Updated with the latest information on implementation of the Affordable Care Act

March 2013









Health Reform: A Guide for Employers

Simple answers to health reform's complex issues facing every employer, and what you can do now to protect your business – and your future.

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Health Reform:
A Guide for Employers

The Patient Protection and Affordable Care Act (PPACA) was signed into law on March 23, 2010 and was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The "Affordable Care Act (ACA)" is used to refer to the final, amended version of the law. The health reform legislation enacted significant changes in how Americans will purchase and utilize health insurance and health care for the next decade. This legislation will affect everyone – individuals and businesses – and has significant impact on how all of us manage our health, our finances and our businesses.

The Word & Brown Companies have been providing health insurance products to consumers and businesses for nearly 30 years. Our experience and expertise provides us with the unique perspective and ability to determine effective ways to continue to provide individuals and businesses with the best healthcare products at the best price.

This guide highlights the areas of health reform that most impact employers. We developed the guide as an employer resource to help you understand the principal changes enacted by the health reform legislation.

Inside you'll find some basic questions and answers that will help you understand current and upcoming changes, take advantage of new benefits and tax credits and implement requirements established by the law. We've included a simple time line of what happens when, along with the *10 Things Every Employer Should Know About Health Reform*.

Keep in mind that health reform legislation is complex and many of the specifics are still being worked out. Some are awaiting procedural guidelines from various government agencies – including the states, as various parts of the law come into effect.

We recommend you contact a licensed health insurance broker to make sure your business is properly prepared and to answer specific questions regarding changes to your benefits, how to select the best health plan for your business and new plan options that can keep your employees – and your business – healthy and strong.







Q Will my current health plan benefits change?

If you currently have a health plan for your business, based on the new law, you may have seen a few changes to your plan. The law provided for "grandfathering" of policies that were in effect on or before March 23, 2010, allowing you to keep your benefits for currently enrolled employees, dependents and new hires, but mandating new elements be added to these policies (see chart at right) beginning in September of 2010.

In June of 2010, the Department of Health and Human Services issued regulations that detailed plan changes that would cause a health plan to lose its "grandfathered" status, and then be required to implement the new plan requirements. For details on those regulations, see page 2.

All new group health plans established *after* March 23, 2010, with plan years beginning on or after September 23, 2010, must include these new elements as well as several other coverage requirements.

CHANGES TO EXISTING PLANS
(in place on or before March 23, 2010)

- dependents covered until age 26
- no lifetime benefit maximums
- no annual limits for essential benefits*
- coverage can't be rescinded except for fraud

NEW PLAN REQUIREMENTS
(effective September 23, 2010)

Above changes, plus

- 100% coverage for preventive care
- children under the age of 19 cannot be denied for pre-existing conditions
- no prior authorization or referral for ob/gyn (can be primary provider)
- no prior authorization or increased cost-sharing for emergency care
- coverage for clinical trials

*does not apply to individually purchased plans



Q Will I pay less for my health insurance coverage – or more?

This issue will not be completely resolved until after Health Insurance Exchanges are implemented in 2014 (for more on Exchanges, see pages 3 and 4). Health reform legislation requires health insurance companies to add new benefits to all policies and this could increase the cost of health insurance in the near future.

However, since more businesses and individuals will be entering the insurance-buying pool, it is hoped more buyers will help lower premiums for everyone. It is expected that Health Insurance Exchanges will encourage more competition in the health insurance industry to help bring down rates as well.

In the meantime, to help offset the cost of insurance, you should determine if you are eligible for the **Small Business Health Care Tax Credit** (see IRS worksheet on page 3). Now is also a great time to contact your insurance broker to review the benefits you have in place and evaluate your options for coverage. Your broker can help you find ways to lower your premiums through HSAs, fixed contribution plans and more.

Health Reform Implementation so far . . .



Expanded care for dependents

Kids stay on parents' plan to age 26 and can't be denied coverage for pre-existing conditions to age 19.

No lifetime or annual limits*

No lifetime dollar maximum limits or annual maximum limits on essential benefits.

*annual limits exclusion applies only to employer plans

Tax credits for small employers

If you have fewer than 25 employees and your average wage is under $50,000, you may qualify for tax credits to offset premium costs.



Reinsurance for employers with retirees

Program for employers providing insurance to retirees over 55 not eligible for Medicare.

