of the revised notice to each covered employee enrollee in the next annual health plan mailing, usually your open enrollment period	x	x	X	X
Review and Revise you Business Associate Agreement executed on or after January 25, 2013 the compliance date is September 23, 2013. For contracts already in existence prior to January 25, 2013, the earlier of: The date the contract or other arrangement is renewed or modified on or after September 23, 2013 or September 22, 2014				

Plan Year	First PCORI Payment Due Date
November 1, 2011 to October 31, 2012	July 2013
December 1, 2011 to November 30, 2012	July 2013
January 1, 2012 to December 31, 2012	July 2013
February 1, 2012 to January 31, 2013	July 2014
March 1, 2012 to February 28, 2013	July 2014
April 1, 2012 to March 31, 2013	July 2014
May 1, 2012 to April 30, 2013	July 2014
June 1, 2012 to May 31, 2013	July 2014
July 1, 2012 to June 30, 2013	July 2014
August 1, 2012 to July 31, 2013	July 2014
September 1, 2012 to August 31, 2013	July 2014
October 1, 2012 to September 30, 2013	July 2014

Patient Protection Affordable Care Act	Employer Size		Funding	
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Exchange Notice Requirement: ***(Distribution delayed until October 2013)*** ***Penalty delayed*** Notice should include information regarding employee purchases coverage through an Exchange then they may no longer be eligible for employer contribution toward health coverage on a pre-tax basis. Notices must be submitted to new hires within **14 days of hire**. The law also requires the notice to explain that if the employer plan's payment of plan costs is less than 60%, the employee may be eligible for a premium assistance tax credit if he or she purchases coverage in the Exchange. Awaiting Guidance. Starting in 2014, small business with up to 100 employees* (states may apply waiver to insure business with up to 50 employees in their xchange) and individuals without employer-sponsored coverage will be able to buy insurance on state-administered "exchanges." State-based Exchanges will be administered by a government agency or non-profit organization. A qualified health plan, to be offered through the new American Health Benefit Exchange/Insurance Marketplaces must provide essential health benefits which include cost sharing limits. No out-of-pocket requirements can exceed those in Health Savings Accounts, and deductibles in the small group market cannot exceed $2,000 for an individual and $4,000 for a family. On line enrollment for the SHOP on-line enrollment will not be available until January 2014. Minimum employee participation mandate of 75%. Employer Premium Tax Credits that provide coverage for 25/50 or fewer employees with $50,000/$40,000 maximum average wage. Premium Tax Credit for employer maximum of 35%, Tax Exempt employer maximum 25% of 50% of contribution/premium payment.	Compliance Required	Compliance Required	Compliance Required	Compliance Required
Model COBRA Continuation Coverage Election Notice: The notice must contain information about individual's right to continue health care coverage in current plan as well as other health coverage alternatives that may be available through the Health Insurance Marketplace with tax credits. Additional note requirement that pre-existing condition exclusion and/or limitations will be prohibited **beginning January 2014** under the Patient Protection Affordable Care Act. IRS proposed regulations lower and middle –income employees who quit or are laid off, or employees' widowed or divorced spouses who are eligible for COBRA but do not enroll, will be entitled to premium subsidies to buy health insurance in public exchanges that begin operating in 2014. Currently proposed regulations state that the COBRA plan would have to fail the 9.5% affordability test and satisfy the 400% federal poverty level test to access COBRA single-coverage. Comments are being received on this proposed regulation and potential penalty.	Compliance Required	Compliance Required	Compliance Required	Compliance Not Required
HITECH Upgrades: *4010 to 5010 **June 2012**, *Health Plan Identifier Application **November 5, 2014 small plans November 5, 2015.** All covered entities must use HPID s in standard transactions by **November 7, 2016.** ***Electronic Fund Transfers**: V-Payment/ACH Payment **by January 2014**. Explanation of Benefit and Explanation of Payment documentation will be implemented. Group health plans must file a certification with the Secretary of HHS that their plan is in compliance with the "administrative simplification" rules for electronic fund transfer, health claim status and health care payment. *Conversion from ICD 9 to ICD 10 **October 2014.** Hybrid timeline for ICD 9 and ICD 10 October 2014 *Automatic electronic > 200 enrollment 2014 possible delay. *On-Line Enrollment with price comparison calculator *Healthcare Transparency/Cost Estimator Services/Price Awareness *Electronic Medical Records Dec 31, 2015 Delayed until January 2012 *Standardized Web Portals The penalty for non-compliance is $1.00 per covered life per day of non-compliance, to a maximum of	Compliance Required	Compliance Required	Compliance Required	Compliance Required

