**ACTUARIAL VALUE**

**What is the Actuarial Value Calculator and how is it used?**

Health and Human Services (HHS) created the Actuarial Value (AV) Calculator to determine what percentage of coverage non-grandfathered individual and insured small group plan benefits provide. This percentage determines the “metal tiers” of coverage for plans sold both on and off a public Health Insurance Marketplace.

- A Bronze plan covers 60% of the full actuarial value of the plan’s benefits
- A Silver plan covers 70% of the full actuarial value of the plan’s benefits
- A Gold plan covers 80% of the full actuarial value of the plan’s benefits
- A Platinum plan covers 90% of the full actuarial value of the plan’s benefits

HHS allows a +/- 2% range for each metal tier (i.e. a silver plan must have an actuarial value between 68% and 72%).

The AV Calculator is often confused with the Minimum Value (MV) Calculator. The AV Calculator is used only for determining the actuarial value of individual and insured small group plans for purposes of differentiating the level of coverage they provide. The MV Calculator is used for purposes of determining if employer-sponsored group plans meet the minimum value standards of the employer mandate. More information on the MV Calculator can be found under the Minimum Value topic of this FAQ page.

The AV Calculator and methodologies are available on the [CMS website](https://www.cms.gov). Please note: there are versions for each year of coverage since the regulations took effect in 2014.

**ADMINISTRATIVE SIMPLIFICATION**

**What are the Administrative Simplification regulations under PPACA, and who needs to comply with these provisions?**

The Administrative Simplification rules and guidelines are intended to create a level of uniformity in electronic standards that ultimately should make the health care system more efficient by reducing administrative burdens on all parties. The rules specifically apply to electronic information transactions between insurers, health care professionals, banks, and financial institutions.

The provisions included in this initiative impact parties differently. There are no direct impacts to consumers. The majority of the impacts are on health care professionals, insurers, clearing houses, and
banks. Below is a list of provisions that have direct impacts on certain employers, depending on how they fund their health plans.

**Electronic Funds Transfer and Remittance Advice Transactions**

In most cases today, the electronic remittance advice and the health care payment information that health plans send to health care providers go through banks and clearinghouses in different formats through different networks. Effective January 1, 2014, the Department of Health and Human Services (“HHS”) will require health plans to use a uniform file format to transmit electronic payments of health care funds to financial institutions. New operating rules will make it easier for health care providers to associate a payment with the matching remittance advice.

With the increased claim payment efficiency, employers should see more real-time transparency in cash flow. However, we don’t expect employers will need to take specific steps to comply with this provision.

**The Health Plan Identifier**

The Department of Health and Human Services (HHS) requires all health plans to obtain a ten-digit "unique identifier" from a government sponsored agency. The Health Plan Identifier (HPID) is intended to streamline electronic transactions between carriers, administrators, health care professionals, and financial institutions.

The law requires self-funded employers or group health plans to obtain their own HPIDs. Fully insured plans do not need to do anything to comply with this regulation as the insuring company will have its own identifier.

Effective October 31, 2014, HHS announced that, until further notice, it will delay enforcement of regulations related to obtaining the HPID and using the HPID in Health Insurance Portability & Accountability Act (HIPAA) transactions.

Prior to HHS’s announcement, the following compliance dates were in effect:

- Health plans with annual receipts of $5 million or more were required to obtain HPIDs by November 5, 2014.
- Small health plans, defined as plans with annual receipts of $5 million or less, were required to obtain HPIDs by November 5, 2015.
- All plans that generate the electronic transactions were required to use the identifier in those transactions by November 7, 2016, pending the "operating rules" of the transactional use.

These compliance dates are now delayed, even though the HPID regulations have not specifically changed. We will continue to provide updates as more guidance and information becomes available.
Enrollment/Disenrollment and Premium Payments

While the requirements are still being developed, operating rules for this group of transactions are required to go into effect January 1, 2016. We expect these two types of transactions to directly impact employers, but do not know at this time to what extent.

ANNUAL LIMITS

What are restricted annual limits and lifetime maximums under the PPACA?

Health care reform ends the lifetime limit on the cost of essential health benefits, known as the lifetime maximum limit. The law requires plan's starting on or after September 23, 2010 to follow the rule. The lifetime maximum rule does not apply to grandfathered individual plans. The law also ends annual cost limits on the value of essential health benefits, known as annual dollar limits. Health care reform raises the annual dollar limit each year for all employer and new individual plans:

- Plan's beginning September 23, 2010 have a limit of $750,000
- Plan's starting September 23, 2011 have a limit of $1.25 million
- Plans effective on September 23, 2012 have a limit of $2 million

On January 1, 2014 the limits end for most plans.

The PPACA does allow some limits. There can be a limit on the cost per visit per hour and on the number of visits over a period of days. For example, a person can be limited to three annual visits, but with no cost limits per visit.

Some people may no longer be on their employer’s group health plans because they are at the plan’s lifetime maximum limit. This may also be true of dependents. The PPACA allows these people to rejoin plans during the open enrollment period on or after Sept. 23, 2010.

Health care reform allows these limits for non-essential health benefits.

APPEALS

What does the PPACA say about appeals?

Health care reform says that the appeals process must include an external appeal. The review must follow a state’s external review law. Or, if there is no state external review law, insurance carriers must have independent organizations that meet federal rules review their appeals.

AUTOMATIC ENROLLMENT

What is the status of the ACA automatic enrollment provision?
Automatic enrollment was repealed on November 2, 2015. This provision would have required automatic enrollment and re-enrollment activities for employers with more than 200 employees.

**BEHAVIORAL HEALTH**

**How will the PPACA affect behavioral health products and services?**

The PPACA requires behavioral health services be included as essential health benefits, which are being defined by the Secretary of Health and Human Services. The law applies the federal mental health and substance abuse parity law to qualified health plans offered through the state insurance exchanges/Marketplaces as well as those in the individual and small group market beginning in 2014.

Parity in the state insurance exchanges/Marketplaces will not apply to individual policies or small groups (50 employees or less).

Health insurance reform legislation amended the 2008 Public Health Service Act, effective as of October 3, 2009, and extended mental health parity to individual insurance policies. There is no effective date for this change, so it is unclear when the extension on individual policies becomes effective.

**CADILLAC TAX**

**What is the Cadillac Tax?**

The Cadillac tax is a 40% permanent annual tax on employers that provide high-cost benefits through an employer-sponsored group health plan. Based on changes made in December 2015, the effective date has been delayed two years from 2018 to 2020 and the tax will be deductible for employers who pay it.

The Consolidated Omnibus Budget Reconciliation Act (COBRA) rule determines benefits that should be taxed. This rule accounts for:

- all employer-sponsored coverage
- premiums
- flexible spending accounts
- health reimbursement accounts
- health savings accounts
- supplementary coverage

The employer must calculate the tax and report it to the plan administrator, who pays the tax to the Internal Revenue Service.

The original proposed threshold amounts for benefits subject to the tax in 2018 were $10,200 for self-only coverage and $27,500 for family coverage. There are higher benefit limits ($11,850 for self-only
coverage and $30,950 for other coverage) for retirees and for people in high risk jobs. All these amounts will be adjusted before the tax takes effect in 2020 and indexed in future years.

