Employer Mandate

Requirement to Offer Coverage

The employer mandate applies to applicable large employers with 50 or more full-time employees (including full-time equivalents). It requires large employers to either offer full-time employees and their dependents minimum essential coverage that is affordable and meets minimum value requirements, or risk paying an excise tax (penalty).

The penalty will go into effect in 2015 for employers with 100 or more full-time employees and full-time equivalents, and 2016 for most employers with 50-99 full-time employees and full-time equivalents (as long as they qualify under transition relief). A penalty would generally apply if an employee applied to the public exchange and was deemed eligible for a subsidy either because the employee did not receive an offer of minimum essential coverage or the coverage the employer did offer did not meet minimum value or affordability requirements.

If the employer does not offer minimum essential coverage, the employer may be subject to a $2,000 per full-time employee per year penalty if even just one full-time employee applies and is found eligible for an applicable premium tax credit or cost-sharing reduction under the public insurance exchange.

If the employer’s coverage meets minimum essential coverage but the coverage is deemed unaffordable and does not provide minimum value for some full-time employees, those employees may also obtain health insurance through a public insurance exchange and qualify for an applicable premium tax credit or cost-sharing reduction. In such case, the penalty would be $2,000 per full-time employee who qualified for the applicable premium tax credit or cost-sharing reduction.

The penalty enforcement was delayed until 2015; the penalty amount is based on a 2014 enforcement date. The penalty amounts ($2,000 and $3,000) will be adjusted annually, starting in 2015.

Penalties

Penalty for Large Employers Not Offering Coverage

The monthly penalty assessed to an employer who does not offer coverage will be equal to the number of its full-time employees minus 30 (the penalty waive the first 30 full-time employees) multiplied by one-twelfth of $2,000 for any applicable month. The penalty enforcement was delayed until 2015.

Penalty for Large Employers Offering Coverage

If the employer’s coverage fails to meet one of two criteria, the employee offered employer-sponsored coverage can obtain premium credits for exchange coverage:

1. Affordability: The individual’s required contribution toward the plan premium for self-only coverage cannot exceed 9.5% of his/her household income. The second criterion has to do with adequacy.

2. Minimum Essential Coverage: The health plan for coverage offered must meet the minimum essential coverage requirements.

Continued on Page 2
Employers who offer health insurance coverage that is unaffordable or inadequate will not be treated as meeting the employer requirements if at least one full-time employee declines their coverage and obtains a premium credit in an exchange plan.

The penalty enforcement was delayed until 2015. The monthly penalty assessed to an employer for each full-time employee who receives a premium credit will be one-twelfth of $3,000 for any applicable month. The total penalty for an employer is the total number of the firm's full-time employees minus 30, multiplied by one-twelfth of $3,000 for any applicable month.

→ Automatic Enrollment

Effective in 2015, the Affordable Care Act (ACA) requires employers with more than 200 full-time employees to automatically enroll all new full-time employees in one of the employer's health benefits plans (subject to any waiting period authorized by law), and to continue the enrollment of current employees in a health benefits plan offered through the employer.

This provision was scheduled to be effective January 1, 2014, but prior guidance indicated compliance would not be required until regulations are issued. The new FAQs state that guidance will not be ready by 2014; thus the automatic enrollment provision will be delayed beyond 2014.

→ 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 for inflation). The thresholds increase for individuals in high-risk professions and for employers that have a disproportionately older population.
Determining full-time employees
for purposes of shared responsibility for employers regarding health coverage
Determining Full-Time Employees for Purposes of Shared Responsibility for Employers Regarding Health Coverage

**Definitions**

**Full Time Employee**

"Section 4980H(c)(4) provides that a full-time employee with respect to any month is an employee who is employed on average at least 30 hours of service per week."

**Part Time Employee**

A part-time employee is an employee who is employed on average less than 30 hours per service week with respect to any month.

**Variable Hour Employee**

"An employee is a variable hour employee if, based on the facts and circumstances at the date the employee begins providing services to the employer (the start date), it cannot be determined that the employee is reasonably expected to work on average at least 30 hours per week."

