Getting Ready for 2014 Plan Year Renewal

The things that employers should keep in mind.

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All Employers

Notice of the Exchange

The Requirement

- Employers are required to provide all new hires and current employees with a written notice about the health benefit Exchange and some of the consequences if an employee decides to purchase a qualified health plan through the Exchange in lieu of employer-sponsored coverage.
- This disclosure requirement is generally effective for employers beginning on October 1, 2013.
- Employees hired on or after the effective date must be provided the Notice of Exchange at the time of hiring.

The Contents of the Notice

- With this notice, employees must be informed of the following:
  - The existence of the Exchange, given a description of the services provided by the Exchange, and told how to contact the Exchange to request assistance.
  - They may be eligible for a premium tax credit or a cost-sharing reduction (under PPACA § 1402) through the Exchange if the employer plan's share of the total cost of benefits under the plan is less than 60%.
  - If they purchase a qualified health plan through the Exchange, then they may lose any employer contribution toward the cost of employer-provided coverage; and all or a portion of employer contributions to employer-provided coverage may be excludable for federal income tax purposes.

Three Fees/Taxes

Comparative Effectiveness Research Fees (a.k.a. PCORI Fee/CERF)

What is it?

- Health care reform created a new nonprofit corporation, the Patient-Centered Outcomes Research Institute, to support clinical effectiveness research.

- This entity will be funded in part by fees (sometimes referred to as "PCORI fees" or "CER fees") paid by certain health insurers and applicable sponsors of self-insured health plans.

- These fees do not apply to plans that provide "excepted benefits."

Who Pays it and When?

- Fees are payable in connection with policy/plan years ending after September 30, 2012, but stop applying for policy/plan years ending after September 30, 2019.
- While insurers will file reports and pay the fees for insured policies, self-insured plan sponsors must file reports and pay these fees.
- Plan sponsors and insurers will file IRS Form 720 to report the fees and make annual payments.
- This return must be filed each year by July 31 of the calendar year immediately following the last day of the policy year (for insured plans) or the plan year (for self-insured plans).

The Amount of the Fee

- These fees will be calculated as the average number of covered lives under a policy or plan multiplied by $1 for plan years ending after October 1, 2012.
- The multiplier increases to $2 for the next plan year, then may rise with health care inflation through plan years ending before Oct. 1, 2019, when the fees are slated to end.
- To determine the average number of covered lives, plan sponsors generally can use any reasonable method in the first plan year and will choose from several proposed approaches in later years.

Required Contributions Toward Reinsurance Payments (a.k.a. Transitional (*Temporary*) Reinsurance Fee)

What is it?

- Under the ACA, each state is required to establish a transitional reinsurance program to help stabilize premiums for coverage in individual market inside and outside of Marketplaces (a.k.a. Exchanges) during the years 2014 through 2016. If a state decides not to establish a transitional reinsurance program, the Department of Health and Human Services (HHS) will create and operate the program on its behalf.
- The program is funded through a reinsurance assessment on all health insurance carriers and self-insured plan sponsors. The collected fee is used to support reinsurance payments to carriers that cover high-cost individuals in non-grandfathered individual market plans.

Who Pays it and When?

- **For self-insured plans**, self-insured group plans sponsors are ultimately liable for reinsurance contribution fees. The self-insured ERs can use a TPA or ASO contractor to transfer the fees.
- **For fully-insured plans**, carriers are responsible to pay the fees.

- A self-insured health plan must make reinsurance contributions for major medical coverage, with certain exceptions.
- For this purpose, HSAs, health FSAs, expatriate health plans, and prescription drug plans are expressly excluded.

The Amount of the Fee

- HHS will establish a national reinsurance contribution rate each year.
- The annual per capita contribution rate for 2014 announced by HHS is **$63 ($5.25 per month)**. HHS will collect all contributions and allocate reinsurance payments on a national basis.
- The same contribution rate applies to self-insured group health plans, although those plans are excluded from receiving reinsurance payments under the program. States may elect to operate their own reinsurance programs, and can require supplemental contributions and administrative cost payments.
- Contributing entities are to make reinsurance contributions annually. Enrollment data must be provided to HHS by November 15 (generally calculated based on January through September data, even for non-calendar-year plans).
- HHS will notify the contributing entity, by the later of December 15 or 30 days after receiving the data, of the amount of the contribution for the year, and payment is due 30 days after notification.

