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HEALTH CARE REFORM

HELPING YOU NAVIGATE CHANGES FOR YOUR BUSINESS

This document is designed to provide a general overview of portions of the Affordable Care Act and should not be relied upon as legal or tax advice. Federal and state laws and regulations are subject to change. Seek professional advice regarding how the new requirements will affect your particular circumstances from an independent tax advisor or legal counsel. Information may have changed since publication.

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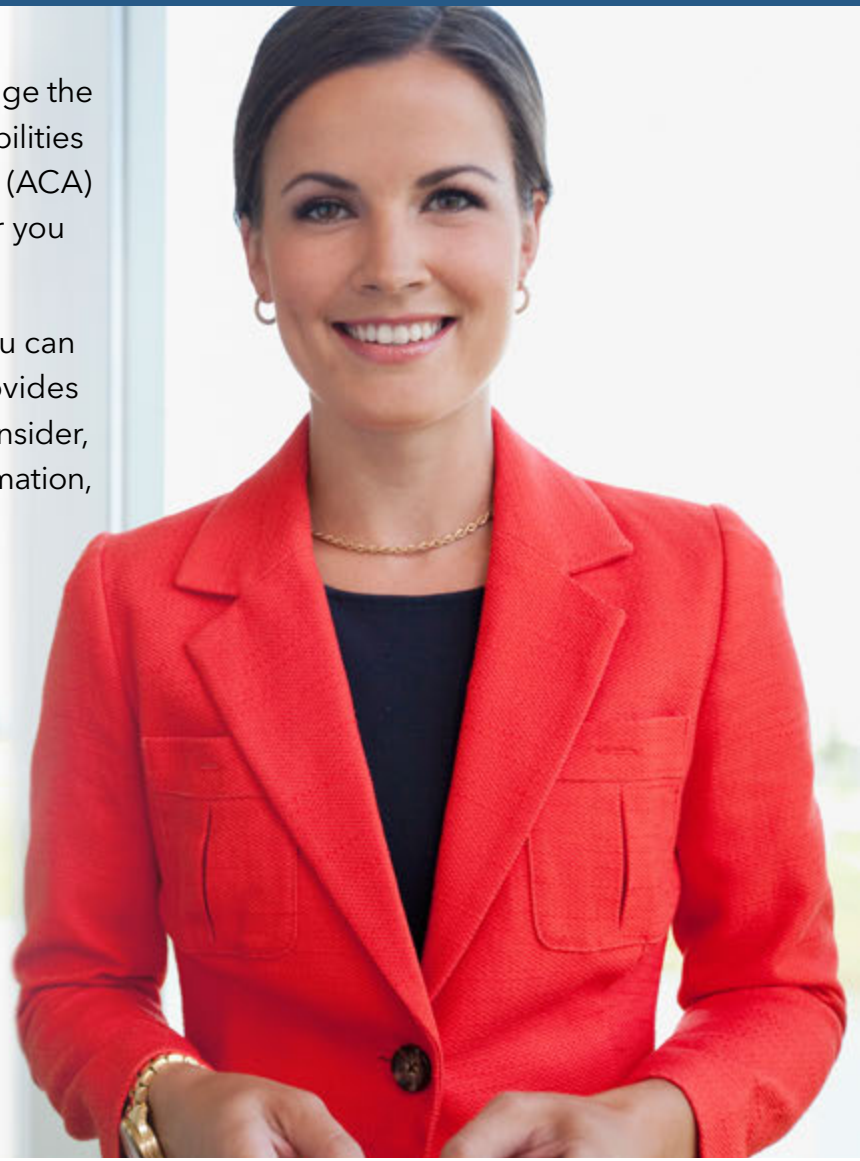
INTRODUCTION

There's no question — health care reform has changed and will continue to change the way most Americans receive health care. From exchanges to employer responsibilities to new taxes and fees, navigating the many aspects of the Affordable Care Act (ACA) can be challenging.* But this new market also offers an exciting opportunity for you to reshape your health care strategy and maintain a successful business.

As your health care partner, we're here to help you through those changes so you can make the right decisions for your employees and your business. This guide provides you with a high-level overview of the main provisions, things you may need to consider, and steps you need to take as a result. For more detailed and state-specific information, visit the health care reform area of **businessnet.kp.org**.



LEGEND

Look for these symbols to see which provisions are most relevant to your business.

SMALL BUSINESS (1 to 50 employees; increases to up to 100 employees in 2016)

LARGE BUSINESS (51 or more employees, includes labor & trust funds)

HEALTH CARE INDUSTRY (implemented by insurers and providers)

*The U.S. Department of Health and Human Services recently began referring to exchanges as health insurance marketplaces. Throughout this document, we refer to the more widely known term of exchange.

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WHAT YOU'RE ASKING US ABOUT HEALTH CARE REFORM

The ACA affects every business differently. Some of its regulations are still being defined and many of the effective dates keep changing. Here are answers to some of the top questions we're hearing from you.

Do I have to offer coverage and how will my plans change?

- Does the ACA require employers to offer coverage?
- Can I send my employees to the exchanges instead of offering coverage?
- How does the ACA define essential health benefits?
- Do I have to offer dependent child coverage?
- What are "grandfathered" health plans?
- What are some of the things I need to know if I offer one or more grandfathered plans?

What employer requirements do I need to be concerned with?

- Does my company need to report the cost of health benefits on employee W-2 forms?
- What are some of the things I need to know about providing my employees with a Summary of Benefits and Coverage?

What are some of the costs associated with health care reform?

- What additional fees might my business face as a result of the ACA?
- How will I know if I'll be subject to a penalty?
- Am I eligible for a tax credit on my premiums?
- What's the excise or "Cadillac" tax?
- Does the new W-2 reporting requirement mean that health care is now taxable?
- Does ACA affect the way rates are calculated?

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PROVISION TIMELINE

HOW AND WHEN WILL HEALTH CARE REFORM IMPACT YOUR BUSINESS?