Patient Protection Affordable Care Act	Employer Size		Funding	
Patient Protection Affordable Care Act Administrative Costs March 23, 2010	**< 50 employees**	**>50 employees**	**Fully Funded Compliance Required**	**Self Funded Compliance Required**
$20.00 per covered life per year. A double penalty applies in the case of a misrepresentation by the employer.				
Employer Cost Share Program/Pay or Play Penalty: **Beginning Plan Years January 2014 and thereafter (July 2, 2103 announcement that the IRS penalty will be delayed until January 2015 HB 2667 vote 246-161 individual mandate 251-174 vote)** the pay or play rule will be effective. If employers with at least 50 full-time equivalent employees fails to offer minimum essential major medical health coverage to its full-time employees and their dependents, and at least one full-time employee who works on average 30 hours or more a week/130 hours a month and/or 120 consecutive seasonal days a year obtains a subsidized coverage in a state health insurance Exchange/Insurance marketplaces the 4980H(a) penalty is $2,000 times the total number of full-time employees employed by the employer for employees in excess of the employee deductible of thirty (30). Hours of service include both hours paid based on performance of duties as well as paid time for vacation, holiday, illness, incapacity (including disability) layoff, jury duty, military duty or leave of absence. Special rules apply to unpaid leave subject to the FMLA of 1993 and the Uniformed Service Employment and Reemployment Rights Act of 1994 that the averaging method exclude if from calculation so that the employee is not disadvantaged by taking these leaves. Rules only apply to employees who are in continuing service, not to those who are terminated and then rehired. Employees rehired with less than a 26 week break in employment may apply "rule of parity" if rehired with a greater than 26 week break, will be treated as new hire. Employees not paid on an hourly based may be calculated on (1) counting actual hours of service; (2) using a days-worked equivalency, which credits the employee with 8 hours of service for each day or (3) using a weeks-worked equivalency of 40 hours of service per week. A large employer will be treated as having offered coverage to its full-time employees and their dependents for a calendar month if, coverage is offered to 95% of its full-time employees as long as dependent coverage was also offered. Failure to offer coverage to 95% of all full-time employees will result in the 4980H (a) penalty being imposed. 12.13.13: Status of Volunteer Firefighters under the Affordable Care Act At this time the IRS has not initiated a formal rulemaking proceeding to determine whether volunteer firefighters (or any other volunteer) are to be considered employees for purposes for the Accountable Care Act. Therefore, it would be premature to draw any conclusions on how the IRS could rule on this issue or to take action n support of any legislation without more clarification. If volunteer firefighters are considered employees for purposes of the Accountable Care Act, many volunteer fire departments may find they have more than fifty (50) employees and are therefore subject to the Accountable Care Act employer mandate, which does not go into effect until January 1, 2015. Measurement Period: of 12 consecutive months not less than 6/3 months. Begin no later than July 1, 2013 and ends no earlier than 90 days before the first day of the plan year that begins on or after January 1, 2014. Payroll Departments need to review reporting for hours worked, measurement period, high turnover positions, unpaid work hours, employees being paid outside of payroll, unpaid work hours, variable hourly employees, temporary staff, terms and rehires. Typically independent contractors, sole proprietors and partners are not included in the measurement period. Contract workers from a professional staffing agency will defer to state definition of employee for measurement requirement application. Affordability Test/Employer Shared Responsibility Penalty: If the coverage does not meet the "affordability test" or the "minimum value test" and at least one full time employee obtains subsidized coverage in a state health insurance Exchange/Marketplaces than the employer would pay a 4980H (b) penalty. $3,000	Compliance Not Required	Compliance Required	> 50 full time equivalent employee's compliance required: **Small employer (generally under 50) maximum deductible $2,000 individual and $4,000 family and maximums for High Deductible Plans Out of Pocket Maximums cannot exceed $6,250 Out of Pocket and $7,500 family Out of Pocket.** **Awaiting final regulations**	>50 full time equivalent employees compliance required