Health Insurance Industry Fee (a.k.a. Annual Insurance Fee)

What is it?

- Health care reform imposes an annual fee to insurers beginning in 2014 for the purpose of funding federal and state Exchanges. The total fee collected in the first year, 2014, will be $8 billion; gradually increasing to $14.3 billion in 2018 and indexed for rate of premium growth in 2019 and thereafter. The fee applies to fully-insured plans including dental and vision plans; but self-funded plans are excluded from this requirement.

Who Pays it and When?

- **Who pays the fees?**
  Insurers
  (Note: Self-insured employers are exempt from this requirement.)

- **When is the fee due?**
  Each insurer will make its payment by September 30 of each applicable calendar year to the Secretary of the Treasury.

- **Will the fee have any impact on fully-insured group health plan premiums?**
  YES. It is expected that this requirement will increase group health premiums in coming years. Some insurers have already indicated that the full amount of about 2 - 2.5% of premium would be added upon the upcoming renewal as early as February 2013; and may be increasing to 3 - 4% of premium in future years. Each insurer is expected to have its own calculation method to allocate its insurer's fee into the groups' premiums. For any specific question regarding the possible premium increase from this provision, you may want to contact your insurer directly..

The Amount of the Fee

- **How is the fee determined?**
  Each insurer's fee will be determined based on its respective market share of premium revenue from the previous calendar year. For example, the 2014 fee will be based on an insurer's 2013 premium revenue and the percentage of the market it represents among all health insurers of US health risks. Then, the market share of the insurer is used to determine its share of the total $8 billion (for 2014).

- **What types of coverage does the fee apply to?**
  The fee applies to most health insurance coverage including dental and vision plans. However, self-insured plans, accident, disability income, specific disease and illness, and long-term care are not subject to this requirement.

	PCORI Fee (a.k.a. CERF Fee)	Health Insurance Industry Fee	Transitional Reinsurance Fee
Effective	2012 ~ 2019 1st Payment: July 31, 2013 (Based on a plan year)	2014 ~ (Permanent) 1st Payment: est. Jan, 2015 (Based on a calendar yr.)	2014 ~ 2016 1st Payment: est. Jan, 2015 (Based on a calendar yr.)
Fully-Insured	No action needed. Premium impact only✓	No action needed. Premium impact only✓	No action needed. Premium impact only✓
Self-insured	☑ **Incl. HRA**	N/A	☑
How much ?	1st YR: $1 x Avg. # of covered lives 2nd YR**:** $2 x Avg. # of covered lives 3rd YR+: Increased by the % in the projected per capita amount of the National Health Expenditures (HHS)	The exact dollar amount depends on each carrier. **2014:** 2 ~ 2.5% of premium Increasing to 3 ~ 4 % in future years (Ref. CIGNA's est.)	**2014:** **$63*** x Avg. # of covered lives (*2015 & 2016 – the fee amount will be decreased gradually. The exact fee hasn't been announced yet.)
ER's To do list (Self-insured ERs)	•Calculate the Avg. # of covered lives •Calculate the total fees •Pay with the Form 720 by July 31 of the year following the last day of the plan yr .	N/A Insurance companies are expected to include the fees in the future premiums for fully-insured plans.	•Calculate the Avg. # of covered lives •Calculate the total fees •Submit an annual enrollment count etc. by Nov. 15 to HHS. •Pay the applicable fees to HHS (est. Jan. 2015)
Purpose	The fee is collected to fund the Patient-Centered Outcomes Research Institute under ACA.	To fund the Health Insurance Marketplaces (Exchanges).	To help stabilize individual market premiums inside and outside of Marketplaces (Exchanges).

90 Day Waiting Periods

Effective Date

- Effective as of plan years beginning on or after January 1, 2014, group health plans and insurers are prohibited from applying a waiting period that exceeds 90 days.
- This prohibition applies to group health plans and insurers but not to certain "excepted benefits."
- Grandfathered health plans must also comply with the waiting period requirements.

What is it?

