

How the Health Care Reform Legislation Will Impact Your Individual and Employer Clients

IN 2014

- The individual mandate requirement to purchase health insurance for all citizens and legal residents takes effect. There are specified exceptions and under current law violators will be subject to a phased-in excise tax penalty for noncompliance of either a flat-dollar amount per person or a percentage of the individual's income, whichever is higher. In 2014, the percentage of income determining the fine amount would be one percent, then two percent in 2015, with the maximum fine of 2.5% taxable (gross) household income capped at the average family bronze-level insurance premium. The alternative is a fixed-dollar amount that begins at \$325 per person in 2015 and goes to \$695 in 2016.
- The employer responsibility requirements take effect for companies that employ more than 50 FTEs (with an exemption for seasonal workers). If an employer does not provide coverage to its FTEs (30 hours or more) and one or more of the employees receive a premium-assistance tax credit to buy coverage through the exchange, the employer must pay a fine of \$2,000 per year for each full-time employee. However, the legislation exempts the first 30 employees from the fine calculation (i.e., if the employer has 51 employees and doesn't provide coverage, the employer pays the fine for 21 employees).
 - Coverage must meet the essential benefit requirements in order to be considered compliant with the mandate.
 - An employer with more than 50 employees that does offer qualified coverage but has at least one FTE receiving the premium assistance tax credit will pay the lesser of \$3,000 for each of those employees receiving a tax credit, or \$2,000 for each of its full-time employees total.
 - An individual and family income up to 400% of FPL is eligible for a premium assistance tax credit if the actuarial value of the employer's coverage is less than 60% or the employer requires the employee to contribute more than 9.5% of the employee's family income toward the cost of coverage.
 - When determining whether an employer has 50 employees, both for the purposes of the fine and the responsibility requirements generally, part-time employees must be taken into consideration based on aggregate number of hours of service. Part-time employees do not have to be offered coverage, but they will be partially included in the calculation to determine whether or not these provisions apply to a particular employer.
- For employers that have a waiting period for coverage for new employees, waiting periods of more than 90 days are prohibited for all plans, including grandfathered plans.
- All of the market reforms for all individual market and fully insured group markets take effect. All plans must be offered on a guaranteed-basis, preexisting condition limitations will be prohibited, annual and lifetime limits will be fully prohibited, including for grandfathered plans, and the size of a small-employer group will be redefined to one to 100 employees (although

states may elect to keep the size of small groups at 50 employees until 2016). In addition, all fully insured individual and small groups up to 100 employees (and any larger groups purchasing coverage through an exchange) will have to abide by strict modified community rating standards with premium variations only allowed for age (3:1), tobacco use (1.5:1), family composition and geographic regions, to be defined by the states, and experience rating would be prohibited. Wellness discounts will be allowed for group plans under specific circumstances.

- States are required to have their exchanges up and running. Each state can have a separate exchange for employers and individuals, or merge their exchanges to include both markets. States can also apply for a waiver on their exchange design from HHS, and currently operational state exchanges (UT and MA) are exempt.
- The standards for qualified coverage, which will apply to all fully insured group and individual products to be sold both inside and outside the exchanges, begin. The essential benefit standards will also be used to determine if large employer coverage is sufficient enough relative to the employer responsibility requirements. The essential benefit standards include specific mandated benefits, cost-sharing requirements, out-of-pocket limits and a minimum actuarial value of 60%. They also allow for catastrophic-only policies for those 30 and younger.
- The employee free choice voucher program takes effect. It requires employers that provide and contribute to health coverage to give vouchers to each employee who is required to contribute between eight percent and 9.8% of their household income (indexed to the premium growth rate) toward the cost of coverage, if such employee's household income is less than 400% of FPL and the employee does not enroll in a health plan sponsored by the employer. The value of vouchers would be adjusted for age, and the vouchers would be used in the exchanges to purchase coverage that would otherwise be unsubsidized. The employee can also keep amounts of the voucher in excess of the cost of coverage elected in an exchange without being taxed on the excess amount. The amount of the voucher must be equal to the amount the employer would have provided toward such employee's coverage (individual vs. family based on the coverage the employee elects through the exchange) with respect to the plan to which the employer pays the largest portion of the cost.
- Employers of 200 or more employees will have to auto-enroll all new employees into any available employer-sponsored health insurance plan. Waiting periods in existing law can apply. Employees may opt out if they have another source of coverage. **Important note: The effective date of this provision is unclear and may be determined via regulation to take effect earlier.**
- Premium taxes on most private health insurers based on premium volume take effect, which can be passed directly down to fully insured plan consumers. This tax WILL NOT apply to self-insured plans, nonprofit insurers that receive over 80% of their gross revenues from government programs like Medicare, Medicaid and CHIP, and voluntary employee benefit associations that

are established by non-employers. Certain tax-exempt health plans would also pay less because they will calculate the fee based on only 50% of their premiums. The amount of the total assessed tax on the industry will start at \$8 billion in 2014, rise to \$113 billion in 2015 and 2016, \$13.9 billion in 2017, and \$14.3 billion in 2018. After 2018, the fee would be indexed to the annual amount of premium growth in subsequent years.

- Employer-sponsored wellness program rules for all employer group plans under HIPAA improve and employers can increase the value of workplace wellness incentives up to 30% of premiums, with HHS discretion to increase the incentives to 50%. In addition, a 10-state pilot program to extend wellness programs to the individual market begins, with the potential expansion to the entire individual market in 2017.
- Cooperative plans will be allowed to be sold. Multistate national plans will be offered to individual and small employers through the state-based exchanges.
- Premium assistance tax credits for individuals and families making up to 400% of FPL begin. These subsidies are available only for individual coverage purchased through the exchange, not employer-sponsored coverage.
- Expansion of the Medicaid program for all individuals, including childless adults, making up to 133% of the FPL begins. Mandatory state-by-state employer premium-assistance programs begin for those eligible individuals who have access to qualified employer-sponsored coverage. States can also create a separate non-Medicaid plan for those with incomes between 133% and 200% of FPL that do not have access to employer-sponsored coverage.