Q How do "grandfathered plans" continue to receive the same benefits?

On June 14, 2010, the Department of Health and Human Services issued regulations meant to clarify the parts of health reform law allowing the "grandfathering" of current health plans. This allows you to keep your current insurance without having to implement some of the changes in plans required by the new federal health reform laws. (See page 1.) The list at right details plan changes that trigger a loss of grandfathered status. Minor changes to a plan are allowed – detailed below.

Note that fully insured health plans subject to collective bargaining agreements have been able to maintain their grandfathered status until their current agreement terminates. Retiree-only and "excepted health plans" such as dental plans, long-term care insurance or Medigap are currently deemed as exempt from new health reform requirements.

To find out if a change to your plan would cause you to lose your grandfathered status and your current benefits, review your plan materials and check with your insurance broker.

ROUTINE PLAN CHANGES THAT WILL **NOT TRIGGER A LOSS OF "GRANDFATHERED" STATUS**

- cost adjustments to keep pace with medical inflation
- the addition of new benefits
- modest adjustments to existing benefits
- voluntarily adopting new consumer protections under the new law
- making changes to comply with state or other federal laws

NOTES: Premium changes are not taken into account when determining whether or not a plan is grandfathered.

PLAN CHANGES THAT WOULD CAUSE A HEALTH PLAN TO **LOSE ITS "GRANDFATHERED" STATUS** AND TRIGGER NEW FEDERAL REQUIREMENTS

- **SIGNIFICANTLY CUT OR REDUCE BENEFITS.** For example if a plan no longer provides coverage for diabetes, cystic fibrosis, etc.
- **RAISE CO-INSURANCE CHARGES.** A plan cannot raise the amount an employee must pay for hospital coverage from 20% to 25%, for example.
- **SIGNIFICANTLY RAISE CO-PAYMENT CHARGES.** In order to retain grandfathered status, plans may increase copays by no more than the greater of $5 (adjusted annually for medical inflation) or a percentage equal to medical inflation plus 15%. For example, a plan that raises a copayment from $30 to $50 over the next two years will lose grandfathered status.
- **SIGNIFICANTLY RAISE DEDUCTIBLES.** To keep grandfathered status, plans may increase deductibles on out-of-pocket maximums by not more than the amount of medical inflation plus 15%. Using an average inflation rate of 4-5%, this limits deductibles to increase by no more than 19-20% from 2010 to 2011 or 23-25% from 2010 to 2012. In real terms, that means that a plan with $1,000 deductible could have increased a maximum of $200 the first year and another $50 the next year.
- **SIGNIFICANTLY LOWER EMPLOYER CONTRIBUTIONS.** Grandfathered plans can decrease the premium paid by the employer by no more than 5%.
- **ADD OR LOWER ANNUAL LIMITS.**
- **CHANGE INSURANCE COMPANIES**. If a company with a grandfathered plan changes carriers and the new plan changes any item listed above, then the company loses its grandfathered plan status.

Health Reform Implementation so far . . .

Health Premium Regulation

80% of premiums must be spent on health care services and quality improvement for small group health plans and individual plans, 85% for large group plans.

New restrictions on HSA, FSA and MSA fund use

Over-the-counter drugs without a prescription can no longer be reimbursed and tax for non-medical use increases to 20%.



Quality of care reporting

Group health plans required to provide info on health improvement and patient safety to enrollees at open enrollment.

Accountable Care Organizations (ACO)

Incentives for physicians to form groups (ACOs) to coordinate care and improve care quality.

W-2 reporting requirement

Employers who issued 250 or more W-2s for tax year 2011 must report the value of health insurance for tax year 2012.

Information and related materials are subject to change without notice.

Q Can I get tax credits for providing insurance to my employees?

YES! If you're a small business or tax-exempt organization that provides health insurance coverage to your employees, you may qualify for the **Small Business Health Care Tax Credit,** where you can claim up to 35% of health insurance premiums (25% for tax-exempt organizations). Use the IRS worksheet at right to help you see if you qualify. Beginning in 2014, these tax credits will increase to 50% (25% for tax-exempt organizations) and are only available to qualifying employers who purchase coverage in the Exchange.