- **Definition of "Waiting period":** the period that must pass before coverage for an employee or dependent who is otherwise eligible to enroll under the terms of a group health plan can become effective.
- **Cumulative service requirement**
  If a group health plan or health issuer conditions eligibility on an employee having a completed a number of cumulative hours of service, up to 1,200 hours may be required; more than 1,200 hours would be considered designed to avoid compliance with the 90-day waiting period limitation.
- **Counting days**
  All calendar days are counted beginning on the enrollment date, including weekends and holidays.

Examples

- **Example 1**: A group health plan provides that full-time employees are eligible for coverage under the plan. Employee Bill begins employment as a full-time employee on January 19.

  Conclusion. Any waiting period for Bill would begin on January 19 and may not exceed 90 days. Coverage under the plan must become effective no later than April 19 (assuming February lasts 28 days).

- **Example 2**: A group health plan provides that only employees who have completed specified training and achieved specified certifications are eligible for coverage under the plan. Employee Lisa is hired on May 3 and meets the plan's eligibility criteria on September 22.

  Conclusion. Lisa becomes eligible for coverage on September 22, but for the waiting period. Any waiting period for Lisa would begin on September 22 and may not exceed 90 days. Coverage under the plan must become effective no later than December 21.

Examples (Cont.)

- **Example 3**: A group health plan provides that employees are eligible for coverage after one year of service.

  Conclusion. The plan's eligibility condition is based solely on the lapse of time and, therefore, is NOT allowed because it exceeds 90 days.

- **Example 4**: A group health plan is a calendar year plan. Prior to January 1, 2014, the plan provides that full-time employees are eligible for coverage after a 6-month waiting period. Employee Sarah begins work as a full-time employee on October 1, 2013.

  Conclusion. The first day of Sarah's waiting period is October 1, 2013 because that is the first day Sarah is otherwise eligible to enroll under the plan's eligibility rule. Beginning January 1, 2014, the plan may not apply a waiting period that exceeds 90 days. Accordingly, Sarah must be given the opportunity to elect coverage that begins no later than January 1, 2014 (which is 93 days after Sarah' s start date) because otherwise, on January 1, 2014, the plan would be applying a waiting period that exceeds 90 days. The plan is not required to make coverage effective before January 1, 2014 under the rules of this section.

Pre-existing Conditions

Overview

- Effective as of plan years beginning on or after January 1, 2014, a plan may not impose any pre-existing condition exclusion.
- This will be the case whether or not an individual has prior creditable coverage and whether or not the individual is a late enrollee.
- The prohibition includes both denial of enrollment and denial of specific benefits based on a preexisting condition.
- A PCE also includes any limitation or exclusion based on information relating to an individual's health status, "such as a condition identified as a result of a pre-enrollment questionnaire or physical examination given to the individual, or review of medical records relating to the pre-enrollment period."

Out-of Pocket Limits

Overall Cost-Sharing Limitation (Out-of-Pocket Maximum)

- A plan must not impose cost-sharing in excess of the maximum out-of pocket amount in effect for high deductible health plans for 2014.

- For 2014, the HDHP maximum out-of-pocket expense limit (that is, the sum of the plan's annual deductible and other annual out-of-pocket expenses (other than premiums) that the insured is required to pay, such as co-payments and co-insurance for an HDHP) cannot exceed $6,350 for self-only coverage and $12,700 for family coverage.

- For 2015 and later years, the maximum is subject to increase.

Wellness Programs

Overview

- A new set of rules governing standard based wellness programs.
- Rules are similar to those set forth in current HIPAA current regulations (Participation and standard based programs), but with refinements.
- HIPAA wellness program incentive limit will increase from 20% to 30% of total cost of coverage.
- The reward limit may be increased to 50% of the cost of coverage for smoking cessation programs.

Approved Clinical Trials

Overview

- Group health plans providing coverage to a qualified individual may not deny the individual participation in an approved clinical trial, deny (or limit or impose additional conditions on) coverage of routine patient costs for items and services furnished in connection with the trial, or discriminate against the individual based on participation in the trial.
- A group health plan may not:
  - deny any qualified individual the right to participate in a clinical trial as described below;
  - deny, limit, or impose additional conditions on the coverage of routine patient costs for items and services furnished in connection with participation in the clinical trial; and
  - may not discriminate against any qualified individual who participates in a clinical trial.