U.S.-issued expatriate plans, vision, dental, accident, disability and long-term care benefits are not included in the Cadillac Tax.

**CLINICAL TRIALS**

**Does the PPACA require coverage of clinical trials?**

Yes. The legislation requires coverage of routine patient care costs related to clinical trials beginning January 1, 2014.

We expect the financial impact to be relatively small as many of the expenses associated with clinical trials are already covered.

**COLLECTIVE BARGAINING AGREEMENTS**

**If employees are covered by a collective bargaining agreement, do employers have to follow health care reform rules, or is the plan grandfathered until the next collective bargaining agreement? Also, how does the law impact multiple unions in one benefit option?**

Collectively bargained agreements must follow reform rules. If these plans were in place when the law passed on March 23, 2010, they are a grandfathered plan. If a grandfathered plan gets rid of some benefits, increases costs or reduces what employers pay than it would lose its status and have to follow health care reform rules.

All of the PPACA rules that apply to grandfathered plans also apply to grandfathered collectively bargained plans for all plans beginning on or after September 23, 2010. The law also allows self-insured plans with collective bargaining agreements to remain grandfathered under the same rules.

The PPACA says insured collectively bargained plan may maintain grandfathered status until the last of their agreements in place before March 23, 2010 ends. PPACA rules then apply after the final termination date, and then all plans must comply with health care reform.

If there are three collective bargaining agreements under one plan, then the PPACA will not apply until the last of the three agreements ratified prior to March 23, 2010 ends.

**COST SHARING**

**What are the cost-sharing limits that take effect in 2014?**

These cost-sharing limits apply to all non-grandfathered plans, regardless of size or funding type.

For 2014, in-network out-of-pocket (OOP) maximums cannot exceed $6,350 self-only and $12,700 family. In 2015, those amounts change to $6,600 for self-only coverage and $13,200 for family coverage.
All in-network copays, deductibles and coinsurance for EHBs provided through the same carrier/vendor [e.g., medical, mental health/substance abuse (MHSA), prescription drug, non-excepted dental and vision] must accumulate to a single OOP maximum.

**DENTAL BENEFIT MAXIMUMS**

**Will dental annual dollar maximums and orthodontic lifetime dollar maximums be removed from dental policies in 2014?**

If a dental-only policy is separate from a medical plan, PPACA rules do not apply. If the dental plan is part of an employee medical plan and defined as an essential health benefit, but is not an excepted benefit under Health Insurance Portability and Accountability Act, known as the health insurance rule, PPACA rules may apply to dental coverage.

Health insurance rules consider dental benefits as excepted benefits. When plans have dental/vision benefits on a separate policy, certificate or contract the health insurance rule treats dental/vision benefits as excepted benefits. They would also treat dental benefits as excepted benefits if the coverage is not a key part of a group health plan. If employees can decline dental benefits when they enroll for medical coverage, or if they have to pay an additional monthly premium or contribution for those dental benefits, than the dental benefits are not considered a key part of those medical plans.

If dental benefits are not part of a medical plan, annual limits and lifetime maximum limits could apply.

**DEPENDENT COVERAGE**

**What are the rules for extending dependent coverage to age 26?**

Beginning September 23, 2010, the PPACA has required all plans to provide coverage without limits to dependents until their 26th birthday.*

The PPACA Extended Dependent Coverage rule applies to all health insurance plans, including medical, behavioral and pharmacy benefits. The rule does not apply to “excepted benefits” under the Health Insurance Portability and Accountability Act such as dental/vision benefits offered separately from medical health benefits.

Health care reform also requires employee health plans to reimburse medical care expenses to any covered dependents until their 26th birthday, or the scheduled termination date determined by the plan (such as end of month or end of year following the 26th birthday). Spouses and children of dependents are not eligible unless the plan already covered them.

In addition, young adults qualify for this coverage even if they no longer live with a parent, are not a dependent on a parent’s tax return, or are no longer students. Both married and unmarried young adults can qualify for the dependent coverage extension, although that coverage does not extend to a young adult’s spouse or children. Student, military or marital status does not affect dependent eligibility.
According to a changed tax code rule, we interpret a dependent for purposes of this requirement to mean a son, daughter, stepson, stepdaughter or eligible foster child of the taxpayer.

Until 2014, grandfathered plans are not required to cover dependents that have access to their own employer-sponsored coverage. Beginning 1/1/14, all plans must cover dependents to age 26, even if they have access to coverage through their own employer.

Health care insurance reform requires that adult dependents be treated the same as all other dependents. For example, employers can’t charge more for adult dependents.

*Some states require that insurance policies provide dependent coverage beyond age 26; these rules and any associated restrictions apply after age 26.

Can people use their flexible spending account, health reimbursement account and health savings account funds for dependents up to age 26?

Health care reform does allow people to use money from their health reimbursement account and flexible spending accounts on dependent children (up to age 26, or when their plan coverage ends, after their birthday).

Giving flexible spending account coverage to dependents may be an employer’s option under health care reform law. We advise clients to check with their legal counsel.

People may not use money from their health savings accounts for their covered dependents, unless their federal income tax returns also list the dependents. If the adult dependent child can’t be listed as a tax dependent, any HSA distributions for the dependent would be taxable and subject to an Internal Revenue Service penalty. In this situation, the adult child may open his/her own health savings account and contribute up to the plan’s allowable family maximum contribution.

DOCTOR CHOICE

What does the PPACA say about choosing a primary care physician (PCP)?

The PPACA requires that health insurance plan customers be allowed to designate any available participating PCP or pediatrician as their health care professional. Plans cannot require a referral for OB-GYN care and women can designate their specialist as their PCP.

EARLY RETIREE REINSURANCE PROGRAM

What is the PPACA Early Retiree Insurance Program?

The PPACA created the Early Retiree Insurance Program, a temporary program, for employers providing health insurance coverage to retirees over age 55 who can’t get Medicare. The government offers employers a tax break for a portion of health benefits costs they give to retired employees ages 55 and over and their spouses, surviving spouses and dependents that can’t be on Medicare.
The program is over when the federal funds set aside are gone. The Department of Health and Human Services announced on April 1, 2011 that it could no longer accept applications for the program after May 5, 2011. Early Retiree Insurance Program funds will run out in late 2011 or early 2012.

Health and Human Services requires all program reimbursement requests to have a claim listing. The PPACA says a claim that can be reimbursed is between $15,000 and $90,000, adjusted annually per the consumer price index. Up to 80 percent of reimbursements made can be reimbursed. Employers must use the funds from the tax break to start Health and Human Services-certified programs that lower costs for plan participants with chronic and high-cost conditions.

**EMERGENCY CARE**

**What is the emergency care coverage for in-network versus out-of-network for grandfathered plans?**

For non-grandfathered health insurance plans, the PPACA requires cost sharing for emergency services obtained either in-network or out-of-network to be equivalent.

There is no higher out-of-network cost share for emergency services and health plans and insurers will not be able to charge higher co-pays or coinsurance or require prior authorization for emergency services obtained out of network. This policy applies to all individual market and group health plans, except grandfathered plans.

