2014 PPACA Overview

57 million people younger than 65 do not have access to affordable healthcare benefits. Sixty-seven (67%) percent of the population financially resides between 100%-400% federal poverty level. TML MultiState IEBP (IEBP) political subdivision business experiences about a seventy-one (70.8%) percent population between 100%-400% federal poverty level. Insurance Marketplace Timetable Enrollment began 10.1.13 through 12.1.13. Extension has been applied due to technical difficulties. Extension exists through March 31, 2014 with the possibility of application for exemption due to documented enrollment problems. Federal Government stating website should be updated by the end of November 2013. More than two (2) million Texans will be eligible for tax credits. Texas has more eligible for tax credits than any other state Kaiser Study released 11.5.13. Medicaid Expansion (average 2.3% rate load) includes age 19-65 who have incomes below 138% of FPL income determined by modified adjusted gross income (MAGI) from most recent federal income tax filing rules, and pregnant women, families (parents/caretaker relatives). HHS awards Affordable Care Act funds to expand access to care in 236 communities to serve more that 1.25 million. USA Today 3.30.14 states health care spending growth hits 10-year high in fourth quarter cost rose 5.6%.

Patient Protection Affordable Care Act Administrative Costs - March 23, 2010 Reconciliation Bill signed March 30, 2010	Employer Size		Funding	
ADMINISTRATIVE	< 50 employees; Seasonal Employee is 120 seasonal days or more a year would be a size of group FTE.	>50 employees	Fully Funded Compliance Required	Self Funded Compliance Required
Calendar Year 2012 W-2 Form reporting required to be furnished to employees in January 2013 for employers that were required to file 250 W-2 Forms. Notice 2012-9 includes information on how to report, what coverage to include and how to determine the cost of coverage. September 2013 CBO Budget Outlook Report did not reflect W-2 benefit reporting as a revenue line item.	N/A IRS publishes guidance giving at least 6 months of advance notice of change to the transition.		X	X
Medical Loss Ratio (MLR) Payment: Employer subsidy vs. employee risk. 3.17.14 discussion of delay in payment due to increase in administrative costs for HITECH upgrades. April 1, 2014 announcement released on annual reporting procedures for the 2013 MLR Reporting Year. The MLR data will be collected by the Center for Consumer Information and Insurance Oversight (CCIIO) within the Centers for Medicare & Medicaid Services (CMS). Guidance information http://cciio.cms.gov/resources/factsheets/aca_implementation_faqs13.html (March 8, 2013). Must file claims by legal entity authorized to do business in the State. Reports will be filed using the MLR module of CMS' online Health Insurance Oversight System (HIOS). Timeline for filing: March 14, 2014 proposed rule allowing .3 percent of earned premiums for ICD-10 conversion costs in 2014. April 4, 2014 HIOS MLR module registration window opens, May 1, 2014 MLR data report submission window opens, June 1, 2014 MLR data report filing deadline. MLR data must be uploaded and both designated officials must attest to the accuracy of the data before this deadline.	Return Premium/Contribution excess if loss ratio is ≤85	Return Premium/Contribution excess if loss ratio is ≤80	Return Premium/Contribution excess if loss ratio is <85	N/A
Grandfather Status Loss: Plan Years after January 2014 will be mandated to be PPACA Compliant. November 14, 2013: Obama states individuals may keep insurance for another year with appropriate price comparison transparency to the Insurance Marketplace. **3.6.14** - two year delay in implementation of non Affordable Care Act (ACA) compliant, grandfathered plans have an extension until 2016, meaning some could be enrolled in these policies into 2017. Current Grandfather Groups lose status if they increase in a benefit percentage cost-sharing requirement, regardless of the status: an increase in deductible if out of pocket amount excess medical inflation plus 15%, increase in copayment if the increase exceeds $5 (adjusted for medical inflation) or medical inflation plus 15%. Medical Inflation means the increase since March 2010 in the overall medical care component of the Consumer Price Index for all Urban Consumers (CPI-U) (unadjusted). A decrease in the employer's contribution rate by more than 5% measured by each tier of coverage. Elimination of all or substantially all benefits to diagnose or treat a particular condition. Adding a new overall annual dollar limit or decreasing the overall annual dollar limit in effect on March 2010. Any change must be measured relative to the plan in effect on March 23, 2010. Any of the following plan changes may also trigger the loss of grandfathered status. The addition of a new prescription drug tier with new cost-sharing, an increase in cost-sharing related to wellness incentives or penalties, an increase in retiree self-pay rates, transfer of employees into a less generous plan or plan option where the transfer is not due to bona fide employment-based reason, and certain changes made in response to the Mental Health Parity and Addiction Equity Act such as increasing cost sharing for medical/surgical benefits instead of lowering cost sharing for mental health and or substance use disorder benefits. Changes that do not trigger grandfather status loss: signing a new insurance contract, switching from insured to self-insured coverage, changing third party administrators, pharmacy benefit managers and changing the plan's network or switching PPO networks. Effective Plan Years after 2014 patient protection affordable care act compliance will be required for: attained age twenty-six benefits, no cost-share Phase I-III preventive benefits, network benefit deductible and out of pocket cost shares for emergent and immediate care, appeal procedure, direct access to primary care physicians, pediatricians, and OB-GYNs, compliance with non discrimination rules to prevent favoring highly compensated participants, measurement of provider performance based outcomes. Appropriate disclosure regarding affordability and	Grandfathered Employers Only	Grandfathered Employers Only	Grandfathered Employers Only	Grandfathered Employers Only

