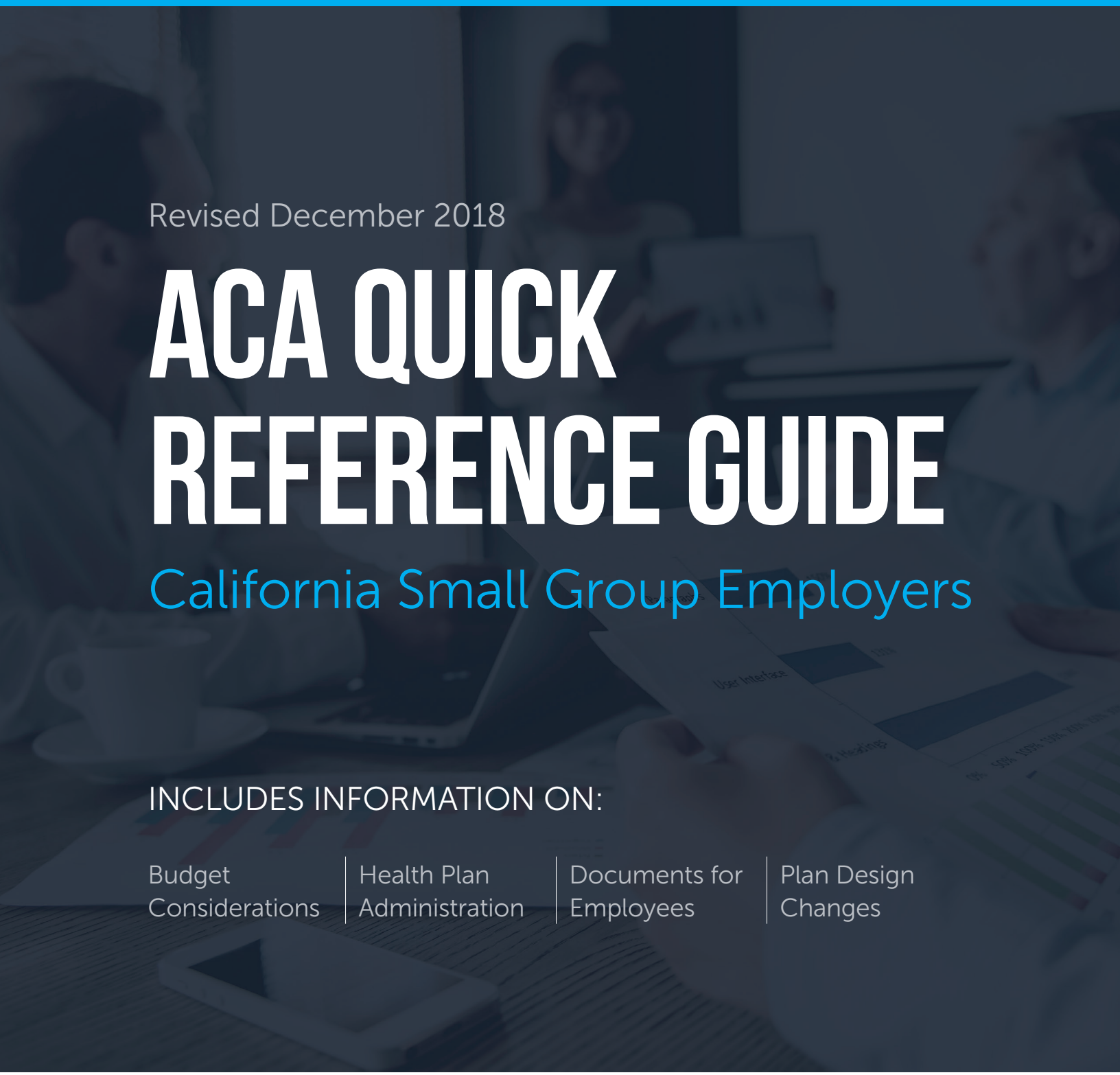
WBCompliance



Revised December 2018

ACA QUICK REFERENCE GUIDE

California Small Group Employers

INCLUDES INFORMATION ON:

Budget Considerations | Health Plan Administration | Documents for Employees | Plan Design Changes

Small Group Insurance Rating Structure

The federal Affordable Care Act (ACA) only allows for rate variance by four factors: age, family composition, geographic location, and tobacco use. California, however, prohibits tobacco use as a rating factor (CA AB 1083).