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times each full-time employee who receives subsidized coverage in Exchange/Marketplaces. Penalty (b) impacts the employer who offers health coverage to its full-time employees and their dependents but the coverage does not meet the "affordability test" or the minimum value test and at least one full-time employee obtains subsidized coverage in a state health insurance exchange, then the employer would pay a 4980H (b) penalty. The amount would be $3,000 times each full time employee who receives subsidized coverage in Exchange with a maximum of the 4980H (a) penalty amount that would have been due if the employer did not receive coverage. » "Affordability Test" allows the employers to measure 9.5% of the employee's wages from the employer, as reported in Box 1 of the Form W-2 instead of household income in regards to the most cost effective minimum qualified health plan option actuarially equivalent to the Bronze Plan. » Employers should be aware that there are two "play or pay" tests – the **objective test** and the **subjective test**. The objective test asks whether the covered employer provides any level of health care coverage. If the answer is no, the employer penalty is $2,000 per employee (with a 30 person deductible). The subjective test asks if the employer provides health care coverage, is that coverage sufficiently affordable and robust. Coverage is sufficiently affordable if the cost is 9.5% or less of employee's W-2 form compensation for the most cost effective single coverage for an employee's benefit plan. » The Penalty will be the lesser of the objective and subjective test-the IRS wants to make sure the employers who are providing some level of coverage do not end up paying more in penalties than an employer who is not providing any coverage. » Employers will be penalized if an employee receives a premium tax credit provided by the Federal Government to Insurance Marketplaces/Exchanges on behalf of individuals whose income is between 100 and 400 percent of the poverty level. The existence of premium tax credit matters to employers because a penalty will apply if one employee receives a premium tax credit. Minimum Essential Major Medical Actuarial Value Calculator: 60% Bronze Plan/Individual Deductible not excess of $2,000 individual/$4,000 family for small employers. Maximum Out of Pocket: The 2013 maximum out of pocket for major medical plans currently excluding prescription plans is $6,250 for single coverage and $12,500 for family. The 2014 maximum out of pocket has not been released, discussion for 2014: Individual $6,350, Family $12,700. » 7.25.13 Delayed Notice for maximum out of pocket mandate ▪ There is a transition rule for the first plan year with respect to prescription drug coverage. ▪ For plan years beginning on or after January 1, 2015, the out of pocket maximum must be applied to both major medical and prescription drugs together. For the first plan year beginning on or after January 1, 2014, if the plan has separate service providers for major medical and prescription drugs, the out of pocket maximum is applied separately to each service provider. ▪ The out of pocket maximum applies to all non-grandfathered self-insured plans. 12.11.13 The 2014 out of pocket maximum for individuals is **$6,350 and $12,700** for a family. For 2014 only, if a plan or issuer uses a pharmacy benefit manager to administer prescription benefits, the prescription drug coverage is permitted to have its own out of pocket maximum up to the 2014 limit and the major medical coverage is also permitted to have its own out of pocket maximum up to the 2014 limit. All out of pocket maximums must be coordinated for 2015. The deductible limits of $2,000 and $4,000 apply only to the individual and small group markets and to not				

