2014

Information Reporting Requirements for Employers

The U.S. Treasury Department and the IRS have issued two sets of final rules on minimum essential coverage information reporting and employer health insurance coverage information reporting. Under the Affordable Care Act, insurers, self-insuring employers, and other parties that provide minimum essential health coverage are required to report information on this coverage to the IRS and to covered individuals. Large employers (generally those with 50 or more full-time employees, including full-time equivalents) are also required to report information to the IRS and to their employees about their compliance with the employer shared responsibility provisions and the health care coverage they have offered.

The final regulations provide guidance on the content, manner, and timing of information required to be reported to the IRS and furnished to individuals and employees, and also describe a variety of options to reduce or streamline information reporting. The regulations apply for calendar years beginning after December 31, 2014. **A reporting entity will not be subject to penalties if it first reports beginning in 2016 for 2015**. Reporting entities are encouraged to voluntarily comply with the information reporting provisions for 2014.

90-Day Limitation on Waiting Periods

In plan years beginning on or after January 1, 2014, a group health plan or group health insurance issuer may not apply any waiting period that exceeds 90 days. A waiting period is the period of time that must pass before coverage for an employee or dependent who is otherwise eligible to enroll under the terms of a group health plan can become effective.

Annual Limitations on Out-of-Pocket Cost Sharing

Beginning in 2014, non-grandfathered group health plans must ensure that cost-sharing under the plan does not exceed certain limitations.

Special Update: Annual Limit on Deductibles for Small Group Plans Eliminated
Federal legislation eliminates the annual limitation on deductibles for non-grandfathered plans in the small group market, and is effective retroactively to 2010. Those limits were set at $2,000 for self-only coverage and $4,000 for other than self-only coverage for plan years beginning in 2014; however, certain small group plans were allowed to exceed the limits if necessary to reach a given level of coverage, or metal tier.

The annual limitation on out-of-pocket expenses was not eliminated and remains in effect. A set of FAQs clarifies how the requirement applies to coverage of essential health benefits, separate out-of-pocket limits across multiple categories of benefits, and spending for out-of-network and non-covered items and services.

Note: The federal government has extended a transitional policy announced last November, which allows some small businesses to renew group coverage that does not comply with certain rules under Health Care Reform (including the requirement to limit annual out-of-pocket cost sharing), for an additional two years—**to policy years beginning on or before October 1, 2016.**

Click here for more information.

Availability of Health Insurance Exchanges (Marketplaces): See Special Updates Below

Exchanges are expected to begin operating in 2014 as an option for individuals to buy private health insurance. Exchanges will also operate a small business health options program (SHOP) as an option for qualified small employers to purchase employee health coverage. In most states, SHOP participation will be limited to employers with **50 or fewer full-time equivalent employees** in 2014. Beginning in 2016, all SHOPs will be open to businesses with up to 100 employees.

Special Update: SHOP Delays

Online Enrollment Delayed Until November 2014

Online enrollment for small employers to purchase employee health coverage through the federally-facilitated SHOP Marketplace has been delayed for one year, until November 2014. The U.S. Department of Health and Human Services previously announced that all SHOP functions would be available in November 2013. Until online functionality for SHOP is available, small business owners who wish to purchase a SHOP qualified health plan may work with an agent or broker to enroll.

Key Employer Choice Feature of SHOP Exchanges Delayed Until 2015

A final rule delays the requirement for SHOPs to provide employers the option of offering employees a choice of any qualified health plan (QHP) at a single level of coverage selected by the employer, until plan years beginning on or after January 1, 2015. For plan years beginning in calendar year 2014, federally-facilitated SHOPs will only permit employers to select a single QHP from the choices available in the SHOP to offer qualified employees. State-based SHOPs have the option of allowing employers to offer qualified employees a choice of QHPs at a single coverage level.

Coverage of Essential Health Benefits

Non-grandfathered plans offered in the small group market (both inside and outside of exchanges) must cover a core package of items and services known as "essential health benefits" beginning in 2014. Final rules have been issued which outline issuer standards related to coverage of these essential health benefits.

Special Update: The federal government has extended a transitional policy announced last November, which allows some small businesses to renew group coverage that does not comply with certain rules under Health Care Reform (including the requirement to cover essential health benefits), for an additional two years—**to policy years beginning on or before October 1, 2016.** Click here for more information.

Dependent Coverage to Age 26 for Grandfathered Plans Without Exception

The temporary exception for grandfathered plans from the requirement that dependents be covered to age 26 no longer applies for plan years beginning on or after January 1, 2014. As a result, both grandfathered and non-grandfathered group health plans that cover dependents must

make coverage available until a child reaches age 26, regardless of other coverage options.

Employer Shared Responsibility ("Pay or Play"): See Special Update Below

Special Update: Final rules have been issued which delay the "pay or play" requirements until 2016 for large employers who have fewer than 100 full-time employees and who meet specific eligibility conditions. Click here for more.

