Winter/Spring 2016

YOUR GUIDE

to health care reform and the Affordable Care Act: 2014 and beyond

The following is a recap of the key provisions of the Affordable Care Act that went into effect in 2014, and will continue through 2020. This listing is not comprehensive and is subject to change based on new government requirements, regulations and guidance. Your company or group health plan may be exempt from certain requirements and/or subject to more stringent requirements, depending on your group size and situation.

More information about these provisions and others can be found on the government's ACA websites**, healthcare.gov** and **cciio.cms.gov**. If you have any questions regarding your obligations with respect to Health Care Reform, please consult with a knowledgeable legal, tax and/or employee benefits professional.

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2014 recap

A summary of provisions that went into effect in 2014

- **90-Day Waiting Period Limitation**
  Employers cannot have benefit waiting periods greater than 90 calendar days. All calendar days are counted—including weekends and holidays—so three calendar months may not be used in lieu of those 90 actual days. **Timing:** *This provision became effective for plan years beginning on, or after, January 1, 2014, with final regulations issued in February 2014.*

- **Wellness Programs**
  Under the Health Insurance Portability and Accountability Act (HIPAA), insurers and employers are forbidden from discriminating based on health status. Under HIPAA, however, giving premium discounts or rebates in return for adherence to wellness programs is not a violation. The incentive cap for participation in health-contingent wellness programs is 30% of the total annual premiums for individual coverage (50% in the case of wellness programs related to tobacco use). A health-contingent program requires participants to meet certain specified goals or at least show an effort to reach those goals. Fallon's Healthy Health Plan, our comprehensive wellness program, is an example of this. **Timing:** *This provision became effective for plan years beginning on, or after, January 1, 2014, with final regulations issued in February 2014.*

  Note: *In April 2015, the Equal Employment Opportunity Commission (EEOC) proposed additional regulations on wellness programs, intended to apply to them the provisions of the Americans with Disabilities Act (ADA). The EEOC regulations have not yet been finalized, but any employer subject to the ADA should consult them before implementing a wellness program.*

- **Cost Transparency**
  There are transparency provisions in both the ACA and Massachusetts Chapter 224. The ACA provision only applies to Qualified Health Plans (QHPs) sold through a state exchange. The state requirement applies more broadly across the entire fully insured market, and is the more far reaching of the two in terms of its requirements. Fallon launched Fallon SmartShopper, its online, real-time transparency tool in October 2014 to comply with the state provision. **Timing:** *The ACA transparency provisions applicable to QHPs took effect January 1, 2014 nationally. The state law requiring real-time turnaround on cost transparency requests took effect October 1, 2014.*

- **Essential Health Benefits (EHBs)**
  All Merged Market plans are required to include all EHBs in their benefit package. Large groups are not required to cover EHBs, but to the extent that they do they are not allowed to have annual or lifetime dollar caps applicable to any of the EHBs. The 10 categories of EHBs include: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance abuse disorder services; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including dental and vision care. The HMO Blue Small Group Plan is the Massachusetts benchmark plan chosen by the Division of Insurance (DOI). Fallon plans include the EHBs defined in the benchmark plan. **Timing:** *This provision took effect on January 1, 2014. The EHB definition will be reset in 2017, which may result in minor benefit changes at that time.*

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- **Enrollment as a Subscriber in a Non-Group Plan**
  The ACA allows individuals with access to employer-sponsored coverage to purchase non-group plans without restriction. However, this does not mean that the individual will get a subsidy (which, in turn, would trigger a penalty for the employer starting in 2015). The individual will only receive a subsidy if the coverage offered by the employer does not meet the requirements of the Employer Shared Responsibility provision of the ACA. **Timing:** *This provision took effect for non-group enrollments on January 1, 2014.*

- **Merged Market Small Group Factor Changes**
  The ACA only allows four rating factors for individuals and small groups: Age, Family Size, Geographic Area and Tobacco Use (Tobacco has been set at 1:1 in Massachusetts, so it will effectively not be in use). The ACA and state legislation also eliminated the rating limits commonly referred to as "Rate Shock Bumpers" for all rates effective January 1, 2014. **Timing:** *Effective for plan years beginning on, or after, January 1, 2014. Through 2017, a transition period has been granted in Massachusetts to allow the partial use of these additional rating factors: Industry, Participation Rate, Group Size, Intermediary Discount and Group Purchasing Cooperatives.*