	Universal changes to health care coverage	Opportunities and requirements that affect your health care strategy	
		SMALL BUSINESS	LARGE BUSINESS
2010	✔ Choice of primary care provider and access to ob-gyns ✔ Emergency services ✔ Lifetime and annual dollar limits ✔ Pre-existing conditions for under age 19 ✔ Preventive services ✔ No rescissions	✔ Dependent coverage to age 26 ✔ Early Retiree Reinsurance Program ✔ Nondiscrimination ✔ Tax credit up to 35% (24 or fewer full-time or full-time-equivalent employees)	✔ Dependent coverage to age 26 ✔ Early Retiree Reinsurance Program ✔ Nondiscrimination
2011	✔ Medical benefit ratio	✔ Over-the-counter drug reimbursements	✔ Over-the-counter drug reimbursements
2012	✔ Summary of Benefits and Coverage ✔ Women's preventive services	✔ PCORI fee ✔ Summary of Benefits and Coverage	✔ PCORI fee ✔ Summary of Benefits and Coverage
2013		○ FSA contribution limits ○ Notices to employees about exchanges (on hold until the Department of Labor issues regulations)	○ W-2 reporting of benefits ○ FSA contribution limits ○ Notices to employees about exchanges (on hold until the Department of Labor issues regulations)
2014	○ Exchanges go into effect (open enrollment starts October 2013) ○ Essential health benefits ○ Guaranteed availability for adults ○ Community rating by class for small groups and individuals	○ Exchanges go into effect (open enrollment starts October 2013) ○ Tax credit up to 50% (24 or fewer full-time or full-time-equivalent employees) ○ Community rating by class for small groups and individuals ○ Wellness program rewards ○ Health insurer fee ○ Reinsurance program contribution	○ Employer shared responsibility ○ Wellness program rewards ○ Health insurer fee ○ Reinsurance program contribution
2016			○ SHOP expands to businesses with up to 100 employees (if states haven't already done so)
2017			○ States may expand SHOP to businesses with 100+ employees
2018		○ Tax on high-cost ("Cadillac") insurance plans	○ Tax on high-cost ("Cadillac") insurance plans

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SMALL BUSINESS CHECKLIST

What you need to know

You understand that offering your employees access to quality health care can give you a competitive edge — enabling you to hire more talented staff while keeping your current employees healthier and more productive at work and at home. But the high costs of health care can be a real challenge for small business owners.

The ACA:

- offers new opportunities through the Small Business Health Options Program (SHOP), including small business tax credits to employers with 24 or fewer full-time-equivalent employees
- enables smaller employers to be part of a single risk pool with other participating small businesses
- ensures your employees in nongrandfathered commercial plans (with some exceptions, such as retiree and dental-only plans) have access to preventive services with no cost sharing — encouraging them to get care before they need costly and invasive treatment
- makes coverage for adult dependents available until they turn 26 — when dependent coverage is offered in commercial plans (with some exceptions, such as retiree and dental-only plans)
- allows for no pre-existing condition exclusions for children — or, starting in 2014, for adults

What to consider

As a small business with 1 to 50 full-time-equivalent employees, your first step is to decide how best to invest in the health of your employees. Under the ACA, you have several options to consider:

- ✔ continue purchasing group coverage directly from an insurer
- ✔ make coverage available to your employees through the SHOP
- ✔ offer neither group coverage nor access to the SHOP — sending your employees to the exchange in your state

What to do

The actions you need to take depend on your business size and how you plan to prioritize health care as a business strategy in the coming years.

- ✔ Understand the pros and cons of each coverage option.
- ✔ Get familiar with the SHOP, including available plan tiers and cost sharing.
- ✔ Decide what you plan to do well in advance of your first renewal on or after January 1, 2014:
  - If you have a nongrandfathered plan, you'll be offered the metal tier plan closest to your current plan. Decide whether you'd like that plan, or select a different metal tier plan.
  - If you have a grandfathered plan and have the option to keep that plan (it's likely that not all insurers will allow grandfathered plans, and if they do, they may not allow them in all states), decide whether you'll keep your grandfathered plan or choose a metal tier plan.

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SMALL BUSINESS CHECKLIST

  - If you have a grandfathered plan and can't keep that plan, you may be moved into the metal tier plan that most closely resembles your grandfathered plan. Decide whether you'll keep that metal tier plan or choose a different metal tier plan.

- ✔ If you have 24 or fewer full-time-equivalent employees, evaluate whether you're eligible for the tax credit. You can carry any eligible health care tax credit back one year.
- ✔ If you're a larger small business with part-time workers — or a subsidiary of a larger organization — you'll need to determine whether you're subject to ACA's employer shared responsibility regulations. Use the calculator on the right to see if this provision applies to your business.
- ✔ Make sure you're limiting annual employee paycheck contributions to flexible spending accounts (FSAs) to $2,500.
- ✔ Depending on when future Department of Labor regulations become effective — no earlier than summer 2013 — provide written notice about health insurance exchanges for current employees, and going forward for new employees.
- ✔ Review your current wellness program to make sure you're maximizing employee rewards. In 2014, the maximum reward for health-contingent wellness programs will increase to 30% of the cost of coverage (the Department of Health and Human Services is proposing up to 50% for programs that prevent or reduce tobacco use).
- ✔ Get ready for a possible requirement to report the cost of employees' health benefit coverage on 2013 W-2 forms distributed in January 2014 (employers who filed fewer than 250 W-2 forms for the preceding calendar year are exempt from this requirement until the IRS issues further guidance).

Get more support and recommendations

- Small business section on HealthCare.gov
- U.S. Small Business Administration's health care site
- Kaiser Family Foundation fact sheet on health care reform and small business*
- Kaiser Family Foundation — Health Care Reform Resources for Employers

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EMPLOYER SHARED RESPONSIBILITY CALCULATOR

To determine if you meet the threshold of 50 full-time-equivalent workers for any calendar year, you'll average your number of employees across the months in the year:

1. Write down the number of full-time employees who average at least 30 work hours a week or 130 work hours in a calendar month.
2. Calculate the number of full-time equivalents by adding total monthly hours of your part-time employees divided by 120.
3. Add these two numbers together to get your total number of full-time-equivalent employees for the month.

0 full-time employees + (0 total monthly hours for part-time employees ÷ 120)

full-time-equivalent employees for the month = 0

4. Repeat this calculation for every calendar month in the 12-month period.
5. Add all your calendar month totals together. Divide this number by 12 to determine your average monthly full-time-equivalent employee count.

