# Affordable Care Act:

## A Guide for Self-Funded Plans

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This guide has been prepared by Independence Administrators as a general reference source for you to use.
The guide is not intended to provide legal and or tax advice.

# AFFORDABLE CARE ACT UPDATES

## What's new?

This guide provides information that can help you make important decisions about the health coverage you provide to your plan members. Here are some key components to consider in 2017.

## 2017 Out-of-Pocket Maximums

Out-of-Pocket Maximum (OOPM):

- For self-only coverage —$7,150
- For coverage other than self-only (e.g., family coverage) — $14,300.

For plan years beginning January 1, 2016 or later, individual OOPM applies for coverage other than self-only.

## 2017 HSA/HDHP amounts

Health Savings Accounts (HSA). The annual contribution limit for HSA arrangements in 2017 is:

- $3,400 for self-only coverage ($50 more than 2016); and,
- $6,750 for family coverage (unchanged from 2016).

HSA/High-Deductible Health Plans. The minimum deductible for HSA/HDHP arrangements in 2017 is:

- $1,300 for self-only coverage (unchanged from 2016); and,
- $2,600 for family coverage (unchanged from 2016).

The out-of-pocket maximum for HSA/HDHP arrangements in 2017 is:

- $6,550 for self-only coverage (unchanged from 2016); and,
- $13,100 for family coverage (unchanged from 2016).

The annual limit on HSA catch-up contributions, for individuals age 55 and older, remains $1,000.

## Employer shared responsibility

To meet the requirements of the Employer Shared Responsibility provision for 2017, large employers (with 50 or more full-time employees) must offer health coverage that meets the guidelines under the Affordable Care Act (ACA). Generally, a large employer must offer coverage that provides minimum value and is affordable to substantially all of its active, full-time employees (95 percent in 2017). If the employer does not offer coverage or it is not affordable, a penalty may apply.

## Information reporting

- Form 1095-C must be sent to employees by March 2, 2017.
- 1094-C to IRS and copies of 1095-C paper filing are due February 28, 2017.
- 1094-C to IRS and copies of 1095-C, electronic filing are now due March 31, 2017.

## Health and Human Services issues rule to prevent discrimination in health care

The U.S. Department of Health and Human Services Office of Civil Rights (OCR) published a final rule implementing Section 1557 of the Affordable Care Act (ACA).

The rule prohibits discrimination on the basis of race, color, national origin, sex, age, or disability for any health program or activity, for anyone who receives federal funding or assistance, or under any program or activity that is administered by an executive agency or any program or activity administered by an entity established by Title I of the ACA.

## Transitional reinsurance fee

For the 2016 benefit year, the Department of Health and Human Services is offering contributing entities the option to pay the entire benefit year contribution in one payment of $27 per covered employee by January 15, 2017, or two payments: one in January with a payment of $21.60 per covered employee and the remaining payment of $5.40 per covered employee due by November 15, 2017, for the current plan year.

## Grandfathered Plans

Grandfathered plans are exempt from certain provisions of the Affordable Care Act (ACA), while non-grandfathered plans are subject to all ACA provisions. A group health plan that was in existence on or before March 23, 2010, and covers more than one individual on that date is considered "grandfathered," provided the plan follows the grandfathered plan rules of the ACA. Plans may lose their grandfathered status if they make changes that reduce benefits or increase costs to plan members, or do not follow the grandfathered regulations.

The following is a list of provisions that grandfathered health plans are not required to comply with. However, plans may choose to include one or more of these provisions:

- Preventive care
- Women's preventive services
- Internal appeal and external review process
- Choice of a primary care provider
- Referral for OB/GYN services
- Emergency services
- Out-of-pocket maximums
- Clinical trials

Grandfathered plans must offer dependent coverage for adult children up to age 26, including the entire month during which they turn 26, even if the dependent is eligible for employer-sponsored coverage. This change occurred because grandfathered plans originally did not have to offer coverage even if the dependent was eligible for employer-sponsored coverage.

## If you have a Grandfathered Plan

Group health plans must also include a statement in their plan materials to participants or beneficiaries, describing the benefits provided and explaining why the plan is grandfathered as defined by the ACA. Contact information for questions and complaints must also be included. The Department of Labor has also developed sample language.

