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Health Care Reform: General Questions and Answers for Small Employers

Since March 23, 2010, the amount of information being published on health care reform has been overwhelming. As 2014 approaches, the volume and complexity of that information promises to increase. Below, we have created a simple overview of the most pertinent topics, tailored to organizations employing fewer than 10 employees. The information has been presented in a question and answer format to allow you to scan through it and find the information you need quickly.

I've heard about a number of different health care proposals over the last year. Which one did Congress pass?

The new health care reform law is a combination of two bills:

- The Patient Protection and Affordable Care Act (H.R. 3590), which was signed into law on March 23, 2010; and
- The Health Care and Education Reconciliation Act of 2010 (H.R. 4872), which was signed into law on March 30, 2010.

Am I required by law to offer health coverage to my employees?

The health care reform law does not technically require companies to offer health coverage to their employees. However, beginning in 2014, large companies (with more than 50 full-time equivalants) that do not offer coverage, or that offer coverage below a minimum level of coverage, will be subject to penalties if any of their employees receive government subsidies for health coverage through an exchange. These penalties will not apply to small employers that have fewer than 50 full-time equivalent employees in the prior calendar year.

What is a "grandfathered plan"?

A grandfathered plan is a group health plan or health insurance coverage in which an individual was enrolled on the date of enactment of the health care reform legislation (March 23, 2010). Some of the health care reform provisions affecting health plans do not apply to grandfathered plans. A plan can still be a grandfathered plan if it allows new employees, or family members of current employees, to enroll after the date of enactment.

How does health care reform affect grandfathered plans?

Grandfathered plans are exempt from certain insurance market reforms and coverage mandates included in the health care reform legislation and have delayed compliance dates for other provisions.

Specifically, grandfathered plans are not required to: provide first dollar coverage of preventive care; permit selection of any available participating primary care provider; comply with limits on preauthorization requirements, out-of-pocket expenses or cost-sharing; satisfy nondiscrimination rules for fully-insured plans, establish a new appeals process; or meet guaranteed issue or renewal of coverage mandates.

However, some of the health insurance industry reforms apply to grandfathered plans as well as new plans. These reforms include prohibitions on lifetime and annual limits, pre-existing condition exclusions, rescissions of coverage and excessive

waiting periods. Grandfathered plans must also comply with the rules regarding coverage of adult children up to age 26 and provision of a summary of benefits and coverage.

Can a grandfathered plan be amended without losing the grandfathered status?

Plan sponsors can make certain changes to grandfathered plans and maintain their grandfathered status. However, plans will lose their grandfathered status if they make significant changes that reduce benefits or increase costs to consumers.

Specifically, making the following changes would cause a plan to lose its grandfathered status:

- Significantly cutting or reducing benefits;
- Raising co-insurance charges;
- Significantly raising co-payment or deductibles;
- Significantly reducing employer contributions; or
- Adding or reducing an annual limit.

The grandfathered plan rules initially provided that changing insurance companies or policies would cause a health plan to lose grandfathered plan status. However, on Nov. 15, 2010, an amended rule was released stating that a group health plan will not lose grandfathered status merely because of a change in the plan's insurance policy, certificate or contract of insurance, as long as the coverage under the new policy is effective on or after Nov. 15, 2010. Also, to maintain grandfathered status, the plan must provide documentation of the prior plan's terms to the new issuer.

What is the small business tax credit and how do I know if I am eligible?

Beginning with the 2010 tax year, tax credits are available to qualifying small businesses that offer health insurance to their employees. Your business qualifies for the credit if you cover at least 50 percent of the cost of health care coverage for your workers, pay average annual wages below $50,000 and have less than the equivalent of 25 full-time workers (for example, a firm with fewer than 50 half-time workers would be eligible).

The size of the credit depends on your average wages and the number of employees you have. For tax years beginning in 2010 through 2013, the maximum credit is 35 percent of the employer's premium expenses that count toward the credit. The full credit is available to firms with average wages below $25,000 and less than 10 full-time equivalent workers. It phases out gradually for firms with average wages between $25,000 and $50,000 and for firms with the equivalent of between 10 and 25 full-time workers.

What if my small business doesn't offer insurance today, but I choose to start offering insurance this year? Will I be eligible for these tax credits?

Yes. The tax credit is designed to both support those small businesses that provide coverage today as well as those that newly offer such coverage.

