Health Care Reform

2014 – 2015

The Affordable Care Act (ACA) does not require California employers with fewer than 100 employees to provide health insurance. Employers do; however, become responsible for complying with many of the provisions of the ACA when they elect to offer health insurance to their employees. Provisions of ACA took effect for plan years beginning on or after September 23, 2012 with the most significant modifications to health plans beginning in 2014.

When referencing the following pages, keep in mind that California health insurance carriers provided employers with the option to "Early Renew" their health plans in 2013 which means employers could renew off-anniversary in order to maintain their non-ACA compliant plans late into 2014.

Again, in late 2014, the law permitted employers with another opportunity to "Grandmother" the same non-ACA compliant health plans. The "Grandmother" rule allowed employers to continue the delay in transitioning their employees to ACA-compliant plans until the fourth quarter of 2015.

The information on the following pages will help employers determine which provisions their plans will adopt once they transition to ACA-compliant plans. In addition, there are many other provisions that employers must comply with regardless of which type of plans (ACA or non-ACA) they offer.

Please note that the Pay or Play provision requiring employers to offer coverage has been delayed until 2016 for employers with 50 or more full-time or full-time equivalent employees . Employers with 100 or more full-time or full-time equivalent employees must comply in 2015.

2014 & 2015 PROVISIONS

LEGEND (ER SIZE=Applies to this size company; GF=Applies to Grandfathered Plans; NGF=Applies to Non-Grandfathered Plans; F-I=Applies to Fully-Insured Plans)

ER SIZE: 1+
GF: YES
NGF: YES
F-I YES

☐ **Minimum Essential Coverage Reporting** (IRS Code Section 6055)

What: A statement of Minimum Essential Coverage (MEC) must be reported to the IRS using form 1095-C for all employers that have provided health care coverage to their employees and dependents during the year.

When: Insurance carriers will report to the IRS and employees on behalf of their fully insured groups in 2016 for the 2015 plan ongoing. Due by:

- Employees: January 31, 2016
- Paper: February 28, 2016
- Electronic: March 31, 2016

ER SIZE: 50+
GF: YES
NGF: YES
F-I YES

☐ **Employer Mandate Reporting** (IRS Code Section 6056)

What: Employers with 50 or more full-time employees must report all required data elements to the IRS using Form 1094-B. Employers must also provide statements to each of the employees reported for on Form 1094-B.

When: Must report in 2016 for the 2015 plan year ongoing. Due by:

- Employees: January 31, 2016
- Paper: February 28, 2016
- Electronic: March 31, 2016

ER SIZE: 100+
GF: YES
NGF: YES
F-I YES

☐ **Employer Coverage Mandate** (Pay or Play)

What: Employers with 100 or more full-time equivalent employees will be subject to a penalty if they fail to offer at least 70% of their full-time employees (and their dependents) the opportunity to enroll in employer-sponsored coverage and/or if they offer coverage that is deemed unaffordable and/or does not provide minimum value.

Employers must count their employees to determine if they are an Applicable Large Employer (ALE).

- Full-time: Any one person working 30 hours or more per work week.
- Part-time: Calculated by taking the hours worked by part-time employees in a month divided by 120. Note: hours worked includes hours for which employees are entitled to compensation even if no work was performed such as paid leave, sick days, etc.
- Seasonal: Seasonal workers are only included in counts if they work more than 120 days during a year. Seasonal workers are not limited to agricultural or retail work.

Once determined an ALE, it must be established which employees are considered full-time (average 30 or more hours per week), if their coverage plan meets minimum value (60% or higher) and if the plan is affordable (cost to employee not to exceed 9.5% of W-2 annual wages).

When: Employers must comply at their renewal beginning January 1, 2015 going forward. The employer coverage mandate will extend to employers with 50 or more full-time equivalents in 2016 at which time coverage must be offered to at least 95% of their full-time employees (and their dependents).