**EMPLOYER MANDATE**

**What is the employer mandate?**

The employer mandate requires that employers with 50 or more full-time employees must offer medical coverage that is “affordable” (costs no more than 9.66% of an employee’s wages) and provides “minimum value” (covers 60%+ of total costs) to 95% of their full-time employees and their children up to age 26 or face penalties.*

* Before January 2016, employers with 50-99 were not required to offer coverage, and employers with 100 or more complied if they offered coverage to at least 70% of their full-time or FTE employees.

**What are the penalties if employers do not offer coverage in 2016?**

If no coverage is offered to full-time employees AND any full-time employee receives premium assistance from the federal government, the employer penalty is:

- $2,160 annually for each full-time employee minus 30*

If coverage is offered to full-time employees BUT any full-time employee receives premium assistance from the federal government, the employer penalty is the lesser of:

- $3,240 for each employee receiving premium assistance OR
- $2,160 per employee for each full-time employee minus 30*
Read more about the

What reporting must employers complete to confirm their compliance with the employer mandate?

Starting with health coverage offered in 2015, employers with 50 or more full-time employees or full-time equivalents must provide the Internal Revenue Service (IRS) and their employees with information about the coverage offered during the previous calendar year. The first reports are due in early 2016 for coverage offered in 2015. Individuals will not need this information when they file their 2015 income tax returns. For 2015 only, individuals who file their federal income tax returns before receiving their 1095-B and 1095-C forms will not be required to amend their income tax returns once they receive their forms. They should keep their forms, once received, with their tax records.

ENROLLMENT WAITING PERIODS

see Waiting Periods below

EXCEPTED BENEFITS

What are "Excepted Benefits" under PPACA?

**Insured plans**

- Dental and vision benefits offered under an insurance policy that is *separate* from other medical coverage are "excepted benefits" and *not* subject to PPACA health insurance reform provisions such as the Essential Health Benefits (EHB) mandate.

- Dental and vision benefits that are *incorporated into* the insured medical plan *are* not "excepted benefits" and therefore are subject to the PPACA EHB requirement.

**Self-funded plans**

- Dental and vision benefits are treated as "excepted benefits" *only* if individuals can separately elect or reject the dental/vision benefits.

- Dental and vision benefits are *not* "excepted benefits" if employees enrolling in medical automatically get the vision/dental benefits.

EXCHANGE / MARKETPLACE

What is an exchange?

The law requires a new Health Insurance Marketplace, also known as a Health Insurance Exchange, be established in every state beginning January 1, 2014. They will be a new way for individuals and small businesses to purchase health insurance. They will be run by state, federal or combined governments.

Exchanges will offer individuals standard health plans at five levels of coverage ranging from 60 percent to 100 percent of covered costs: bronze – at least 60%, silver – at least 70%, gold – at least 80%,
platinum – at least 90%, and catastrophic – 100%. This program will help make health insurance more affordable for those eligible for a Federal Premium Subsidy (financial assistance).

What is a Marketplace?

The PPACA has a provision which requires the establishment of a Health Insurance Exchange in every state beginning January 1, 2014. In spring of 2013 the Department of Health and Human Services (HHS) started calling this program the Health Insurance Marketplace. While each state may have a different name for their state-based Marketplace, the federally run is called the Health Insurance Marketplace.

In a general sense, Health Insurance Exchange and Health Insurance Marketplace are one in the same.

What is the Employee Notice of Coverage Options, also known as the Employee Notice of the Exchange?

All employers subject to the Fair Labor Standards Act (which includes most employers) are required to notify all employees by October 1, 2013 of availability of the new Health Insurance Marketplace (also known as the Exchange) to purchase health insurance.

For more specific rules and web links to the DOL models available for employers, visit our News page on the latest guidance. The models include fields where employers can populate their company specific data.

FEDERAL PREMIUM ASSISTANCE TAX CREDIT

What is the Federal Premium Assistance Tax Credit?

Beginning in 2014, a Federal Premium Assistance Tax Credit is available to eligible individuals to subsidize the cost of insurance coverage purchased through a state exchange/marketplace. In order to be eligible, the individual’s household income must be between 100 percent and 400 percent of the federal poverty level, and the individual must either:

- Not be offered minimum essential coverage by an employer, or
- Be offered minimum essential coverage, but the coverage is (i) unaffordable (i.e., the cost of coverage exceeds 9.66 percent of the employees household income), or (ii) does not provide the required minimum actuarial value (the plan’s share of the total allowed costs of benefits is less than 60 percent).

Current estimates indicate that 19 million people who secure healthcare coverage through a state insurance exchange/marketplace are likely to be eligible for the subsidy.

FEES AND TAXES

Are there additional fees and taxes employers need to watch and manage?
The Patient Protection and Affordable Care Act (PPACA) has established many new fees and taxes to help fund and create dollars for expanded programs and services. Employers are responsible for some of these, whether they will directly pay new fees and taxes or administer payments through employee tax withholdings.

**Comparative Effectiveness Research Fee (CERF)**

This new annual fee applies to insured and self-insured plans with plan years beginning on or after 10/2/11. The annual fee will partially fund research and evaluations performed by the Patient-Centered Outcomes Research Institute (PCORI), which is intended to determine the effectiveness of various forms of medical services that treat, manage, diagnose or prevent illness or injury.

Insurers will pay the fee on insured plans and will build the fee into their rates. Employers will be responsible for paying the fee on self-insured plans.

**When?**

- Applies for plan years beginning on or after 10/2/11
- First payments were due 7/31/2013
- Fee continues through 9/30/2019 with the last payment due 7/31/2020

**How Much?**

- Initial annual fee begins at $1 per participant, including dependents
- Increases to $2 for plan years beginning on or after 10/2/12
- Amount for future years is indexed to national health expenditures

**How to Pay?**

- Tax is self-reported on Excise Tax Form 720

**Health Insurance Industry Fee**

The Health Insurance Industry Fee affects health insurers (including HMOs) and is estimated to start at $8 billion in 2014. It increases year over year before reaching an estimated $14.3 billion in 2018. After 2018, it will continue to increase with premium growth. The fee applies only to insured business, and will be based on each insurer’s share of the taxable health insurance premium base (among all health insurers of U.S. health risks).

In December 2015, the Health Insurance Industry Fee was suspended for 2017.
Reinsurance Fee

*The Reinsurance Fee* totals $25 billion, which will be collected over a three-year period from 2014 through 2016. The majority of the money will be used to lessen the impact of adverse selection in the individual market. The fee applies to both insured and self-funded commercial major medical plans. Health insurers will be responsible for the fee on insured plans. For self-funded plans, employers will pay the fee.

Read our Reinsurance Fee Fact Sheet for more details, including the most recent fee amounts and payment schedules.

Medicare Taxes

Starting January 1, 2013, there will be additional Medicare taxes for high-income individuals. Currently, both employers and employees pay a Medicare tax of 1.45% each, totaling 2.9% on all income. Employers do not have to pay any more under the new Medicare tax - they continue to pay 1.45%. However, they will have to withhold the additional tax for employees earning more than $200,000, and should plan to communicate this to impacted employees.