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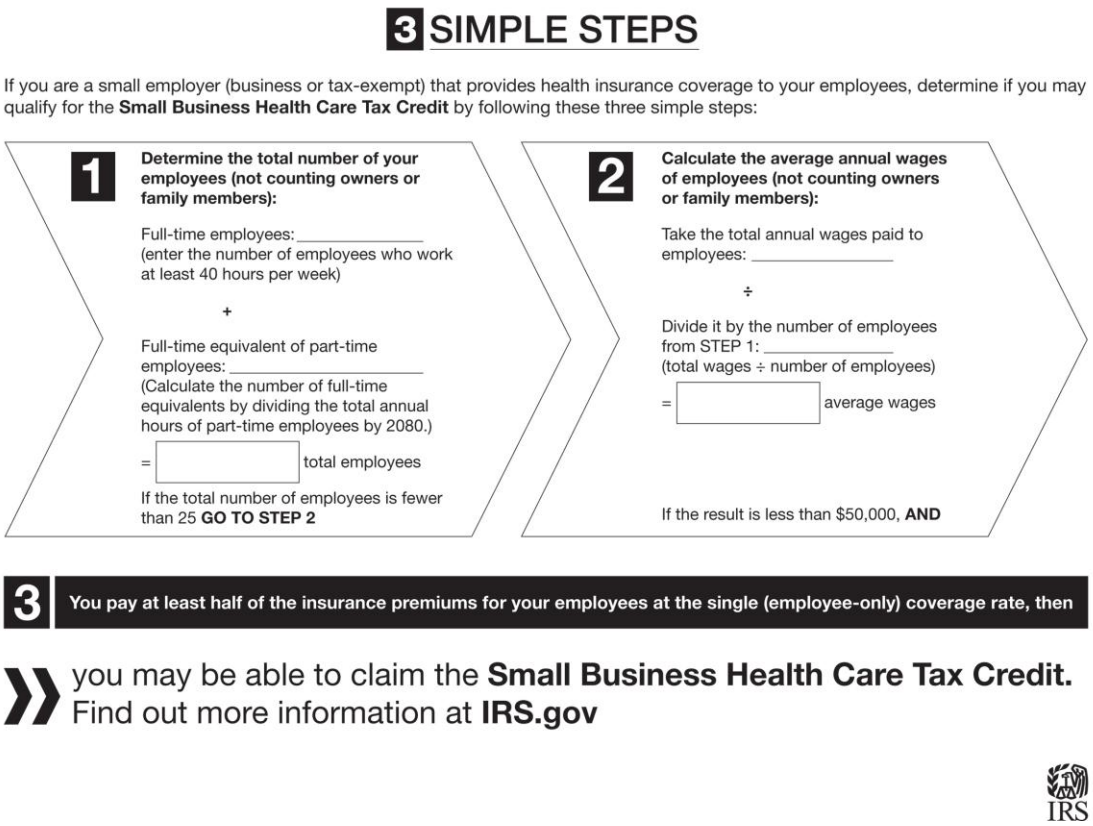
How do I determine if I qualify for the Small Business Health Care Tax Credit?

Determine if you may qualify for the Small Business Health Care Tax Credit by following these three simple steps from the IRS.



Does the new law affect dependent care flex accounts and health flexible spending accounts?

Prior to the passage of the health care reform legislation, dependent care flex accounts are capped at $5,000 annually, and health flexible spending accounts (health FSAs) have no cap (although many employers implement their own caps, typically at the $5,000-$6,000 level or less). The new health care reform law does nothing to change the limits on dependent care accounts, which remain capped at $5,000. However, the law does reduce the annual cap on health FSAs to $2,500. This change is effective on Jan. 1, 2013.

What is a health insurance exchange?

Beginning in 2014, states must establish health benefits exchanges. Individuals and small businesses will be able to purchase health insurance through the exchanges. The intent of the health insurance exchanges is to provide increased purchasing power by pooling a number of insurance buyers together. Beginning in 2017, states may allow employers of any size to purchase coverage through the exchange.

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Where do I learn more about the Health Insurance Exchanges?

The Patient Protection and Affordable Care Act (PPACA) directed the Department of Health and Human Services (HHS) to establish a website to help individuals and small businesses identify affordable health insurance options in their state. HHS intends to implement the website in phases.

In July 2011, HHS announced the availability of the online tool, which is located at www.HealthCare.gov. HHS described its website as a "first of its kind" tool that provides "one-stop shopping access" to a variety of information regarding health insurance coverage.

In November 2011, HHS significantly expanded the website to provide information on local health plan benefits and pricing. The online tool provides information from more than 530 insurers about more than 2,700 coverage plans across all states and the District of Columbia, according to HHS.

The expanded website gives small business owners access to the following information:

- Insurance product choices for a given ZIP code, sorted by out-of-pocket limits, average cost per enrollee, or other factors; and
- A summary of cost and coverage for small group products that shows the deductible, range of co-payment options, included and excluded benefits and benefits available for purchase at additional cost.

The tool also has the ability to filter insurance products based on whether the plans are compatible with health savings accounts (HSAs), include prescription drug, mental health or maternity coverage, or allow for domestic partner or same sex coverage.

In addition, the website provides information about consumer rights, tips on navigating the health insurance market and explanations of PPACA's new protections for health coverage consumers.

According to HHS, small businesses do not fare as well as large employers when negotiating health insurance coverage prices. On average, small employers spend 18 percent more than large employers for the same health insurance coverage. HHS sees the tool as a way to bring transparency to the health insurance marketplace to help ensure that insurers compete for business on the basis of price and quality.

The online tool also allows individuals to search for an insurance plan.

The health insurance finder can be accessed by going to www.HealthCare.gov and clicking on the blue tab at the top of the page. The Colorado Health Benefit Exchange is still under development. More information on Colorado's exchange can be located at www.getcoveredco.org.

Will Health Care Reform impact the premiums we pay for health insurance?

The short answer is "yes." Inclusion of new mandated coverage has impacted rates and will continue to do so as additional mandates are required. In 2014, the small group market will shift to modified community rates. While Colorado has already adopted a form of modified community rates, carriers will only be allowed to consider age, tobacco use, geography, and family tier. The biggest change for Colorado small employers will be the requirement that rates for the highest age band be no more than 3 times greater than the lowest age brand. This will cause rates for younger individuals to be higher than what is required by the current age-banding rules that are in place.