2014 & 2015 PROVISIONS

LEGEND (ER SIZE=Applies to this size company; GF=Applies to Grandfathered Plans; NGF=Applies to Non-Grandfathered Plans; F-I=Applies to Fully-Insured Plans)

ER SIZE: 1+
GF: YES
NGF: YES
F-I YES

☐ **Reinsurance Fee**

What: Program established to help stabilize premiums in the individual health insurance market for the first three years of the Marketplace operation. The $63 fee per covered life (employees and dependents) will be paid by insurance carriers (fully-insured groups) and plan sponsors (self insured groups).

When: First payment due to HHS January 15, 2015 with third year payment taking place in 2017.

ER SIZE: 1+
GF: YES
NGF: YES
F-I YES

☐ **HIT Fee (Health Insurance Tax)**

What: Insurance carriers pay this fee, which is funded via monthly premium, on behalf of fully-insured groups. The fee adjusts annually.

When: This fee is effective January 1, 2014 going forward. This fee deviates from standard tax policy in that it is not tax deductible. The insurer will owe taxes on the paid fee.

ER SIZE: 1+
GF: YES
NGF: YES
F-I YES

☐ **PCORI Fee** (Patient Centered Outcomes Research Institute Fee)

What: An annual fee, included in premium, imposed on insurance carriers (fully insured groups) and plan sponsors (self insured groups) to help fund research to compare the effectiveness, risk and benefits of medical treatments.

When: Plans years ending on or after October 1, 2013 through September 30, 2014 will be assessed a fee of $2 per member (including dependents) and must be paid by July 31 of the calendar year that immediately follows the close of the plan year. The fee will be adjusted for inflation for ongoing plan years.

ER SIZE: 1+
GF: NO
NGF: YES
F-I YES

☐ **Summary of Benefits and Coverage** (SBC)

What: The SBC is a document to help members understand their benefits and coverage by using a simple language and consistent format.. Insurance carriers provide SBCs for fully-insured groups; however, employers must ensure that they are being distributed upon request, initial enrollment, special enrollment and renewal.

When: This provision has been in effect for plan years ending on or after September 23, 2012. The inclusion is to serve as a reminder that SBCs are an ongoing compliance requirement under ACA.

ER SIZE: 1+
GF: NO
NGF: YES
F-I YES

☐ **Notice of Material Modification** (NMM)

What: A Notice of Material Modification is required when an employer makes a material modification (a change that occurs between renewal periods) in which an average participant would consider it an important enhancement or reduction in benefits and coverage. It must be distributed to participants and beneficiaries at least 60 days before the effective date of the change. It is also necessary to distribute an updated SBC within 60 days of the Notice of Modification being distributed.

When: This provision has been in effect for plan years ending on or after September 23, 2012. The inclusion is to serve as a reminder that NMMs are an ongoing compliance requirement under ACA.

2014 & 2015 PROVISIONS

LEGEND (ER SIZE=Applies to this size company; GF=Applies to Grandfathered Plans; NGF=Applies to Non-Grandfathered Plans; F-I=Applies to Fully-Insured Plans)

ER SIZE: 1-50
GF: NO
NGF: YES
F-I YES

☐ **Essential Health Benefits** (EHBs)

What: All non-grandfathered plans offered both inside and outside of the Exchange, must cover a core package of items and services termed Essential Health Benefits. The categories include: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, prescription drugs, laboratory services, mental health and substance abuse services, rehabilitative and habilitative services and devices, preventive and wellness services and chronic disease management, and pediatric services, including oral and vision care (maximum age of 19).

When: All new plans issued beginning January 1, 2014 going forward must offer EHBs. This offering expands January 1, 2016 to employers with 100 or fewer employees.

ER SIZE: 1+
GF: NO
NGF: YES
F-I YES

☐ **Out-of -Pocket Maximum Limits**

What: Insurance carriers are responsible for ensuring plan designs include cost-sharing limits. Out-of-pocket maximums may not exceed out-of-pocket maximums as defined under the Health Savings Account section of the Internal Revenue Code. Maximums must include the plan deductible, coinsurance and copayments. If Rx and other services are provided by vendors other than the insurance carrier, those costs may have separate limits but the combined total must not exceed the established out-of-pocket maximum.

