Affiliated Physicians & Employers Health Plan

A NJ Self-Insured MEWA

2015 – PATIENT PROTECTION AND AFFORDABLE CARE ACT (PPACA) - WHAT TO EXPECT?

The Affordable Care Act (ACA) has made a number of significant changes to group health plans since the law was enacted over four years ago. Many of these key reforms became effective in 2014, including health plan design changes, increased wellness program incentives and reinsurance fees.

Additional reforms become effective in 2015 for employers sponsoring group health plans. For 2015, the most significant ACA development impacting employers is the **shared responsibility penalty** for affected large employers and related reporting requirements. To prepare for 2015, employers should review upcoming requirements and develop a compliance strategy.

This update is intended to provide our enrolled employers with guidance on what services the Affiliated Physicians and Employers Health Plan Trust (APEHP) will be handling and what services you, as the employer, will need to work with your legal or other advisors on. It is not intended to be exhaustive nor should any discussion or opinions be construed as legal advice.

For more information refer to www.dol.gov/ebsa/healthreform.

Major Requirements	Details	Our Process	Who is Responsible?
Cost-sharing Limits	Effective for plan years beginning on or after Jan. 1, 2015, a health plan's out-of-pocket maximum for essential health benefits (EHB) may not exceed: o **$6,600** for self-only coverage; and o **$13,200** for family coverage. For 2015 plan years, health plans with more than one service provider must combine/accumulate the health plan's out-of-pocket maximum between/among all providers. Also, health savings account (HSA) -compatible high deductible health plans (HDHPs) out-of-pocket maximums must be lower than the ACA's limit. For 2015, the out-of-pocket maximum limit for HDHPs is **$6,450** for self-only coverage and **$12,900** for family coverage.	**The APEHP Plan will be updating our cost sharing limits for January 1, 2015 or upon each group's 2015 renewal to comply with the ACA as well as to include Prescription Drug coverage where applicable.** **Any HSA-compatible plans will be updated to comply with the IRS lower out-of-pocket limits.** **Enrolled groups and members will be notified of all changes 60 days in advance.**	**APEHP HEALTH PLAN**
Health FSA Contributions	Effective for plan years beginning on or after Jan. 1, 2013, an employee's annual pre-tax salary reduction contributions to a health flexible spending account (FSA) must be limited to $2,500. The IRS is expected to release the health FSA limit for 2015 later this year.	**Employers should work with their advisors to monitor IRS guidance on the health FSA limit for 2015 if offering an FSA program. The APEHP Plan does not provide this service.**	**EMPLOYER**