Patient Protection Affordable Care Act Administrative Costs - March 23, 2010 Reconciliation Bill signed March 30, 2010	Employer Size		Funding	
ADMINISTRATIVE	**< 50 employees; Seasonal Employee is 120 seasonal days or more a year would be a size of group FTE.**	**>50 employees**	**Fully Funded Compliance Required**	**Self Funded Compliance Required**
minimum essential benefits must be disclosed.				
Summary of Benefits and Coverage (SBC) uniform information about the plan and coverage, as well as a uniform glossary of terms commonly used in health coverage, at the time of enrollment and each subsequent year during annual enrollment and upon request. Both documents must comply with certain appearance and format requirements and must utilize terminology understandable by the average plan enrollee. Must be compliant on or after September 23, 2012. The summary must contain information regarding cost sharing, continuation of coverage, benefit limitations and details on where participants can obtain more information. This summary is required in addition to the ERISA summary plan description. October 2013 update mandate to include reference regarding affordability of plan and compliance to minimum essential coverage. Failure to comply will result in a $1,000 fine per employee.	Compliance Required	Compliance Required	Compliance Required	Compliance Required
Review and Revise your Notice of Privacy Practices and make necessary revisions by September 23, 2013, the compliance deadline for the new rules. If you maintain your Notice of Privacy Practices on your website, you must post the revised notice to the website as of the effective date of the new notice. Distribution of a paper copy of the revised notice to each covered employee enrollee in the next annual health plan mailing, usually your open enrollment period.	x	x	X	X
Review and Revise your Business Associate Agreement executed on or after January 25, 2013 the compliance date is September 23, 2013. For contracts already in existence prior to January 25, 2013, the earlier of: the date the contract or other arrangement is renewed or modified on or after September 23, 2013 or September 22, 2014.				
Exchange Notice Requirement: ***(Distribution delayed until October 2013)*** ***Penalty delayed*** Notice should include information regarding employee purchases coverage through an Exchange then they may no longer be eligible for employer contribution toward health coverage on a pre-tax basis. Notices must be submitted to new hires within **14 days of hire**. The law also requires the notice to explain that if the employer plan's payment of plan costs is less than 60%, the employee may be eligible for a premium assistance tax credit if he or she purchases coverage in the Exchange. Awaiting Guidance. Starting in 2014, small business with up to 100 employees* (states may apply waiver to insure business with up to 50 employees in their exchange) and individuals without employer-sponsored coverage will be able to buy insurance on state-administered "exchanges." State-based Exchanges will be administered by a government agency or non-profit organization. A qualified health plan, to be offered through the new American Health Benefit Exchange/Insurance Marketplaces must provide essential health benefits which include cost sharing limits. No out-of-pocket requirements can exceed those in Health Savings Accounts, and deductibles in the small group market cannot exceed $2,000 for an individual and $4,000 for a family. Online enrollment for the SHOP on-line enrollment will not be available until January 2014. Minimum employee participation mandate of 75%. Employer Premium Tax Credits that provide coverage for 25/50 or fewer employees with $50,000/$40,000 maximum average wage. Premium Tax Credit for employer maximum of 35%, Tax Exempt employer maximum 25% of 50% of contribution/premium payment.	Compliance Required	Compliance Required	Compliance Required	Compliance Required
▪ Model COBRA Continuation Coverage Election Notice: The notice must contain information about individual's right to continue health care coverage in current plan as well as other health coverage alternatives that may be available through the Health Insurance Marketplace with tax credits. Additional note requirement that pre-existing condition exclusion and/or limitations will be prohibited **beginning January 2014** under the Patient Protection Affordable Care Act. IRS proposed regulations lower and middle –income employees who quit or are laid off, or employees' widowed or divorced spouses who are eligible for COBRA but do not enroll, will be entitled to premium subsidies to buy health insurance in public exchanges that begin operating in 2014. Currently proposed regulations state that the COBRA plan would have to fail the 9.5% affordability test and satisfy the 400% federal poverty level test to access COBRA single-coverage. Comments are being received on this proposed regulation and potential penalty. Creditable Coverage Certificates required on terminationsthrough 12/31/14.	Compliance Required	Compliance Required	Compliance Required	Compliance Not Required
Essential Benefits: Minimum Essential Benefit Compliance delayed the effective date until 2015 (along with the delay of the employer penalty	Compliance Required	Compliance Required	Compliance Required	Compliance Not Required

Patient Protection Affordable Care Act Administrative Costs - March 23, 2010 Reconciliation Bill signed March 30, 2010	Employer Size		Funding	
ADMINISTRATIVE	< 50 employees; Seasonal Employee is 120 seasonal days or more a year would be a size of group FTE.	>50 employees	Fully Funded Compliance Required	Self Funded Compliance Required

provision.) The first required reports will occur in early 2016 based on 2015 information.
Ambulatory patient services, Emergency services, Hospitalization, Maternity and Newborn Care, *Mental Health and Substance Use Disorder services (including Behavioral Health*), Mental Health and Substance Abuse Disorder Parity mandate (substantially 2/3 of benefits) and predominately (1/2 of benefits) to medical and surgical care for all Levels of Care Plan Years July 2014 thereafter. Six classifications: network inpatient and outpatient, out of network inpatient and outpatient, emergency room and prescription including medical necessity decisions. Preventive Services mentions: alcohol screening and counseling, depression counseling and tobacco-use screening. EAP parity excluded. EAP cannot be coordinated with benefits under another group health plan. For example, participants in the other group health plan must not be required to exhaust benefits under the EAP (e.g., a gatekeeper EAP) before an individual is eligible for benefits under the other group health plan. *Rehabilitative/Habilitative* Services and Devices, *Pediatric Services including Oral and Vision* Services (Pediatric defined child to attained 19 years of age), Laboratory Services, Preventive and Wellness, Chronic Care Management, Prescription drugs (Use of US Pharmacopeia's (USP) Model Guidelines as a common organizational tool for plans to report drug coverage. Plan must offer one drug for each USP category and class or the number of drugs in the EHB benchmark Plan), Prior Authorization can be used as long as it is not discriminatory Health Plans have two options: Cover at least the greater of: One drug in every category. Same number of drugs in each category and class as the benchmark plan. Essential Benefits defined by the State Benchmark Plan. Plan may have limitations on coverage that differ from the limitations in the EHB – benchmark plan, but covered benefits and limitations on coverage must remain substantially equal to the benefits in the EHB-benchmark plan.

Out of Pocket Maximums: 2014 Individual $6,350, Family $12,700. Actuarial Value (AV) Calculators being designed to assist in measurement of minimum value. Beginning Plan Years after January 1, 2015 the (MOOP) major medical and prescription drug coverage collectively cannot exceed the out of pocket maximum, although separate out of pocket maximums can be retained, as long as the separate out of pocket maximums together do not exceed $6,660/$13,200 (proposed number for 2015).