(JAN 0 + FEB 0 + MAR 0 + APR 0 + MAY 0 + JUN 0 + JUL 0 + AUG 0 + SEP 0 + OCT 0 + NOV 0 + DEC 0) ÷ 12

average monthly full-time-equivalent employee count = 0

* The Kaiser Family Foundation is a nonprofit, private organization not affiliated with Kaiser Permanente.

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LARGE BUSINESS CHECKLIST

What you need to know

As you work to understand how health care reform will help you build a stronger future for your employees, we're here to help you navigate the coming changes. While the ACA doesn't officially define a large business, for employer shared responsibility, a business is considered large if you have 50 or more full-time-equivalent employees.

What to consider

Understand your responsibility as defined by the ACA.

- ✔ If you **don't** offer coverage, you may be subject to tax penalties if both of the following happen:
  - – you fail to offer minimum essential coverage to at least 95% of your full-time employees and, beginning in 2015, their child dependents (if you have fewer than 100 employees, the requirement is reduced — you must cover all but 5% of your employees or all but 5 employees, whichever is less), **and**
  - – any of your full-time employees are certified as eligible to receive a subsidy for a plan on the exchange
- ✔ If you offer coverage to your full-time employees, it must meet the following requirements to qualify as minimum essential coverage:
  - – cover at least 60% of expected costs for an average person or family
  - – limit an employee's share of the premium contribution to 9.5% of the employee's income*
  - – offer coverage to at least 95% of full-time employees and, beginning in 2015, their child dependents (if you have fewer than 100 employees, the requirement is reduced — you must cover all but 5% of your employees or all but 5 employees, whichever is less)
- ✔ None of your full-time employees will qualify for a premium subsidy in the individual exchange if your plans meet the requirements listed above.

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* The IRS has indicated that the percentage of household income calculation will be based on whether self-only coverage exceeds 9.5 percent of an employee's W-2 wages from the employer.

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LARGE BUSINESS CHECKLIST

What to do

- ✔ Make sure you're limiting annual employee paycheck contributions to flexible spending accounts (FSAs) to $2,500.
- ✔ If your company is subject to the Fair Labor Standards Act, has more than 200 full-time employees, and offers employees at least one health plan, prepare at some point in the future to automatically enroll new full-time hires in a coverage option, following any authorized waiting period (no longer than 90 days under the ACA). You'll also have to automatically continue existing selections for current full-time employees from year to year. Employers aren't required to comply with this provision until regulations are issued — estimated by January 2014 — and take effect.
- ✔ If your company is subject to the Fair Labor Standards Act, prepare at some point in the future to provide written notice about health insurance exchanges and other information to current and new employees.
- ✔ If you filed at least 250 W-2 forms for 2011, report the cost of employees' health benefit coverage on W-2 forms distributed in January 2013 and future years. If you filed fewer than 250 W-2 forms for 2012, get ready for a possible requirement to report the cost of employees' health benefit coverage on 2013 W-2 forms distributed in January 2014 (employers who filed fewer than 250 W-2 forms for the preceding calendar year are exempt from this requirement until the IRS issues further guidance).
- ✔ Review your current wellness program to make sure you're maximizing employee rewards. In 2014, the maximum reward for health-contingent wellness programs will increase to 30% of the cost of coverage (the Department of Health and Human Services is proposing up to 50% for programs that prevent or reduce tobacco use).

Get more support and recommendations

- Large business section on HealthCare.gov
- Kaiser Family Foundation — Health Care Reform Resources for Employers*
- U.S. Department of Labor — Affordable Care Act

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* The Kaiser Family Foundation is a nonprofit, private organization not affiliated with Kaiser Permanente.

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PROVISION DIRECTORY

Below is a list of some of the key health care reform provisions for group customers. Select one to view the associated fact sheet. You can return to this page from any fact sheet by clicking on "Provisions" in the navigation toolbar.

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ACCESS TO PRIMARY CARE PROVIDERS AND OB-GYNS

Provision timeline: 2010

Groups affected:

At a glance

Plans that provide for a member to choose a participating primary care provider (PCP) must allow members to choose any participating PCP, including a pediatrician for children, who's available to accept the member.

Plans that require a member to choose a PCP and that cover obstetrical or gynecological care may not require authorization or referral when a female member seeks obstetrical or gynecological care from a participating health care professional who specializes in obstetrics or gynecology.

These mandates became effective starting with plan years beginning September 23, 2010, and apply to nongrandfathered commercial plans (with some exceptions, such as retiree and dental-only plans) that have a provider network.

Insurers and group health plans that are subject to these mandates must also provide a notice about these mandates to subscribers whenever they provide them with a summary plan description, *Evidence of Coverage,* or similar description of benefits.

What you need to know

LARGE AND SMALL BUSINESSES

- You don't have to take any action. Our coverage already complies with these mandates.

Learn more

- HealthCare.gov

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DEPENDENT CHILD COVERAGE

Provision timeline: 2010 2015

Groups affected:

At a glance

Young adults can remain on their parents' group health plan until they turn 26. This mandate became effective starting with plan years that began on or after September 23, 2010, and applies to grandfathered and nongrandfathered commercial coverage — with some exceptions, such as retiree and dental-only plans — if that coverage covers child dependents. In 2015, large groups (with 50 or more full-time-equivalent employees) will need to offer coverage to full-time employees and the child dependents of any full-time employee who receives coverage or potentially pay a penalty.

Further rules regarding dependent child coverage:

- **Exception to mandate —** Grandfathered group health plans with plan years beginning before January 1, 2014, aren't required to cover adult children who are eligible for other employer coverage (not including another plan that one of the child's parents is enrolled in).
- **No premium or coverage variation —** For sons, daughters, stepchildren, foster children, adopted children, and children placed for adoption, premiums and other terms of coverage can't vary based on the child's age (except for children who are 26 and older), except for age-based distinctions that apply to all types of enrollees, including subscribers and spouses. For example, plans can choose to require copayments for a certain service for plan members 19 and older but choose to have no copayment for plan members under 19.
- **Taxability exemption —** For the entire taxable year during which a child turns 26, employers may exclude the value of employer-provided dependent health coverage for that child (legal child, foster child, or stepchild) from an employee's federal taxable income. State income tax rules may be different.