**Seasonal Employee**

"Employees in excess of 50 who were employed during that period of no more than 120 days were seasonal employees, the employer would not be an applicable large employer. Furthermore, § 4980H(c)(2)(B)(i) provides that, for this purpose, seasonal worker means a worker who performs labor or services on a seasonal basis, as defined by the Secretary of Labor... Through at least 2014, employers are permitted to use a reasonable, good faith interpretation of the term "seasonal employee" for purposes of this notice."

**Eligibility for Coverage**

**Variable Hour Employees**

"For variable hour and seasonal employees, employers are permitted to determine whether the new employee is a full-time employee using an "initial measurement period" of between three and 12 months (as selected by the employer)."

"The employer may use both a measurement period of between three and 12 months (the same as allowed for ongoing employees) and an administrative period (waiting period) of up to 60 days for variable hour and seasonal employees."

"The stability period (coverage period) for such employees must be the same length as the stability period for ongoing employees."

**Reference Source:**

Participant Notice Requirements
Multiemployer Plans
## Multiemployer Plans — Participant Notice Requirements

<table>
<thead>
<tr>
<th>NOTICE</th>
<th>DESCRIPTION</th>
<th>WHO PROVIDES?</th>
<th>WHEN?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Summary of Benefits and Coverage (SBC)</strong></td>
<td>As 8 page summary of Plan benefits, coverage and cost sharing arrangements.</td>
<td>Plan</td>
<td>Annually with open enrollment materials or, if Plan does not conduct open enrollment, 30 days prior to start of Plan year. Also must provide within 7 business days of a request from a participant or beneficiary.</td>
</tr>
<tr>
<td><strong>Exchange <em>Marketplace</em> Notice</strong></td>
<td>A 2 part notice an employer must provide to employees about new health insurance marketplaces and their options for health coverage.</td>
<td>Employer</td>
<td>By 10/1/2013 and within 14 days of an employee's date of hire.</td>
</tr>
<tr>
<td><strong>Disclosure of <em>Grandfathered Status</em></strong></td>
<td>Applies to grandfathered Plans. A statement to alert participants and beneficiaries that certain consumer protections may not apply to their benefits.</td>
<td>Plan</td>
<td>First of the plan year and must be provided in Plan materials describing benefits.</td>
</tr>
<tr>
<td><strong>Women's Health and Cancer Rights Act (WHCRA)</strong></td>
<td>Description of benefits under WHCRA and any applicable discrimination and compliance issues.</td>
<td>Plan</td>
<td>Upon enrollment in Plan and annually thereafter.</td>
</tr>
<tr>
<td><strong>Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA)</strong></td>
<td>Information about premium assistance under Medicaid or CHIP.</td>
<td>Plan</td>
<td>Annually, by the first day of the Plan year.</td>
</tr>
<tr>
<td><strong>Notice of Privacy Practices</strong></td>
<td>Description of the Plan's uses of personal health information and information about technical privacy rights.</td>
<td>Plan</td>
<td>Upon enrollment or request, and every 3 years thereafter.</td>
</tr>
<tr>
<td><strong>Summary Plan Description (SPD)</strong></td>
<td>Summary of Plan provisions and standard language as required by ERISA.</td>
<td>Plan</td>
<td>Within 90 days of enrollment in Plan and once every 5 years if Plan Is amended.</td>
</tr>
<tr>
<td><strong>Summary of Material Modifications (SMM)</strong></td>
<td>Summary of changes in any information acquired in SPD.</td>
<td>Plan</td>
<td>Not later than 210 days after the end of the Plan year in which the change is adopted.</td>
</tr>
<tr>
<td><strong>Medicare Part D</strong></td>
<td>Notice about whether or not Medigap coverage provided through the Plan is creditable or non-creditable.</td>
<td>Plan</td>
<td>Annually, by October 15th.</td>
</tr>
<tr>
<td><strong>Summary Annual Report (SAR)</strong></td>
<td>Summary of financial information reported on Plan's IRS Form 5500 and statement to receive annual report.</td>
<td>Plan</td>
<td>Later of 9 months after Plan year ends or, if an extension of time for filing is granted, 2 months after IRS Form 5500 issue.</td>
</tr>
</tbody>
</table>

Paccid Benefit Administrators, Inc.  
CA License #0360747
Private Exchanges
and
Outsourced Benefits Administration
(Mid-Size Employers: 100 to 1,000 employees)

Employer Issues influencing the move to Private Exchanges:

- "Knowledgeable" Benefits Staffing Challenge;
- Increased Compliance and Reporting Requirements;
- Liability Risk related to non-Compliance;
- Increase the coverage options & carrier choice;
- Fewer health carrier options; less price-variance among carriers.

