informed on reform

Health Care Reform Quick Hit Watch List

Health care reform is in full swing, and many Patient Protection and Affordable Care Act (PPACA) items impact health plans or administrative procedures. This watch list is intended to help you focus on what's happening now and in the near future. It's updated when new regulations are released – as of March 11, 2013.

New Medicare Tax Effective Jan. 1, 2013

Employers are required to withhold an additional 0.9% Medicare tax on employee wages exceeding $200,000. While the 1.45% income tax withholding is still in place for all employees and employers, the new Medicare tax adds an additional 0.9% on employee earned income above $200,000. The additional tax is only assessed on the individual, who is ultimately responsible for the tax. However, employers who do not withhold this additional income tax will be liable.

Opportunity for employee communication about couples filing jointly who earn $250,000 or more: if an employee and the employee's spouse's wages are each less than $200,000, but combined are more than $250,000, neither the employee's nor the spouse's employer is obligated to withhold the additional tax. The employee is liable for any additional "high income" tax to the extent that it has not been withheld by the employer. Employees faced with this situation will be expected to make estimated quarterly tax payments.

W-2 reporting for 2012 tax year Beginning with 2012 W-2s distributed in Jan. 2013

Employers that send out more than 250 W-2 forms must report the total cost of their group medical coverage on 2012 tax year W-2's distributed in January 2013.

Flexible spending accounts Effective Jan. 1, 2013

Think about implementing enrollment materials/programs and payroll systems to comply with new contribution limits ($2,500 maximum election per employee). The new cap applies to plan years beginning January 1, 2013 or later.

Employee Notice of the Exchange Effective date delayed to late summer/fall, 2013

All employers are required to notify **all employees** (regardless of sponsored health coverage) of the new Health Insurance Exchange marketplace. Guidance is pending on exact content to include and method of distribution.

GO YOU®

Cigna®

ACTION VARIES

Comparative Effectiveness Research Fee For plan years starting on or after Oct. 2, 2011

Revenues will fund research to determine the effectiveness of various forms of medical treatment. The initial annual fee of $1 per covered life is for plan years that began on or after Oct. 2, 2011. The fee increases to $2 in 2012, then increases to an amount indexed annually to national health expenditures until 2019, when it no longer applies. Reporting and payment using IRS Form 720 is required by July 31 of the calendar year immediately following the last day of the policy or plan year (e.g., liability for a plan year ending Jan. 31, 2013 must be filed by July 31, 2014).

REMEMBER

Fully insured plans: Cigna will pay this fee for its insured plans and a load will be included in our premium. However, an associated HRA and/or qualifying FSA are considered self-insured plans, which therefore must be paid by the employer /plan sponsor.

TO DO

Self-funded plans: Self-funded plans must report on and pay this fee. The rules do not permit Cigna to administer the payment of this fee on behalf of self-insured clients.

Note: to assist clients in computing their fee, at no additional charge, Cigna will provide self-service eligibility reporting for self-funded plans. For fully insured medical plans, Cigna will also provide no-fee self-service HRA and qualifying FSA eligibility reports. Medical eligibility reports will not be available.

As new health care regulation unfolds – and new guidance is provided – we'll continue to keep you informed.

REMEMBER

Health Insurance Industry Fee Effective Jan. 1, 2014

The Health Insurance Industry Fee affects health insurers (including HMOs) and is estimated to start at $8 billion in 2014. It increases year over year before reaching an estimated $14.3 billion in 2018. After 2018, it will continue to increase with premium growth.

The fee applies only to insured business, and will be based on each insurer's share of the taxable health insurance premium base (among all health insurers of U.S. health risks). Plans include all insured individual and group medical plans (HMO, Network, PPO and OAP) regardless of funding type (i.e., Guaranteed Cost or Shared Returns including Minimum Premium), behavioral health, pharmacy, vision and dental benefit plans (including stand-alone), among others.

Impacted plans will be assessed 2-2.5% of premium in 2014. This will increase to 3-4% of premium in future years.

Cigna is required to pay this assessment. Cigna will build additional loads into our premium rates to offset the cost of these fees for any applicable insurance plan.

ACTION VARIES

Reinsurance Assessment Effective Jan. 1, 2014

Collected over the three-year period from 2014 through 2016, this assessment will fund a reinsurance program to help lessen the impact of high-risk individuals entering the Individual market.

REMEMBER

Fully insured plans: Cigna is required to pay this assessment. Cigna will build additional loads into our premium rates to offset the cost of these fees for any applicable insurance plan effective 2/1/2013 and later.

TO DO

Self-funded plans: Employers are liable for the assessment, but they may choose third party administrators to make the payment on their behalf.