- 2014 Plan Year Limits: $6,350 for individuals and $12,700 for families
- 2015 Traditional Plan Year Limits: $6,600 individual and $13,200 anything beyond individual
- 2015 HDHP Plan Year Limits (deductibles no less than $1,300 individual and $2,600 anything beyond individual): $6,450 individual and $12,900 anything beyond individual

When: All new plans issued January 1, 2014 going forward. Annual limits will be adjusted annually.

ER SIZE: 1+
GF: NO
NGF: YES
F-I YES

☐ **Clinical Trial Coverage**

What: Plans may not deny any individual participation in an FDA-approved clinical trial, may not deny or limit the coverage of routine patient costs for items and services provided in connection with the trial, and may not discriminate against participants in a clinical trial.

When: All new plans issued January 1, 2014 going forward.

ER SIZE: 1+
GF: YES
NGF: YES
F-I YES

☐ **Exclusion of Pre-Existing Conditions**

What: Plans may not exclude individuals, regardless of age, from coverage or limit or deny them benefits based on pre-existing medical conditions.

When: All new plans issued January 1, 2014 going forward.

2014 & 2015 PROVISIONS

LEGEND (ER SIZE=Applies to this size company; GF=Applies to Grandfathered Plans; NGF=Applies to Non-Grandfathered Plans; F-I=Applies to Fully-Insured Plans)

ER SIZE: 1+
GF: YES
NGF: YES
F-I YES

☐ Dependent Coverage up to Age 26

What: Plans must make coverage available to dependents up to the age of 26, regardless of their coverage options. Prior to January 1, 2014 dependents up to age 26 could only obtain coverage if coverage was not available to them elsewhere, e.g. the dependent's employer.

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When: All new plans issued January 1, 2014 going forward.

ER SIZE: 1+
GF: NO
NGF: YES
F-I YES

☐ Metallic Level Plans

What: This provision requires that all new plans must meet a minimum actuarial value of 60%, plus or minus 2%. The metallic levels are Platinum – 90%, Gold – 80%, Silver – 70%, and Bronze – 60%.

When: All new plans issued January 1, 2014 going forward.

ER SIZE: 1+
GF: NO
NGF: YES
F-I YES

☐ Guaranteed Coverage

What: Insurance carriers must accept every employer that applies for coverage, with certain exceptions. California already offers guarantee coverage to groups meeting guidelines of California legislation AB1083.

When: This provision is effective for plan years beginning January 1, 2014 going forward.

ER SIZE: 1+
GF: YES
NGF: YES
F-I YES

☐ 90-Day Waiting Period Maximum

What: Employers may not impose waiting periods in excess of 90 days. Coverage must be effective no later than the 91st day, including holidays and weekends. NOTE: California legislation, AB1083, signed in 2012 imposed a shorter, 60-day waiting period through 2014. This legislation was later revised through SB1034 which returned California's waiting period to 90 days, in line with federal guidelines. Each carrier offers different coverage options and administers the transition to shorter waiting periods differently.

When: All new plans issued January 1, 2014 were subject to a 60-day waiting period with some exceptions. All new plans issued January 1, 2015 are in line with the federal maximum waiting period of 90 days.

ER SIZE: 1-50
GF: NO
NGF: YES
F-I YES

☐ Community Rating

What: Since the health of a group is no longer taken into account for rating purposes, a new rating structure known as Community Rating will be used to determine rates in the small group market. NOTE: Community Rating will extend to groups with 100 or fewer employees January 1, 2016. Factors used to establish rates:

- Age
  - Children: 0-20 pooled age band
  - Adults: 21-63 one year age-bands
  - Older Adults: 64+ pooled age band
- Family Size
- Geographic Area (California uses 19 rating regions)

When: All new plans issued January 1, 2014 going forward.

This document is intended to provide a high-level understanding of the compliance requirements facing employers in 2014-2015. Details are a best interpretation of information available as of the print date and should not be construed as tax or legal advice.

Health Care Reform

Employer Compliance