Minimum Essential Coverage Benefit Reporting Requirements
The 6055 reporting requirement is to provide information regarding MEC (minimum essential coverage) as an aid in enforcing the individual mandate provision of the Affordable Care Act. The following entities are responsible for filing the section 6055 return with respect to MEC provided under a group health plan:

1. Health insurance issuer with respect to fully insured coverage
2. In the case of a self-insured single employer/group health plan, the "plan sponsor"
3. In the case of a self-insured multiemployer plan, the association, committee, joint board of trustees or other similar group of representatives of the parties who establish or maintain the plan
4. The employee organization (i.e., union) in the case of a self-insured plan maintained solely by the employee organization
5. In the case of a self-insured governmental group health plan, the governmental employer may enter into a written agreement with another governmental unit to make the required reporting.
6. Participating employers in a MEWA
7. If not otherwise indicated, plan sponsor, plan administrator or entity that maintains the plan

The 6055 return is required to be filed with the IRS no later than February 28 if filing non-electronically, March 31 if filing electronically.

The IRS requires 6055 returns to be filed electronically unless the aggregate of all returns (w-2's 6055 returns) the reporting entity is required to file less than 250.

Information relating to the Reporting Entity	
Name, address and EIN for the person required to make the return	
Information relating to Health Coverage	
Name, address and TIN (or date of birth if a TIN is not available) of the responsible individual	The statue refers to information for the "primary insured". The final rules adopt the term "responsible individual" to reflect self-insured plans. Thus, for example the case of a self-insured group health plan, the responsible individual would normally be the employee.
Name and TIN (or date of birth if a TIN is not available) of each individual covered under the plan	The entity required for reporting should make reasonable efforts to obtain the TIN of all persons covered under the plan (e.g. including dependents). However, the preamble indicates that if such reasonable efforts are made, penalties will not be imposed for failure to provide the information. Reasonable efforts include two

Patient Protection Affordable Care Act Administrative Costs - March 23, 2010 Reconciliation Bill signed March 30, 2010		Employer Size		Funding	
ADMINISTRATIVE		**< 50 employees; Seasonal Employee is 120 seasonal days or more a year would be a size of group FTE.**	**>50 employees**	**Fully Funded Compliance Required**	**Self Funded Compliance Required**
	consecutive annual attempts to obtain the information after the first unsuccessful attempt.				
For each covered individual, the months for which, for at least one day, the individual was enrolled in coverage and entitled to receive benefits.	A written statement must be provided to each responsible indiviudal				
Information relating to fully-insured employer-provided coverage					
Name, address and EIN of the plan sponsor					
Whether the coverage is SHOP coverage	The statute also provides that the 6055 return is required to include the amount of any required employer premium. This requirement is not included in the final regulations.				
What is the purpose of the 6056 reporting requirement? The purpose of the 6056 reporting requirements is to assist Treasury with administration of the play or pay employer penalty rules set forth in Code section 4980H. Treasure also notes that the 6056 reporting requirements are designed to assist Treasury with administration of the premium tax credit under Code section 36B. Who is required to file a 6056 return? Each large employer member is required to satisfy the section 6056 reporting required, however, employer members may contract with third parties to assist with the filing requirements. For example, the plan sponsor of a plan may report the information required by section 6056 to the IRS on behalf of each participant employer member who participates in the plan, however, the employer member must sign the form and the employer member remains liable for penalties arising from the third party's failure to accurately and timely file-i.e., the employer member is not absolved of its obligation simply because a third party has agreed to prepare and file the form. The Multiemployer Plan The multiemployer plan administrator may file a 6056 return for the contributing employer member with respect to the employer member's full-time employees eligible for the plan but the employer member must sign the form. The employer member would file a separate 6056 return for all other full-time employees. When is the 6056 return required to be filed? A return is required to be filed with the IRS by no later than February 28 if filing non electronically –March 31 if filing electronically. The IRS requires 6056 returns to be filed electronically **unless** the aggregate of all returns (W-2's, 6056 returns) is less than 250. A combined 6055 and 6056 form is permitted to be filed.		Compliance Required	Compliance Required	Compliance Required	Compliance Required
Information	**Comments**				
Name, address and EIN of employer member					
Name and telephone number of contact person					
Calendar year being reported					
Certification as to whether the employer member offered to its full-time employees (and their dependents) the opportunity to enroll in an eligible employer sponsored plan by calendar month and the months that MEC was available	Presumably, this appears to apply at the employer member level. If so, it is unclear whether certification can be made if coverage is not offered to ALL full-time employees each month. If yes then the number of full-time employees each month (see below) would arguable not be required.				
The number of full-time employees of the employer member each month	This will enable the IRS to determine which "bucket of excise tax penalty the employer member may be in (if at all) - "sledgehammer" or "tackhammer". An employer member is in sledgehammer bucket if it fails to offer MEC to at least 95% of its full time employees during the month. It is in the tackhammer bucket				

Patient Protection Affordable Care Act Administrative Costs - March 23, 2010 Reconciliation Bill signed March 30, 2010		Employer Size		Funding	
ADMINISTRATIVE		< 50 employees; Seasonal Employee is 120 seasonal days or more a year would be a size of group FTE.	>50 employees	Fully Funded Compliance Required	Self Funded Compliance Required
	if it fails to offer coverage to 100% of its full time employees but offers to at least 95% OR the coverage is not affordable and/or does not provided minimum value.				
For each full-time employee, the name, address and TIN and the number of months actually covered under the plan	For penalty/premium tax credit purposes, this information is relevant ONLY to the extent the coverage offered isn't affordable or doesn't provide minimum value. Keep in mind coverage could be affordable under the employer penalty provisions but not necessarily under the premium tax credit provisions. However the information is relevant for purposes of the individual mandate and will be provided on the 6055 return				
For each full-time employee, the employee's share of the lowest cost monthly premium for self only coverage that also provides minimum value					

The following additional information is expected be requested using indicator codes.