ACA Fees / Assessments:	**Patient Centered Outcomes Research Institute (PCORI):** APEHP is paying the PCORI Fee on behalf of its members - $1 per covered life / $2 per covered life in 2014. The Internal Revenue Service has released Notice 2014-56 providing an update to the fee paid by health insurers and self-funded group health plans to fund the Patient Centered Outcomes Research Institute. The fee is paid for all covered lives in specified health insurance policies and self-funded group health plans for plan and policy years ending after 9/30/2012 and before 10/1/2019. The fee is updated for each payment period based on the percentage increase in the projected per capita amount of the National Health Expenditures as determined by the Department of Health and Human Services. The fee amount for plan and policy years ending on or after 10/1/14 and before 10/1/2015 goes from $2.00 to $2.08 per covered life. For policy years and plan years ending 10/1/2015, through 9/30/2019, the adjusted applicable dollar amount will be published in guidance of general applicability in the Internal Revenue Bulletin.	**The APEHP handles payment of the PCORI Fee for all its enrolled Employers.**	**APEHP HEALTH PLAN**
	ACA Transitional Reinsurance Fee: The Reinsurance Fee is assessed on a per capita basis and is $5.25 per member per month ($63 per member per year) in 2014. It decreases each year for the subsequent two years. In 2015, the fee is $3.67 per member per month ($44 per member per year) and is yet to be determined for 2016. This fee is required of **ALL** Employers in any Health Plan.	**The APEHP handles payment of ACA Transitional Reinsurance Fees.** **Employers will be advised by the APEHP of any changes to these fees for 2015 prior to January 1, 2015 and they will be included in your January Invoice.**	**APEHP HEALTH PLAN**
	Health Insurance Provider Fee: Section 9010 of the Patient Protection and Affordable Care Act (ACA) imposes a fee on each covered entity engaged in the business of providing health insurance for United States health risks. Effective 1/1/2014 – Insured Carriers and self-insured MEWAs with over $25 million in premium (contributions) will be assessed the Health Insurer Fee which can range from approximately 1.5-3% of total premium (contributions). This fee is passed on to all enrolled groups in a MEWA.	**The APEHP handles payment of the ACA Health Insurance Provider Fee.** **Employers will be advised by the APEHP of any changes to these fees for 2015 prior to January 1, 2015 and they will be included in your January Invoice.**	**APEHP HEALTH PLAN**
Employer Shared Responsibility/ Pay or Play Penalties:	Under the ACA's Employer Shared Responsibility Penalties, also known as pay or play penalties, applicable large employers (ALEs) that do not offer health coverage to their full-time employees (and dependent children) that is affordable and provides minimum value will be subject to penalties if any full-time employee receives a government subsidy for health coverage through an Exchange. ALEs are employers with **50 or more** full-time employees (including full-time equivalent employees, or FTEs) on business days during the preceding calendar year. The pay or play rules were set to take effect on Jan. 1, 2014. However, the IRS delayed the employer penalty provisions and related reporting requirements for one year, until **Jan. 1, 2015**. There are two types of employer shared responsibility payments or penalties under the Affordable Care Act (ACA). The first penalty under Internal Revenue Code (Code) Section 4980H(a) is the penalty for failure to offer health coverage. Effective for plan years beginning on or after January 1, 2015, a $2,000 annual penalty applies to a large employer that fails to offer at least 70 percent of its full-time employees (FTEs) health coverage. For plan years beginning on or after January 1, 2016, the $2,000 penalty applies to an employer that fails to offer health coverage to at least 95 percent of its FTEs. The $2,000 penalty is assessed on a monthly basis, but applies to all of an employer's FTEs, minus 30 FTEs (or minus 80 FTEs for 2015).	**Employers should work with their advisors to determine their ALE status and any reporting requirements. The APEHP Plan does not provide this service.**	**EMPLOYER**

	The second penalty under §4980H(b) is for the failure to offer coverage that meets the minimum value and affordability requirements. The Section 4980H(b) penalty is a $3,000 annual penalty assessed on a monthly basis, and applies to each FTE who isn't offered minimum value affordable coverage by the large employer, goes to the Marketplace Exchange and receives an exchange subsidy for insurance he or she purchases through the Marketplace Exchange. It is important to note that even if an employer offers coverage to 70 percent of its FTEs for 2015 and 95 percent of its FTEs for 2016 and beyond, the employer could still be subject to penalties under Section 4980H(b) if the coverage is unaffordable or does not provide minimum value. Also, even if an employer meets the 70/95 percent threshold, it still faces the potential for the $3,000 Section 4980H(b) penalty for every FTE who isn't offered coverage (*i.e.*, the 30/5 percent safe harbor employees) if that employee receives an exchange subsidy for insurance he/she purchases through the Marketplace Exchange.		
Affordability of Coverage	Under the ACA employer shared responsibility rules, an employer must offer coverage that is affordable to avoid potential §4980H(b) penalties. In addition, individuals enrolling for coverage through a public Marketplace will not qualify for subsidized coverage if they are eligible for employer-sponsored group health coverage that is affordable. Coverage is "affordable" if the employee contribution for employee-only (single) coverage does not exceed the required contribution percentage of household income. Originally, for 2014, the required contribution percentage for determining affordability was set at 9.5%. For 2015, as long as the employee contribution for employee-only (single) coverage does not exceed 9.56%, coverage will be deemed affordable for employees and any dependents eligible for coverage. The affordability will be indexed for future plan years. Because an employer generally will not know an employee's household income, the IRS provided three affordability safe harbors that employers may use to determine affordability based on information that is available to them. The final regulations provide safe harbor approaches for assessing whether an employer's coverage is affordable. These safe harbors allow an employer to measure affordability based on: o **The employee's W-2 wages** – Coverage is affordable if the employee's monthly contribution does not exceed 9.56% of annual Form W-2 wages (as reported in Box 1). This is calculated retrospectively for the previous calendar year. To qualify for this safe harbor, the employee's required contribution must remain a consistent amount or a consistent percentage of all Form W-2 wages during the year. o **The employee's rate of pay** - Take the hourly rate of pay for each hourly employee and multiply that rate by 130 hours per month to determine a monthly "rate of pay." The employee's monthly contribution amount is affordable if it is equal to or lower than 9.56% of this computed monthly wage estimate, regardless of the number of hours the person actually works ; or o **The federal poverty level** - Coverage is affordable if the employee's monthly contribution does not exceed 9.56% of the FPL for a single individual.	**Employers should work with their advisors to determine if their plan is "Affordable". The APEHP Plan does not provide this service.**	**EMPLOYER**
Minimum Value	Under the ACA, a plan provides minimum value if the plan's share of total allowed costs of benefits provided under the plan is **at least 60 percent** of those costs. The IRS and HHS provided the following three approaches for determining minimum value: o MV Calculator (provided by HHS); o Design-based safe harbor checklists; and o Actuarial certification.	**Employers will be provided with the Plan's AV Value as certified by a Qualified Actuary. We do confirm that all Plans offered by the APEHP meet the minimum Actuarial Value of 60%.**	**EMPLOYER**