Employees earning up to $200,000 will continue to pay the same 1.45% Medicare tax. Employees earning more will be taxed an additional .9% on all earnings over the $200,000. *Employers are liable* for this added tax if they do not begin withholding the additional .9% once earnings reach $200,000.

For married couples, the additional Medicare tax is assessed on total household earnings above $250,000. Therefore, employees with income under $200,000 may actually have a joint income above this threshold. In such cases, the employee is liable for the additional Medicare tax, and will be expected to make estimated quarterly payments.

There is also an additional 3.8% Medicare tax on investment income (interest, dividends, and capital gains). The amount of investment income to be taxed is determined by the lesser of:

- The Modified Adjusted Gross Income above the threshold of
  - $200,000 for an individual
  - $250,000 for married or joint income
- Total investment earnings

Individuals who believe they may be assessed this new tax should consult their tax advisor or Certified Public Accountant (CPA) for guidance.
FLEXIBLE SPENDING ACCOUNTS

How are flexible spending accounts affected by PPACA?

Health care reform changes how most over-the-counter drugs are now paid for. The law now requires a prescription for health saving and spending account reimbursements. Flexible spending accounts and health reimbursement accounts, which cover 213d expenses, and health savings accounts rules all change with health care reform law.

The PPACA affects flexible spending accounts the most. The debit cards may no longer be used to purchase over-the-counter drugs or medicines.

Most retailers can identify items that could be reimbursed at the time of purchase, so the flexible spending account debit cards will pay for only the eligible items. Individuals must pay for over-the-counter drugs and medicines another way.

If you have a flexible spending account, submit a doctor’s prescription and store receipt with the required reimbursement request form. A person can still use remaining FSA funds from the prior year to pay for eligible items, up to two and a half months after the end of the preceding plan year. Insurance carriers require people to keep prescriptions and receipts as documentation required for reimbursement.

IRS Notice 2010-59 gave retailers until January 15, 2011 to update their systems. If a retailer did not follow the rule by the deadline, FSA debit cards will not work at their location.

If a person has a prescription can he or she purchase over-the-counter drugs with a flexible spending account debit card?

If a person has a doctor’s prescription for an over-the-counter medication, and would like to use the flexible spending account, most retailers will need a different form of payment. That person must submit a reimbursement request form with the register receipt and prescription.

However, the Internal Revenue Service released clarification Notice 2011-05 on December 22, 2010, which says that if a prescription for an over-the-counter drug is filled by a licensed pharmacist and has an Rx number, then a pharmacy may process the transaction on the debit card as a prescription item. The pharmacy must hold a record of the Rx number, the name of the purchaser (or the person named on the prescription) and the date and amount of the purchase. These records must be available to the employer or the flexible spending account administrator when requested. Some pharmacies may not dispense an over-the-counter drug as a prescription item, so it won’t process on the flexible spending account debit card.

Because the way pharmacies handle over-the-counter prescriptions varies, we recommend you submit receipts and prescriptions for prescribed over-the-counter and medicine reimbursement through direct submit process.
The PPACA may allow coverage of your dependent’s eligible expenses. Speak with legal counsel to determine if and when your flexible spending account plan may provide coverage of a dependent’s expenses.

FLEXIBLE SPENDING ACCOUNTS CONTRIBUTION CAP

How does the PPACA affect flexible spending account annual contributions?

Health care reform currently limits an individual’s flexible spending account contributions to $2,500 per taxable year. The amount will be adjusted annually as the Department of Health and Human Services decides.

Employers have been given the flexibility to roll up to $500 from the 2013 contributions into 2014, so their employees could spend the dollars accumulated in 2013 toward 2014 eligible health expenses.

Does the contribution cap impact the dependent care flexible spending account?

No. Health care reform impacts only the flexible spending account annual contribution limit. Dependent care contributions remain capped at $5,000 per year maximum.

How will health care reform affect flexible spending account contribution caps for flexible spending accounts that don’t run on a calendar year?

The PPACA currently caps flexible spending account contributions at $2,500 per taxable year. The contributions count on a calendar/taxable year and not by a plan year, even if the plan starts on a date other than January 1.

FREE CHOICE VOUCHERS REPEALED

What is the free choice voucher?

PPACA required employers beginning in 2014 to provide financial subsidies for employees with income less than 400 percent of the Federal Poverty Level to purchase health coverage from a state insurance exchange, if the employer’s plan was not affordable. Employers offering coverage would have been required to provide any employee meeting the income requirement a free-choice voucher if the employee’s cost of coverage under the employer-sponsored plan was more than 8 percent, but less than 9.8 percent of such employee’s household income.

Congress repealed the PPACA free choice voucher provision on April 15, 2011.

FULL-TIME EMPLOYEES

How will PPACA establish hours worked/full-time employee status?

The employer mandate requires that "large employers" (i.e., employers with 50 or more full-time employees or full-time equivalents) offer affordable coverage that provides minimum value to all full-time employees and their dependents.
A full-time employee is one who works on average 30 hours a week. For many employees, it is easy to determine whether they are full-time, but how is a large employer to treat employees who work variable hours?

Treasury Notice 2012-58 describes safe harbor methods that large employers may use to determine whether a particular employee is a "full-time employee" for purposes of the employer mandate,

It's complex, and the rules differ for new employees and ongoing employees, so we suggest that you refer to the Notice and work with your legal counsel to deal with the nuances of your unique employee population.

**What might an example be of how the look back, administrative and stability periods work together?**

The following simple example illustrates how the Treasury safe harbor method would apply in a hypothetical situation:

- John is an employee and his hours vary.
- His employer has selected the maximum 12-month initial **measurement period** to determine whether its employees are "full-time." [An employer can choose a measurement period of between 3 -12 months.]
- John's employer has also elected the maximum 3 month **administrative period** during which to gather the hours worked data, crunch the numbers, make the determination as to full-time status and to notify its employees regarding the eligibility for coverage.
- For purposes of the employer mandate that begins on January 1, 2014, John's employer would **look back** at the average monthly hours John worked during the 12-month initial measurement period of 10/1/11 through 9/30/12, **and** during the 90-day administrative period of 10/1/12 - 12/31/13, John's employer determines that he is full-time employee and communicates to John his eligibility for coverage.
- Beginning on January 1, 2014, John's employer must thereafter treat John as a full-time employee for a 12-month **stability period** that ends on 12/31/14 even if John's average hours worked during this stability period are fewer than 30 hours per week. [The stability period can be no less than the measurement period used by the employer to determine the employee’s status for the stability period.]
- John's employer will thereafter reassess his status going through the same process for the next stability period that commences on 1/1/15.

**GRANDFATHERED PLANS**

**What are grandfathered plans?**
Any plan (insured or self-insured) in effect on March 23, 2010, the date the Patient Protection and Affordable Care Act (PPACA) became law, is treated as a grandfathered plan. Plans established after PPACA cannot be grandfathered.

The advantage of being grandfathered is that these plans do not have to follow some health insurance reform provisions, such as the requirement to cover all preventive care services with no cost-sharing, for as long as they remain grandfathered.

The Departments of Health & Human Services, Labor, and Treasury developed rules for maintaining grandfathered status. The rules identify the types of benefit reductions or employer contribution reductions that will trigger a loss of a plan’s grandfather status. A change of insurance carriers, TPAs or switching funding type (insured to self-insured or vice versa) does not affect a plan’s grandfather status.