- **Metallic Tiers, Actuarial Value and Minimum Value**
  All Merged Market plans sold inside and outside an exchange are required to conform to limited ranges of actuarial values associated with "Metallic" tiers. Metallic tiers are a way of classifying health insurance products which have similar actuarial value. Actuarial Value (AV) is calculated as the percentage of total average costs for covered benefits that a plan will cover. Large groups are subject to a similar requirement called Minimum Value (MV). Large groups will not be required to conform to a metallic tier range, but will need to meet an MV floor. Failure to do so could expose a large group to penalties under the Employer Shared Responsibility requirement in 2015. **Timing:** *Effective for plan years beginning on, or after, January 1, 2014.*

- **Out-of-Pocket Maximums**
  For plan years starting in 2014, all non-grandfathered plans (including both insured and self-funded plans of large and small employers) are required to have an out-of-pocket maximum. The out-of-pocket maximum is a total cost-sharing limit for Essential Health Benefits (EHBs). It includes deductibles, coinsurance, copayments or similar charges and any other required expenditure that is a qualified medical expense with respect to EHBs covered under the plan. The maximum may not exceed amounts specified in the law, which for 2016 are $6,850 for self-only coverage and $13,700 for family coverage. **Timing:** *Effective for plan years beginning on, or after, January 1, 2014.*

2015 recap

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- **Summaries of Benefits and Coverage (SBCs)**
  Insurers and employers are required to provide a standard SBC to subscribers during an open enrollment period, upon enrollment, at renewal or upon request. Employers are responsible for distributing SBCs with other plan enrollment materials to their employees. Fallon provides employers with electronic or printed copies for any Fallon plan offered to employees. **Timing:** *Initially distributed in September 2012, but updated SBCs had to be available for plans renewing on, or after, January 1, 2014. Further updates took effect on January 1, 2016, and a more significant overhaul of the SBC template is expected for 2017.*

- **Coverage of Dependent Children to Age 26**
  Under the ACA, all commercial plans were required to offer coverage to dependent children until they reach their 26th birthday. That requirement was implemented in 2010-11. While that requirement remains in effect, a provision of the Employer Shared Responsibility regulations will require employers subject to Employer Shared Responsibility to offer coverage to dependent children reaching age 26 until the end of the month in which they turn 26. **Timing:** *Fallon Health implemented this change—as groups renewed beginning on January 1, 2015—for all commercial plans, regardless of group size.*

- **Employer Shared Responsibility**
  Employers with 50 or more full-time employees or full-time equivalents are subject to this mandate, to varying degrees depending on their group size. Employers may be assessed penalties if one or more of their employees receives a subsidy or premium tax credit for purchasing individual coverage from the exchange, and if any of the following apply:

  - Minimum Essential Coverage (MEC) is not provided to at least 95% of full-time employees and their dependents
  - Coverage is provided, but does not meet federal guidelines regarding Minimum Value (MV), which is 60%.
  - Coverage is provided, but is not affordable, meaning the employee's share of the single premium exceeds 9.5% of household income (or any of the safe harbor income measurements utilized by the employer, i.e., employee's W-2 wages)

  The penalty calculations vary depending upon which part of the mandate an employer doesn't meet, but they can generally range from $2,000 - $3,000 annually, per employee. For the 2015 plan year only, employers subject to the provisions must meet a lower threshold of offering MEC to at least 70% of their full-time employees. Starting in 2016, all employers subject to the provisions will need to meet the standard threshold of offering MEC to at least 95% of their full-time employees. **Timing:** *Originally scheduled to take effect in 2014, this provision went into effect on January 1, 2015 for groups with 100 or more full-time employees/equivalents and went into effect on January 1, 2016 for groups with 50 or more full-time employees/equivalents.*

  - **Full-Time Employee**—a full-time employee for any calendar month is an employee, who has on average, at least 30 hours of service per week during the calendar month, or at least 130 hours of service during the calendar month.

  - **Full-Time Equivalent Employee (FTE)**—to determine how many FTEs for a month that an employer has, they must:
    1. Combine the number of hours of service of all non full-time employees for the month, but cannot include more than 120 hours of service per employee.
    2. Divide the total by 120.