Reporting of Coverage	The ACA requires ALEs to report information to the IRS and to employees regarding the employer sponsored health coverage. The IRS will use the information that ALEs report to verify employer sponsored coverage and administer the employer shared responsibility provisions. This reporting requirement is found in Internal Revenue Code **Section 6056**. In addition, the ACA requires every health insurance issuer, sponsor of a self-insured health plan, government agency that administers government-sponsored health insurance programs and any other entity that provides minimum essential coverage (MEC) to file an annual return with the IRS reporting information for each individual who is provided with this coverage. Related statements must also be provided to individuals. This reporting requirement is found in Internal Revenue Code **Section 6055**. Both of these reporting requirements become effective in 2015. The first returns will be due in 2016 for health plan coverage provided in 2015. o The Section 6055 and 6056 returns must be filed with the IRS by **Feb. 28** (or **March 31**, if filed electronically) of the year after the calendar year to which the returns relate. o Written statements must be provided to employees no later than **Jan. 31** of the year following the calendar year in which coverage was provided. ALEs with self-funded plans will be required to comply with both reporting obligations, while ALEs with insured plans will only need to comply with Section 6056 reporting. To simplify the reporting process, the IRS will allow ALEs with self-insured plans to use a single combined form for reporting the information required under both Section 6055 and Section 6056.	**Employers should work with their advisors to determine if they are required to file these returns and for completion of these forms. The APEHP Plan does not provide this service.**	**EMPLOYER**
Required Notices	**Marketplace Notice:** Employers are required to provide the notice to each new employee at the time of hiring beginning October 1, 2013. For 2014, the Department will consider a notice to be provided at the time of hiring if the notice is provided within 14 days of an employee's start date.	**Employers should work with their advisors to determine if and when they need to file this notice. The APEHP Plan does not provide this service.**	**EMPLOYER**
Health Plan Identifier (HPID)	**HPID** stands for Health Plan Identifier. The Health Insurance Portability and Accountability Act (HIPAA) requires the Department of Health and Human Services (HHS) to adopt standards for certain transactions to promote the efficient and uniform transmission of health information. One of the standards is a unique identifier for health plans. Health plans, including self-funded plans, will either be a controlling health plan or a sub-health plan. A controlling health plan is required to obtain an HPID. A sub-health plan is not required to obtain an HPID, unless it is identified in covered transactions. Self-funded customers should consult their legal counsel if they have questions about whether or not they might be a controlling health plan or sub-health plan. PURPOSE OF HPID: The HPID will be used in standard transactions and administrative simplification initiatives under HIPAA. For example, HHS may use the HPID to track compliance with health plan certification. The HPID requirement applies to group health plans subject to HIPAA's administrative simplification provisions, including insured and self-insured plans. For example, major medical plans, dental plans, vision plans, HRA's and FSA's. If you have any self-insured program outside of your coverage through the APEHP Health Plan MEWA (such as major medical plans, dental plans, vision plans, HRA's and FSA's), you may be required to file for a CHP or SHP. Please consult your advisor or legal counsel.	**The APEHP will be the CHP (Controlling Health Plan) and all employers enrolled in the MEWA will be SHP's (Sub health plans).** **However, if you offer other program(s) outside of the APEHP MEWA you may be considered a CHP for those program(s) and, therefore, required to file for an HPID. Please consult your advisor or legal counsel if you offer any such program.** ***Controlling Health Plan Organization Name: Affiliated Physicians and Employers Master Trust*** ***HPID Number: 7629071649***	**APEHP HEALTH PLAN / EMPLOYER**