- Member Level Rating
  - » Each individual will be rated (cap of three on children under 21).
- A 3:1 ratio limits the rate charged to a 64-year-old to three times the amount charged to a 21-year-old.
- Risk Adjustment Factors are no longer used.
- Single-year age bands (except 0-14 and 64+): Rate increases occur on policy anniversaries only – not in the birthday month.

Dependent Rating Structure Change for 2018

The ACA initially called for a member-level rating structure with one rate for dependent children (through age 20) and unique rates beginning at age 21. For new and renewing business effective 1/1/2018 and later, carriers may charge one rate for children ages 0-14 and unique rates for dependents ages 15, 16, 17, 18, 19, 20, and above. Dependents ages 0-14 will also see increases in premiums as a result of this rating structure change, on a smaller scale than those in the 15-20 age group. The increase in child rates also results in very small decreases in adult rates. The actual rate variances will differ by insurance carrier.

Under the amended rules, carriers may still only charge for the three oldest dependents under the age of 21.

While this will reduce the rate spike from age 20 to 21 in the future, it will substantially increase costs for employees with dependents turning ages 15-20 in 2018. Starting in 2019, the rate increase for ages 15-20 will be much more gradual (than in 2018), but the 2018 rating structure change will significantly affect employees with dependent coverage.

Group Size Calculation: Full Time + Full Time Equivalent

- Group size is counted by Full Time (FT) + Full Time Equivalent (FTE) employees. A group's FT+FTE calculation determines whether a group falls into the Small Group or Large Group market segment. Group size calculation also determines ACA employer mandate and employer reporting responsibilities.
- Full Time: An employee who averages 30 hours of service a week or 130+ hours of service a month.
- Full Time Equivalents: All Part Time (PT) employees' hours of service per month are totaled and divided by 120.
  - » If a PT employee averages 121-129 hours of service per month, round down to 120 for this calculation.
- Example: 40 FT employees + 20 PT employees all providing an average of 60 hours of service per month
  - » 20 PT employees x 60 hours of service/month = 1,200 hours
  - » 1,200 hours total/120 hours = 10 FTEs
  - » 40 FT + 10 FTEs = group size 50

Taxes & Fees

The following fees, mandated by the ACA, are assessed on health insurance carriers. These taxes and fees are integrated into fully insured plan rates.

- **PCORI - Patient Centered Outcomes Research Institute***
  - » Goal: Funds the exploration of the effectiveness of medical treatment
  - » Amount: Approximately $2.36/member; continues to be adjusted for inflation
  - » Duration: Plan years ending after 9/30/2012 and ending before 10/1/2019
- **Health Insurer Tax**
  - » Goal: Funds premium tax credits and cost-sharing subsidies for lower-income individuals and families who get coverage from the Covered California Individual Marketplace
  - » Amount: Varies based on carrier's net premium for applicable year
  - » Duration: Ongoing

Common Law Employees

Under common law rules, anyone who performs services for an employer is the employer's employee if the employer controls what will be done and how it will be done.

- Changing an employee's status from W-2 to 1099 does not change the IRS's consideration of the employee's status.
- Temporary staffing employees may fall under this umbrella, especially for temporary employees on long assignments.
- This is an important consideration for employers using a Professional Employer Organization (PEO) or staffing agency.

Note: In Section 3508 of the Internal Revenue Code (IRC), workers (real estate agents and sellers) are an exception and are not treated as FT employees with regard to the employer mandate and associated penalties. Because of this, they are not considered FT employees and their hours of service are not counted in determining an employer's FTE count.

*Applies to employers with self-insured plans also.

90-Day Waiting Period Maximum

The ACA mandates that employers may not impose a waiting period that exceeds 90 calendar days. Health plans cannot impose a waiting period.

- Many California groups elect "first of the month following 30 days of employment" or "first of the month following 60 days of employment" to comply with this waiting period mandate.
- Employers may delay eligibility up to an additional month to allow for a bona fide orientation period in order to meet the plan's substantive eligibility conditions (for example, being in an eligible job classification, achieving job-related licensure requirements specified in the plan's terms, or satisfying a reasonable and bona fide employment-based orientation period).
- Ensure waiting periods are listed clearly and correctly in employee handbooks.