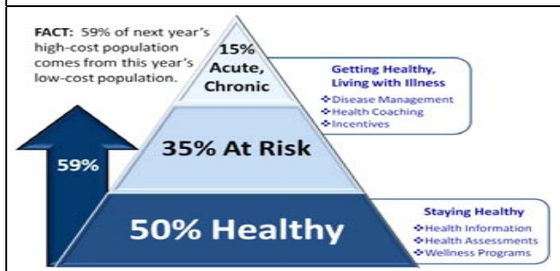
Information	Comments
Whether coverage offered to full-time employee provides minimum value	
Whether the employee had the opportunity to enroll the spouse	
Whether the employee's effective date of coverage was affected by a waiting period	If the employer member cannot indicate that coverage was offered to a full-time employee during a month, an excise tax could apply unless the employer member can show that the employee was in an otherwise applicable permissive waiting period.
Total number of employees for each calendar month	Unclear what purpose this information serves. The penalty buckets described above are determined by reference to the percentage of full-time employees who are offered coverage—not the percentage of employees.
If employer member was conducting business during a month	
If the employer member expects that it will be an ALE in the subsequent year	
For each full-time employee, the level of coverage offered or, if not offered the reason it wasn't offered. For example, an employer member would report the following through a code (i) if coverage was offered, the level of coverage- employee only, employee and employee's dependent's only, employee and employee spouse only or family (ii) that coverage was NOT offered during a month but (a) the employee was in a waiting period (b) the employee was not full-time that month; (c) the employee was not employed that month or (d) no other exception applies; (iii) coverage was offered but the employee was not full-time and (iv) the employer met one of the affordability safe harbors.	These specific codes are designed to fill gaps in the general reporting requirements identified in A above; however, the reporting required here is meticulous.

What information is required to be included on the employee statement?
A form must be furnished to the employee that identifies the following information:
Name address and TIN of employer member
Information included in the 6056 return filed with the IRS with respect to that full-time employee. Presumably, this includes the following:
1095-C

1. Number of months covered

Patient Protection Affordable Care Act Administrative Costs - March 23, 2010 Reconciliation Bill signed March 30, 2010	Employer Size		Funding	
ADMINISTRATIVE	< 50 employees; Seasonal Employee is 120 seasonal days or more a year would be a size of group FTE.	>50 employees	Fully Funded Compliance Required	Self Funded Compliance Required
2. Employee's share of premium/contribution 3. Whether coverage provides minimum value 4. Whether spouse may be enrolled 5. Waiting period 6. Reason coverage not offered Exact elements from the 6056 return filed with IRS that must be furnished to full-time employees. How is the 6056 information reported and 1095 C? As noted above, the 6056 return will be filed electronically unless the employer member qualifies for a small filer exemption, which is based on the number of all returns – not just the 6056. It appears that the 6056 information will be reported on a yet to be developed for 1094 and 1095. Employer members will file an employee statement on 1095-C as well as a transmittal form, 1094-C for all returns. Generally, the employee statement furnished to the employee must be mailed however, it can be provided electronically if the following requirements are satisfied. 1. Employee must affirmatively consent to receive the statement electronically. The consent must be electronic or on paper if confirmed electronically. 2. Certain requirements regarding withdrawal of consent must be satisfied. 3. Notice of a material change in software must be provided. Prescription covers at least the greater of one drug in every U.S. Pharmacy Category				
NCQA/URAC Accreditation	Accreditation required for Qualified Health Plan Exchange/Marketplaces recognition	Accreditation required for Qualified Health Plan Exchange/Marketplaces recognition	Accreditation required for Qualified Health Plan Exchange/Marketplaces recognition	Accreditation required for Qualified Health Plan Exchange/Marketplaces recognition
Automatic Enrollment Employer in excess of 200 employees 2014 **(Delayed)**	Awaiting final regulations	Awaiting final regulations	Awaiting final regulations	Awaiting final regulations
Small Employer Premium Tax Credit: Full Time Employees + full time equivalents +total employees. If the total is less than 25/50 take the total wages of the full time and full time equivalents and divide by number of employees-average wage amount. If the result is less than $50,000 the employer may be able to qualify for the premium credit. Premium Tax Credit for employer maximum of 35%, Tax Exempt employer maximum 25%. Eligible small tax-exempt employers described in Code section 50(c) may claim the refundable credit by filing a Form 990-T with an attached Form 8941 showing the calculation of the claimed credit. A tax-exempt employer is not eligible to claim the credit unless it is an organization described in Code section 501 (c) that is exempt from tax under Code section 501 (a). An enhanced version of this credit goes into effect on January 1, 2014. See www.irs.gov for more information. 1. September 7, 2011 - IEBP received a call from Congressman Hall that he would introduce the bill • Initial Bill 3072 • Congressman Thornberry co-sponsored • Washington Meetings with: Hall, Burgess, Gonzales, Olson, Barton, Cornyn, Green, Brady, and Doggett • Association Meetings: Meeting with NLC and AGRiP for additional State support 2. MultiState Bill Sponsorship • **3.3.14** - Congressman Hall introduces HR 6234 (Arkansas, Kentucky, North Carolina, Colorado, Maine, working with: Oregon, Rhode Island, New Hampshire, Washington, Maryland, and Indiana) • **3.31.14** - Texas, Arkansas, Michigan, and NLC. Projected SGR receives another 12 month extension form 24.5% Medicare cut. Wyden states he will work on a permanent fix prior to 12 month extension end. Hutchinson is meeting with Wyden and Hall will be meeting with Camp. NLC in communication with Reid. On 3.31.14 Senate approved the delay in the sustainable growth rates decrease payment until April 1, 2015. Vote 64 to 35 in US Senate. ◦ Thornberry co-sponsored bill ◦ Griffin (Arkansas) ◦ Boozman (Arkansas) ◦ Pete Olson (Arkansas)	Recipients are Qualified Health Plans	N/A	25/50 fewer employees	Most self-funded groups are larger than 25/50 employees.

