Since its passage in 2010, the impact of healthcare reform, known as the Patient Protection and Affordable Care Act, has mostly been limited to new coverage mandates, the now expired early retiree reimbursement program, and the new summary of benefits and coverages (SBCs).

For the first time, the major provisions of healthcare reform are starting to take form. To this point, reporting on these provisions has been difficult due to the significant lack of clarity. Federal rule making is a multi-step process and changes are often made last minute or even after the effective date. At this point an update on the provisions that affect county government as employers is prudent. The most salient issues are presented and organized by topic below.

**PCORI Fee**
The Patient-Centered Outcomes Research Institute (PCORI) fee was created by the healthcare reform act to help people make more informed decisions about their healthcare. In the first effective year, medical benefit plans are required to contribute $1.00 per employee. The fee doubles to $2.00 for the second year and beyond. When this fee is due depends on when a plan’s year ends. As soon as instructions are released, the specified entity, as defined by your benefit arrangement, will need to pay this fee on behalf of the medical plans.

Although dental, vision and HSA plans are exempt, HRA and FSA plans are not. An employer may be required to pay the fee if they have an HRA and/or FSA. Guidance for making that determination can be found on the Federal Register. If you would like help finding this provision online feel free to call the WCA office.

**Reinsurance Fee**
A transitional reinsurance fee will be effective from 2014 through 2016. A total of $25 billion will be collected to fund the transition of individuals with pre-existing conditions into the individual
health insurance market. The insurer or third-party administrator of the medical benefit plan is required to pay this fee; however, expect the fee to be directly passed on to employers. The fee is $63.00 per covered life for the first year.

**Health Insurer Tax**
Health insurance companies will be required to pay a tax on their premiums beginning in 2014. This fee is expected to be 2% of premium; however, this fee does not apply to self-insured groups.

**Non-Discrimination Rule**
The non-discrimination rule of the healthcare reform act prohibits employers from discriminating in favor of highly compensated employees with regard to health benefits. Self-funded employers abide by this rule in compliance with the existing IRS Code. For that reason, self-funded plans are exempt from this provision in the healthcare reform act.

**Health Insurance Exchanges**
Effective January 1, 2014, a health insurance exchange will be available to individuals and small employers (50 FTE or less). In Wisconsin, the federal government will run the exchange; however, opportunity still exists for state government to play various roles.

Many aspects of the exchange that will impact employers are yet to be finalized. Since most counties qualify as large employers, and large employers cannot participate in the exchange until 2017, the immediate impact of the exchange is limited. The first requirement will be that employers inform employees about the existence of the exchange. Guidance will be released on how employers need to communicate this to employees, but this notice will be required this fall.

The exchange is unlikely to be practical for local government employees; however, employees may still research the exchange to weigh their options. It should be noted that the employees’ research and subsequent submission of data directly to the exchange might result in the exchange contacting employers to confirm information. The healthcare reform act specifically allows for this.

**Thirty-Hour Rule**
Beginning January 1, 2014, the Affordable Care Act requires large employers to offer affordable health care coverage to their full-time employees. If a large employer does not offer affordable health coverage that provides a minimum level of coverage to their full-time employees, they may be subject to an Employer Shared Responsibility payment if at least one of their full-time employees receives a premium tax credit for purchasing individual coverage on the insurance exchange. A full-time employee is an individual employed on average at least 30 hours per week.
To be subject to these Employer Shared Responsibility provisions, an employer must have at least 50 full-time employees or a combination of full-time and part-time employees that is equivalent to at least 50 full-time employees (for example, 100 half-time employees equals 50 full-time employees).

If the employer is considered a large employer subject to the Employer Shared Responsibility provisions, it must offer affordable health coverage to its employees who work on average 30 hours per week. For the purpose of determining eligibility for benefits based on the 30-hour rule, an employer may establish a look-back period of not less than 3 months, but not more than 12 months. If an employee worked an average of 30 hours or more during the look-back period, the employee must be offered affordable coverage going forward for at least six months or a duration equal to the look-back period, whichever is greater. For example, if an employer uses a look-back period of 12 months from January 1, 2014, and an employee is found to have worked 30 hours per week on average during the look-back period, then the employee must be offered affordable health care coverage for 12 months going forward from January 1, 2014. More details on this provision can be found in IRS Notice 2012-58. Elected boards are not addressed in the rules. It would seem that elected officials who sit on boards or commissions would need to be counted as a partial employee. As an employer, it would then be an option to offer benefits to these types of employees.

“Pay-or-Play” Rules
Although most local governments are considered large employers and are therefore not eligible to participate in the exchange until 2017, they may still be impacted indirectly by the exchanges if employees participate as individuals. Although employers are not required to offer health benefits coverage, there are penalties if coverage is not offered or if that coverage does not meet the “minimum value” or “affordability” tests.

The “minimum value” threshold is 60% of total plan costs. If an employer plan does not pay for 60% or more of the plan costs, it does not meet this threshold. Employer medical plans will need to be run through calculators to determine if this threshold is met.

An employer’s plan is “affordable” if the employee’s required contribution to the plan does not exceed 9.5% of the employee’s household income for that year. Recent guidance by the IRS has recognized the burden this would have placed on employers and allows the comparison to be made to the employee’s W-2 wages and self-only coverage. This provision is unlikely to impact full-time employees; however, employers will need to make the calculations for all eligible employees to determine if the affordable test is met. If even one employee accesses the exchange and is eligible for a subsidy due to the affordability test, the employer penalty is a per employee charge for each full-time employee over 30 hrs.

Although these regulations are not final, preliminary calculators can be found at the following url if you wish to get started early: http://cciio.cms.gov/resources/regulations/index.html#pm.

Employers should begin to study these provisions to determine potential short- and long-term impacts.

Cadillac Plan Tax
Current law calls for a 40% excise tax on the value of health benefits coverage exceeding $10,200 for individual coverage and $27,500 for family coverage (indexed annually). Barring a change in law, this tax is expected to impact many employers. Although it will be quite some time before the final rules are written, planning for this provision now will help reduce its impact in 2018.


90-Day Waiting Period
When hiring new personnel, employers must offer health benefits coverage to eligible employees within 90-days of the hire date. Note that when calculating 90 days, weekend and holiday days need to be counted. Coverage offered must be effective the first day after 90 calendar days. For groups needing to modify their waiting period to comply, this change needs to be made effective at the start of the first plan year beginning January 1, 2014.

Deductible Limits
Many have mentioned deductible limits as a barrier to making plan changes to avoid the Cadillac Plan Tax. The healthcare reform act limits the size of deductibles for some; however, the deductible limits do not apply to self-funded employers or large group employers.

Additional Mandates
Various additional mandates will impact employers in the coming years. Some of these include coverage for routine services provided in connection with clinical trials, requirement to count prescription co-pays in the out-of-pocket limits, and removal of pre-existing condition exclusions for all members. As these mandates increase the utilization of employers’ plans, it will also increase costs.

The healthcare reform act is vast and complex. Although passed in 2010, the majority of the rules necessary to implement the law have not yet been written. WCA will continue to review and alert you as pertinent guidance is issued. As you plan for the future, recognize that rules and guidance as we know them today may change before they become final. WCA will alert you when we become aware of guidance, and also report on any changes; however, it may be necessary for employers to study certain provisions with legal council before proceeding with plans for the future.

CARTOON

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