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apply to TML IEBP. The deductible and copayment amounts do not accumulate for benefits that are not essential benefits. The out of pocket maximum is $6,350 for self-only coverage and $12,700 for family Coverage. For 2014, if a plan issuer uses a pharmacy benefit manager to administer prescription benefits, the prescription drug coverage is permitted to have its own out of pocket maximum up to the 2014 limit and major medical coverage is also permitted to have its own out of pocket maximum up to the 2014 limit. The out of pocket maximum regulations do not define "cost Sharing". The definition of cost sharing excludes premiums/contributions, deductible, benefit percentage/coinsurance, out of network costs and out of benefit plan scope. There is not definition, at this time, for essential health benefits for self-insured health plans. HHS has informally indicated that such plans may use any state benchmark plan to define essential health benefits.				
Essential Benefits: Ambulatory patient services, Emergency services, Hospitalization, Maternity and Newborn Care, *Mental Health and Substance Use Disorder services (including Behavioral Health* treatment), *Rehabilitative/Habilitative* Services and Devices, *Pediatric Services including Oral and Vision* Services (Pediatric defined child to attained 19 years of age), Laboratory Services, Preventive and Wellness, Chronic Care Management, Prescription drugs (Use of US Pharmacopeia's (USP) Model Guidelines as a common organizational tool for plans to report drug coverage. Plan must offer one drug for each USP category and class or the number of drugs in the EHB benchmark Plan), Prior Authorization can be used as long as it is not discriminatory Health Plans have two options: Cover at least the greater of: One drug in every category Same number of drugs in each category and class as the benchmark plan. Essential Benefits defined by the State Benchmark Plan. Plan may have limitations on coverage that differ from the limitations in the EHB – benchmark plan, but covered benefits and limitations on coverage must remain substantially equal to the benefits in the EHB-benchmark plan. Out of Pocket Maximums: Deductibles: Individual $2,000 Family $4,000 Out of Pock Individual $6,250, Family $12,500- Discussion for 2014 Individual $6,350, Family $12,700. Actuarial Value(AV) Calculators being designed to assist in measurement of minimum value. Mental Health and Substance Abuse Disorder Parity (substantially 2/3 of benefits) and predominately (1/2 of benefits) to medical and surgical care for all Levels of Care Plan Years July 2014 thereafter. Six classification: network inpatient and outpatient, out of network inpatient and outpatient, emergency room and prescription including medical necessity decisions. EAP excluded. **December 31, 2013** Minimum Essential Benefit Compliance delayed the effective date until 2015 (along with the delay of the employer penalty provision.) The first required reports will occur in early 2016 based on 2015 information. The 6055 reporting requirement is to provide information regarding MEC (minimum essential coverage) as an aid in enforcing the individual mandate provision of the Accountable Care Act. The following entities are responsible for filing the section 6055 return with respect to MEC provided under a group health plan: 1. Health insurance issuer with respect to fully insured coverage 2. In the case of a self-insured group health plan, the "plan sponsor" 3. In the case of a self-insured multiemployer plan, the association, committee, joint board of trustees or other similar group of representatives of the parties who establish or maintain the plan 4. The employee organization (i.e., union) in the case of a self-insured plan maintained solely by the employee organization 5. In the case of a self-insured governmental group health plan, the governmental employer may enter into a written agreement with another governmental unit to make the required reporting. The 6055 return is required to be filed with the IRS no later than February 28 if filing non-electronically, March 31 if filing electronically. The IRS requires 6055 returns to be filed electronically unless the aggregate	Compliance Required	Compliance Required	Compliance Required	Compliance Not Required

Patient Protection Affordable Care Act	Employer Size		Funding	
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of all returns (w-2's 6055 returns) the reporting entity is required to file less than 250.				
Information / Comments				
Information relating to the Reporting Entity				
Name, address and EIN for the person required to make the return				
Information relating to Health Coverage				
Name, address and TIN (or date of birth if a TIN is not available) of the responsible individual — The statue refers to information for the "primary insured". The proposed rules adopt the term "responsible individual" to reflect self-insured plans. Thus, for example the case of a self-insured group health plan, the responsible individual would normally be the employee.				
Name and TIN (or date of birth if a TIN is not available) of each individual covered under the plan — The entity required for reporting should make reasonable efforts to obtain the TIN of all persons covered under the plan (e.g. including dependents). However, the preamble indicates that if such reasonable efforts are made, penalties will not be imposed for failure to provide the information. Reasonable efforts include two consecutive annual attempts to obtain the information after the first unsuccessful attempt.				
For each covered individual, the months for which, for at least one day, the individual was enrolled in coverage and entitled to receive benefits. — The proposed rules include additional detail on coverage periods that must be included in the return.				
Information relating to fully-insured employer-provided coverage				
Name, address and EIN of the plan sponsor				
Whether the coverage is SHOP coverage — The statue also provides that the 6055 return is required to include the amount of any required employer premium. This requirement is not included in the proposed regulations.				
<u>What is the purpose of the 6056 reporting requirement?</u> The purpose of the 6056 reporting requirements is to assist Treasury with administration of the pay or play employer penalty rules set forth in Code section 4980H. Treasure also notes that the 6056 reporting requirements are designed to assist Treasury with administration of the premium tax credit under Code section 36B. <u>Who is required to file a 6056 return?</u> Each employer member is required to satisfy the section 6056 reporting required, however, employer members may contract with third parties to assist with the filing requirements. For example, the plan sponsor of a plan may report the information required by section 6056 to the IRS on behalf of each participant employer member who participates in the plan, however, the employer member must sign the form and the employer member remains liable for penalties arising from the third party's failure to accurately and timely file-i.e., the employer member is not absolved of its obligation simply because a third party has agreed to prepare and file the form.	Compliance Required	Compliance Required	Compliance Required	Compliance Required

Patient Protection Affordable Care Act	Employer Size		Funding	
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The Multiemployer Plan

The multiemployer plan administrator may file a 6056 return for the contributing employer member with respect to the employer member's full-time employees eligible for the plan but the employer member must sign the form. The employer member would file a separate 6056 return for all other full-time employees.