Patient Protection Affordable Care Act Administrative Costs - March 23, 2010 Reconciliation Bill signed March 30, 2010	Employer Size		Funding	
ADMINISTRATIVE	**< 50 employees; Seasonal Employee is 120 seasonal days or more a year would be a size of group FTE.**	**>50 employees**	**Fully Funded Compliance Required**	**Self Funded Compliance Required**
▸ Tom Cotton (Arkansas) ▸ Rick Crawford (Arkansas) ▸ Pryor (Arkansas) ▸ Michaud (Maine)				
Standardized Web Portal Information-Outstanding	see fully or self funded compliance guidelines	see fully or self funded compliance guidelines	Compliance Required	Compliance Not Required

Patient Protection Affordable Care Act Administrative Costs - March 23, 2010	Employer Size		Funding	
PATIENT PROTECTION BENEFIT EXPANSION	**< 50 employees**	**>50 employees**	**Fully Funded Compliance Required**	**Self Funded Compliance Required**
Health Flexible Spending: In 2013 **PPACA** implemented maximum plan year dollar limit of $2,500 and made the requirement of a provider prescription order to purchase over the counter medication. IRS Notice 2005-42 incorporates a two month and fifteen day extension of section 125 funds. IRS Notice 2012-40 allows up to a $500.00 carryover of unused dollars (for unreimbursed health claims only) from one flex year to the next if not in excess of plan year capped dollar amount of $3,000.00. 2013 amendment or new contract will be required. Employer will have the option upon December 2013 Plan Year's thereafter to execute a Section 125 2-month and 15-day grace period agreement or a up to $500.00 unreimbursed healthcare Carry Over Agreement.	Compliance Required	Compliance Required	Compliance Required	Compliance Required
Wellness Compliance: Currently 20% variance in review for 30% variance Public Health Service Act (PHSA) Section 2705 approved June 3, 2013. Confirmation of Completion: Biometric Screening/Health Power Assessment. Tobacco use 50% variance PHSA Section 2705 approved June 3, 2013. Well Woman Act: US Preventive Services Task Force (USPSTF) Expanded Coverage of Preventive Services for Women without cost sharing expenses: Contraceptive benefits, breastfeeding support, domestic violence screening, female condoms, medications for risk reduction of breast cancer in women who are at increased risk for breast cancer and low risk for adverse medication effects. Tamoxifen (Evita) not released yet or Raloxifene. Effective for Plan Years beginning 9.24.14 thereafter. Over the Counter Prescriptions: Doctor Ordered: Aspirin, Folic Acid, Fluoride Chemoprevention Supplements, Iron Deficiency Supplements, and Vitamin D supplementation to prevent falls in community-dwelling adults age 65 years and older who are at an increased risk for falls.	Awaiting final Regulations	Awaiting final Regulations	Awaiting final Regulations	Awaiting final Regulations
	Awaiting final Regulations	Awaiting final regulations	Awaiting final regulations	Awaiting final regulations
Employer Cost Share Program/**Pay or Play Penalty** for Full Time Equivalent Employee Population/Measurement Period : **Beginning Plan Years January 2014 and thereafter (July 2, 2103 announcement that the IRS penalty will be delayed until January 2015 HB 2667 vote 246-161 individual mandate 251-174 vote)** the pay or play rule will be effective. Failure to offer coverage to 95% of all full-time employees will result in the 4980H (a) penalty being imposed. **2.10.14** Treasury Department officials announced that employers with **50 to 99 employees** will not be required to report on full-time staff until **2016.** Groups with 100 or more employees do not receive delay, but the FTE definition accuracy will be 70% vs. 95%. 2016 95% thereafter	Compliance Not Required	Compliance Required	>50 full time equivalent employees compliance required	>50 full time equivalent employees compliance required

Patient Protection Affordable Care Act Administrative Costs - March 23, 2010	Employer Size		Funding	
PATIENT PROTECTION BENEFIT EXPANSION	< 50 employees	>50 employees	Fully Funded Compliance Required	Self Funded Compliance Required
will be required. For the FTE measurement period seasonal/variable employee means customary annual employment/fiscal year/benefit plan year of six (6) months. Employers may utilize a 12 months to review but coverage must begin no later than 13 months from the employee's start date. April 3, 2014 House votes 248 to 179 to repeal ACA's 30 hour workweek rule to redefine hew the healthcare reform law defines a full-time employee, raising the bar to 40 hours from 30 hours a week. First day of Plan Year after 1.1.15. <100 and >50 plan years after 1.1.16. Starting in 2016 FTE status will be required by averaging the total number of FTEs for each of the 12 months in the preceding year. Employer may exclude the first 80 FTE from penalty calculations under Section 4980H. This amount will decrease to 30 employees in 2016. Solely for purposes of the penalties under Code Section 4980H, employers are not required to offer dependent coverage to foster or stepchildren; employers must offer coverage only for employees' biological and adopted children. Penalties will not apply for the 2015 plan year for certain employers that have taken steps toward satisfying the pay-or-lay rule requirement. If employers with at least 50 full-time equivalent employees fails to offer minimum essential major medical health coverage to its full-time employees and their dependents, and at least one full-time employee who works on average 30 hours or more a week/h hours a month and/or 120 consecutive seasonal days a year obtains a subsidized coverage in a state health insurance Exchange/Insurance marketplaces the 4980H(a) penalty is $2,000 times the total number of full-time employees employed by the employer for employees in excess of the employee deductible of thirty (30). Hours of service include both hours paid based on performance of duties as well as paid time for vacation, holiday, illness, incapacity (including disability) layoff, jury duty, military duty or leave of absence. Special rules apply to unpaid leave subject to the FMLA of 1993 and the Uniformed Service Employment and Reemployment Rights Act of 1994 that the averaging method exclude if from calculation so that the employee is not disadvantaged by taking these leaves. Rules only apply to employees who are in continuing service, not to those who are terminated and then rehired. Employees rehired with less than a 26 week break in employment may apply "rule of parity" if rehired with a greater than 26 week break, will be treated as new hire. Employees not paid on an hourly based may be calculated on (1) counting actual hours of service; (2) using a days-worked equivalency, which credits the employee with 8 hours of service for each day or (3) using a weeks-worked equivalency of 40 hours of service per week. As under the proposed regulations, this includes any payment made or due for vacation, holiday, illness, incapacity, layoff, jury duty, military duty or leave of absence. The hours of unpaid volunteers-volunteer firefighters, federal or state sponsored volunteers who do not receive compensation excepts for reimbursement of reasonable expenses and certain reasonable benefits and nominal fees, hours worked for income that is taxed as income from sources outside the US and unpaid interns and of student in federal work-study programs would not count toward FTE calculations. Paid student work and grant money employees should be included in the FTE count. At this time the IRS has not initiated a formal rulemaking proceeding to determine whether volunteer firefighters (or any other volunteer) are to be considered employees for purposes for the Affordable Care Act. Therefore, it would be premature to draw any conclusions on how the IRS could rule on this issue or to take action n support of any legislation without more clarification. If volunteer firefighters are considered employees for purposes of the Affordable Care Act, many volunteer fire departments may find they have more than fifty (50) employees and are therefore subject to the Affordable Care Act employer mandate, which does not go into effect until January 1, 2015. Measurement Period: of 12 consecutive months not less than 6/3 months. Begin no later than July 1, 2013 and ends no earlier than 90 days before the first day of the plan year that begins on or after January 1, 2014. Payroll Departments need to review reporting for hours worked, measurement period, high turnover positions, unpaid work hours, employees being paid outside of payroll, unpaid work hours, variable hourly employees, temporary staff, terms and rehires. Typically independent contractors, sole proprietors and partners are not included in the measurement period. Contract workers from a professional staffing agency will defer to state definition of employee for measurement requirement application. Affordability Test/Employer Shared Responsibility Penalty: If the coverage does not meet the "affordability test" or the "minimum value test" and at least one full time employee obtains subsidized coverage in a state health insurance Exchange/Marketplaces than the employer would pay a 4980H (b) penalty. $3,000 times each full-time employee who receives subsidized coverage in Exchange/Marketplaces. Penalty (b) impacts the employer who offers health coverage to its full-time employees and their dependents but the coverage does not meet the "affordability test" or the minimum value test and at least one full-time employee obtains subsidized coverage in a state health insurance exchange, then the employer would pay a 4980H (b) penalty. The amount would be $3,000 times each				