If a plan is no longer grandfathered, it must comply with all applicable ACA requirements. You may need to add benefits that you may not have had previously when the status changes from grandfathered to non-grandfathered.

# BENEFIT AND PLAN SUMMARY UPDATES

## Out-of-Pocket Maximum (OOPM)

The out-of-pocket maximum (OOPM) is the maximum dollar amount plan members will pay during a plan year for their in-network coverage. OOPM includes deductibles, copayments, and coinsurance for in-network services. OOPM applies to non-grandfathered plans (self-funded and fully insured). OOPM applies to individual and family coverage.

- The OOPM limit for self-only coverage is $7,150 for 2017.
- For coverage other than self-only (e.g., family coverage), the OOPM is $14,300 for 2017.

Beginning in plan years on or after January 1, 2016, the OOPM limit for self-only coverage applies to all individuals regardless of whether the individual is in self-only or family coverage. For example, a family plan for 2017 with a $14,300 family out-of-pocket limit cannot have cost sharing that exceeds $7,150 for any individual member.

The OOPM requirements apply to non-grandfathered self-funded group, individual market, small group, and large group.

## 2017 HSA/HDHP amounts

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- $3,400 for self-only coverage ($50 more than  2016); and,
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- $6,550 for self-only coverage (unchanged from 2016); and,
- $13,100 for family coverage (unchanged from 2016).

The annual limit on HSA catch-up contributions, for individuals age 55 and older, remains $1,000.

# NOTIFICATIONS AND COMMUNICATIONS

## COBRA Notification

The Affordable Care Act (ACA) does not affect the plan sponsor's responsibilities under the Consolidated Omnibus Budget Reconciliation Act (COBRA). However, the ACA has modified the content of the COBRA election notice to include information about the existence of The Marketplace and the potential to receive subsidies, if qualified.

The Department of Labor (DOL) has an example of a **COBRA claims notice** that plans may use to satisfy both the COBRA election notice and the employee notification requirements. An example is available on the DOL's website.

## Summary of Benefits and Coverage (SBC)

The Department of Health and Human Services (HHS), the Department of Labor (DOL) and the Department of the Treasury finalized the Summary of Benefits and Coverage

The SBC template updates include an additional example of coverage and language and terminology to improve consumers' understanding of their health benefits coverage. A new example for a foot fracture explains what a plan covers in an emergency.

Under the ACA, insurers and health plans are required to provide a brief summary of what the plan covers and the cost sharing responsibility for the consumer. Plans and insurers are also required to provide a comprehensive uniform glossary of terms.

Health plans must use the finalized SBC template beginning on the first day of the first open enrollment period that begins on or after April 1, 2017.

## Health and Human Services issues rule to prevent discrimination in health care

The U.S. Department of Health and Human Services Office of Civil Rights (OCR) published a final rule implementing Section 1557 of the ACA.

The rule prohibits discrimination on the basis of race, color, national origin, sex, age, or disability for any health program or activity, for anyone who receives federal funding or assistance, or under any program or activity that is administered by an executive agency or any program or activity administered by an entity established by title I of the ACA.

# FEES FOR GROUP HEALTH PLANS

## Patient-Centered Outcomes Research Institute

The Affordable Care Act (ACA) established a private, independent, non-profit, non-governmental organization, the Patient-Centered Outcomes Research Institute (PCORI), whose role is to fund and produce reliable, evidence-based research. Its work is guided by patients, caregivers, and the health care community to determine the comparative clinical effectiveness of medical treatments.

Self-funded plan sponsors are responsible for reporting the PCORI fee. It is based on the average number of lives covered under the health insurance policy or self-funded plan ("covered lives" includes plan participants and covered dependents/beneficiaries), multiplied by the applicable dollar amount for that plan year.

The 2016 PCORI fee to be paid in 2017 is $2.17 per participant, which is due July 31, 2017.

