Sterling Benefits, LLC

PREMIER PROVIDER OF EMPLOYEE & EXECUTIVE BENEFITS

Health Care Reform ~ Checklist

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Health Care Reform Checklist

A brief checklist for employers

When it comes to Health Care Reform, there's a lot to know — and a lot to do. We want to help you understand the Affordable Care Act (ACA) mandates and let you know that you are not in this alone. To make it a little less overwhelming, we've created this brief to-do list for you.

This list focuses only on key items employers may need to act upon. This checklist applies to small (2 to 99 employees) and large (100+) fully insured employer groups. Please be sure to make note of the checklist items that apply to your group size.

Federal and State laws and regulations are subject to change. We'll continue to send out updates as they become available, but we encourage you to review the information and utilize our Resource Website, our News Feed, and office as a resource in addressing questions and concerns. The website and news feed include previous Sterling Benefits, LLC publications, hot topics, resource links, highlights, timelines, calendars, and release of latest updates. Please feel free to share these resources and invite people to sign up for electronic Reform updates.

As always, we appreciate the opportunity to be of service. Please feel free to contact us for further guidance at 757-624-5200.

Brenda Cutting
Christina Fortney

Sterling Benefits Reform News Feed
http://sterlinghcr.blogspot.com/

2012—2013 Health Care Reform Provisions

- **Small Business Tax Credit** – Employers with fewer than 25 employees (small group) should check to see if they qualify for the Small Business Tax Credit. For tax years beginning in 2014, the credit will be available only to small businesses that purchase health coverage through a Health Benefit Exchange (Exchange). You should seek advice from an accountant and attorney to determine how the credit may affect your specific situation.
- **Determine Grandfathering Status** – Grandfathered status can be lost when there is significant reduction of benefits, increased out-of-pocket spending for employees, and changing from insurance carriers. Non-Grandfathered plans need to include all of the additional rights and patient protects, as well meet the non-discrimination rules. Grandfathered plans are not subject to all of the patient protections and are required to distribute the PPACA Grandfathered Notice.
- **Limit employee contributions to health flexible spending accounts (FSA)** – Beginning in 2013, employee salary reduction contributions to health FSAs will be limited to $2,500 per plan year, with indexed increases allowed in future years to adjust for inflation.
- **Provide a Summary of Benefits and Coverage (SBC)** – On or after Sept. 23, 2012, group health plans and health insurance issuers offering group or individual health insurance coverage are required to use standards in compiling and providing an SBC that accurately describes the benefits and coverage under the applicable plan or coverage. These standards ensure that information is presented in a clear and uniform format that helps plans and individuals better understand their health coverage and compare coverage options across different types of plans and insurance products. The final regulations require that the SBC be provided by the employer in several instances (upon application, by the first day of coverage if there are any changes, special enrollees, upon renewal, upon request and off-renewal changes).
    - Notices of Material Modifications must be provided 60 days prior to any mid-year plan changes. The duty can be satisfied by providing either a separate notice describing the material modification or by providing an updated coverage summary that reflects the change. (This does not apply to renewals of coverage.)
- **W-2 Reporting** – Employers who file 250 or more employee W-2 forms (large group) will be required to report the cost of employees' health benefit coverage on the employees' 2012 W-2 forms that are distributed in January 2013. (This requirement is informational only and does not mean that employees will be taxed on these dollars.) Businesses that filed fewer than 250 W-2s for the 2012 tax year are currently exempt until the IRS indicates otherwise.
- **Medical Loss Ratio Rebate** – If a health insurer does not spend at least 80 percent (small group) / 85 percent (large group) of the premiums it receives on health care services and activities to improve health care quality during the calendar year, the insurer must rebate the difference (rebate) by August 1 of the following year. Carriers are required to provide notice of rebate to the enrollees and the group policyholder. Employers receiving rebates can use the rebates to lower future premium rates or give each enrollee a portion of the rebate amount.
- **Provide written notice about Health Benefit Exchanges (Exchanges)**. Beginning October 1, 2013, employers must provide written notice to current employees, and, going forward, new employees, to inform them of the Exchanges and the circumstances under which they may be eligible for health insurance subsidies.

2014 Health Care Reform Provisions

What Employers Need to Do

- **Offer Minimum Essential Coverage (MEC)** – Employers will want to consider whether they need to make changes to the cost and quality of the coverage offered to avoid penalties that will apply if that coverage is considered unaffordable or low in value. Beginning in 2014, employers with 50-plus full-time employees may be subject to a penalty if they do not offer affordable Minimum Essential Coverage (MEC). The penalty is calculated as follows:
  - **Employers Not Offering Coverage:** If an employer does not offer MEC and one or more full-time employees receive a premium credit or cost-sharing subsidy through the Exchange, the penalty is $2,000 per year per full-time worker. When calculating the penalty, the first 30 full-time workers are subtracted from the payment calculation.
  - **Employers Offering Coverage:** If an employer offers MEC and one or more full-time employees receive a premium credit or cost- sharing subsidy through the Exchange, the penalty is $3,000 per employee who receives a premium credit or cost-sharing subsidy.

An employer-sponsored plan that satisfies the ACA's reform requirements must:

- Be affordable to the employee (i.e., required share of the employee's premium for self-only coverage cannot exceed 9.5 percent of his or her W-2, Box 1 income).
- Provide minimum value (i.e., the plan must pay more than 60 percent of medical costs across a typical population).

What Employers Need to Know – The following items become effective January 1, 2014 and your plan should automatically adjust to comply with the ACA provision requirements applicable to your group plan.