TO DO

Prepare for 2014, when the employer mandate kicks in

Employers with 50+ full-time employees (or full-time equivalents) must offer medical coverage that is "affordable" and provides "minimum value" to their full-time employees (and their dependent children to age 26) or be subject to penalties. This mandate is effective January 1, 2014, regardless of grandfathered status. There is transitional relief for employer-sponsored plans that currently begin on a date other than January 1, if they comply upon the first day of their 2014 plan year.

- Employees who work 30 hours per week are deemed full-time.
- Coverage is affordable if employee contributions are less than 9.5% of:
  - an employee's W-2 wages,
  - an employee's monthly wages (hourly rate x 130 hours per month), OR
  - the Federal Poverty Level for a single individual.
- A plan must pay 60% of the costs of covered health services to be considered as providing "minimum value."
- Employers cannot have more than a 90-day waiting period after an employee becomes eligible for coverage.
- Dependents are considered children up to age 26. Spouses are not included in the definition.
- **Requirement for plans beginning/renewing on or after January 1, 2014:** Previously, grandfathered plans were not required to extend coverage to dependents. In 2014, these grandfathered plans will need to allow dependents access to their parent's plan until age 26, even if they are able to obtain their own coverage.


CONSIDER

Determining your full-time employees: Safe harbor methods may be used to determine the full-time status of current and new employees who work variable hours. These methods are complex and differ for ongoing and new employees. Employers should consider the methods carefully with their own legal counsel.


REMEMBER

Employer mandate penalties: The penalty for employers not offering any coverage to their employees is $2,000 per FTE (minus the first 30). The penalty for employers offering a plan that is not "affordable" or does not provide "minimum value" is the *lesser* of:

- $3,000 per FTE receiving the tax credit for exchange coverage, or
- $2,000 per FTE (minus the first 30).

There are no tax penalties for employers with fewer than 50 full-time employees, or full-time equivalents.

Employers with non-1/1 plan effective dates will not incur any penalties if they comply upon the first day of their 2014 plan year. Employers cannot change a January 1 effective date now to take advantage of this relief.


REMEMBER

Guaranteed Issue

Beginning with the first plan year on or after 1/1/2014, the guaranteed-issue provision requires that health insurance issuers offering coverage in the individual or group market accept every individual and employer that applies for coverage, regardless of medical history or health status (guaranteed availability). Issuers will also renew coverage (guaranteed renewability).


CONSIDER

Guaranteed Availability:

- Applies to non-grandfathered fully insured individual, small (1-50 employees until 2016 when the definition expands to 1-100 employees) and large group coverage
- Non-grandfathered individual and non-grandfathered group plans must accept every individual and employer who applies for coverage


CONSIDER

Guaranteed Renewability:

- Health insurance issuers must renew all coverage in the individual and group market
- Exceptions to this rule (e.g., non-payment of premium, fraud, etc.)
- Applies to non-grandfathered fully insured Individual, small and large group coverage
- Self-funded and grandfathered plans are not required to comply with this provision. However, the same requirements already apply to all group plans (regardless of funding or grandfathered status) under the 2001 HIPAA requirements.

Keep these rolling requirements on your radar as they impact plans either annually or as new plan years begin throughout the year.

REMEMBER

Medical loss ratio (MLR)

First rebates were issued by Aug. 1, 2012 for 2011 calendar year experience.

No impact to self-funded plans

For insured plans only: Insurers/HMOs must provide rebates if their combined MLR for all policies issued in a state is less than 80% in the small group and individual markets or 85% in the large group market.

Note: Employee Assistance Plan (EAP) programs in CA and NV are considered fully insured and rebate eligible.

TO DO

Women's preventive health services

For plan years beginning on or after Aug. 1, 2012

Non-grandfathered plans must cover women's preventive care services without cost- sharing. Well-woman visits, screening for gestational diabetes and HPV testing are among the basic services to be covered, plus contraceptives for non-religious, non-exempt employers. Beginning August 1, 2013, employees of religiously affiliated non-profit employers will be automatically enrolled in separate individual health insurance policies that provide contraceptive coverage at no cost to the employer or the employee.

TO DO

Summary of Benefits and Coverage (SBC) and glossary of health coverage and medical terms

For open enrollment periods and plan years beginning on or after Sept. 23, 2012

All plans must provide a standardized SBC and access to a uniform glossary for open enrollment periods beginning on or after Sept. 23, 2012. For plan years beginning on or after Sept. 23, 2012, an SBC must be provided to newly eligible and special enrollees, and to anyone who requests it. Samples of a completed SBC and the uniform glossary are housed on the Center for Consumer Information and Insurance Oversight (CCIIO) website. We have also created a complimentary SBC Toolkit for your open enrollment and employee communications needs: www.cigna.com/SBC-Toolkit.

Note: The penalty for "willful" non compliance is $1,000 per violation per enrollee.