Private Exchange Services that Employers Want:

- Annual and New Employee Enrollment;
- Online decision-support and coverage information tools;
- Employee online enrollment for multiple coverages and carriers;
- Employer online access to Enrollment and Coverage information;
- Life-event processing;
- Single for employer contribution processing;
- Electronic data and eligibility communication to carriers;
- Dependent verification and audits;
- COBRA eligibility and reporting;
- Compliance notices to employees/plan-participants;
- Plan Communication and education
"PRIVATE" HEALTH INSURANCE PURCHASING EXCHANGES: An Alternative Health Care Option for Employers

by Lori Brogin

For the past two years, there has been a renewed focus on "Private" Health Insurance Purchasing Exchanges. Such focus is in large part due to the 2014 deadline by which states must establish "Public" Health Insurance Purchasing Exchanges as mandated under the Patient Protection and Affordable Care Act ("Health Care Reform").

"Private" Health Insurance Purchasing Exchanges are created when employers come together to use their collective purchasing power to obtain health insurance for their employees. Employer groups may vary in size — they range from small to large — but their ultimate goal is the same: to provide low cost, quality health care.

These Exchanges typically provide more services than available through a "traditional" health insurance product. And, often times they are provided for a fee that is much less than the overall administrative and compensation fee that is included as part of today's "traditional" product.

Lower Initial Premium Cost
The Health Carrier's administration-loaded portion of the premium for an Exchange is typically 9-12% of premium; this is 3-5% less than the 15% administration-loaded for coverages sold to an individual employer. The Exchange administration fee is typically 4-6% of premium, whereas, the typical agent/broker compensation is 5-10% of premium.

Premium-Renewal Stability
In the Exchange, the employer is now part of a larger purchasing-pool consisting of many employers. Claims experience is spread across the large pool of employees. As a result, there is typically less volatility in annual premium renewals.

Reduced Administration Work
Exchanges often issue only one employer invoice for all coverages (health, dental, vision and life). This includes billing different carriers on a single invoice. There is only one monthly invoice for an employer to adjudicate and pay.

Choice of Carriers and Coverage Options
Exchanges typically offer choice of several "different" health, dental, and vision plans in addition to several different HMO and PPO health coverage options.

Member, Field & Claim Assistance Service
Most Exchanges have dedicated staff to handle employer and employee telephone calls regarding coverage, enrollment or claim assistance. Many Exchanges have Field Service staff for enrollment, employee education and addressing employer issues.

COBRA, Certificate of Creditable Coverage and Compliance Issues
COBRA administration (for all coverages and carriers) is typically integrated as part of the overall Exchange invoice system and provided at no additional cost. Exchanges are often times setup as ERISA Trust Funds, and as a result, the responsibility for compliance issues and certificates of coverage falls on the Exchange. This shifts the regulatory and fiduciary burden from the employer to the Exchange.

An article about employee benefit firms' expansion into "Private" Health Insurance Exchanges was recently featured on the front-page of the Business Section of USA Today. As Julie Appleby wrote in her April 23, 2011 piece, "Private exchanges, mainly run by former insurance executives and benefit consulting firms, operate in more than 20 states...One of the nation's largest benefits firms, Aon Hewitt, said it will launch an exchange aimed at large employers. It hopes to have at least 100,000 workers enrolled by early next year." As Health Care Reform continues to evolve, "Private" Health Insurance Purchasing Exchanges will present a smart option for the business community.

Lori Brogin, Esq., manages several Private Exchanges for PacFed Benefit Administrators, Inc., the parent company of which is Pacific Federal.