For a group health plan to decide to stay grandfathered, the plan must weigh the financial result of following health reform rules against being able to make cost-effective benefit plan changes.

Insured collectively bargained plans are subject to a special grandfathering rule. They do not have to follow any PPACA health insurance reforms until the last of the collective bargaining agreements under the plan in effect on March 23, 2010 ends. At this point, the PPACA’s other grandfathered rules would apply.

GUARANTEED ISSUE

What is guaranteed availability?

Beginning with the first plan year on or after January 1, 2014, health insurers must accept every individual and employer that applies for coverage.

This provision applies to non-grandfathered fully insured individual, small group and large group coverage.

Issuers must offer all products that are approved for sale, including non-grandfathered closed blocks of business. This means insurers must offer coverage under a plan that was previously closed and not available to new membership.

Effective July 16, 2014, guaranteed availability no longer applies to insured plans issued in the U.S. territories (Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa and the Northern Mariana Islands).

What is guaranteed renewability?

Beginning with the first plan year on or after January 1, 2014, health insurers must renew all coverage in the individual and group market if the individual or group chooses to renew.

This provision applies to non-grandfathered fully insured individual, small group and large group coverage. The only exceptions to this rule are situations such as non-payment of premium or fraud.
Guaranteed renewability already applies to all group plans (including self-insured and grandfathered plans) under the 2001 Health Insurance Portability and Accountability Act (HIPAA) requirements.

Effective July 16, 2014, guaranteed renewability no longer applies to insured plans issued in the U.S. territories (Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa and the Northern Mariana Islands).

HEALTH REIMBURSEMENT ACCOUNTS

How are health reimbursement accounts affected by PPACA?

Health care reform impacts purchases of most over-the-counter drugs that now require a prescription for reimbursement. Flexible spending accounts and health reimbursement accounts, which cover 213d expenses, as well as health savings accounts are impacted.

If you have a health reimbursement account that includes over-the-counter drugs, you must submit your doctor’s prescription and the store receipt along with a reimbursement request form. With the PPACA’s extension of Dependent Coverage up to age 26 rule, your health reimbursement account can cover eligible dependent expenses for children up to age 26, or when his/her coverage ends.

HEALTH SAVINGS ACCOUNTS

How are health savings accounts affected by PPACA?

Health care reform impacts purchases of most over-the-counter drugs—they now require a prescription for reimbursement. Flexible spending accounts and health reimbursement accounts, which cover 213d expenses, and health savings accounts are all impacted.

Unlike flexible spending account debit cards, eligible expenses purchased with your health savings account debit card will not be verified at the register. To avoid incurring the Internal Revenue Service Health Savings Account Distribution Tax Penalty it’s important to understand which expenses are covered.

While the new law applies to health savings accounts, people are responsible to use health savings accounts debit cards properly. Unlike flexible spending account debit cards, eligible expenses purchased with an health savings account debit card will not be verified at the register. Therefore, it is important individuals understand the new rules to avoid building up tax penalties.

Does the PPACA allow health savings accounts to cover dependent expenses?

As part of health care reform, the PPACA does not allow you to cover eligible dependent expenses with health savings accounts when the dependent is not listed on your federal income tax return.

If your adult child dependent does not qualify as a tax dependent, any health savings accounts payments for that dependent’s expenses would be taxed under the Internal Revenue Service Health Savings
Account Distribution Tax Penalty. However, your adult dependent child may open his/her own health savings accounts and contribute up to your medical plan’s allowable family maximum.

People with health savings accounts must keep their prescriptions and receipts and submit them for reimbursement. Individuals should always keep a copy of these documents. If the Internal Revenue Service audits a tax return, it requires copies of all the prescriptions and receipts related to health savings accounts.

HEALTH SAVINGS PENALTY INCREASE

Is the Internal Revenue Service increasing the penalty on health savings account distributions for non-eligible expenses?

Yes. Health care reform increased the tax penalty on health savings account payments that are not used for eligible expenses from 10 percent to 20 percent of the payment amounts.

The PPACA does not allow you to cover eligible dependent expenses with health savings account when the dependent is not listed on your federal income tax return. If your adult child dependent does not qualify as a tax dependent, any health savings account payments for that dependent’s expenses would then be taxed under the Health Savings Account Distribution Tax Penalty.

Your adult dependent child could open his/her own health savings account and contribute up to your medical plan’s allowable family maximum.

If a health savings account does not run on the calendar year, does the Internal Revenue Service penalty increase on the health savings account’s renewal?

No. The penalty is tied to the Internal Revenue Service tax year. The penalty increased to 20 percent beginning January 1, 2011. It is the same no matter what the previous plan year-end date is.

INDIVIDUAL MANDATE

What is the PPACA rule called the individual mandate?

Effective January 1, 2014, almost everyone must have "minimum essential coverage" or pay a penalty. People have minimum essential coverage if they are enrolled in:

- An employer-sponsored plan
- A government plan such as Medicare or Medicaid
- Individual coverage
- A U.S.-issued expatriate plan

There are a few exceptions when the penalty does not apply:

- Religious reasons
• Not lawfully present in the United States
• In prison
• The cost of coverage exceeds 8 percent of household income
• Income below 100 percent of the poverty level
• Hardship waiver obtained
• Not covered for a period of less than three months during the year

Any resident of the U.S. territories (Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa and the Northern Mariana Islands) will be treated as having minimum essential coverage, regardless of whether they have coverage or not.

What penalties apply to individuals who do not maintain minimum essential coverage beginning January 1, 2014?

Individuals will pay penalties for each month they don’t have coverage. The annual penalties are prorated if someone has coverage for part of the year. The annual penalties are:

• **2014** – Greater of $285 ($95 per adult and $47.50 per child) or 1% of income over tax-filing threshold

• **2015** – Greater of $975 ($325 per adult and $162.50 per child) or 2% of income over tax-filing threshold

• **2016** – Greater of $2,085 ($695 per adult and $347.50 per child) or 2.5% of income over tax-filing threshold

What reporting is required to confirm compliance with the individual mandate?

Starting with health coverage offered in 2015, insurers and employers who self-insure their group health plans must provide the Internal Revenue Service (IRS) and each covered individual with information about whether they had minimum essential coverage during each month of the year.

This reporting requirement applies to employers of all sizes. The first reports are due in early 2016 for coverage offered in 2015. Individuals will need this information when they file their 2015 income tax returns.

INTERNATIONAL AND EXPATRIATE PLANS

How does the PPACA affect international and expatriate plans?

Based on December 2014 legislation:
- U.S.-issued expatriate plans are exempt from most PPACA market reforms except the requirement to provide dependent coverage to age 26
- U.S.-issued expatriate plans are considered minimum essential coverage that meets the individual mandate and are considered eligible plans for purposes of the employer mandate
- U.S.-issued expatriate plans are exempt from the health insurance fee after 2015, the reinsurance fee, the CERF fee and the Cadillac tax
- U.S.-issued expatriate plans are not required to provide a Summary of Benefits and Coverage
- Different Medical Loss Ratio reporting and calculation rules apply to expatriate plans because they are structured differently and have more administrative costs

LIMITED MEDICAL PLANS

What will happen with the limited benefit or "mini-med" plans come 2014?