What you need to know

LARGE BUSINESSES

- You may need to include the value of dependent medical coverage for adult children on your employees' W-2 forms if you file more than 250 W-2 forms per year.

LARGE AND SMALL BUSINESSES

- You should notify your employees that HSA disbursements for an employee's children's medical expenses are exempt from federal income tax only if the child meets a narrower IRS definition of a dependent. Otherwise, the disbursements may be considered nonqualified expenses, subject to tax and penalties.

Learn more

- HealthCare.gov
- U.S. Department of Labor

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EARLY RETIREE REINSURANCE PROGRAM

Provision timeline: 2010

Groups affected:

At a glance

The Early Retiree Reinsurance Program (ERRP) helps groups offer coverage for certain early retirees and their spouses, surviving spouses, and dependents. Administered by the Department of Health and Human Services (HHS), the program provides a total of $5 billion to reimburse participating employment-based plans for a portion of health benefits costs. It went into effect on June 1, 2010.

What you need to know

LARGE AND SMALL BUSINESSES

- The Center for Medicare & Medicaid Services (CMS) stopped accepting applications on May 5, 2011.

Learn more

- ERRP website
- HealthCare.gov
- Where you stand in the queue for additional reimbursements

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EMERGENCY SERVICES

Provision timeline: 2010

Groups affected:

At a glance

Effective for plan years beginning on or after September 23, 2010, emergency services for nongrandfathered commercial plans (with some exceptions, such as retiree and dental-only plans) are covered:

- with no preauthorization
- whether or not the provider is a participating provider
- at the same copayment or coinsurance rate whether services are provided by participating or nonparticipating providers
- with no difference in coverage limitations between participating and nonparticipating providers
- regardless of any coverage requirements except exclusions, coordination of benefits, cost sharing, or an affiliation (waiting) period

What you need to know

LARGE AND SMALL BUSINESSES

- If your employees receive covered out-of-network emergency care, they may still be responsible for the difference between the amount billed by the provider and the amount covered by their plan.

Learn more

- HealthCare.gov

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GRANDFATHERED STATUS

Provision timeline: 2010

Groups affected:

At a glance

If you have a commercial plan that has had at least one enrollee at all times since March 23, 2010, and that meets all grandfathering requirements, that plan is grandfathered and is exempt from some ACA requirements. Grandfathered plans are subject to some ACA mandates, such as those on:

- lifetime and annual dollar limits
- rescissions
- coverage of dependent children until they turn 26

What you need to know

LARGE AND SMALL BUSINESSES

If you offer one or more grandfathered plans:

- Include the required statement of grandfathered status in any plan materials provided to a participant or beneficiary that describe the benefits provided under the plan, stating that you believe the plan is a grandfathered health plan as defined by the ACA and providing contact information for questions and complaints.
- Retain, and make available upon request, records documenting the plan terms that were in effect on March 23, 2010, and any other documents that confirm your plan's grandfathered status. Keep these records as long as you claim a plan to be grandfathered.
- You can add or remove employees and family members to your grandfathered plan without affecting your plan's status.
- You have the flexibility to change your insurer without losing your grandfathered status.
- Make sure you're familiar with all the requirements you need to follow to maintain grandfathered status, and what changes could jeopardize that status.
- Plans that are currently grandfathered because they are maintained as part of a collective bargaining agreement ratified before March 23, 2010, are generally able to maintain their grandfathered status through the end of the current bargaining agreement.

Learn more

- HealthCare.gov
- Keeping your grandfathered status

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LIFETIME AND ANNUAL DOLLAR LIMITS

Provision timeline: 2010 2014

Groups affected:

At a glance

For grandfathered and nongrandfathered commercial plans (with some exceptions, such as retiree and dental-only plans), the ACA banned lifetime dollar limits on essential health benefits starting with plan years beginning on or after September 23, 2010. Plans can still apply lifetime dollar limits on any benefits that aren't defined as essential health benefits.

Annual dollar limits for essential health benefits will also be prohibited for plan years beginning on or after January 1, 2014. For plan years beginning on or after September 23, 2012, but before January 1, 2014, plans can't set an annual limit that's lower than $2 million. Plans may apply annual dollar limits on any benefits that aren't defined as essential health benefits.

Lifetime and annual day, visit, and frequency limits are still allowed.

What you need to know

LARGE AND SMALL BUSINESSES

- Nongrandfathered small group plans will be moved to metal tier plans starting January 1, 2014. These plans won't have lifetime or annual dollar limits on essential health benefits.
- We're analyzing the federal guidance about how to define essential health benefits for the purpose of applying the annual and lifetime dollar limit mandate to large group plans.

Learn more

- HealthCare.gov

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NONDISCRIMINATION IN ELIGIBILITY AND BENEFITS

Provision timeline: 2010 2014

Groups affected:

At a glance

The nondiscrimination in eligibility and benefits provision seeks to ensure that benefits offered don't discriminate among employees. Group plans aren't allowed to have:

- different waiting periods for different classes of employees
- different contribution amounts for different classes of employees
- carve-out and benefit options that are available to management but not other employees

However, employers can continue to charge lower-earning employees lower premiums. As an example, an employee who earns $30,000 can be charged a $30 premium while a similarly situated employee earning $50,000 can be charged a $50 premium without the plan being considered discriminatory.

What you need to know

LARGE AND SMALL BUSINESSES

- You're responsible for making sure your group complies with nondiscrimination rules. However, there's currently no established date by which plans must comply with this regulation. The provision was scheduled to be effective the first plan year after September 23, 2010, but has since been delayed pending the release of regulations or other administrative guidance. Grandfathered plans wouldn't have to comply until at least 2014.

Learn more

- Internal Revenue Service notice

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PRE-EXISTING CONDITIONS TO AGE 19

Provision timeline: 2010 2014

Groups affected:

At a glance

Effective for plan years beginning on or after September 23, 2010, health plans can't limit or deny coverage to children under 19 based on pre-existing conditions. A pre-existing condition is a physical or mental condition, disability, or illness diagnosed prior to enrollment. Starting in 2014, the same protection will be provided to adults.

What you need to know

LARGE AND SMALL BUSINESSES

- This provision applies to all nongrandfathered plans.

Learn more

- HealthCare.gov
- Kaiser Family Foundation*

* The Kaiser Family Foundation is a nonprofit, private organization not affiliated with Kaiser Permanente.