Employer Mandate

50+ FTE employers are required to offer affordable health insurance coverage (providing minimum value and minimum essential coverage) to "all" FT employees and their dependent children to age 26.

- Groups with 50+ FTEs, called Applicable Large Employers (ALEs), must comply.
- "All" employees: 95% of employees (all but the greater of 5% or five FT employees).
- Minimum value: Plan must pay at least 60% of covered benefits, defined as a Bronze plan.
- Employee cost share of the lowest-cost minimum value plan offered for "employee only" coverage must not exceed 9.56% of any of the following three safe harbors for plan years beginning in 2018.
  - » Rate of pay (at the beginning of plan effective date)
  - » W-2 Box 1 income for the corresponding tax year
  - » Federal Poverty Level (at the beginning of the effective date)
- Group size determination is based on the average number of employees from the previous calendar year (see page 2 for calculation instructions).

Controlled Group/Common Ownership

Two or more companies with a common owner may be combined for the purpose of calculating group size. Controlled groups must comply with the ACA's offer of coverage and reporting responsibilities if their combined total is 50+ FTEs.

- Companies with unrelated businesses and separate tax IDs may be combined if the common ownership meets the criteria for a controlled group as outlined in IRC Section 414 (b), (c), (m), or (o). It is important to consult with a trusted tax advisor on these common ownership scenarios.

IRS Employer Reporting

ACA regulations require information reporting to the IRS by ALEs with 50+ FTE employees relating to the health coverage the employer offers, or does not offer, to its FT employees and their dependent children up to age 26. Employers with less than 50 FTE employees sponsoring self-insured plans also are required to report to the IRS.

- Employers subject to this mandate are required to complete the following forms:
  - o ALEs with 50+ FTEs sponsoring fully-insured plans or self-insured plans: IRS Forms 1094-C and 1095-C
  - o Non-ALEs with less than 50 FTEs sponsoring a self-insured plan: IRS Forms 1094-B and 1095-B
  - o Non-ALES with less than 50 FTEs sponsoring a fully-insured plan: No reporting required
- The IRS uses these reports to determine whether or not the employer must pay any noncompliance penalties, and also to determine a Marketplace participant's eligibility for a Premium Tax Credit (PTC).

IRS Reporting Deadlines

The chart on the next page shows the employer reporting responsibilities and deadlines.

Who Reports?	Plan Type	Forms	Purpose	Copy to Covered Individuals/ Employees	Paper Submission to IRS	Electronic Submission to IRS
Employers with <50 FTEs sponsoring self-insured plans	Self-insured	1094-B 1095-B	Enforce individual mandate	1095-B and 1095-C only: On or before last day of January (For 2018 reporting, IRS extended deadline to March 4, 2019)	On or before last day of February	On or before last day of March* (For 2018 reporting, deadline extended until April 1, 2019: since March 31, 2019 is a Sunday)
ALEs: plan sponsors with 50+ FTEs	Fully-insured	1094-C 1095-C (Parts I & II)	Enforce employer mandate			
	Self-insured	1094-C 1095-C (Parts I, II, & III)	Parts I & II: Enforce employer mandate Part III: Enforce individual mandate			

**Entities filing at least 250 IRS Form 1095-B/Cs must file electronically*

Noncompliance: Employer Reporting

An ALE (or Non-ALE group with self-insured coverage) that does not comply with the ACA's employer reporting responsibilities faces hefty penalties.

- Most penalties have a maximum cap, although there is no cap for intentional disregard of the employer reporting responsibilities, which is $530 per filing (2017 tax year)/$540 per filing (2018 tax year).
- Employer penalties have increased since the inception of the ACA and may continue to rise.
- Failure to furnish IRS reporting return (form 1094-B or 1094-C) or individual statements (form 1095-B or 1095-C) to employees is $260 per filing (2017 tax year)/$270 per filing (2018 tax year), with a maximum penalty of $3,218,500 (2017 tax year)/$3,282,500 (2018 tax year).
- Penalties are lessened if the employer complies within a certain preset timeframe after the due date.

Noncompliance: Employer Mandate

If an ALE does not offer affordable minimum essential coverage, providing minimum value 60%, to full-time employees and their dependent children up to age 26, the employer could face one of two penalties under IRS Code Section 4980H (a) and (b). An employer will never be assessed both penalties. An employer will never be assessed both penalties for any month.