Insurers will continue to provide its limited medical policies until 12/31/13, after which health benefit Exchanges, along with premium and cost sharing subsidies, will begin providing affordable coverage alternatives for our current limited medical customers. Insurers will continue working with its limited-medical clients and customers to help them prepare for 2014. Insurers look forward to continuing to serve the voluntary market through our current and expanding portfolio of voluntary ancillary products.

MEDICAID

How does the PPACA affect Medicaid eligibility?

Under the PPACA, Medicaid eligibility is extended to 133 percent of the Federal Poverty Level for those states electing to expand the eligibility level. In 2012, the Federal Poverty Level for a family of four at 133% was $30,657. Subsidies will be made available to families and individuals with household income up to 400 percent of the poverty level, declining incrementally as income levels raise, which for a family of four at 400 percent of the Federal Poverty Level, is approximately $92,200.

MEDICAL LOSS RATIO

What are the minimum medical loss ratio (MLR) requirements?

Under the health care reform law, health insurers have to spend at least 80 percent (for individual and small group) or 85 percent (for large group) of their policy premiums in a given state on claims. If their medical loss ratio (claims over premiums) is less than the required percentage, the difference has to be paid to individual and group policyholders as a rebate.

Rebates will be based on the MLR for a group of policies known as a "block" or "cell." A block is defined by:

- Segment: Individual, small group or large group
Limited medical plans and plans covering expatriates have a different formula for calculating the medical loss ratio due to the unique features of these plans.

HHS adjusted the calculation for limited medical plans through 2014 and extended the adjustment for expatriate plans indefinitely.

**MEDICARE PART D COVERAGE GAP**

**Does the PPACA eliminate the Medicare Part D Coverage Gap, known as the "Donut Hole," for Seniors?**

The law gradually closes the gap between 2010 and 2020 by establishing progressively lower coinsurance for generic drugs and providing coverage for brand-name drugs (with discounts from pharmaceutical manufacturers) in the gap. By 2020, the donut hole is reduced to 25 percent coinsurance instead of 100 percent.

The federal Medicare Part D 28 percent drug subsidy has been maintained.

**MEDICARE PART D SUBSIDY**

**How has the PPACA affected the Medicare Part D subsidy?**

Beginning on January 1, 2013, the tax-free 28 percent federal Medicare Part D retiree drug subsidy can no longer be deducted by an employer as a business expense. From a policy perspective, this was viewed as double dipping.

Under the PPACA, accounting rules require that any changes in retiree liabilities be reported in an employer’s financial statements in the quarter in which the changes were enacted. This is not a cash charge, but represents a charge to liability/deferred tax assets. It’s not clear yet what impact this rule will have on retiree health care programs, but it does prompt employers to consider how they may structure retiree plans in the future.

**MINIMUM ESSENTIAL COVERAGE**

**How can the minimum essential coverage provisions be satisfied?**

Individuals satisfy the minimum essential coverage requirement with:

- Eligible employer-sponsored coverage
- Individual health plan
- Grandfathered health plan
• Medicare part A
• Medicaid
• Children’s Health Insurance Program
• TRICARE (military health system)
• Veterans Affairs
• Other coverage as may be designated by the Department of Health and Human Services
• Coverage purchased through a state insurance exchange or the federal exchange
• U.S.-issued expatriate coverage

MINIMUM VALUE

What is the Minimum Value Calculator and how is it used?

The Minimum Value (MV) Calculator helps to determine whether an employer-sponsored group health plan meets the minimum value standard of having at least 60% coverage on in-network health benefits. Health and Human Services (HHS) created the MV Calculator to help ensure applicable large employers comply with this minimum standard of coverage under the Employer Mandate regulations.

Employers with 50 or more full-time employees – regardless of grandfathered status or funding arrangement – must offer “affordable” health care coverage that provides “minimum value” to full-time employees and their dependent children up to age 26, or employers could face possible penalties.

Read the Employer Mandate fact sheet to learn more on how to determine if these standards are met and what the penalties are for not meeting the standards.

OVER-THE-COUNTER DRUGS

What are over-the-counter drugs and medicines?

Drugs and medicines that people can buy without a doctor’s prescription and that do not require a pharmacist are called over-the-counter drugs and medicines. However, for health care reform, some of these over-the-counter drugs and medicines will require a prescription for reimbursement from health saving and spending accounts. Some examples are acid controllers, allergy and sinus medication, pain relievers and stomach remedies.

Some over-the-counter items like insulin, bandages, medical supplies and vision care supplies are still eligible for reimbursement without a prescription.

Is an official prescription required, or may a doctor provide another form of documentation, such as a note of medical necessity?
The Internal Revenue Service in Notice 2010-59 says that a prescription is a written or electronic order for a medicine or drug that meets the state’s legal requirements in which the medical expense is paid and issued by a person legally-authorized to issue prescriptions.

**What impact does health care reform have on what people can buy with their flexible spending accounts, health reimbursement accounts and health savings accounts?**

Purchases of most over-the-counter drugs on or after January 1, 2011 require a prescription for reimbursement from flexible spending accounts, health reimbursement accounts and health savings accounts.

Unlike flexible spending accounts and health reimbursement accounts, insurers do not check health savings accounts purchases. People are responsible to use the account only for eligible expenses, and prescriptions and receipts are needed when they complete federal income taxes. In the event of an audit, the Internal Revenue Service will require the documents.

The PPACA affects only over-the-counter drugs. Individuals may continue to buy eligible over-the-counter items without a prescription, such as insulin, bandages and medical supplies.

**Which types of accounts are impacted by new rules for eligible over-the-counter drug expenses?**

Purchases of most over-the-counter drugs require a prescription for reimbursement. Reform affects all flexible spending accounts and health reimbursement accounts which cover 213d expenses, and health savings accounts. The PPACA will affect flexible spending accounts the most. The debit cards can no longer buy over-the-counter drugs or medicines.

**What if flexible spending accounts, health reimbursement accounts and health savings accounts are not based on calendar year?**

Over-the-counter drugs purchased after December 31, 2010 require a prescription for reimbursement regardless of when the benefit-plan year started.

For example an FSA that runs from July 2010 to June 2011 should reimburse over-the-counter drugs purchased from July 1, 2010 through December 21, 2010 without prescriptions, but any over-the-counter drug purchased from January 1, 2011 through June 30, 2011 requires a prescription for reimbursement.

**Will the change in which over-the-counter drugs and medicines are eligible for reimbursement without a prescription drive up health care costs by encouraging more doctor visits?**

Over-the-counter drugs products will still be a great value to people, even without the tax credits made possible by flexible spending, health reimbursement and health savings accounts.

Many individuals will likely not seek to be reimbursed for over-the-counter drugs and medicines-it could take time and effort it could take to request a reimbursement from the tax-deferred programs that require a prescription under reform.
People with many over-the-counter drug expenses, such as those managing long-term allergies, will likely seek a doctor's prescription. Over-the-counter prescriptions can be used for reimbursement up to one year from the date they are written. A good time to get an over-the-counter prescription is during an annual wellness exam or any scheduled visit.