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PREVENTIVE CARE

Provision timeline: 2010 2012

Groups affected:

At a glance

Commercial nongrandfathered plans (with some exceptions, such as retiree and dental-only plans) must cover certain preventive services with no cost sharing for plan years beginning on or after September 23, 2010.

The requirement to cover certain women's preventive services, including contraceptive services, became effective for plan years beginning on or after August 1, 2012. Not all plans are subject to the requirement to cover contraceptive services:

- **Group health plans sponsored by certain religious employers —** These plans are exempt from the requirement to cover contraceptive services.
- **Nonprofit organizations with religious objections to covering contraceptive services —**
  - For plan years beginning before August 1, 2013, the federal agencies will not enforce the requirement to cover contraceptive services for certain organizations.
  - HHS has proposed that certain organizations wouldn't be required to contract or pay for those services. To ensure that women covered by those employers' plans have access to recommended contraceptive services, HHS has proposed that the health insurer would cover these services separately at no cost to either the employer or to covered individuals. This proposal will not become effective until the federal agencies issue final regulations.

Some states may require that regulated health plans cover certain contraceptive services.

What you need to know

SMALL BUSINESSES

- We've added women's preventive services to your grandfathered and nongrandfathered coverage at your first renewal on or after August 1, 2012.
- Adding these services doesn't affect a plan's grandfathered status.

LARGE BUSINESSES

All new large groups will automatically have our Health Care Reform Preventive Services Package included in their group's plan. Existing groups with nongrandfathered plans will have women's preventive services added to those plans at their first renewal on or after August 1, 2012. Existing groups with grandfathered plans:

- can choose whether to purchase the Health Care Reform Preventive Services Package; adding this package doesn't affect a plan's grandfathered status
- that currently cover health care reform preventive services with no cost sharing had the women's preventive services added to their coverage at their first renewal on or after August 1, 2012; adding coverage for these women's preventive services doesn't cause these plans to lose their grandfathered status

Learn more

- HealthCare.gov
- U.S. Department of Health & Human Services

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PROVISION FACT SHEET

RESCISSIONS

Provision timeline: 2010

Groups affected:

At a glance

Group health plans and insurers can't cancel a member's coverage, except in case of fraud or intentional misrepresentation, such as if a person leaves a material fact off the application. In cases of termination that results from fraud or misrepresentation, we're required to provide the member with 30-day advance notice and the right to appeal the rescission decision.

In general, when an employer notifies Kaiser Permanente of a member's retroactive termination within the employer's contractual limits, it's not considered rescission. These transactions are usually administrative and reflect routine changes in enrollment. Terminations outside contractual limits are less routine and require additional review to ensure compliance.

What you need to know

LARGE AND SMALL BUSINESSES

- Make sure your employees understand how important it is to be accurate and honest when filling out their applications.

Learn more

- HealthCare.gov

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SMALL BUSINESS HEALTH CARE TAX CREDIT

Provision timeline: 2010 2014

Groups affected:

At a glance

Under the ACA, businesses with 24 or fewer full-time-equivalent employees may qualify for a small business tax credit of up to 35 percent (25 percent for tax-exempt groups) to help them afford the cost of health care premiums. In 2014, the tax credit goes up to 50 percent (35 percent for tax-exempt groups) and is available to qualified small businesses that participate in the Small Business Health Options Program (SHOP). Small employers can claim the credit through 2013 and for two additional years beginning in 2014.

The maximum credit will be available to employers with 10 or fewer full-time-equivalent employees and average annual wages below $25,000. Businesses that receive state health care tax credits may also qualify for the federal tax credit. Dental and vision care also qualify for the credit.

What you need to know

SMALL BUSINESSES

The ACA doesn't require small businesses to offer health insurance. Businesses may qualify for the small business tax credit if they:

- have 24 or fewer full-time-equivalent employees for the taxable year (for example, two half-time employees equal one full-time employee for purposes of the credit)
- pay average annual wages below $50,000
- contribute 50% or more toward employee health insurance premiums

LARGE BUSINESSES

Large businesses aren't eligible for this tax credit.

Learn more

- HealthCare.gov
- Internal Revenue Service
- Calculator for California small businesses

CALCULATING YOUR TAX CREDIT

To determine how many full-time-equivalent workers you have:

1. Take the number of full-time employees who work at least 40 hours a week.

0 full-time employees

2. Calculate the number of full-time-equivalent employees by dividing the total annual hours of your part-time employees by 2,080.

0 total annual hours for part-time employees

2,080

3. Add these two numbers together to get your total number of full-time-equivalent employees.

0

You can also calculate your eligibility using the IRS Small Business Health Care Credit Estimator.

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MEDICAL BENEFIT RATIO (MEDICAL LOSS RATIO)

Provision timeline: 2011

Groups affected:

At a glance

As part of the ACA, insurers are required to report their medical benefit ratio (MBR) — the amount of premium revenue spent on medical care and services — to the HHS. For large groups, the minimum amount insurers must spend on care is 85 percent of premium revenue. For small groups, it's 80 percent of premium revenue. Insurers who don't meet or exceed these minimum levels are required to issue rebates to customers.

Please keep in mind that although the federal government refers to this requirement as a medical loss ratio, Kaiser Permanente and other insurers use the term medical benefit ratio.

What you need to know

LARGE AND SMALL BUSINESSES

- You don't need to take any action. At Kaiser Permanente, our focus is on reinvesting premiums to care for our members — not generating shareholder returns. Our June 1, 2012, final MBR filing for 2011 was above the ACA-established thresholds in all commercial group areas.

Learn more

- HealthCare.gov
- Commonwealth Fund

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OVER-THE-COUNTER REIMBURSEMENTS AND FSA/HRA/HSA CHANGES

Provision timeline: 2011 2013

Groups affected:

At a glance

As of January 1, 2011, over-the-counter (OTC) drugs or medicines — except prescribed OTC drugs and insulin — no longer qualify as eligible medical expenses for health reimbursement arrangements (HRAs), health savings accounts (HSAs), flexible savings accounts (FSAs), and Archer medical savings accounts (MSAs). Although Kaiser Permanente doesn't currently offer MSAs, our members may have accounts through their employers.