A summary of provisions that went into effect in 2015

An employer's number of FTEs (or part-time employees) is only relevant to determining whether an employer is an Applicable Large Employer (ALE). An ALE does not need to offer minimum essential coverage to its part-time employees to avoid an Employer Shared Responsibility payment. A part-time employee's receipt of the premium tax credit for purchasing coverage through the Massachusetts Health Connector cannot trigger an Employer Shared Responsibility payment. More detailed information about full-time employees can be found here: *www.irs.gov/Affordable-Care-Act/Employers/Identifying-Full-time-Employees.*

- **Employer Reporting on Health Care Coverage**
  For tax year 2015 and beyond, the ACA requires insurers and employers to annually report certain information.

  Social Security numbers are part of the information that must be reported, so Fallon Health will be reaching out to its members to collect Social Security numbers for themselves and those family members/ dependents covered under their plan. In addition, Fallon is reaching out to employers for their Tax I.D. , or Employer Identification Numbers. Employer groups can send the information they collect to their Fallon Health sales coordinator. Fallon Health is also contacting brokers to let them know that Social Security numbers are required.

  - **Form 1095-A is for individuals who receive coverage through the Massachusetts Health Connector (non-group coverage)** – This *form is created by the Massachusetts Health Connector* and contains information an individual needs to complete Form 8962, Premium Tax Credit (PTC). The individual must complete this form and include it with their tax return if they received premium assistance through advance credit payment, or if they want to claim the PTC when they file their return. **Timing:** *This went into effect for the 2015 tax season.*

  - **Form 1095-B applies to fully insured groups (large and small), self-funded small groups (under 50), and individuals who get covered outside of the Massachusetts Health Connector** – This *form is created by insurers or self-funded small groups* and provides information the employee needs to report on their income tax return for them, their spouse and dependents as proof of qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year. Individuals who do not have minimum essential coverage and who do not qualify for an exemption may be liable for the individual shared responsibility payment. **Timing:** *This will be required for the 2016 tax season.*

  - **Form 1095-C applies to fully insured and self-insured large groups** – This *form is created by employers large enough (50 or more full-time employees, including full-time equivalents) to be subject to the Employer Shared Responsibility provision.* This form includes information about the health coverage offered to the employee. If the employee purchased coverage through the Massachusetts Health Connector and wishes to claim the premium tax credit, this information will assist them in determining whether or not they are eligible. If the employer is fully insured, their members will get form 1095-B from their insurer, and the employer generally only needs to fill out Parts I and II of form 1095-C. If the employer is self-insured, they need to fill out all parts of form 1095-C (including Part III). **Timing:** *This will be required for the 2016 tax season.*

2016 recap

A summary of provisions that go into effect in 2016 and beyond

- **Merged Market Stays at 50 Employees or Fewer**
  The current Merged Market includes individuals and small group employers with 50 employees or fewer. The ACA originally dictated that this market was to be expanded to include employers with 100 employees or less, but a change in the law in late 2015 kept the Merged Market at 50 employees or less. While the Merged Market will stay at 50 employees or fewer, the method of counting employees will change from eligible employees (former state definition) to a new definition that takes into account an employer's entire workforce (e.g., FTE count similar to federal Employer Shared Responsibility). **Timing:** *The expansion of the Merged Market from 50 employees or fewer to 100 employees or fewer was originally scheduled to take effect for plan years beginning on, or after, January 1, 2016, but a change in the law in late 2015 kept the Merged Market at 50 employees or fewer.*

2020 recap

- **Excise Tax on High-Cost Plans (The "Cadillac Tax")**
  This provision calls for a 40% excise tax on the value of employer-sponsored coverage in excess of $10,200 for individual coverage and $27,500 for family coverage. The dollar thresholds are tied to the Consumer Price Index (CPI). This tax may also apply to Health Reimbursement Accounts (HRAs), Health Savings Accounts (HSAs) and Flexible Spending Accounts (FSAs), including money that employees now put away tax-free for qualified medical expenses. **Timing:** *This provision was originally scheduled to take effect in 2018, but it was delayed until 2020.*

More info

Helpful links for additional ACA information

Fallon Health website:
- fallonhealth.org/reform

Federal websites:
- Healthcare.gov
- cms.gov/cciio

State website:
- mass.gov

IRS website:
- irs.gov

Department of Labor website:
- dol.gov

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