When is the 6056 return required to be filed?

A return is required to be filed with the IRS by no later than February 28 if filing non electronically –March 31 if filing electronically.

The IRS requires 6056 returns to be filed electronically **unless** the aggregate of all returns (W-2's, 6056 returns) is less than 250.

Information	Comments
Name, address and EIN of ALE employer member	
Name and telephone number of contact person	
Calendar year being reported	
Certification as to whether the employer member offered to its full-time employees (and their dependents) the opportunity to enroll in an eligible employer sponsored plan by calendar month	Presumably, this appears to apply at the employer member level. If so, it is unclear whether certification can be made if coverage is not offered to ALL full-time employees each month. If yes then the number of full-time employees each month (see below) would arguable not be required.
The number of full-time employees of the employer member each month	This will enable the IRS to determine which "bucket of excise tax penalty the employer member may be in (if at all) - "sledgehammer" or "tackhammer". An employer member is in sledgehammer bucket if it fails to offer MEC to at least 95% of its full time employees during the month. It is in the tackhammer bucket if it fails to offer coverage to 100% of its full time employees but offers to at least 95% OR the coverage is not affordable and/or does not provided minimum value.
For each full-time employee, the name, address and Tin and the number of months actually covered under the plan	For penalty/premium tax credit purposes, this information is relevant ONLY to the extent the coverage offered isn't affordable or doesn't provide minimum value. Keep in mind coverage could be affordable under the employer penalty provisions but not necessarily under the premium tax credit provisions. However the information is relevant for purposes of the individual mandate and will be provided on the 6055 return
For each full-time employee, the employee's share of the lowest cost monthly premium for self only coverage that also provides minimum value	

Patient Protection Affordable Care Act	Employer Size		Funding	
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The following additional information is expected be requested using indicator codes.

Information	Comments
Whether coverage offered to full-time employee provides minimum value	
Whether the employee had the opportunity to enroll the spouse	
Whether the employee's effective date of coverage was affected by a waiting period	If the employer member cannot indicate that coverage was offered to a full-time employee during a month, an excise tax could apply unless the employer member can show that the employee was in an otherwise applicable permissive waiting period.
Total number of employees for each calendar month	Unclear what purpose this information serves. The penalty buckets described above are determined by reference to the percentage of full-time employees who are offered coverage—not the percentage of employees.
If employer member was conducting business during a month	
If the employer member expects that it will be an ALE in the subsequent year	
For each full-time employee, the level of coverage offered or, if not offered the reason it wasn't offered. For example, an employer member would report the following through a code (i) if coverage was offered, the level of coverage-employee only, employee and employee's dependent's only, employee and employee spouse only or family (ii) that coverage was NOT offered during a month but (a) the employee was in a waiting period (b) the employee was not full-time that month; (c) the employee was not employed that month or (d) no other exception applies; (iii) coverage was offered but the employee was not full-time and (iv) the employer met one of the affordability safe harbors.	These specific codes are designed to fill gaps in the general reporting requirements identified in A above; however, the reporting required here is meticulous.

What information is required to be included on the employee statement?

A form must be furnished to the employee that identifies the following information:

Name address and TIN of employer member

Information included in the 6056 return filed with the IRS with respect to that full-time employee.

Presumably, this includes the following:

1. Number of months covered
2. Employee's share of premium/contribution

Patient Protection Affordable Care Act	Employer Size		Funding	
Patient Protection Affordable Care Act Administrative Costs March 23, 2010	< 50 employees	>50 employees	Fully Funded Compliance Required	Self Funded Compliance Required
3. Whether coverage provides minimum value 4. Whether spouse may be enrolled 5. Waiting period 6. Reason coverage not offered Exact elements from the 6056 return filed with IRS that must be furnished to full-time employees How is the 6056 information reported? As noted above, the 6056 return will be filed electronically unless the employer member qualifies for a small filer exemption, which is based on the number of all returns – not just the 6056. It appears that the 6056 information will be reported on a yet to be developed for 1094 and 1095. Employer members will file an employee statement on 1095-C as well as a transmittal form, 1094-C for all returns. Generally, the employee statement furnished to the employee must be mailed however, it can be provided electronically if the following requirements are satisfied. 1. Employee must affirmatively consent to receive the statement electronically. The consent must be electronic or on paper if confirmed electronically. 2. Certain requirements regarding withdrawal of consent must be satisfied. 3. Notice of a material change in software must be provided. Prescription covers at least the greater of one drug in every U.S. Pharmacy Category				
90 day limitation on Waiting Periods: January 1, 2014 thereafter. A group may not apply any waiting period that exceeds 90 days. Note: Waiting period of more than 90 days are subject to a $600 per employee fine.	Compliance Required	Compliance Required	Compliance Required	Compliance Required
Prohibition of Pre-Existing conditions for >19 years of age participants Plan Years Jan 2014 thereafter	Compliance Required	Compliance Required		
Individual Mandate: Health Care Reform requires individuals to obtain "minimum essential coverage" Waivers will be allowed for specified individuals and circumstances. 2014 Tax penalty is $95 per individual to a maximum of $285 per family, or 1% of household income, 2015 Tax penalty is $325 per individual to a maximum of $975 per family, or 2% of household income, 2016 Tax penalty $695 per individual to a maximum of $2,085 per family, or 2 1/2% of household income. 12.19.13 The Department of Health and Human Services issued a bulletin advising consumers "If you have been notified that your individual market policy will not be renewed, you will be eligible for a hardship exemption and will be able to enroll in catastrophic coverage. Sebelius state the premiums for catastrophic plans were on the average about 20% lower than premiums for other plans. 12.23.13 Need to enroll by 12.23.13 for benefits effective 1.1.14. Premium payments are due as late as 1.10.14. Ultimately, a person has until March 31, 2014 for coverage. Must enroll by the 15th of each month to get coverage the 1st of the next month.	N/A	N/A	N/A	N/A
NCQA/URAC Accreditation	Accreditation required for Qualified Health Plan Exchange/Marketplaces recognition	Accreditation required for Qualified Health Plan Exchange/Marketplaces recognition	Accreditation required for Qualified Health Plan Exchange/Marketplaces recognition	Accreditation required for Qualified Health Plan Exchange/Marketplaces recognition
Transitional Reinsurance Fund: The program designed to help stabilize premiums in the individual health insurance market for those with pre-existing conditions, will be effective from 2014 through 2016. Fees of $63.00 PPPY (Employee, Dependent, COBRA, Retirees accessing plan) to support this transitional reinsurance program will be assessed against both insured and self-funded group health plans. HHS will collect the reinsurance fees on an annual basis. By Nov 15 of each year, the contributing entity must submit	Compliance Required	Compliance Required	Compliance Required	Compliance Required

Patient Protection Affordable Care Act	Employer Size		Funding	
Patient Protection Affordable Care Act Administrative Costs March 23, 2010	< 50 employees	>50 employees	Fully Funded Compliance Required	Self Funded Compliance Required
the number of covered lives subject to the fee that calendar year. HHS will notify the contributing entity of the total fee to be paid within 15 days of submission or by December 15. Payment to HHS will be within 30 days of receiving notice of the amounts. Established in each state by January 1, 2014. The program will operate from November 2014 through 2016. November 2014 is projected to be timeframe for first payment. The total amount of fees to be collected over the three-year period is $25 billion. Of this amount, $20 billion will fund the reinsurance program, while the other $5 billion will be paid to the U.S. Treasury. This program, designed to help stabilize premiums in the individual health insurance market for those with pre-existing conditions, will be effective from 2014 through 2016. Health insurance issuers and third party administrators will pay the assessment to fund state nonprofit reinsurance entities, which will establish high-risk pools for the individual market. 11.7.13 received information about a proposed waiver of the reinsurance fee for self-insured, self-administered plans including governmental plans. 12.2.13 received information that the new proposed about for self-funded employers is $44.00 Per Participant Per Year. In discussion at the Federal level that 80% of claims in excess of $60,000 will be paid by the fund original discussion was 80% of claims in excess of $45,000 up to a cap of $250,000.00.				