- Penalty "A" – 4980H (a)
  - » Assessed when a 50+ FTE employer does not offer minimum essential coverage (MEC) to at least 95% of its FT employees (all but the greater of 5% or 5 FT) and their dependent children to age 26. The penalty triggers when one employee receives a Premium Tax Credit (PTC) for the coverage on Covered California or the Marketplace for out-of-state employees.
  - » For the 2018 tax year, the annual penalty is $2,320 x all FT employees, minus the first 30. The penalty is calculated on a monthly basis at 1/12 of $2,320 or $193.33 per month.
  - » Example: An employer with 80 FT employees does not offer MEC to its FT employees and their dependents and at least one of those 80 employees receives a PTC from Covered California or the Marketplace for out-of-state employees for a full year.
    - 80 FT employees – 30 = 50
    - 50 x $2,320 = $116,000 penalty

Noncompliance: Employer Mandate (continued)

- Penalty "B" – 4980H (b)
  - » Assessed when the 50+ FTE employer offers coverage that is not affordable by ACA standards and/or does not provide 60% minimum value. The penalty triggers when an employee receives a PTC for coverage on Covered California or the Marketplace for out-of-state employees..
  - » For the 2018 tax year, the penalty is $3,480 per FT employee receiving a PTC. The penalty is calculated on a monthly basis at 1/12 of $3,480 or $290 per month.
  - » Example: An employer with 65 FT employees does not offer coverage that is affordable, and 20 of those employees receive a PTC for coverage through Covered California or the Marketplace for out-of-state employees for a full year.
    - 20 x $3,480 = $69,600 penalty
  - » An employer that does not incur Penalty "A" may incur Penalty "B" if any of the 5% or 5 FT employees who are not offered affordable coverage that meets MV gets a PTC from Covered California or the Marketplace for out-of-state employees.

Summary of Benefits & Coverage (SBC)

The ACA requires individual and group health plans to provide a Summary of Benefits & Coverage (SBC) to all applicants and enrollees. Along with the SBC an employer must provide a Uniform Glossary to all applicants and enrollees.

- The aim is to make plan benefit displays uniform for all carriers, making it easy for consumers to compare benefits.
- The format was developed by the Department of Health & Human Services (HHS).
- A carrier's Summary of Benefits does not meet the criteria for the SBC.

60-Day Notice of Material Modification

The ACA requires an employer offering group health coverage to provide a notice of plan modification to enrollees at least 60 days prior to the effective date of any modification.

- This requirement does not pertain to carrier-issued renewal modifications.
- Section 102 of ERISA law includes a modification to the coverage that would be considered by an average plan participant to be an important change.

Metal Tier Plans (Bronze, Silver, Gold, and Platinum)

All plans must classify their actuarial value (percent of costs paid by the plan for covered benefits, in-network) by metal tier.

Metal Tier Name	Actuarial Value
Platinum	Plan pays 90% of the costs for covered benefits *in-network.* (Higher premiums, lower out-of-pocket (OOP) costs)
Gold	Plan pays 80% of the costs for covered benefits *in-network.*
Silver	Plan pays 70% of the costs for covered benefits *in-network.*
Bronze	Plan pays 60% of the costs for covered benefits *in-network.* Bronze level plans and above satisfy the "minimum value" requirement of the employer mandate. (Lower premiums, higher OOP costs)

Out-of-Pocket (OOP) Maximum Limits

The ACA caps the allowable OOP maximum, which is the maximum financial exposure a participant may experience in a health plan year for covered benefits. 2018 OOP maximum limits are as follows:

- $7,350 for self-only (employee-only) coverage
- $14,700 for EE + Spouse/Domestic Partner, EE + Child(ren), or EE + Family

Essential Health Benefits (EHB)

The ACA mandates that all Individual and Small Group insurers offer plans that provide EHB in these 10 categories:

1. Ambulatory Services
2. Emergency Services
3. Hospitalization
4. Maternity & Newborn Care
5. Mental Health & Substance Abuse
6. Prescription Drugs
7. Rehabilitative and Habilitative Services
8. Laboratory Services
9. Preventive and Wellness Services
10. Pediatric Dental & Vision