Patient Protection Affordable Care Act Administrative Costs - March 23, 2010	Employer Size		Funding	
PATIENT PROTECTION BENEFIT EXPANSION	< 50 employees	>50 employees	Fully Funded Compliance Required	Self Funded Compliance Required
full time employee who receives subsidized coverage in Exchange with a maximum of the 4980H (a) penalty amount that would have been due if the employer did not receive coverage. » "Affordability Test" allows the employers to measure 9.5% of the employee's wages from the employer, as reported in Box 1 of the Form W-2 instead of household income in regards to the most cost effective minimum qualified health plan option actuarially equivalent to the Bronze Plan. » Employers should be aware that there are two "play or pay" tests – the **objective test** and the **subjective test**. The objective test asks whether the covered employer provides any level of health care coverage. If the answer is no, the employer penalty is $2,000 per employee (with a 30 person deductible). The subjective test asks if the employer provides health care coverage, is that coverage sufficiently affordable and robust. Coverage is sufficiently affordable if the cost is 9.5% or less of employee's W-2 form compensation for the most cost effective single coverage for an employee's benefit plan. » The Penalty will be the lesser of the objective and subjective test-the IRS wants to make sure the employers who are providing some level of coverage do not end up paying more in penalties than an employer who is not providing any coverage. » Employers will be penalized if an employee receives a premium tax credit provided by the Federal Government to Insurance Marketplaces/Exchanges on behalf of individuals whose income is between 100 and 400 percent of the poverty level. The existence of premium tax credit matters to employers because a penalty will apply if one employee receives a premium tax credit. Minimum Essential Major Medical Actuarial Value Calculator: 60% Bronze Plan/Individual Deductible not excess of $2,000 individual/$4,000 family for small employers. Maximum Out of Pocket: 2014 $6,250 for single coverage and $12,500 for family. Transition Rule: Effective with the plan year beginning on or after January 1, 2014, non grandfathered group health plans must comply with a new annual limit on cost sharing, also known as an out-of-pocket maximum. Regarding the out of pocket maximum transitional rule for both fully insured and self-insured plans, the DOL guidance provides that for the first plan year beginning after January 1, 2014 if the plan utilizes multiple service providers to administer the types of benefits that will be subject to the PPACA annual out of pocket maximum (essential health benefits if fully insured or a "permissible definition of essential health benefits" if self-insured), if each service provider has a separate out of pocket maximum, each service provider may impose a separate out of pocket maximum of $6,350 individual, Family $12,700. Thus, for example, an out of pocket maximum of $6,350 may be imposed for major medical coverage and a separate out of pocket maximum of $6,350 may be imposed for prescription drug coverage for the first plan year. Notably, if the prescription drug coverage does not currently impose an out of pocket maximum, no out of pocket maximum is required to be imposed for the first plan year. Transition Rule: Beginning Plan Years after January 1, 2015 the (MOOP) major medical and prescription drug coverage collectively cannot exceed the out of pocket maximum, although separate out of pocket maximums can be retained, as long as the separate out of pocket maximums together do not exceed $6,660 (proposed number for 2015).				
90 day limitation on Waiting Periods: January 1, 2014 thereafter. A group may not apply any waiting period that exceeds 90 days. Note: Waiting period of more than 90 days are subject to a $600 per employee fine. A thirty day orientation period may be added to the 90 day waiting period limitation.	Compliance Required	Compliance Required	Compliance Required	Compliance Required
Prohibition of Pre-Existing conditions for >19 years of age participants Plan Years Jan 2014 thereafter	Compliance Required	Compliance Required		
Individual Mandate: Health Care Reform requires individuals to obtain "minimum essential coverage" Waivers will be allowed for specified individuals and circumstances. 2014 Tax penalty is $95 per individual to a maximum of $285 per family, or 1% of household income, 2015 Tax penalty is $325 per individual to a maximum of $975 per family, or 2% of household income, 2016 Tax penalty $695 per individual to a maximum of $2,085 per family, or 2 1/2% of household income. **12.19.13** The Department of Health and Human Services issued a bulletin advising consumers "If you have been notified that your individual market policy will not be renewed, you will be eligible for a hardship exemption and will be able to enroll in catastrophic coverage". Sebelius state the premiums for catastrophic plans were on the average about 20% lower than premiums for other plans. **12.23.13** Need to enroll by 12.23.13 for benefits effective 1.1.14. Premium payments are due as late as 1.10.14. Ultimately, a person has until March	N/A	N/A	N/A	N/A