## Reporting and paying the fee

The group plan sponsor must pay the PCORI fee annually and report it on Internal Revenue Service Form 720, Quarterly Federal Excise Tax Return, under "Part II," on line 133. The fee is due each year by July 31, and is scheduled to be phased out after October 1, 2019.

| If your plan ends | Applicable Dollar Amount | Payment Due Date |
|---|---|---|
| on or after January 1, 2016, and before October 1, 2016 | $2.17 per life covered | July 31, 2017 |
| on or after October 1, 2016, and before January 1, 2017 | $2.17 per life covered + inflation | July 31, 2017 |

## Transitional Reinsurance Fee

The transitional reinsurance fee is assessed on health insurers and group sponsors of self-funded health plans to help stabilize insurance premiums in the individual health insurance marketplace. The fee, which took effect January 1, 2014, is planned to be levied through 2016. Membership counts are due to the federal government by November 15 of the current year.

The fee applies to the number of covered lives within a group health plan. Contributions can be paid in full or split into two payments. The $27 per covered employee fee for 2016 can be paid in full by January 15, 2017, or in two payments: one for $21.60 per covered employee by January 15, 2017, and the second payment of $5.40 per covered employee by November 15, 2017.

## Calculating and paying the fee

The transitional reinsurance fee is filed annually through pay.gov. Annual registration is required by November 15 of the current year.

The PCORI and Transitional Reinsurance fees are calculated by mutiplying the average number of covered lives for the plan year by the applicable dollar amount. To determine the average number of lives covered under a self-funded plan during a plan year, a plan sponsor is permitted to use one of these methods:

- Actual count method. The plan counts the total covered lives for each day of the plan year and divide that number by the total number of days in the plan year.
- Snapshot methods
  - Snapshot count method. The plan counts the number of covered lives on at least one day in each quarter of the plan year and divide by the number of dates chosen. (The dates in the second, third, and fourth quarters must correspond to dates in the first quarter).
  - Snapshot factor method. Similar to the Snapshot count method, except that covered lives, on any date, would be equal to the sum of a) the number of employees with single coverage, plus b) the number of employees with coverage other than single coverage multiplied by 2.35. This method may be advantageous for employers with a high member-to-employee ratio for employees enrolled in coverage other than single coverage.
- Form 5500 method. For self-only coverage, the plan determines the average number of covered lives by combining the number of participants at the beginning of the plan year with the total number of participants at the end of the plan year (each as reported on Form 5500) and divide by two. For plans with self-only and other coverage, the average number of total lives is the sum of total participants covered in the beginning and the end of the plan year.

There is no single method that yields the best calculation for all organizations. There are several scenarios that can be analyzed using the permitted methods and dates to determine the lowest fee calculation.

# REPORTING REQUIREMENTS

## Employer Shared Responsibility

To meet the requirements of the Employer Shared Responsibility provision, large employers must offer health care coverage that meets guidelines under the Affordable Care Act (ACA). Generally, large employers must offer coverage that provides minimum value and is affordable to a substantial number of their active, full-time employees (95 percent for 2017). If the employer does not offer coverage or it is not affordable, a penalty may apply.

The Employer Shared Responsibility provision provides transition relief to employers, insurers, and other entities that provide Minimum Essential Coverage to adapt their health coverage and reporting systems. Both the information reporting and the Employer Shared Responsibility provisions took effect in 2015. Employer groups must report to the IRS under the Employer Shared Responsibility provision in 2017 for 2016 benefit year.

## Forms

Sections 6055 and 6056 of the Internal Revenue Code are for the Employer Reporting requirements. Section 6055 requires each employer offering minimum essential coverage to file a return with the IRS and furnish a statement to individuals. Section 6056 requires large employers to file with the IRS and provide statements to their full-time employees about the health insurance coverage the employer offers.

- Form 1095-C shows what coverage the employer offers their employees
- Form 1095-C: Detailed Employer-provided Health Insurance Offer and Coverage. This is sent to employees and submitted to the IRS by the group.

# PENDING REQUIREMENTS

## Excise Tax on High-cost Plans (Cadillac Tax)

The date to establish the Excise Tax was originally set to begin in 2018, but was delayed until 2020. The excise tax will help offset the costs of health care reform and encourage employers to provide cost-effective plans.