Also, employee contributions to health FSAs are limited to $2,500 annually for plan years beginning on or after January 1, 2013. In subsequent years, this limit will be indexed to the consumer price index and increase accordingly to account for changes in the cost of living.

What you need to know

LARGE AND SMALL BUSINESSES

- If you offer FSAs, make sure your employees get information from you or your vendor about the stricter reimbursement rules. All members with spending accounts should keep any relevant prescription or other documentation in case the card vendor or IRS requests substantiation.
- Members using HSA and Archer MSA debit cards should be extra careful as OTC purchases may go through at the point of sale even if the purchases don't qualify for reimbursement. Members will be responsible for substantiating their expenses with physician prescriptions, receipts, bills, and any other documentation needed for tax purposes. As of January 1, 2011, nonqualified purchases using HSA or MSA funds are now subject to a 20 percent tax penalty.
- If you offer an FSA, make sure you've established a $2,500 limit on your employees' annual pretax salary contributions.

Learn more

- Internal Revenue Service
- HealthCare.gov
- Society for Human Resource Management

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NEW FEES

Provision timeline: 2012 2014 2018

Groups affected:

At a glance

New fees on insurers included in the ACA may translate into rate changes. The new fees include:

- **Health insurer fee —** Starting in 2014, this annual fee on insurers will be collected as a percent of premium on all fully insured plans. The size of this fee will vary depending on the insurer's net written premiums.
- **Patient-Centered Outcomes Research Institute (PCORI) fee —** The ACA established a research institute to commission studies on drugs, medical devices, tests, surgeries, and care delivery — with a broad goal of improving the overall quality and efficiency of our nation's health care system. To help fund this research, health insurers and sponsors of self-funded group health plans will be assessed an annual fee between 2012 and 2019.
- **Transitional Reinsurance Program Contribution —** The ACA created this program to help stabilize the individual market during the first years of the exchanges. It provides additional payments to insurers that enroll the highest-cost individuals, both on and off the exchanges. To fund these payments, a fee will be collected from group health plans — including all insurers, self-funded plans, and third-party administrators — from 2014 through 2016.
- **Excise ("Cadillac") tax —** Starting in 2018, there will be a 40% excise tax on the "excess benefit" of any employer-sponsored group health plan with costs that exceed a predetermined level.

What you need to know

LARGE AND SMALL BUSINESSES

- **PCORI fee**
  - This fee has been included in all rate proposals with October 1, 2012, and later effective dates.
  - The fee is set to expire in 2019.
- **Health insurer fee and transitional reinsurance program contribution**
  - These new fees will be included in your rate proposals starting in late 2013 or January 2014 depending on your Kaiser Permanente region.
  - The reinsurance contribution is set to expire by January 2017.
- **Excise tax on high-cost health plans**
  - Although the excise tax on high-cost health plans doesn't take effect until 2018, many employers are starting to analyze their benefit programs to find ways to minimize the impact of this new tax.
  - Customers with collectively bargained plans have a special interest in starting the process to work through any necessary negotiations before the tax takes effect.

Learn more

- Internal Revenue Service

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PROVISION FACT SHEET

SUMMARY OF BENEFITS AND COVERAGE

Provision timeline: 2012

Groups affected:

At a glance

Generally effective with plan years that started on or after September 23, 2012, insurers and employer groups must provide a Summary of Benefits and Coverage (SBC) to potential applicants, new enrollees, and current policyholders for grandfathered and nongrandfathered commercial plans (with some exceptions, such as retiree and dental-only plans). The SBC summarizes a plan's benefits and cost sharing in a standardized, easy-to-read format. This allows people who are looking for coverage to compare plans easily.

What you need to know

SMALL BUSINESSES

- Make sure you have current SBCs for all the plans you offer.

LARGE BUSINESSES

We'll be providing you with SBCs:

- when we receive an application for a new group, and by the first day of coverage if there is any change in the SBC
- upon your group's renewal
- upon request

Learn more

- HealthCare.gov
- U.S. Department of Labor sample SBC

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W-2 REPORTING OF BENEFITS

Provision timeline: 2012

Groups affected:

At a glance

The ACA requires employers — fully insured and self-funded groups with grandfathered and nongrandfathered plans — to report the cost (including any employee contribution) of employer-sponsored health benefits on their employees' W-2 forms. Some types of coverage aren't subject to this requirement, including dental-only coverage, amounts contributed to an HSA, HRA, or Archer MSA, and the amount of any salary reduction election to a health FSA.

The amount reported is informational only — it doesn't change the status of health care coverage that's otherwise tax-exempt. For employers who were required to file at least 250 W-2 forms for the 2011 tax year, this reporting provision takes effect with W-2 forms for the 2012 tax year.

What you need to know

SMALL BUSINESSES

- Employers who filed fewer than 250 W-2 forms for the previous calendar year (tax year 2011) have been granted transitional relief and don't have to report the costs of coverage on their 2012 W-2 forms. This relief will stay in place until the IRS issues new guidance.

LARGE BUSINESSES

- This is a requirement for employers who filed at least 250 W-2 forms for the previous calendar year (tax year 2011).
- Employers who filed fewer than 250 W-2 forms for the previous calendar year (tax year 2011) have been granted transitional relief and don't have to report the costs of coverage on their 2012 W-2 forms. This relief will stay in place until the IRS issues new guidance.
- Exemptions apply, but in general, most large employers must comply with this provision with the 2012 tax year (W-2s provided in January 2013).

Learn more

- Internal Revenue Service
- Society for Human Resource Management

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PROVISION FACT SHEET

EMPLOYER SHARED RESPONSIBILITY

Provision timeline: 2014

Groups affected:

At a glance

Beginning January 1, 2014, employers with 50 or more full-time-equivalent employees who don't offer minimum essential coverage to full-time employees and their child dependents will face potential tax penalties. This provision is known as employer shared responsibility.

Full-time employees are those who work a monthly average of at least 30 hours a week or 130 hours a month. Part-time employees also count toward the 50-employee threshold, so you'll need to calculate the number of full-time equivalents (FTEs) that they represent (see sidebar). However, your part-time employees aren't included in calculations of tax penalties. And part-time employees or child dependents receiving premium subsidies through health insurance exchanges don't trigger any tax penalties for you.