Patient Protection Affordable Care Act Administrative Costs - March 23, 2010	Employer Size		Funding	
PATIENT PROTECTION BENEFIT EXPANSION	**< 50 employees**	**>50 employees**	**Fully Funded Compliance Required**	**Self Funded Compliance Required**
31, 2014 for coverage. Must enroll by the 15th of each month to get coverage the 1st of the next month.				
Fair Health Premium › Tiered Rates with offset of High Risk Managed by the 3 R's: Reinsurance, Risk Corridor, Risk Adjustment › Age Bands : 0-20; 21-63; > 64 Current IEBP Bands: <35, 36-45, 46-50, 51-55, 56-60, 61-65, 66-70, >71 with gender factor variances › Geographic › Tobacco 1:5 › Age 1:3 › Community Rating: Health insurance issuers providing individual or small group policies covering 100 or fewer individuals must abide by strict community rating rules with premium variations › Three Rs: Risk Adjusted, Reinsurance, Risk Corridor	Awaiting final Regulations	Awaiting final Regulations	Awaiting final Regulations	Awaiting final Regulations
Prohibition of Discrimination: Age, Disability, Life Expectancy	Compliance Required	Compliance Required	Compliance Required	Compliance Required

Patient Protection Affordable Care Act Administrative Costs - March 23, 2010	Employer Size		Funding	
ACCOUNTABLE CARE ACT ADMINISTRATIVE FEES AND COMPLIANCE	**< 50 employees**	**>50 employees**	**Fully Funded Compliance Required**	**Self Funded Compliance Required**
Patient Centered Outcome Research Institute (PCORI): The "plan sponsor" (self-funded designated employer) fee is addressed under Section 4376 for applicable self-insured plan. The current regulations identify a fee structure for plan years 2012-2018. The annual filing will be identified on the revised IRS Form 720. Fees must be paid by July 31, 2013 of the calendar year immediately following the last day of the plan years **ending after September 30, 2012 revised to Plan Years on or after October 1, 2012).** Fee is $1.00 per participant for 2012, **$2.00** per participant for 2013, and fee will be indexed for future payments. HRA and H.S.A. counts will be fee applicable if integrated with a health plan. HRAs must be linked to group health care coverage in order to continue to offer benefits in 2014. Only exclusion is RRAs. If a retiree is accessing HRA dollars, the retiree will not be eligible for premium tax credits. Annually, an employer is mandated to allow opt in/out of HRA accounts which could assist in the spend-down of the account. Eligibility audits and documentation requirements should be implemented Public Sector trend is 8% -10% error rates. Private Sector is 6%-8% error rate.	$1.00 PPPY Compliance Required	$1.00 PPPY Compliance Required	Compliance Required	Compliance Required
Transitional Reinsurance Program: The program is designed to help stabilize premiums in the individual health insurance market will be effective from 2014 through 2016. Fees of $63.00 Per Participant Per Year (Employee, Dependent, COBRA, Retirees accessing plan) to	Compliance Required	Compliance Required	Compliance Required	Compliance Required

Plan Year	First PCORI Payment Due Date
November 1, 2011 to October 31, 2012	July 2013
December 1, 2011 to November 30, 2012	July 2013
January 1, 2012 to December 31, 2012	July 2013
February 1, 2012 to January 31, 2013	July 2014
March 1, 2012 to February 28, 2013	July 2014
April 1, 2012 to March 31, 2013	July 2014
May 1, 2012 to April 30, 2013	July 2014
June 1, 2012 to May 31, 2013	July 2014
July 1, 2012 to June 30, 2013	July 2014
August 1, 2012 to July 31, 2013	July 2014
September 1, 2012 to August 31, 2013	July 2014
October 1, 2012 to September 30, 2013	July 2014

Patient Protection Affordable Care Act Administrative Costs - March 23, 2010	Employer Size		Funding	
ACCOUNTABLE CARE ACT ADMINISTRATIVE FEES AND COMPLIANCE	< 50 employees	>50 employees	Fully Funded Compliance Required	Self Funded Compliance Required
support this transitional reinsurance program will be assessed against both insured and self-funded group health plans. Health Human Services will collect the reinsurance fees on an annual basis. **3.10.14** - Self-insured health plans must pay into the fund but they cannot draw from it. Meanwhile, only insurers in the individual market — inside and outside the exchanges — can draw payments from it. It was originally $63 per year ($5.25 per month) per participant. Employers will be allowed to pay the fee in two installments. The first upfront payment, the larger of the two ($52.50 per year per covered life), would be payable soon after the contributing entity submits an enrollment count. The second payment ($10.50 per year per covered life) would be payable during the fourth quarter, about nine months later. The **2015** annual reinsurance contribution rate drops down to **$44** per enrollee; that will be split into a **$33 first installment, and an $11 second installment** nine months later **for the 2015 benefit year**. Those amounts would be payable in January 2016 and late in the fourth quarter of 2016. The rule also excluded employers that self-insure health claims while also self-administering its claim services without a TPA, from making reinsurance contributions for 2015 and 2016. **3.5.14** - changes to Reinsurance Program 2015 uniform reinsurance payment parameters - $70,000 attachment point, a $250,000 reinsurance cap and a 50% coinsurance rate. Finalized their proposal to decrease the attachment point from 2014 from $60,000 to $45,000 with an 80% coinsurance rate. This means plans will be reimbursed 80% of costs in excess of $45,000 for an enrollee. The cap on reimbursable claims remains at $250,000.				
Annual Health Insurance Provider Fee: Net Premium in 2014/by total industry net premiums from health, vision, dental, and retiree benefits. Take the ratio of the net premium and aggregate industry premium and multiply by the applicable amount to achieve the health insurance provider fee schedule for 2014=$8B – 2018=$14.3B. File IRS Form 8963 by April 15 of the year. Exclusions: self insured employers, governmental entities, certain non-profit organizations, certain VEBAS **12.2.13** Received information that MEWA's, VEBAs and self-funded employers are considered as covered entities and will be included in the Provider Fee payment. The IRS will take into account 50% of the net premiums written for amounts over $25 million and up to $50 million and 100% of the net premiums written that are over $50 million. Thus, for any covered entity with net premiums written of $50 million or more, the IRS will not take into account the first $37.5 million of net premiums written/deductible. If covered entity is exempt from tax under section 501(a) and is described in section 501 (c)(3), (4), (26), or (29), the IRS will take into account only 50% of the remaining net premiums written of that entity (or member) that are attributable to its exempt activities.	Awaiting June 21, 2013 regulatory response from comments.	Awaiting June 21, 2013 regulatory response from comments.	Awaiting June 21, 2013 regulatory response from comments.	Awaiting June 21, 2013 regulatory response from comments.
Student Health Insurance	Non Compliant with PPACA	Non Compliant with PPACA	Non Compliant with PPACA	Non Compliant with PPACA
Revision to Provider Payment Model	Provider Delivery System: Fee for Service vs. Shared Risk Pricing	Provider Delivery System: Fee for Service vs. Shared Risk Pricing	Provider Delivery System: Fee for Service vs. Shared Risk Pricing	Provider Delivery System: Fee for Service vs. Shared Risk Pricing