Patient Protection Affordable Care Act	Employer Size		Funding	
Patient Protection Affordable Care Act Administrative Costs March 23, 2010	**< 50 employees**	**>50 employees**	**Fully Funded Compliance Required**	**Self Funded Compliance Required**
Annual Insurance Provider Fee: Net Premium in 2014/by total industry net premiums from health, vision, dental, and retiree benefits. Take the ration of the net premium per industry premium and multiply the cost to achieve the annual insurance provider fee schedule for 2014=$8B – 2018=$14.3B. Awaiting public comments. Current discussion is in regards to definition of covered entity and will that include self-funded employers or will it only include commercial carriers. Awaiting June 21, 2013 meeting. In some portion of the language it states self-insured and governmental entities are excluded and in other portions of the language it defines self-insured and governmental entities as "covered entities". **Proposed regulation is in comment and definition phase of development.** 12.2.13 Received information that MEWA's, VEBAs and self-funded employers are considered as covered entities and will be included in the Provider Fee payment. The IRS will take into account 50% of the net premiums written for amounts over $25 million and up to $50 million and 100% of the net premiums written that are over $50 million. Thus, for any covered entity with net premiums written of $50 million or more, the IRS will not take into account the first $37.5 million of net premiums written/deductible. If covered entity is exempt from tax under section 501(a) and is described in section 501 (c)(3), (4), (26), or (29), the IRS will take into account only 50% of the remaining net premiums written of that entity (or member) that are attributable to its exempt activities. 12.6.13 Form 8963, Due 5.1 no later than 8.31 2014 Fee Year (Plan Years after 2014) No decision on medical loss ratio rebate calculation. Covered Entity: a health insurance issuer within the meaning of section 9832(b)(2) defined in section 9832(b)(2) as an insurance company, insurance service, or insurance organization that is licensed to engaged in the business of insurance in a State that is submit to State law that regulates insurance (within the meaning of section 5149b)(2) of the Employee Retirement Income Security Act of 1974 (ERISA)) Exclusions from definition of Covered Entity: Self-insured employer: The term covered entity does not include any entity (including a voluntary employees' beneficiary association under section 501(c)(9) (VEBA)) that is part of a self-insured employer plan to the extent that such entity self-insures its employees' health risks. The term self-insured employer means an employer that sponsors a self-insured medical reimbursement plan within the meaning of 1.1105 11 (b)(1)(i) of this chapter. Governmental Entity: the term covered entity does not include any governmental entity. For this purpose, the term governmental entity means (a) the government of the US: (b) any state or a political subdivision thereof (as defined for purposes of section 103) including for example, a State health department or a State insurance commissions: (c) any Indian tribal government (as defined in section 7701(a)(40)) or a subdivision the of (determined in accordance with section 7871(d)) or (d) any agency or instrumentality of any of the foregoing nonprofit corporations. The term covered entity does not include any entity (a) that is incorporated as a nonprofit corporation under a State law, (b) no part of the net earnings of which inures to the benefit of any private shareholder or individual, (c) no substantial part of the activities of which is carrying on propaganda, or otherwise attempting to influence legislation, (d) more than 80% of gross revenues of which is received from government programs that target low-income, elderly or disabled populations.	Awaiting June 21, 2013 regulatory response from comments.	Awaiting June 21, 2013 regulatory response from comments.	Awaiting June 21, 2013 regulatory response from comments.	Awaiting June 21, 2013 regulatory response from comments.

Patient Protection Affordable Care Act	Employer Size		Funding	
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Student Health Insurance	Non Compliant with PPACA	Non Compliant with PPACA	Non Compliant with PPACA	Non Compliant with PPACA
Revision to Provider Payment Model	Provider Delivery System: Fee for Service vs. Shared Risk Pricing	Provider Delivery System: Fee for Service vs. Shared Risk Pricing	Provider Delivery System: Fee for Service vs. Shared Risk Pricing	Provider Delivery System: Fee for Service vs. Shared Risk Pricing
State High Risk Pools	Awaiting final regulations	Awaiting final regulations	Awaiting final regulations	Awaiting final regulations