Large Employers

Employer Mandate

What is the Employer Mandate?

- Beginning in 2014, certain large employers may be subject to penalty taxes for failing to offer health care coverage for all full-time employees (and their dependents), offering minimum essential coverage that is unaffordable, or offering minimum essential coverage under which the plan's share of the total allowed cost of benefits is less than 60%.

- The penalty tax is due if any full-time employee is certified to the employer as having purchased health insurance through an Exchange with respect to which a tax credit or cost-sharing reduction is allowed or paid to the employee.

Noncalendar Year Plans

- There are 3 transition rules for employers maintaining noncalendar-year plans as of Dec. 27, 2012.
  - Relief for employees eligible on Dec. 27. 2012. An employer will not face penalties for full-time employees who were eligible for coverage as of Dec. 27, 2012, as long as the employer offers them affordable coverage with a minimum 60% value by the first day of the plan year that starts in 2014.
  - Relief if coverage offered to at least one-third of employees. For employees not eligible for the above plan as of Dec. 27, 2012, the same penalty relief applies if the employer offered at least one-third or more of its employees coverage during the most recent open enrollment period before Dec. 27, 2012.
  - Relief if at least one-quarter of employees covered. The penalty relief also would apply if at least one-quarter of employees were covered under one or more noncalendar-year plans that had the same plan year on Dec. 27, 2012

Who is a Large Employer?

- An employer is large if it employed an average of at least 50 full-time employees on business days during the preceding calendar year. The controlled group rules in IRS 414 (b),(c), (m) and (o) apply to determine of an employer is subject to this provision.
- In determining the number of full-time employees, an employer must add up the total number of hours worked in a month by part-time employees, divide by 120, and add that number to the number of full-time employees.
- A "full-time employee" for any month is an employee who is employed for an average of at least 30 hours of service per week.

Who is a Large Employer?

- There is transition relief for purposes of the applicable large employer determination for the 2014 calendar year that allows an employer the option to determine its status as an applicable large employer by reference to a period of at least six consecutive calendar months, as chosen by the employer, in the 2013 calendar year (rather than the entire 2013 calendar year).

- An employer may determine whether it is an applicable large employer for 2014 by determining whether it employed an average of at least 50 full-time employees on business days during any consecutive six month period in 2013.

Who is a Large Employer?

- A special rule enables an employer that has more than 50 full-time employees solely as a result of seasonal employment to avoid being treated as an applicable employer.
- Under this rule, an employer will not be considered to employ more than 50 full-time employees if (a) the employer's workforce only exceeds 50 full-time employees for 120 days, or fewer, during the calendar year; and (b) the employees in excess of 50 who were employed during that 120-day (or fewer) period were seasonal workers.
- A "seasonal worker" means a worker who performs labor or services on a seasonal basis as defined by the DOL, including agricultural workers covered by 29 CFR § 500.20(s)(1) and retail workers employed exclusively during holiday seasons.

Special Rules

- **Who are considered employees?**
  - Use common law standard.
- **How are hours of service counted?**
  - Hourly employees. To determine the full-time status of employees paid on an hourly basis, employers must use actual hours of service (including leave) for which payment is made or due.
  - Nonhourly employees. Employers may choose from three methods to determine the full-time status of nonhourly employees:
    - Actual hours of service. Count actual hours of service worked for which payment is made or due.
    - Days-worked equivalency. Credit an employee working at least one hour of service in a day with eight hours of service for that day.
    - Weeks-worked equivalency. Credit an employee working at least one hour of service in a week with 40 hours of service for that week.

Large Employers who do not offer Coverage

- Large employers who do not offer "minimum essential coverage" to substantially all of its full-time employees and have at least one full-time employee who receives premium tax credits would be assessed a fee of $2,000 for every full-time employee beyond the first 30 employees.
- The "applicable payment amount" for 2014 is $166.67 with respect to any month (that is, 1/12 of $2,000).
- The amount will be adjusted for inflation after 2014.
- **30-Employee Reduction**.
  - The number of individuals employed by an applicable large employer as full-time employees during any month is reduced by 30 for purposes of calculating the penalty tax on large employers not offering a health care plan.
  - While this reduction may decrease the amount of the penalty tax that may otherwise be due, it does not change the employer's status as an applicable employer.
  - Application to controlled groups on a pro rata basis.