**Will physicians require individuals to go in for an office visit in order to receive prescriptions for over-the-counter drugs and medicines?**

A doctor may choose to see a person before prescribing an over-the-counter drug. It's best if physicians know a person's medical history, along with learning if the person is taking any other drugs or medicines, before prescribing any other drug or medication.

Because prescriptions for over-the-counter medications could be up to one year from the date written, a good time to get a prescription is during an annual wellness exam or any scheduled visit.

**PART-TIME EMPLOYEES**

**Does the PPACA provision known as the employer mandate extend to part-time employees?**

The employer mandate applies to large employers, defined as employing an average of 50 full-time employees (i.e., employees working at least 30 hours per week) or equivalent. For 2015, the employer mandate will apply only to employers with 100 or more full-time employees. Beginning in 2016, it will expand to include employers with 50 or more full-time employees.

To determine whether an employer meets PPACA’s 50-full-time-employees threshold, take the aggregate number of hours worked by the part-time employees in a particular month and divide that total by 120 to determine the equivalent number of full-time employees. Add the full-time equivalent number to the total number of actual full-time employees to determine whether the employer meets the 50-full-time-employees threshold.

The calculation is used for the purpose of determining whether an employer is subject to the employer mandate. The employer mandate provision does not apply to an employer’s part-time employees.

**PRE-EXISTING CONDITIONS**

**What does the PPACA say about pre-existing conditions?**

Beginning with the first plan year beginning on or after September 23, 2010, all individual and group health insurance plans are prohibited from denying coverage to anyone under the age of 19 based on a pre-existing condition. The ban includes benefit limitations and coverage denials.

Beginning January 1, 2014 nobody can be denied coverage based on pre-existing conditions.

Grandfathered individual plans are exempt from this requirement.

**PREVENTIVE CARE**
How does the PPACA address preventive care?

All non-grandfathered plans must cover preventive care services and immunizations with no cost-sharing. Cost-sharing includes deductibles, coinsurance, copayments or any other payment required when care is received. Annual dollar limits are also prohibited for both non-grandfathered and grandfathered plans.

What preventive care services are covered for women?

On August 1, 2011, HHS released an amendment to the Interim Final Regulations for preventive care. Beginning August 1, 2012, non-grandfathered plans will be required to cover the following additional preventive care services for women, with no cost sharing:

- Annual well-woman visits
- Screening for gestational diabetes
- HPV DNA testing for women 30 years and older
- Sexually-transmitted infection counseling
- HIV screening and counseling
- Food and Drug Administration (FDA)-approved contraception methods and contraceptive counseling
- Breastfeeding support, supplies and counseling
- Screening and counseling for interpersonal and domestic violence

Plans may impose cost sharing on brand name preventive drugs if a generic version is available and is just as effective and safe for the patient to use. Cost sharing would not be permitted on the generic drug.

Religious Exemption:
A religious employer is defined as an organization that meets all of the following criteria:

- The promotion of religious values is the purpose of the organization
- The organization primarily employs individuals who share the religious beliefs of the organization
- The organization serves primarily people who share the religious beliefs of the organization
- The organization is a nonprofit organization as described in the Internal Revenue Code Sections 6033(a)(1) and 6033(a)(3)(A)(i) and (iii).
These requirements are based on recommendations by the independent Institute of Medicine (IOM). There was an opportunity for public comments to be submitted by September 30, 2011.

On January 20, 2012, HHS issued a news release stating their intent to modify the August 2011 interim final regulations for preventive care. This will allow non-profit employers who, based on religious beliefs, do not currently provide contraceptive coverage in their insurance plans and do not qualify for the exemption, to delay compliance. These groups will be allowed an additional year, until August 1, 2013, to comply with the new requirement to cover contraceptive services.

All other non-grandfathered plans will be required to cover FDA-approved contraceptive services for plan years beginning on or after August 1, 2012, unless they qualify for an exemption as a religious employer.

Please visit hrsa.gov to read the Guidelines for Women’s Preventive Services*.

QUALIFIED HEALTH PLANS

What is a Qualified Health Plan?

A qualified health plan is coverage offered through a state insurance exchange, which will be open to individuals and small groups in 2014.

Under the PPACA, qualified health plans may not have pre-existing condition limitations or lifetime maximums or annual limits on the dollar amount of essential health benefits, which the Secretary of Health and Human Services will define.

Each state exchange’s qualified health plans must cover essential health benefits at five levels: bronze (60 percent), silver (70 percent), gold (80 percent), platinum (90 percent) and young adult. Only an insurer or health maintenance organization with a license and in good standing in the state may offer exchange plans.

RESCISSIONS (CANCELLATION) OF SELF-INSURED PLANS

What do the PPACA provision prohibiting rescissions (cancellation) mean for individual policyholders and covered individuals?

The PPACA bans rescission (cancellation) of healthcare coverage of an individual except for fraud or material misrepresentation provided the policy/plan provides for rescission.

The ban applies to individual policies and insured and self-insured group health plans (including grandfathered plans). If coverage is rescinded, the law requires 30 days advance notice to the enrollee.

RISK ADJUSTMENT

WHAT IS RISK ADJUSTMENT?
Risk adjustment is a stabilization program designed to spread the financial risk that health plans (insurers) assume for their enrolled population – in and out of the public health care Marketplaces. It is designed to encourage insurers to offer a variety of health plans with stable premiums.

**SELF-INSURED CLIENT AND ERISA**

Does the Employee Retirement Income and Security Act (ERISA) shelter self-insured plans from provisions of the PPACA?

No. Health insurance reform provisions of PPACA are incorporated into ERISA, so they apply to all self-insured plans governed by ERISA.

**SMALL BUSINESS SUBSIDY - SMALL BUSINESS HEALTHCARE REFORM**

Who qualifies for the small business subsidy?

Under the PPACA small business subsidies are provided to businesses that employ the equivalent of 25 or fewer full-time employees (excluding the owner) with average annual compensation below $50,000 per employee.

For tax years 2010 through 2013, the maximum credit for a for-profit business is 35 percent of the employer’s cost of health insurance, if the employer provides more than 50 percent of employee premium expenses. The credit is claimed on the employer’s annual income tax return. If the small business is a not-for-profit, the maximum subsidy is 25 percent. The Internal Revenue Service will provide further information on how tax-exempt employers claim the credit.

Subsidies will increase in 2014 to 50 percent of the for-profit employer’s cost of health insurance and 35 percent for the not-for-profit businesses. The subsidies will phase by 2014 for firms having 10 to 25 full-time workers, or the equivalent, with average wages between $25,000 and $50,000.

**SMALL EMPLOYER**

What is the definition of "small employer?"

The national small group definition was scheduled to expand in 2016 from 1-50 to 1-100 total employees (any person that receives a W-2). However, this rule was repealed early October, 2015, leaving the definition of small group as 1-50 total employees, unless a state defines differently. Non-grandfathered, insured, small group health plans must comply with community rating standards and Essential Health Benefits (EHB) rules.

States currently expanding their small group definition to 1-100 total employees: CA, CO, NY and VT.