Patient Protection Affordable Care Act	Employer Size		Funding	
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Medicare Tax Increase for High Earners: Beginning in 2013, individuals making $200,000 and joint filers making $250,000 must pay an increase of 0.9% in the Medicare tax. A 3.8% tax on unearned income for high-income individuals will also take effect. 12.2.13 An employer is required to collect the additional tax from employees only to the extent the employer pays wages to employees in excess of $200,000 in a calendar year. This rule applies regardless of the employee's filing status or other income. Overview of Rules: Married individual filing a joint return: $250,000, married individual filing a separate return $125,000 any other case $200,000. Additional Medicare tax increase 0.9%.	Awaiting final regulations	Awaiting final regulations	Awaiting final regulations	Awaiting final regulations
After January of 2016, the stop loss individual minimum attachment point requirement is raised to $40,000.				Compliance Required
Excise Tax on High Cost Employer-Provided Health Coverage: In 2018, plan administrators will pay a 40% tax for any health insurance plan that is above the threshold of $10,200 for singles and $27,500 for families. This excise tax would apply to the amount of the premium that is above these thresholds.	Awaiting final Regulations	Awaiting final regulations	Awaiting final regulations	Awaiting final regulations
Coverage for routine medical procedures within clinical trial services	Compliance Required	Compliance Required	Compliance Required	Compliance Required
Fair Health Premium	Awaiting final Regulations	Awaiting final Regulations	Awaiting final Regulations	Awaiting final Regulations
>> Tiered Rates with offset of High Risk Managed by the 3 R's: Reinsurance, Risk Corridor, Risk Adjustment	Awaiting final Regulations	Awaiting final Regulations	Awaiting final Regulations	Awaiting final Regulations
>> Age Bands : 0-20; 21-63; > 64 Current TML IEBP Bands: <35, 36-45, 46-50, 51-55, 56-60, 61-65, 66-70, >71 with gender factor variances	Awaiting final Regulations	Awaiting final Regulations	Awaiting final Regulations	Awaiting final Regulations
>> Geographic	Awaiting final Regulations	Awaiting final Regulations	Awaiting final Regulations	Awaiting final Regulations
>> Tobacco 1:5	Awaiting final Regulations	Awaiting final Regulations	Awaiting final Regulations	Awaiting final Regulations
>> Age 1:3	Awaiting final Regulations	Awaiting final Regulations	Awaiting final Regulations	Awaiting final Regulations
>> Community Rating: Health insurance issuers providing individual or small group policies covering 100 or fewer individuals must abide by strict community rating rules with premium variations				
Prohibition of Discrimination: Age, Disability, Life Expectancy	Compliance Required	Compliance Required	Compliance Required	Compliance Required
Automatic Enrollment Employer in excess of 200 employees 2014 **(Delayed)**	Awaiting final regulations	Awaiting final regulations	Awaiting final regulations	Awaiting final regulations
Small Employer Premium Tax Credit: Full Time Employees + full time equivalents +total employees. If the total is less than 25/50 take the total wages of the full time and full time equivalents and divide by number of employees-average wage amount. If the result is less than $50,000 the employer may be able to qualify for the premium credit. TML IEBP has a new bill that dropped on 3.12.13 number 1076. Congressman Hall has introduced the bill with Thornberry as co-sponsor. Employer Premium Tax Credits that provide coverage for 25/50 or fewer employees with $50,000/$40,000 maximum average wage. Premium Tax Credit for employer maximum of 35%, Tax Exempt employer maximum 25%. **12.2.13** For the years 2010 to 2013, many small tax-exempt organizations that provide health insurance coverage to their employees may qualify for a special tax credit. A small tax-exempt employer may be entitled to a maximum credit of 25% of the employer's health insurance premium expenses. Eligible small tax-exempt employers described in Code section 50(c) may claim the refundable credit by filing a Form 990-T with an attached Form 8941 showing the calculation of the claimed credit. A tax-exempt employer is not eligible to claim the credit unless it is an organization described in Code section 501 (c) that is exempt from tax under Code section 501 (a). An enhanced version of this credit goes into effect on January 1, 2014. The maximum credit will increase from 25% to 35%. See www.irs.gove for more information.	Recipients are Qualified Health Plans	N/A	25/50 fewer employees	Most self-funded groups are larger than 25/50 employees.
Web Portal Information	see fully or self funded compliance	see fully or self funded compliance	Compliance Required	Compliance Not Required

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Patient Protection Affordable Care Act Administrative Costs March 23, 2010	< 50 employees	>50 employees	Fully Funded Compliance Required	Self Funded Compliance Required
	guidelines	guidelines		
Texas Emergency Room and Anesthesiologist Network Providers	Minimize Covered Individual Out of Pocket Expenses	Minimize Covered Individual Out of Pocket Expenses	Minimize Covered Individual Out of Pocket Expenses	Minimize Covered Individual Out of Pocket Expenses
Electronic Medical Records: Group health plans must certify to the Society of HHS that they are using electronic systems for processing health claims, enrollment and premium/contributions payments and that their systems are in compliance by December 31, 2015. Delay until Jan 2017.	Awaiting final regulations	Awaiting final regulations	Awaiting final regulations	Awaiting final regulations