Employer Mandate

- An applicable large employer will pay a penalty tax (i.e., make an assessable payment) for any month that—
  - (1) the employer offers to its full-time employees (and their dependents) the opportunity to enroll in "minimum essential coverage" under an eligible employer-sponsored plan for that month; and
  - (2) at least one full-time employee of the employer has been certified to the employer as having enrolled for that month in a QHP for which a premium tax credit or cost-sharing reduction is allowed or paid.

Employer Mandate

- If an employee is offered affordable minimum essential coverage under an employer-sponsored plan, then the individual generally is ineligible for a premium tax credit and cost-sharing reductions for health insurance purchased through an Exchange.

- But employees covered by an employer-sponsored plan will be eligible for the premium tax credit if the plan's share of the total allowed costs of benefits provided under the plan is less than 60% of those costs (that is, the plan does not provide "minimum value"), or the premium exceeds 9.5% of the employee's household income.

Employer Mandate

- The penalty tax (assessable payment) is equal to $250 (1/12 of $3,000, adjusted for inflation after 2014) times the number of full-time employees for any month who receive premium tax credits or cost-sharing assistance (this number is not reduced by 30).

- This penalty tax (assessable payment) is capped at an overall limitation equal to the "applicable payment amount" (1/12 of $2,000, adjusted for inflation after 2014) times the employer's total number of full-time employees, reduced by 30.

Affordability

- There are three affordability safe harbors to determine whether an employer's coverage satisfies the 9.5 percent affordability for purposes of the penalty tax.

- These safe harbors include:

  - the Form W-2 wages safe harbor,

  - the rate of pay affordability safe harbor , and

  - the Federal poverty line safe harbor.

Notice to Employer of Premium Assistance

- The penalty tax is triggered, in part, by the employer receiving a certification that one of its employees is determined to be eligible for a premium assistance credit or a cost-sharing reduction.
- The employee may be eligible because the employer does not provide minimal essential coverage through an employer-sponsored plan.
- Or the employee may not be eligible because the coverage the employer offers either is not affordable, or the plan's share of the total allowed cost of benefits is less than 60%.
- The employer must also receive notification of the appeals process established for employers notified of potential liability for penalty taxes.

Notice to Employer of Premium Assistance

- When the Exchange determines an applicant is eligible to receive advance payments of the premium tax credit or cost-sharing reductions based in part on a finding that his or her employer does not provide minimum essential coverage, or provides coverage that is not affordable, or does not meet the minimum value standard, the Exchange is required to notify the employer and identify the employee.
- This notice includes the employee's identity, that the employee has been determined eligible for advance payments of the premium tax credit, that the employer may be liable or a shared responsibility payment, and that there is an opportunity to appeal.

Reporting of Health Insurance Coverage

- "Applicable large employers" are required to report to the IRS whether they offer their full-time employees and their employees' dependents the opportunity to enroll in "minimum essential coverage" under an eligible employer-sponsored plan and to provide certain other information.

- Reporting employers must also provide a related written statement to their full-time employees.

Reporting of Health Insurance Coverage

- The reporting and statement requirements apply to coverage provided on or after January 1, 2014.
- The first information returns will be filed in 2015.
- The IRS will use the information that employers report to verify employer-sponsored coverage and to administer the shared employer-responsibility provisions.

Which Employers Are Subject to This Reporting Requirement?

- This requirement applies to "applicable large employers," which are specifically defined under health care reform.

- An employer is an "applicable large employer" for a calendar year if it employed an average of at least 50 full-time employees on business days during the preceding calendar year.

What Information Must Be Reported to the IRS?