ARE YOUR AVERAGE EMPLOYEE WAGES LESS THAN $50,000 (from step 2)? YES NO

DO YOU PAY AT LEAST HALF OF THE INSURANCE PREMIUM FOR YOUR EMPLOYEES AT THE SINGLE (EMPLOYEE ONLY) COVERAGE RATE? YES NO

If you said "YES" to both of the above you may be able to claim the SMALL BUSINESS HEALTH CARE TAX CREDIT. Visit www.IRS.gov for more details.

IRS TAX CREDIT WORKSHEET

STEP 1

DETERMINE THE TOTAL NUMBER OF YOUR EMPLOYEES
(not counting owners or family members)

_____ full-time employees
(number of employees who work at least 40 hours per week)

+ _____ add the number of full-time equivalent of part-time employees (calculate the number of full-time equivalents by dividing the total annual hours of part-time employees by 2080.)

= _____ total employees

If your total employees is less than 25 go to step 2

STEP 2

CALCULATE THE AVERAGE ANNUAL WAGES OF EMPLOYEES
(not counting owners or family members)

_____ total annual wages you pay to employees

÷ _____ divide it by the number of employees from STEP 1
(total wages ÷ number of employees)

= _____ average employee wages



Q What is a Health Insurance Exchange?

With health reform, Health Insurance Exchanges will be where individuals and businesses with 100 or fewer employees can shop for insurance beginning in 2014. Exchanges allow individuals and small businesses to join together and get better prices and more choices in health insurance – the kinds of things that big corporations can negotiate for their employees. Exchanges are being established on a state-by-state basis. In the Exchange, individuals will also be able to see if they qualify for a government subsidy to help pay for their insurance or enroll in a commercial plan when they don't. The Exchanges must be operational in each state by 2014. States have the flexibility to make the group size maximum 50 for 2014-2015 then increase to 100 in 2016.

What's coming up for Health Reform . . .



Medicare tax increase
Medicare Part A tax rate on wages goes up from 1.45% to 2.3% for certain individuals.

Employee notification requirement
Employers must provide employees with info on employer plans, health exchanges and subsidies.

Open enrollment for Health Exchanges
Open enrollment scheduled to begin for state Health Insurance Exchanges in October for coverage effective in 2014.



Maximum 90-day waiting period
Group health insurance plans beginning on or after January 1, 2014 may not impose waiting periods longer than 90 days to cover all employees eligible.

Q Will I be required to buy my insurance from the state Health Insurance Exchange?

No. The requirement is that everyone have health insurance – health reform doesn't dictate where you must purchase it. The state Health Insurance Exchange is simply a new place to buy insurance that will be available to individuals and small businesses.

In fact, for small employers it will allow you to offer health benefits to permanent, full-time employees, while temporary or part-time employees can purchase health insurance on their own via the Exchange.

You can continue to utilize your licensed health insurance broker to make sure you're getting the best benefits for your employees and to help you find the best rates. Keep in mind that depending on plan participation, the state Health Insurance Exchange may not offer you the same number of choices and benefit plan designs that allow you to choose what works best for your business.

2014 HEALTH INSURANCE PLAN REQUIREMENTS

- deductibles for small groups limited to $2,000 for individuals and $4,000 for families (in-network providers only)
- waiting periods for coverage limited to 90 days (small group only)
- guaranteed issue and renewability
- premium rating based on age, area, family composition and tobacco use*

*does not apply in California



What's coming up for Health Reform . . .

Wellness incentives

Employers can offer rewards of 30-50% of premiums to employees who take part in wellness and meet health standards.*

Individual mandate

Everyone must have health coverage or pay penalty. (See page 5 for updated information.)

Employer mandate

Employers with 50 or more full-time equivalent employees must provide affordable coverage or pay a penalty if any full-time employee receives a subsidy.

Large employer auto enrollment

Employers with more than 200 full-time employees that offer coverage must auto-enroll employees. Employees can opt out.

Health Insurance Exchanges operating

States must have exchanges up and running by 2014 or feds will come in and set it up themselves.

"Metal" classification of health plans

Health plans will be categorized as platinum, gold, silver or bronze to indicate benefit coverage level.

Information and related materials are subject to change without notice.

Q Am I required to provide my employees with health insurance?