What you need to know

SMALL BUSINESSES

- Small businesses with fewer than 50 full-time-equivalent employees aren't subject to employer shared responsibility obligations.
- If you're a larger small business with part-time workers — or a subsidiary of a larger organization — you may be subject to employer shared responsibility obligations.

LARGE BUSINESSES

Under employer shared responsibility, large group employers can avoid potential penalties by offering minimum essential coverage to full-time employees and their child dependents under 26 that:

- covers at least 60% of expected costs for an average person or family

continue ›

CALCULATING FULL-TIME EQUIVALENTS

To determine if you meet the full-time-equivalent threshold for the employer shared responsibility provision for any calendar year, you'll average your number of employees across the months in the year:

1. Write down the number of full-time employees who average at least 30 work hours a week or 130 work hours in a calendar month.
2. Calculate the number of full-time equivalents by adding total monthly hours of your part-time employees divided by 120.
3. Add these two numbers together to get your total number of full-time-equivalent employees for the month.

0 full-time employees + 0 total monthly hours for part-time employees / 120

full-time-equivalent employees for the month = 0

4. Repeat this calculation for every calendar month in the 12-month period.
5. Add all your calendar month totals together. Divide this number by 12 to determine your average monthly full-time-equivalent employee count.

JAN 0 + FEB 0 + MAR 0 + APR 0 + MAY 0 + JUN 0 + JUL 0 + AUG 0 + SEP 0 + OCT 0 + NOV 0 + DEC 0 / 12

average monthly full- time-equivalent employee count = 0

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EMPLOYER SHARED RESPONSIBILITY

Provision timeline: 2014

Groups affected:

- limits an employee's share of the premium contribution to 9.5% of the employee's income*
- is available to at least 95% of full-time employees and their child dependents up to age 26 (if you have fewer than 100 employees, the requirement is reduced – you must cover all but 5% of your employees or all but 5 employees, whichever is less)

If employers don't offer coverage that complies with the three bullets listed earlier, **and** any full-time employees are certified as eligible to receive a subsidy through the exchange, the employer penalty will be $2,000 multiplied by the number of full-time employees employed for the year minus the first 30 employees.

If employers offer coverage that doesn't meet the minimum value or affordability guidelines and employees are then certified as eligible to receive a subsidy through the individual health insurance exchange, the employer penalty will be $3,000 per full-time employee certified as eligible to receive a premium tax credit or cost-sharing subsidy — up to a maximum of $2,000 per year for each full-time employee, minus the first 30 employees. This penalty will be calculated calendar month to calendar month.

There are some safe harbors in place to make this transition easier for you. For example, if you don't currently offer dependent child coverage but begin to take steps toward that goal in 2014, then you can avoid potential penalties until 2015. To determine what your responsibilities are, contact your own legal counsel and tax and financial experts.

Learn more

- IRS Questions and Answers on Employer Shared Responsibility Provisions Under the Affordable Care Act
- Kaiser Family Foundation flow chart†
- HealthCare.gov
- U.S. Department of Labor

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* The Internal Revenue Service has indicated that the percentage of household income calculation will be based on whether self-only coverage exceeds 9.5 percent of an employee's W-2 wages from the employer.

† The Kaiser Family Foundation is a nonprofit, private organization not affiliated with Kaiser Permanente.

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ESSENTIAL HEALTH BENEFITS

Provision timeline: 2014

Groups affected:

At a glance

Starting with plan years beginning on or after January 1, 2014, the ACA requires nongrandfathered individual and small group commercial plans (with some exceptions, such as retiree and dental-only plans) to cover essential health benefits (EHBs), as defined by ACA regulations (see the 10 general categories of essential health benefits).

For at least 2014 and 2015 plan years, the definition of EHBs will differ in each state. Each state may define EHBs by choosing a "base-benchmark" plan from among four specified options and supplementing that plan as necessary to include any missing categories of benefits. The modified benchmark plan will serve as the "EHB-benchmark" plan for that state. Plans subject to this requirement must provide benefits that are substantially equal to the EHB-benchmark plan, and must meet other requirements included in the regulations.

What you need to know

SMALL BUSINESSES

- Starting with plan years beginning on or after January 1, 2014, all our nongrandfathered individual and small business plans will include coverage for essential health benefits.
- If you currently have a nongrandfathered plan, you'll be offered the metal tier plan closest to your current plan. Choose the offered plan or select a different metal tier plan.
- You'll be able to select options from among the metal tiers whether you choose to enroll employees inside or outside of the SHOP.

LARGE AND SMALL BUSINESSES

- We'll make any necessary changes to make sure that our plans comply with ACA and state requirements regarding essential health benefits and cost sharing.
- We're analyzing the federal guidance about how to define essential health benefits for the purpose of applying the annual and lifetime dollar limit mandate to large group plans.

Learn more

- HealthCare.gov

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PROVISION FACT SHEET

GUARANTEED AVAILABILITY

Provision timeline: 2014

Groups affected:

At a glance

Under guaranteed availability, insurers can't deny coverage to any individual plan applicant based on health status, age, gender, or other defined factors. Beginning January 1, 2014, applicants can't be denied coverage based on pre-existing conditions (such as a physical or mental condition, disability, or illness diagnosed prior to enrollment), their medical expenses over the past year, or other factors that might predict their use of health services.

For businesses, guaranteed availability also provides for continuous open enrollment throughout the year, during which group coverage can't be denied on the basis of the health status of employees.

What you need to know

SMALL BUSINESSES

- Under guaranteed availability, insurers can establish minimum contribution and participation requirements for small businesses applying for group coverage. However, beginning in 2014, insurers must allow for an annual open enrollment period from November 15 through December 15, during which groups that don't meet these requirements must be offered coverage upon application.

LARGE BUSINESSES

- You don't have any action to take.

Learn more

- Kaiser Family Foundation*

* The Kaiser Family Foundation is a nonprofit, private organization not affiliated with Kaiser Permanente.