- The employer's return, which must in the form be set out by the IRS, must contain the following information—
  - the employer's name, date, and employer identification number (EIN);
  - a certification of whether the employer offers its full-time employees and their dependents the opportunity to enroll in "minimum essential coverage" under an eligible employer-sponsored plan (as defined in Code § 5000A(f)(2));
  - the number of full-time employees the employer has for each month during the calendar year;
  - the name, address, and taxpayer identification number (TIN) of each full-time employee employed by the employer during the calendar year and the months (if any) during which the employee and any dependents were covered under a health benefit plan sponsored by the employer during the calendar year; and
  - any other information required by the IRS.

What Information Must Be Reported to the IRS?

- Employers that offer the opportunity to enroll in "minimum essential coverage" must also report—
  - the months during the calendar year for which coverage under the plan was available;
  - the monthly premium for the lowest cost option in each of the enrollment categories under the plan;
  - the employer's share of the total allowed costs of benefits provided under the plan;
  - in the case of an employer that is an applicable large employer, the length of any waiting period with respect to such coverage; and
  - in the case of an employer that is an offering employer, the option for which the employer pays the largest portion of the cost of the plan and the portion of the cost paid by the employer in each of the enrollment categories under such option.

Written Statements to Full-Time Employees

- Employers required to submit a report of health insurance coverage to the IRS must also furnish a written statement to each of their full-time employees whose name was required to be included in the report.
- This statement must include—
  - the name, address, and contact information of the reporting employer; and
  - the information required to be shown on the return with respect to the individual.
- The written statement must be furnished to full-time employees on or before January 31 of the year following the calendar year for which the information was required to be reported to the IRS.

Small Employers

Insurance Mandates

Fair Health Insurance Premiums (Individual & Small Group Market)

- Premiums charged by insurers in the individual & small group market may vary with respect to a particular plan or coverage only by:
  - whether the plan or coverage covers an individual or family,
  - the rating area, as established under state standards,
  - age, except that the rate may not vary by more than a factor of 3 to 1 for adults, and
  - tobacco use, except the rate may not vary by a factor of more than 1.5 to 1.

Comprehensive Health Coverage Requirement

- Effective for plan years beginning on or after January 1, 2014, health insurance insurers offering coverage in the individual or small group market must ensure that such coverage includes the "essential health benefits package."
- This requirement does not apply to "excepted benefits."
- Insurance coverage and health plans that qualify as grandfathered health plans are not required to comply with comprehensive health coverage requirement.

Comprehensive Health Coverage Requirement

- To provide the essential health benefits package, a plan must—
  - provide essential health benefits,
  - limit cost-sharing, and
  - provide either bronze, silver, gold, or platinum level coverage (that is, benefits that are actuarially equivalent to 60%, 70%, 80%, or 90% (respectively) of the full actuarial benefits provided under the plan), as or a catastrophic plan (also known as "young invincibles" coverage).

Comprehensive Health Coverage Requirement

- What precisely constitutes "essential health benefits" is to be defined by regulations, but they include minimum benefits in ten general categories and the items and services covered within those categories—
  - Ambulatory patient services
  - Emergency services
  - Hospitalization
  - Maternity and newborn care
  - Mental health and substance use disorder services, including behavioral health treatment
  - Prescription drugs
  - Rehabilitative and habilitative services and devices
  - Laboratory services
  - Preventive and wellness services and chronic disease management
  - Pediatric services, including oral and vision care.

Cost Sharing Limits

Cost Sharing Requirements

- Health care reform requires that "cost-sharing" be limited.
- This requirement applies to all individual and small nongrandfathered group insured health plans
- Cost-sharing includes deductibles, co-insurance, co-payments or similar charges, and any other required expenditure which is a qualified medical expense with respect to essential health benefits covered under the plan.
- Cost-sharing does not include premiums, balance billing amounts for non-network providers, or spending for noncovered services.

Cost Sharing Requirements

- **Limit on Annual Deductible:**
  - For non grandfathered plans, the annual deductible must not exceed :
    - $2,000, in the case of a plan covering a single individual, or
    - $4,000 in the case of any other plan.
  - The above figures will be indexed and may increase for years after 2014.
  - The maximum deductible amounts may be increased by the maximum amount of reimbursement reasonably available to a participant under a "flexible spending arrangement."

SHOP EXCHANGES

Small Business Health Option (SHOP Exchange)

- The Exchange that each state is to establish by 2014 must create a Small Business Health Options Program ("SHOP Exchange") to assist qualified employers in the state who are small employers to enroll their employees in QHPs offered in the small group market.