Although businesses are not specifically required to provide health insurance coverage, you could pay hefty penalties if your employees get coverage through a state Exchange. Beginning in 2014, if you have 50 or more full-time equivalent employees and you do not offer affordable coverage with minimum value (60%) to your full-time employees and even one receives a government subsidy to purchase insurance through a state Exchange, you will be required to pay a penalty fee. These penalty fees are not tax-deductible. Also beginning in 2014, employers with more than 200 employees will be required to automatically enroll employees into health insurance plans, although employees may opt out of coverage.

PENALTY FOR EMPLOYERS WITH 50 OR MORE FULL-TIME EQUIVALENT EMPLOYEES WHO DO NOT OFFER HEALTH INSURANCE (effective 2014)

- $2,000 for each full-time employee after the first 30 if any full-time employee receives a government subsidy for health insurance in the Exchange.

PENALTY FOR EMPLOYERS WITH 50 OR MORE FULL-TIME EQUIVALENT EMPLOYEES WHO OFFER HEALTH COVERAGE THAT IS NOT AFFORDABLE (effective 2014)

- $3,000 for each full-time employee who receives a government subsidy for health insurance in the Exchange or
- $2,000 for each full-time employee after the first 30, whichever is less.

DO YOU HAVE LESS THAN 50 FULL-TIME EQUIVALENT EMPLOYEES? YES NO

DO YOU OFFER HEALTH COVERAGE TO YOUR FULL-TIME EQUIVALENT EMPLOYEES? YES NO

If you answered "NO" to both questions, you may be at risk for a penalty fee beginning in 2014. Contact your licensed insurance broker for more information.

Q Do individuals have to buy insurance?

Starting in 2014, if you aren't covered through your employer and don't purchase coverage on your own, you will have to pay a yearly fine of $95 per person or 1.0% of taxable income (whichever is greater). In 2015, the penalty increases to $325 or 2% of taxable income (whichever is greater). In 2016 the penalty is $695 or 2.5% of taxable income. In 2017 and thereafter, the penalty will be increased annually by the cost-of-living adjustment.

Q Where can individuals find good rates on health insurance?

A licensed insurance broker is a great way to find the best rates for health insurance. Many brokers have online quoting right on their websites, so you (or your employees or dependents) can just enter some basic information and get an instant quote and comparison of available plans.

When comparing plans, be careful about buying a no-frills plan from a company you don't recognize – you may be in for a shock at what is left out of the coverage when it comes time to use it. An insurance broker can make sure a plan fits your needs and gives you coverage that will protect your health and your family.

You can also compare plans using services like **Health*Compare*.com** for individual and family insurance or **Joppel.com** for Medicare-approved plans; both offer plan comparisons and enrollment assistance online and over the phone.

Keep in mind, too, that some insurers offer coverage directly to consumers, while others write policies exclusively through authorized brokers. It's important to pick the option that works for you and your loved ones.

What's coming up for Health Reform . . .

No pre-existing condition exclusions

Coverage cannot be denied for those with pre-existing conditions.

Comprehensive coverage requirement

Individual and small group plans must include essential health benefits.

Limits on deductibles and copayments

Health plans must limit out-of-pocket costs (deductibles and copayments) to amounts allowed for HSA plans.

Ban on all annual limits

Plans may no longer impose any annual benefit limits.



Cadillac plan excise tax

Tax on employer plans valued at over $10,200 for individuals and $27,500 for families.

Q I've heard of "metal plans" being offered through Health Exchanges. What are these plans?

In order to participate in a state or federal government Health Insurance Exchange, an insurance company will have to offer plans that fit within four levels of coverage, which are being called "metal" plans: **Bronze**, **Silver**, **Gold** and **Platinum**. An insurance company doesn't have to offer plans in all four levels, but does have to offer at least one Silver and one Gold plan.

While each plan must cover the same *scope* of benefits, the *value* of these benefits will vary. For example Bronze plans will offer the least generous coverage, while Platinum plans will have more coverage with lower deductibles, lower copayments, etc. As a result, Platinum plan premiums will be the highest, with Bronze plan premiums the lowest.

Some individuals will also be able to purchase "catastrophic" plans that cover essential benefits but have high deductibles. Only young adults (under 30) and individuals who've been exempted from the individual mandate because there's no available affordable coverage will be able to purchase catastrophic plans.