- **Plan exclusions for pre-existing conditions are no longer allowed** – This is an update to the provision from 2010 that did not allow exclusions for children under the age of 19 with a pre-existing condition. This applies to grandfathered and non-grandfathered plans; however, grandfathered individual health plans are exempt from this requirement.
- **Essential Health Benefits (EHB)** – Cost-sharing toward services must accumulate to a plan's out-of-pocket maximum, including flat-dollar copayments for services that are defined as EHB. The ACA requires all non-grandfathered small group employers to provide EHB. Large group employers do not have to cover EHB services, but if they choose to do so, they are prohibited from having annual dollar limits and cost-sharing for EHB services and all services must accumulate to the plan's out-of-pocket maximum.
- **Out-of-pocket maximums** – Maximums for all non-grandfathered plans will be capped at the same level at which health savings account (HSA) plans are capped. In 2013, these levels are $6,250 single/$12,500 family. (In 2014, these levels will be $6,350 single/$12,700 family.)
- **Plan deductibles** – Annual limitation on plan deductibles is $2,000 single/$4,000 family. This applies to non-grandfathered small groups with the exception of 50-plus as they are not considered small group. There is an exception for leaner plans if you cannot "reasonably" meet the approved actuarial values with a $2,000 deductible.

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- **Adjusted community rating (ACR)** rules will apply to non-grandfathered individual and small group insurance markets effective for plan years (policy years in the individual market) beginning on or after Jan. 1, 2014. Under the ACA's provisions, the use of actual or expected health status or claims experience to set rates for premiums is prohibited. Other rating factors such as age, geographic area and tobacco use may be used to vary premiums, within certain limits.
- **New taxes and fees** under the health reform law will impact fully insured and self-funded plans. For fully insured customers, the cumulative financial impact of the health care reform fees in 2014, based on the government rule and industry analysis, shows a projected increase in the premium of about 4 percent. Here is what you need to know about these fees and how they will impact your business:
  - The **Patient-centered Outcomes Research Institute (PCORI) Fee** affects fully insured and self-funded plans. The fee funds research that evaluates and compares health outcomes, clinical effectiveness, risks and benefits of medical treatments and services.
    - Effective 2012-2019, health insurance issuers and employers sponsoring self-funded group health plans must pay $1 per member per year. The fee increases to $2 per member per year in the second year. Then, the fee adjusts based on the percentage increase in the projected per capita amount of national health expenditures.
    - In the case of fully insured coverage, Insurance Carriers must file and pay the fee. The nominal fee is rolled into the premium.
  - The **Transitional Reinsurance Fee** impacts both fully insured and self-funded plans. The fees are distributed to health insurance issuers in the non-grandfathered individual market that disproportionately attract individuals at risk for high medical costs. The intent is to spread the financial risk across all issuers to provide greater financial stability.
    - The fee is temporary and is collected from 2014-2016.
    - The Transitional Reinsurance Fee is assessed on a per capita basis for both fully insured and self-funded plans. For fully insured plans, Insurance Carriers will collect the Reinsurance Fee through premium rates, when approved by the state.
    - The fee is effective Jan. 1, 2014 and the first payment is due Jan. 15, 2015.
    - The Reinsurance Fee is about $5 to $6 per member per month for the first year. This does not include any fees the state may collect if it establishes its own reinsurance program.
    - The health reform law specifies the total amounts of the Reinsurance Fee that must be collected: $12 billion in 2014, $8 billion in 2015 and $5 billion in 2016, totaling $25 billion.
  - The **Insurer Fee,** also called the Health Insurance Tax, applies to health insurance issuers and impacts fully insured customers only. The Insurer Fee will fund premium tax subsidies for low-income individuals and families who purchase health insurance through Health Insurance Exchanges.

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- The Insurer Fee is an annual, permanent fee beginning in 2014.
- The amount is determined by the market share of the health insurance issuer.
- The fee is due no later than Sept. 30 of the following calendar year, so the first payment is due by Sept. 30, 2014.
- Industry sources have estimated the impact of the fee during the first year to be about 2.3 percent of the total premium.

- The **Risk Adjustment Fee** is assessed on issuers of risk-adjusted plans in the non-grandfathered individual and small group markets, whether in or out of the Exchanges, to help fund the administrative costs of running the Risk Adjustment Program. The Risk Adjustment Program is intended to protect health insurance issuers of risk-adjusted plans, such as Insurance Carriers, against adverse selection by redistributing premiums from plans with low-risk populations to plans with high-risk populations. In other words, it helps level the playing field.
  - The Risk Adjustment Fee is estimated to be about $1 per member per year.
  - The fee will be rolled into the premium and not called out separately on invoices.
  - The Risk Adjustment Fee is permanent and begins in 2014.

Notes:

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IMPORTANT: This document has been compiled from numerous sources and is designed to provide a general overview of the new health reform law. It does NOT attempt to cover all of the law's provisions and should NOT be used as legal advice for implementation activities.

We encourage you to seek any professional advice, including legal counsel, regarding how the new requirements will affect your specific plan.

Links - Further Reading

HR 3590 – Patient Protection and Affordable Care Act.

HR 4872 – Health Care and Education Reconciliation Act.

HealthCare.gov

HHS – The U.S. Department of Health and Human Services.

IRS – The Federal Internal Revenue Service.

White House Fact Sheets

Healthcare Reform Website

www.healthreform.gov has been archived. The new website is:

HealthCare.gov