- Purchasing employer-provided health coverage for employees through a SHOP, however, will entitle certain qualified employers to obtain a small business health care tax credit
- Eligible employers are those defined by the state as a "small employer."

Small Business Health Option (SHOP Exchange)

- Some states, such as NY and CA, will run their own exchanges, while others (i.e. 33 states) will be operated in part or entirely by the federal government.
- Generally, a SHOP is required to carry out all of the functions of an Exchange, but is not required to carry out certain requirements related to individual coverage.
- A state may choose to merge its individual and small group market risk pools and operate the Exchange and SHOP through the same structure, and may allow individuals and employees of small businesses to have the same plan options.
- If a state does not merge the individual and small group market risk pools, the SHOP must permit each qualified employee to enroll only in QHPs in the small group market.

Employer Credits and Subsidies

Overview

- For tax years beginning in 2014 and later, the maximum small business health care tax credit available to eligible small employers increases to 50% of nonelective contributions, but the requirements for the contribution arrangement are different from those applicable to earlier tax years.

- The nonelective contributions for 2014 and later tax years must be made on behalf of employees who enroll in a qualified health plan offered to employees by the employer through an Exchange.

What is a Small Employer?

- In order to qualify to receive a small business health care tax credit in any tax year, an employer must be either an eligible small employer or a tax-exempt eligible small employer, as defined in Code § 45R.
- **Definition of Eligible Small Employer**
  - There are three requirements that an employer must satisfy to be an "eligible small employer." With respect to any tax year—
  - the employer must have no more than 25 full-time equivalent (FTE) employees for the tax year;
  - the employer's FTEs must have average annual wages that do not exceed $50,000 (for 2010 through 2013); and
  - the employer must have a contribution arrangement in effect that meets the requirements of Code § 45R(d)(4).
  - Members of a controlled group or an affiliated service group are treated as a single employer for purposes of the credit.

Fully-Insured Plans

Reforms that Apply to Insured Health Plans

- Guaranteed-Availability Rules Applicable to Small and Large Group Markets
- Guaranteed-Renewability Rules Applicable to All Insurance
- Process for Review and Disclosure of Rate Increases
- Fair Health Insurance Premium Requirement (Rating Limitations)—Applicable Only in the Individual and Small Group Markets
- Comprehensive Health Coverage Requirement (Essential Health Benefits Package)—Applicable Only in the Individual and Small Group Markets
- Medical Loss Ratio (MLR) Requirements
- New Nondiscrimination Rules
- Annual Insurance Fee (a.k.a. Health Insurance Industry Fee)

Self-insured Plans

Reforms that Apply to Self-Insured Plans

- Dependent coverage for adult children up to age 26;
- Coverage of preventive health services without cost-sharing (grandfathered plans are exempt);
- No rescissions of coverage, except in the case of fraud or intentional misrepresentation of material fact;
- No lifetime limits on essential health benefits and annual limits are restricted until 2014 (in 2014, all annual limits are prohibited); and
- Improved internal claims and appeals process and minimum requirements for external review (grandfathered plans are exempt).

Reforms that do not Apply to Self-insured Plans

- Essential Health Benefits Package
- Medical Loss Ratio Rules
- Small Employer Tax Credit
- Review of Premium Increases
- Annual Insurance Fee (a.k.a. Health Insurance Industry Fee)
- Guaranteed availability/ renewability
- Limit on Annual Deductible
- Actuarial value (i.e. bronze, silver, gold, or platinum level coverage)

Grandfathered Plans

Grandfathered Plan Rules

- Certain rules do not apply to "grandfathered plans," or at least do not apply to certain participants in those plans.
- A grandfathered group health plan is a group or individual plan in which an individual was enrolled on 3/23/10.
- It can also be an insured or a self-insured arrangement.
- The determination is made separately for each plan that the employer offers.