Plans will be compared using a measure called "actuarial value" that compares what percentage of health costs are covered by the plan. The chart below gives you an idea of how the actuarial values will be applied to different plans levels.

PLAN LEVEL ACTUARIAL VALUES

PLAN LEVEL	INSURANCE COVERS	YOU PAY
Platinum	90%	10%
Gold	80%	20%
Silver	70%	30%
Bronze	60%	40%

ESSENTIAL BENEFIT PLANS EFFECTIVE 2014

Each non-grandfathered plan must provide coverage for a set of minimum **Essential Health Benefits** that will include items and services in the following ten categories:

- Outpatient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive, wellness and chronic disease services
- Pediatric services, including oral and vision care



Q What is the difference between a Public Exchange and a Private Exchange?

Private health exchanges – operated by insurance brokers or insurance companies – give employers another way to shop for a variety of medical plans as well as supplemental insurance products like disability, dental and vision plans. These online portals make it easy to compare plans, shop for the best rates and even enroll.

Private exchanges often include benefit support services such as assistance from brokers to help with administrative tasks like enrollment and renewal.

Private health exchanges also make it easy for businesses to expand employee benefits and offer additional health coverage not included in most major medical plans like dental coverage, vision exams, chiropractic services and even life insurance, in a one-stop shop without a lot of administrative work.

Information and related materials are subject to change without notice.

10 Things Every Business Should Know About Health Reform

1 Consult a Knowledgable Insurance Professional
A licensed health insurance broker, serving as your consultant, can be valuable to you in understanding the facts of health reform.

2 Public and Private Health "Exchanges" Come Online
Open enrollment is scheduled to begin in October of 2013 for Health Insurance Exchanges, with coverage effective January 2014. Private health insurance exchanges are also expanding to offer businesses and employees more choices for coverage at an affordable rate.

3 Health Plans Will Be Classified in "Metal" Categories
Health insurance plans will receive a metal rating – Platinum, Gold, Silver or Bronze – based on "actuarial value" calculations. For example, Platinum plans will provide coverage for 90 percent of costs while policyholders pay 10 percent. Bronze plans would offer 60 percent coverage while policyholders would pay the remaining 40 percent of medical costs out-of-pocket.

4 Tax Credits for Small Employers
Employers with fewer than 25 employees and average annual wages of less than $50,000 may claim a tax credit for the cost of providing insurance beginning with 2011 tax returns. Beginning in 2014 this tax credit is only available to eligible small employers who purchase coverage through the Exchange.

5 W-2 Reporting
Businesses that issued 250 or more W-2s in 2011 must begin to report on 2012 W-2s (issued Jan. 2013) the aggregate value of health benefits provided to each employee including medical, dental and vision coverage.

6 "Essential Health Benefits" Defined
Beginning in 2014, health plans must provide coverage for a minimum set of products and services in the following 10 categories: outpatient 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 chronic disease services and pediatric services including oral and vision care.

7 Requirement to Inform Employees
Beginning in 2013, employers must provide each employee with written information on the employer health plan, health exchanges, available subsidies for insurance and guidelines on how to purchase insurance. Further guidance is scheduled for release in late summer, early Fall of 2013, postponed from the original March 2013 deadline.

8 Automatic Enrollment
Employers with more than 200 employees must automatically enroll employees in employer-sponsored plans; however, the IRS has said that rules for this requirement will not be issued until 2014.

9 Limits on Flexible Spending Accounts (FSAs)
Beginning January 1, 2013, FSAs, which allow employees to save tax-free dollars that can be used to pay medical expenses not covered by insurance plans, will have a plan year limit of $2,500 in 2013 (indexed for cost of living adjustments after 2013).

10 Employer Play or Pay
Beginning in 2014, employers with 50 or more full-time equivalent employees will pay a penalty fee if they do not offer health coverage or if they offer coverage which is not affordable or doesn't have minimum value (60%) and at least one full-time employee receives a premium subsidy.

The information contained in this guide is not intended as specific legal, medical, financial or other advice. Every attempt has been made to ensure the accuracy of the information contained herein, according to general information currently available to the public regarding health reform legislation. This information is subject to change based on changes in the law or administration of the law.

The Word & Brown Companies suggest employers consult a licensed insurance broker and tax professional to understand the requirements under the law specific to their business' individual circumstances and conditions.

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