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HEALTH INSURANCE EXCHANGES

Provision timeline: 2014 2016 2017

Groups affected:

At a glance

Beginning October 1, 2013, health insurance exchanges will open in each state, giving small businesses and individuals the ability to easily compare, purchase, and enroll in health plans. Each exchange will be operated by either that state's government, the federal government, or some type of state and federal partnership. The ACA allows for four main levels of coverage within the exchange — bronze, silver, gold, and platinum — also known as "metal tiers." Each tier has a different actuarial value — the percent that the health plan will pay for covered essential health benefits based on the claims of a standard population:*

- Platinum — 90% actuarial value
- Gold — 80% actuarial value
- Silver — 70% actuarial value
- Bronze — 60% actuarial value

For example, a silver plan will pay for 70 percent of covered essential health benefits expenses. The average member will pay for the remaining 30 percent through some combination of deductibles, copayments, and coinsurance. Because the plans within each metal tier will offer similar coverage of health care expenses, it will be easier for employees to shop for and compare plans. Not all states will offer all four levels of coverage.

What you need to know

SMALL BUSINESSES

The exchange for small businesses is called the Small Business Health Options Program (SHOP). The initial open enrollment will be from October 1, 2013, to March 31, 2014.† Some of the benefits of the SHOP include:

- **More choice —** The SHOP consolidates the buying power of small businesses to offer more options for affordable health care coverage.

continue ›

* The ACA allows a difference of +/- two points for actuarial value percentage.

† For federally facilitated exchanges, the HHS has proposed a one-year delay in the implementation of the provision intended to give small business employees the choice of multiple health plan options within each metal tier. The proposed delay is optional for state-operated exchanges. States may also choose to delay other aspects of the SHOP, including open enrollment.

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HEALTH INSURANCE EXCHANGES

Provision timeline: 2014 2016 2017

Groups affected:

- **One-stop shopping experience —** Employees can research, compare, purchase, and enroll in primary and ancillary coverage, such as dental and vision, all through the SHOP website.
- **Easy comparisons —** Since all insurers within each tier are required to offer the same approximate actuarial level of coverage, it will be easy to compare pricing, benefits, and features to make a more informed decision.[1]
- **Less administration —** The SHOP will handle enrollment, plan administration, and billing, which will help employers save time and resources.[2]
- **One monthly payment —** Employers make only one monthly payment directly to the SHOP (if premium aggregation is available in your state).
- **Tax credit —**The small business tax credit is only available through participation in the SHOP.

LARGE BUSINESSES

- For 2014, the SHOP will only be open to groups with up to 50 or 100 employees, depending on the state.
- In 2016, all states will make the SHOP available to groups with up to 100 employees.
- In 2017, states can open their SHOP to even larger employers.

Learn more

- HealthCare.gov
- Kaiser Family Foundation — current status of health insurance exchanges in your state[3]

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[1] For federally facilitated exchanges, the HHS has proposed a one-year delay in the implementation of the provision intended to give small business employees the choice of multiple health plan options within each metal tier. The proposed delay is optional for state-operated exchanges. States may also choose to delay other aspects of the SHOP, including open enrollment.

[2] Federally facilitated exchanges will not be handling premium billing in 2014.

[3] The Kaiser Family Foundation is a nonprofit, private organization not affiliated with Kaiser Permanente.

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PROVISION FACT SHEET

RATING REFORMS FOR INDIVIDUALS AND SMALL BUSINESSES

Provision timeline: 2014 2016

Groups affected:

At a glance

Beginning in plan years on or after January 1, 2014, the ACA has defined new standards for individual and small group rates. Under these standards, health plans must maintain a single risk pool for nongrandfathered coverage in the individual market and another single risk pool for nongrandfathered coverage in the small group market. Health plans will also be required to base rates for nongrandfathered plans in the individual and small group insurance markets at the member level using community rating by class. Under these new guidelines, there will be no medical underwriting, and health plans will be allowed to vary rates based only on the following factors:

- **Individual vs. family enrollment —** Different rates can be charged based on whether the plan covers only an individual or a family (an individual plus spouse or dependents).
- **Geographic area —** Rates can be higher for people who live in areas with high medical costs.
- **Age limited to a ratio of 3 to 1 for adults —** Older adults can't be charged more than three times the rate of a younger person. Under this guideline, the HHS has proposed three uniform age bands:
  - **Band 1: child age bands —** a single age band from age 0 to 20
  - **Band 2: adult age bands —** one-year age bands from age 21 to 63
  - **Band 3: older adults —** a single age band for age 64 and older
- **Tobacco use —** People who use tobacco products can be charged higher rates, but they can't exceed more than 1.5 times the rate of a non – tobacco user. A person could achieve nonsmoker status by either being a nonsmoker or, in the small group market, by participating in a smoking cessation program consistent with wellness program requirements. States can decide not to permit rate restrictions for tobacco use.

continue ›

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PROVISION FACT SHEET

RATING REFORMS FOR INDIVIDUALS AND SMALL BUSINESSES

Provision timeline: 2014 2016

Groups affected:

What you need to know

SMALL BUSINESSES

- All our plans will comply with these regulations.
- These regulations ensure that all employees who apply for coverage in an individual or small group plan can't be denied coverage based on their medical history or medical condition.

LARGE BUSINESSES

At the moment, most large fully insured and self-funded employers are exempt from this requirement. These requirements will apply to groups of 51 to 100 employees starting in 2016. Beginning in 2017, if a state chooses to include large groups in its SHOP exchange, these rating restrictions will then apply to nongrandfathered large commercial groups in the state. Self-funded group health plans would be exempt.

Learn more

- Kaiser Family Foundation *Health Insurance Market Reforms: Rate Restrictions**
- HHS final rule on rate review

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* The Kaiser Family Foundation is a nonprofit, private organization not affiliated with Kaiser Permanente.

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PROVISION FACT SHEET

WELLNESS PROGRAM REWARDS

Provision timeline: 2014

Groups affected:

At a glance

The U.S. Departments of Health and Human Services, Labor, and the Treasury have proposed rules that would provide incentives for participating in workplace wellness programs. Employees could receive a reward (premium discounts or rebates, lower cost-sharing requirements, extra benefits) that equals up to 30 percent of the total cost of health coverage. This would increase to a maximum of 50 percent if they participate in programs to prevent or reduce tobacco use. There would also be protections in place to prevent discrimination against employees.

What you need to know

LARGE AND SMALL BUSINESSES

- These proposed rules would be effective for plan years beginning on or after January 1, 2014.
- Review your current wellness program to make sure you're maximizing employee rewards.

Learn more

- HealthCare.gov

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