Employers with 50 or more full-time equivalent employees may be required to make an annual shared responsibility payment if any full-time employee is certified to receive a premium tax credit or cost-sharing reduction payment.

Expanded Medicaid and CHIP: See Special Update Below

By 2014, states would be required to extend Medicaid coverage to all individuals under 65 who have incomes up to 133% of the federal poverty level. The law would also fund the Children's Health Insurance Program through 2015, and require states to maintain the current eligibility levels for children in the Medicaid and CHIP programs.

Special Update: The U.S. Supreme Court has ruled that the portion of the law which threatens states' existing Medicaid funding for failure to comply with the requirements related to expanding the scope of Medicaid coverage is unconstitutional.

Guaranteed Availability of Coverage and Limits on Variations in Premiums

For plan years beginning on or after January 1, 2014, issuers offering non-grandfathered group plans must accept every employer that applies for coverage, with certain exceptions. Issuers that offer coverage in the small group market must limit any variation in premiums with regard to a particular plan or coverage to age and tobacco use (within limits), family size, and geography. Final rules have been issued to implement these requirements.

Special Update: The federal government has extended a transitional policy announced last November, which allows some small businesses to renew group coverage that does not comply with certain rules under Health Care Reform (including the requirements related to guaranteed availability and limits on premium variations), for an additional two years—**to policy years beginning on or before October 1, 2016.** Click here for more information.

Individual Shared Responsibility

The individual mandate, which became effective on January 1, 2014, requires every individual (regardless of age, including children) to have minimum essential health coverage for each month, qualify for an exemption, or make a payment when filing his or her federal income tax return. To view final rules on the mandate, click here.

Special Update: The Treasury Department and the IRS have issued proposed rules on the individual mandate, which provide guidance on additional issues that were identified in the preamble to the final rules. Among other things, the rules clarify the treatment of health reimbursement arrangements (HRAs) and wellness program incentives for purposes of determining the exemption for individuals who cannot afford employer-sponsored coverage.

For more information regarding the individual shared responsibility provision, click here for IRS

FAQs.

No Annual Limits or Preexisting Condition Exclusions

All annual dollar limits on coverage of "essential health benefits" are prohibited for group health plans issued or renewed beginning January 1, 2014.

Also effective for plan years beginning on or after January 1, 2014, group health plans are not permitted to exclude individuals from coverage or limit or deny benefits on the basis of preexisting medical conditions. (The prohibition on exclusions of children under 19 years of age on the basis of pre-existing conditions began 6 months from the date the law was enacted.)

Premium Subsidies

In 2014, the law will provide tax credits to individuals and families with incomes above Medicaid eligibility and below 400% of the Federal Poverty Level to buy coverage through state-based Exchanges. These individuals and families would be entitled to the credits if they are not eligible for or offered other "acceptable coverage."

The IRS has issued final regulations relating to the tax credit. Please click here for more information.

Repeal of Free Choice Voucher Requirement: See Special Update Below

Special Update: President Obama has signed into law a bill that eliminates the requirement under the Affordable Care Act that employers provide free choice vouchers to certain employees.

Beginning in 2014, employers who offer health insurance coverage would have been required to provide a "free choice" voucher for purchasing health care through state-based Exchanges to qualifying employees whose household incomes were at or below 400% of the federal poverty level and whose required premium contributions for the employer's coverage would be between 8% and 9.8% of their household income. The dollar amount of the voucher would have been equal to the premium contribution the employer would have paid on behalf of the employee under the employer's plan.

The provision was repealed as part of the Department of Defense and Full-Year Continuing Appropriations Act of 2011.

Small Business Tax Credit

For up to two years starting in 2014, eligible small businesses (generally those with no more than 25 full-time equivalent employees with average annual wages that do not exceed $50,800, adjusted for inflation) that buy health coverage through a SHOP and pay at least half of the premium cost for employees may receive a tax credit of up to 50% of the contribution.

Transitional Reinsurance Program Fees

The Transitional Reinsurance Program is a three-year program, beginning in 2014 and continuing through 2016, that reimburses insurers in the individual insurance market for high claims costs. The program will be funded through fees to be paid by employers sponsoring

certain self-insured plans and issuers of insured health plans. Enrollment counts are due by November 15, 2014. Fees must then be paid within 30 days after notification from HHS. (Payments are collected in two installments.)

A self-insured group health plan responsible for the contributions may elect to use a third party administrator or administrative services only contractor for transfer of the reinsurance contributions. Click here for information from the IRS regarding the treatment of contributions made under the program.

Note: For 2015 and 2016, certain self-insured, self-administered group health plans do not have to pay the fee.

Wellness Programs

Wellness programs that require an individual to satisfy a standard based on a health factor in order to obtain a reward must comply with specific nondiscrimination rules under HIPAA (the Health Insurance Portability and Accountability Act). For plan years beginning on or after January 1, 2014, the maximum permissible reward that may be offered for such programs is increased from 20% to 30% of the cost of coverage (final rules further raise the maximum from 20% to 50% for wellness programs designed to prevent or reduce tobacco use).