# INDEPENDENCE ADMINISTRATORS IS HERE TO HELP

Independence Administrators offers tailored, cost-effective, third-party administration (TPA) solutions for organizations based in the Philadelphia, PA region that self-fund, or may be considering self-funding their health benefits.

Independence Administrators offers an exceptional commitment to customer service and high-value, cost-effective benefits administration. Independence Administrators is focused on providing value to its customers. We deliver comprehensive, centralized health benefits management services that provide seamless, consistent service for your plan whether local or national.

In addition to this Employer Guide, Independence Administrators offers additional educational resources, including a quarterly Regulatory Updates newsletter and Special Regulatory Bulletins.

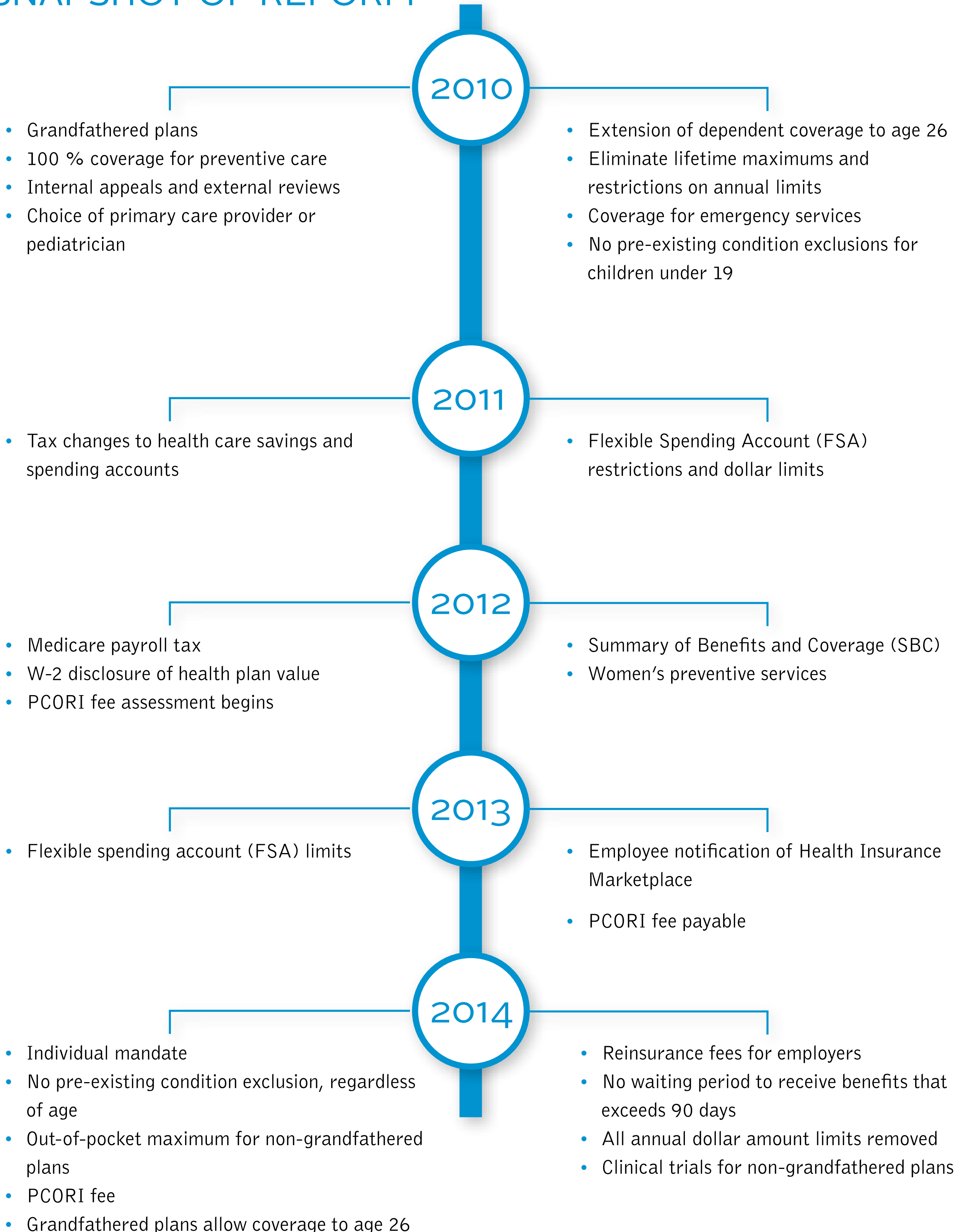
# Resources

- Snapshot of Reform (2010 - 2020)
- ACA Benefits and Coverage

Sources for this guide include:

- ibxtpa.com
- cms.gov
- dol.gov
- federalregister.gov
- irs.gov

# SNAPSHOT OF REFORM



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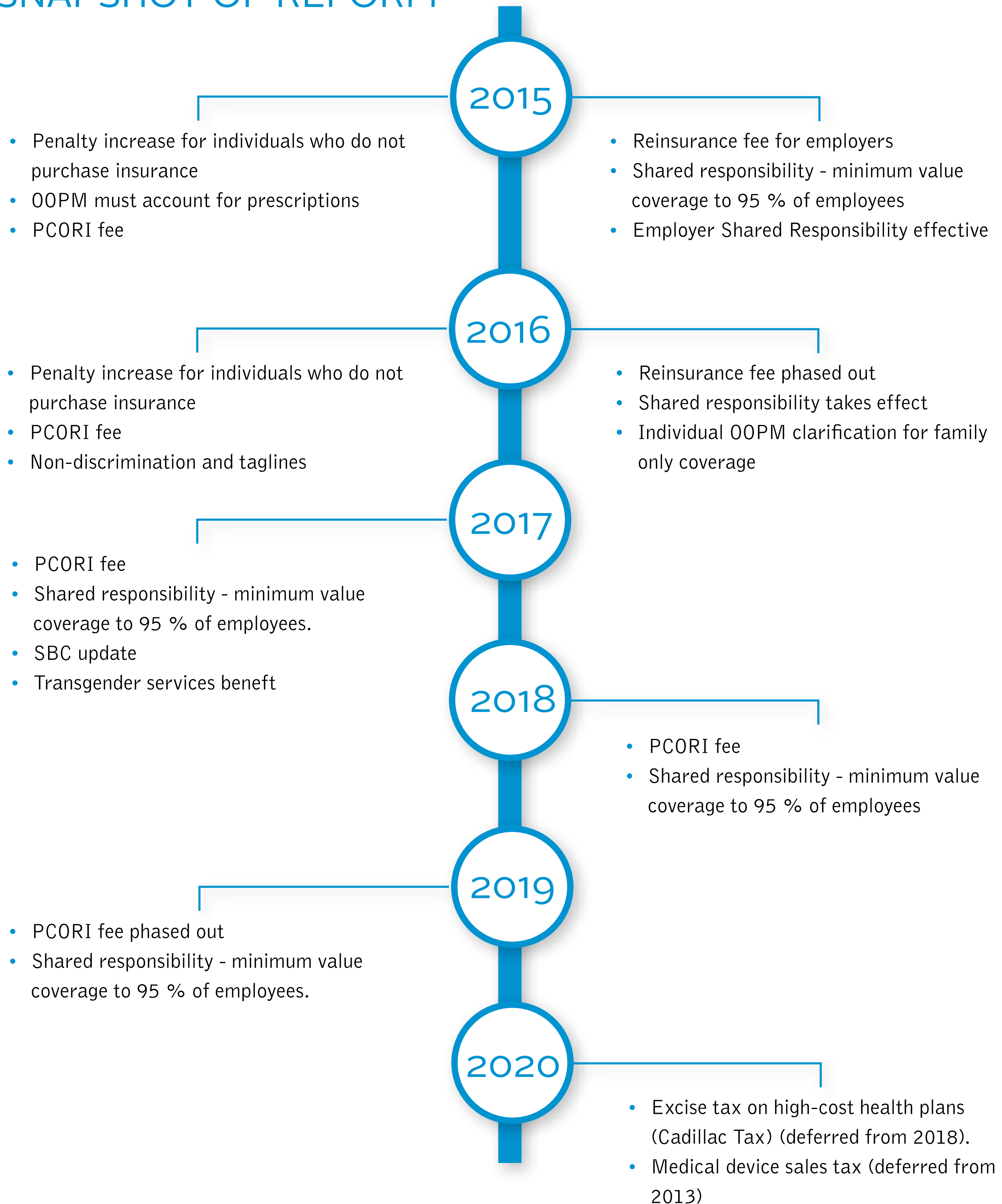


The intent of this timeline is to provide a snapshot of the major provisions for self-funded plans, therefore it should not be viewed as all encompassing.