Expanding the small group definition beyond 50 total employees could present a significant change for insured groups with 51 or more full-time/full-time equivalent (FTE) employees, as these employers are considered "large employers” for most ACA rules.
Non-grandfathered insured employer groups that fit a state-defined small group size greater than 50 total employees, and whose workforce is comprised of 51 or more full-time/FTE employees will need to comply with both the small group market rules and the employer mandate. Such insured group health plans must comply with minimum value and affordability rules to avoid employer penalties despite higher premiums resulting from the small group rules. Consequently, these impacted employers may consider self-insuring their plans.

As an example, if a state expands its small group definition to 1-100 employees, an employer would be subject to both sets of rules if it had 95 total employees, comprised of 65 full-time employees.

U.S.-issued expatriate plans can continue to define a “small employer” as having 1-50 employees in 2016 and beyond.

Fully insured groups in states that expand the definition may have to comply with both requirements

* The small group size is set by every state and is determined by number of actual employees (any person that receives a W-2). The definition of an “applicable large employer” for purposes of the employer mandate is set by federal law and is any employer with 50 or more full-time and full-time equivalent employees.

SUMMARY OF BENEFITS AND COVERAGE

When were employers required to begin delivering the Summary of Benefits and Coverage to their employees?

The Summary of Benefits and Coverage provision applies to employees and dependents of domestic group and individual health plans. It applies to all fully insured and self-insured plans, regardless of grandfathered status. It does not apply to Medicare plans or U.S.-issued expatriate plans.
Effective September 23, 2012, health insurers and self-insured group health plans were required to provide a standard Summary of Benefits and Coverage (SBC) document to all individuals enrolling in medical coverage. This includes mid-year enrollment for new employees and those experiencing a special enrollment event, and 'upon request' by other enrollees.

Except for the 'upon request' requirement, the date by which the SBC needs to be provided is actually driven by the enrollment method:

The SBC must be provided as part of any written application materials that are distributed by the plan or issuer for enrollment.

If the plan does not distribute written application materials for enrollment, the SBC must be distributed no later than the first date the participant is eligible to enroll in coverage for the participant and any beneficiaries.

In the case of renewal or reissuance, if the issuer requires written application materials for renewal (in either paper or electronic form), it must provide the SBC no later than the date the materials are distributed. If renewal or reissuance is automatic, the SBC must be provided no later than 30 days prior to the first day of the new policy year.

What is a "material modification" and how do employers communicate this to their employees?

A material modification is any change that an average participant would consider an important enhancement or reduction in benefits.

If a material change is made to a plan during the plan year that is not reflected in the most recent Summary of Benefits and Coverage, a notice must be provided at least 60 days before the effective date of the change.

For example, if a 1/1 renewal wants to make a change on 2/1, they will need to communicate it on 2/1 and make the change effective in April, which thus gives the requisite 60-day advance notice.

Note: This timing applies only to changes that become effective during the plan year.

Where can an individual customer go to view a sample of the Summary of Benefits and Coverage?

Templates for both the current SBC and new SBC proposed in December 2014 are available at the [Department of Labor website](http://www.dol.gov).

**TAFT HARTLEY FUNDS**

Does PPACA impact Taft-Hartley Funds/Groups the same as employers?

Yes. However, a special grandfathering rule for insured collectively bargained plans says they do not have to follow all health insurance rules at the beginning. When the last of the plan’s collective bargaining agreements that started on or before March 23, 2010 ends, then all other grandfathered plans rules apply.
Many Taft-Hartley plans had annual limits on the dollar amount of essential health benefits and, like all other plans, could apply for a waiver from the ban on annual limits.

**U.S. TERRITORIES**

**How does the PPACA apply to U.S. territories, such as the U.S. Virgin Islands and Puerto Rico?**

Certain PPACA requirements have been modified for the territories (Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa and the Northern Mariana Islands). For example, the legislation provided funding to establish Marketplaces in the territories, but if a territory declined to create a Marketplace, the Medicaid funding cap was increased for that territory.

The Individual Mandate provision states that any resident of the territories will be treated as having minimum essential coverage, regardless of whether they have coverage or not. If individuals are deemed to have minimum essential coverage, they may not be eligible for federal premium assistance to purchase coverage through the Marketplace (if a Marketplace is established in their territory).

The reinsurance fee doesn’t apply in the U.S. territories since none of the territories created a reinsurance program.

Effective July 16, 2014, the following additional PPACA provisions no longer apply to insured plans issued in the U.S. territories:

- Required coverage of Essential Health Benefits (EHB)*
- Medical Loss Ratio (MLR) rebates
- Employer mandate (a territory may enact a comparable provision under its own law)
- Guaranteed issue
- Rate review*
- Community rating*
- Single risk pool*
- Risk corridors and risk adjustment*

* Applies only to individual and small group insured plans

**W-2 REPORTING**

**What are the PPACA rules relating to W-2 reporting of the value of employer-sponsored health coverage?**
Starting with the 2012 tax year, the PPACA requires employers who distribute 250 or more Form W-2s for the tax year to include the value of applicable employer-sponsored coverage on each employee's W-2 Form. This is not considered taxable income and is for information purposes only. Employee premiums may still be made on a pre-tax basis.

IRS Notice released October 12, 2010, made this reporting requirement for the 2011 tax-year voluntary. Employers that choose not to report the aggregate cost of employer-sponsored coverage for the 2012 tax year and beyond will be subject to tax penalties. While the Form W-2 has not changed, the IRS added a code "DD" that employers should put in box 12 to report the value.

It is important to note that this requirement applies to employers who distribute 250 or more W-2s, not simply to employers with 250 or more employees. A high-turnover employer with 200 employees may send out more than 250 W-2s.

**What gets reported on the 2012 W-2, total premium or just what the employee pays for coverage?**

Total premium reflecting both employer and employee contributions is required to be reported.

**WAITING PERIODS**

**What is the PPACA rule on enrollment waiting periods?**

The PPACA prohibits employers from imposing enrollment waiting periods that exceed 90 days beginning January 1, 2014. This provision applies to both grandfathered and non-grandfathered plans.

**WAIVER PROCESS/SPECIAL CONSIDERATION**

**How do employers and insurers apply for a waiver to delay following the PPACA annual limit rule?**

If compliance with the PPACA’s annual limit for essential health benefits rule causes a big loss of coverage or increase in monthly premiums, the interim final rules allow for one-year waivers. Plans must get waivers annually until 2014 when all plans need to follow the annual limits rule.

Limited benefit plans or mini med plans, often have annual limits well below what the PPACA interim final regulations require. These plans offer health benefits to part-time employees, seasonal workers and volunteers who otherwise may not be able to get health insurance they can afford.

On June 17, 2011, the Centers for Medicare and Medicaid Services issued guidance that allows health plans to have annual limits waiver approval through 2013. The new guidance will help ensure that employers can still give employees access to health care coverage they can afford.

Waiver extension requests must in by September 22, 2011, and Annual Limit Updates must be in by December 31, 2012 to extend the waiver through 2013. Any plan that started before September 23, 2010 that wants to keep its annual limit but never asked for a waiver must make the request to by September 22, 2011. There are also new rules how health plans with waivers must explain coverage limits to plan participants.