Patient Protection Affordable Care Act Administrative Costs - March 23, 2010	Employer Size		Funding	
HITECH REQUIREMENTS	< 50 employees	>50 employees	Fully Funded Compliance Required	Self Funded Compliance Required
HITECH Upgrades: - 4010 to 5010 **June 2012** - Health Plan Identifier Application **November 5, 2014 small plans November 5, 2015**. All covered entities must use HPID s in standard transactions by **November 7, 2016**. - **Electronic Fund Transfers**: V-Payment/ACH Payment **by January 2014**. Explanation of Benefit and Explanation of Payment documentation will be implemented. Group health plans must file a certification with the Secretary of HHS that their plan is in compliance with the "administrative simplification" rules for electronic fund transfer, health claim status and health care payment. - Conversion from ICD 9 to ICD 10 **October 2014**. Hybrid timeline for ICD 9 and ICD 10 October 2014. On 3.31.14 Senate approved ICD-10 delay until October 1, 2015. Vote 64 to 35 in US Senate. - Automatic electronic > 200 enrollment 2014 possible delay. - Online Enrollment with price comparison calculator - Healthcare Transparency/Cost Estimator Services/Price Awareness - Electronic Medical Records Dec 31, 2015 Delayed until January 2012 - Standardized Web Portals The penalty for non-compliance is $1.00 per covered life per day of non-compliance, to a maximum of $20.00 per covered life per year. A	Compliance Required	Compliance Required	Compliance Required	Compliance Required

Patient Protection Affordable Care Act Administrative Costs - March 23, 2010	Employer Size		Funding	
HITECH REQUIREMENTS	< 50 employees	>50 employees	Fully Funded Compliance Required	Self Funded Compliance Required
double penalty applies in the case of a misrepresentation by the employer.				
Electronic Medical Records: Group health plans must certify to the Society of HHS that they are using electronic systems for processing health claims, enrollment and premium/contributions payments and that their systems are in compliance by December 31, 2015. Delay until Jan 2017.	Awaiting final regulations	Awaiting final regulations	Awaiting final regulations	Awaiting final regulations

Patient Protection Affordable Care Act Administrative Costs - March 23, 2010	Employer Size		Funding	
OTHER	< 50 employees	>50 employees	Fully Funded Compliance Required	Self Funded Compliance Required
State High Risk Pools	Awaiting final regulations	Awaiting final regulations	Awaiting final regulations	Awaiting final regulations
Medicare Tax Increase for High Earners: Beginning in 2013, individuals making $200,000 and joint filers making $250,000 must pay an increase of 0.9% in the Medicare tax. A 3.8% tax on unearned income for high-income individuals will also take effect. Overview of Rules: Married individual filing a joint return: $250,000, married individual filing a separate return $125,000 any other case $200,000. Additional Medicare tax increase 0.9%.	Awaiting final regulations	Awaiting final regulations	Awaiting final regulations	Awaiting final regulations
After January of 2016, the stop loss individual minimum attachment point requirement is raised to $40,000.				Compliance Required
Excise Tax on High Cost Employer-Provided Health Coverage: In 2018, plan administrators will pay a 40% tax for any health insurance plan that is above the threshold of $10,200 for singles and $27,500 for families. This excise tax would apply to the amount of the premium that is above these thresholds.	Awaiting final Regulations	Awaiting final regulations	Awaiting final regulations	Awaiting final regulations
Coverage for routine medical procedures within clinical trial services	Compliance Required	Compliance Required	Compliance Required	Compliance Required
Texas Emergency Room and Anesthesiologist Network Providers	Minimize Covered Individual Out of Pocket Expenses	Minimize Covered Individual Out of Pocket Expenses	Minimize Covered Individual Out of Pocket Expenses	Minimize Covered Individual Out of Pocket Expenses
1.30.14 Rate and Benefit Information System (RBIS). Reports will be effective next data reporting period scheduled for February 24, 2014. Types of Rate Regulation: Actuarial Justification: In markets with actuarially justified rating requirements, insurers must demonstrate a correlation between case characteristics and increased medical claims cost. Rating Bands: Limit the variation in premiums attributable to health status and other characteristics. Rating bands are either expressed as a ratio of the highest rating factor to the lowest with an allowable a variation of 30%. May take the form of composite rating bands that limits on the combined effects of multiple case characteristics. Adjusted Community Rating: Prohibit the use of health status or claims experience in setting premiums. Other case characteristics, such as age and geography may be used to vary premiums. Community Rating: "Pure" community rating laws prohibit the use of any case characteristics besides geography to vary premiums. `				Ensure payment for claim utilization is properly funded by premium/contribution.
Documented 3.6.14 2015 Open Enrollment Period for Insurance Marketplace November 15, 2014-February 15, 2015, although it was indicated that open enrollment for 2016 and subsequent years would likely remain October 15-December 7.				