Grandfathered Plan Rules

- The following rules apply to grandfathered plans:
  - The rules requiring insured plans to issue a standard plan summary (the four page "highlights" description) and use standardized definitions in that summary,
  - The rules requiring insured and self-insured plans to distribute summaries of material modifications 60 days in advance of any material change, apply to grandfathered plans for plan years beginning on or after March 23, 2012.
  - The waiting period rules,
  - The restrictions on lifetime and annual limits,
  - The rules on rescission,
  - The pre-existing condition prohibition, and
  - The rules on covering adult children (up to age 26) as dependents, although for plan years beginning before January 1, 2014.

Grandfathered Plan Rules

- **The following rules will not apply to grandfathered plans:**
  - Information to the Secretary of HHS
  - Employer Annual Reporting Requirements regarding Quality of Care
  - First Dollar Coverage for Preventive Services
  - Mandated Patient Protections: PCPs, OB-GYNs, and Emergency Care
  - OB-GYNs and pediatricians
  - Code Section 105(h) Non-Discrimination Requirements for Fully-Insured Plans
  - Mandated Claims Appeals Process
  - Guaranteed Availability and Renewability of Coverage (for plan years on or after January 1, 2014)
  - No Discrimination Based on Health Status (for plan years on or after January 1, 2014)
  - Mandated Cost-Sharing Limits (for plan years on or after January 1, 2014)
  - Mandated Coverage for Clinical Trials (for plan years on or after January 1, 2014:

Grandfathered Plan Rules

- **A plan sponsor or an insurance company may make the following changes to its health plan and keep its grandfathered status:**
  - voluntary increase benefits,
  - conform to required legal changes,
  - add new employees and dependents as participants,
  - change third party administrators,
  - renew an insurance policy, and
  - adopt voluntarily other consumer protections in health care reform.

Grandfathered Plan Rules

- A health plan will no longer be considered a grandfathered health plan if a plan sponsor or the insurance company:
  - Eliminates all or substantially all benefits to diagnose or treat a particular condition.
  - Increases a percentage cost-sharing requirement (such as coinsurance) above the level at which it was on 3/23/10.

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Grandfathered Plan Rules

- Increases fixed-amount cost-sharing requirements other than copayments, such as a $500 deductible or a $2,500 out-of-pocket limit, by a total percentage measured from 3/23/10 that is more than the sum of medical inflation and 15%.
- Increases copayments by an amount that exceeds the greater of: a total percentage measured from 3/23/10 that is more than the sum of medical inflation plus 15%, or $5 increased by medical inflation, measured from 3/23/10.

Grandfathered Plan Rules

- Decreases its employer contribution rate by more than five percentage points below the contribution rate on 3/23/10.

- Enters into a new policy, certificate or contract of insurance with an insurance company.

Grandfathered Plan Rules

- With respect to annual limits, a group health plan, or group or individual health insurance coverage, that, on 3/23/10:
  - did not impose an overall annual or lifetime limit on the dollar value of all benefits, imposes an overall annual limit on the dollar value of benefits;
  - imposed an overall lifetime limit on the dollar value of all benefits but no overall annual limit on the dollar value of all benefits, adopts an overall annual limit at a dollar value that is lower than the dollar value of the lifetime limit on 3/23/10; or
  - imposed an overall annual limit on the dollar value of all benefits, decreases the dollar value of the annual limit (regardless of whether the plan or health insurance coverage also imposes an overall lifetime limit on the dollar value of all benefits).

Grandfathered Plan Rules

- **Notice requirements**:
  - A statement must be included in any plan materials provided to participants or beneficiaries (Summary Plan Description) describing the benefits provided under the plan or health insurance coverage, that the plan or health insurance coverage believes it is a grandfathered health plan and providing contact information for questions and complaints.
- **Record Retention Requirements:**
  - Records must be maintained documenting the terms of the plan or health insurance coverage that were in effect on 3/23/10, and any other documents necessary to verify, explain, or clarify its status as a grandfathered health plan.

How Can Employers Control Costs for Plan Year 2014 - Recommended Courses of Action

How Can Employers Control Costs for Plan Year 2014

Suggested changes are….

- Spousal surcharge
- Opt out benefits
- Adding an HSA or HRA option to your existing traditional plan(s)
- Switching to Self-funding
- Health Risk Assessment credit
- Dependent audit
- Billing audit
- Smoker/ non-smoker premium
- Wellness incentives
- Outcome based incentives

Questions??????????

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