# ACA BENEFIT AND COVERAGE CHANGES

| ACA Provision | Description | Plans | | Effective Date |
|---|---|---|---|---|
| | | GF | NGF | |
| Preventive care | In-network preventive care covered with no cost sharing | | ✓ | Plan years on or after 9/23/10 |
| Choice of primary care provider | Members can choose any participating primary care provider or participating pediatrician | | ✓ | Plan years on or after 9/23/10 |
| OB/GYN services | No referral or preauthorization is required to see a participating OB/GYN specialist | | ✓ | Plan years on or after 9/23/10 |
| Emergency services | Emergency services from non-network providers must be covered at in-network cost sharing | | ✓ | Plan years on or after 9/23/10 |
| Internal appeals; external review | An internal appeals and external review process must be implemented | | ✓ | Plan years on or after 9/23/10 |
| Annual Limits (increased in 2011 and 2012; eliminated in 2014) | $750,000 annual limit on essential health benefits | ✓ | ✓ | Plan years on or after 9/23/10 |
| | $1,250,000 annual limit on essential health benefits | ✓ | ✓ | Plan years on or after 9/23/11 |
| | $2,000,000 annual limit on essential health benefits | ✓ | ✓ | Plan years on or after 9/23/12 |
| | No annual limits | ✓ | ✓ | Plan years on or after 1/1/14 |
| Lifetime Limits | No lifetime limits on essential health benefits | ✓ | ✓ | Plan years on or after 1/1/14 |
| Pre-existing condition exclusions | No pre-existing exclusions for children under age 19 | ✓ | ✓ | Plan years on or after 9/23/10 |
| | No pre-existing exclusions for anyone | ✓ | ✓ | Plan years on or after 1/1/14 |
| Flexible Spending Account (FSA) | FSA dollars can only be used for Insulin and over the counter drugs if the plan member has a prescription | ✓ | ✓ | Plan years on or after 1/1/11 |
| Women's Preventive Services | In-network Women's preventive services must be covered with no cost sharing | | ✓ | Plan years on or after 8/1/12 |
| Dependent coverage for children under age 26 | Coverage required regardless of marital or student status, financial support, etc. | ✓ | ✓ | Plan years on or after 9/23/10 |
| | Grandfathered plans not required to offer dependents eligible for coverage under another employer's plan | ✓ | | |
| | No plan able to exclude dependent up to age 26 | ✓ | ✓ | Plan years on or after 1/1/14 |
| Clinical Trials | Allow participation in clinical trial and coverage of routing patient costs for items and services provided | | ✓ | Plan years on or after 1/1/14 |
| Out of pocket maximum (OOPM) on cost shariing | Most members pays during a plan year for in-network services. Includes deductibles, copay and coinsurance | | ✓ | Plan years on or after 1/1/14 |
| | OOPM to include 3rd Party vendor (i.e., PBMs) | | ✓ | Plan years on or after 1/1/15 |
| | Individual OOPM applies of whether there is self-only or Family coverage | | ✓ | Plan years on or after 1/1/16 |
| Waiting period cannot exceed 90 days | | ✓ | ✓ | Plan years on or after 1/1/14 |

GF - Grandfathered
NGF - Non-grandfathered

# ANNUAL CHECKLIST

- ☐ Review benefit and coverage changes.
- ☐ Summary of Benefits and Coverage (SBC) completed for enrollment.
- ☐ Employer Shared Responsibility reporting followed by payment.
- ☐ Accounted for PCORI fee
- ☐ If you are a grandfathered plan, have you issued plan document notice?
- ☐ Review out-of-pocket maximum amounts.
- ☐ Questions? Contact your Independence Administrators account management team.

ibxtpa.com

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