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Healthcare Reform for "Small Employers"

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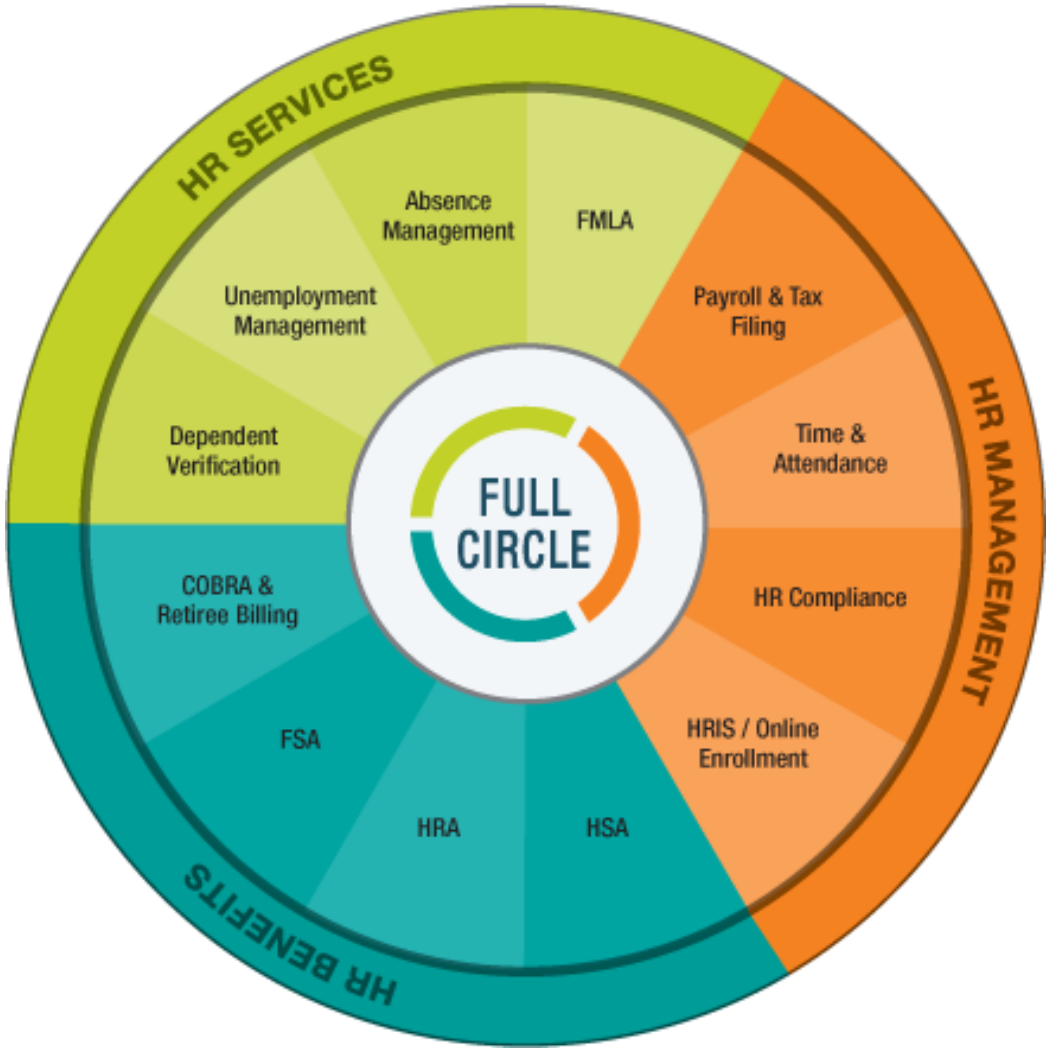

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Agenda

- What is a small employer?
- Fees and Taxes
- 90 day Waiting Period
- Preexisting condition
- Out-of Pocket Limits
- Wellness Programs
- Approved clinical Trials
- Cafeteria Plans & HRAs
- Insurance Mandates
- Exchange Eligibility
- SHOP
- Reporting

What is a small employer?

- There are different definitions under the Affordable Care Act.
  - **Employer Mandate**:
    - 100 in 2015, if certain transitional rules are met
    - 50 in 2016
  - **Insurance Mandate:**
    - 50 in 2015
    - 100 in 2016 and after
  - **Small Employer Tax Credit:**
    - 25 employees

Fees/Taxes

Comparative Effectiveness Research Fees

(a.k.a. PCORI Fee/CERF)

What is it?

- Health care reform created a new nonprofit corporation, the Patient-Centered Outcomes Research Institute, to support clinical effectiveness research.

- This entity will be funded in part by fees (sometimes referred to as “PCORI fees” or “CER fees”) paid by certain health insurers and applicable sponsors of self-insured health plans.

- These fees do not apply to plans that provide "excepted benefits.”

Who Pays it and When?

- Fees are payable in connection with policy/plan years ending after September 30, 2012, but stop applying for policy/plan years ending after September 30, 2019.

- While insurers will file reports and pay the fees for insured policies, self-insured plan sponsors must file reports and pay these fees.

- Plan sponsors and insurers will file IRS Form 720 to report the fees and make annual payments.

- This return must be filed each year by July 31 of the calendar year immediately following the last day of the policy year (for insured plans) or the plan year (for self-insured plans).

The Amount of the Fee

- These fees will be calculated as the average number of covered lives under a policy or plan multiplied by $1 for plan years ending after October 1, 2012.

- The multiplier increases to $2 for the next plan year, then may rise with health care inflation through plan years ending before Oct. 1, 2019, when the fees are slated to end.

- To determine the average number of covered lives, plan sponsors generally can use any reasonable method in the first plan year and will choose from several proposed approaches in later years.

Required Contributions Toward Reinsurance Payments

(a.k.a. Transitional (Temporary) Reinsurance Fee)

What is it?

- Under the ACA, each state is required to establish a transitional reinsurance program to help stabilize premiums for coverage in individual market inside and outside of Marketplaces (a.k.a. Exchanges) during the years 2014 through 2016.

- The program is funded through a reinsurance assessment on all health insurance carriers and self-insured plan sponsors.

- The collected fee is used to support reinsurance payments to carriers that cover high-cost individuals in non-grandfathered individual market plans.

Who Pays it and When?

- **For self-insured plans**, self-insured group plans sponsors are ultimately liable for reinsurance contribution fees.
- The self-insured ERs can use a TPA or ASO contractor to transfer the fees.
- Exempt certain self-insured, self-administered plans from making reinsurance contributions for 2015 and 2016.
  - A self-insured health plan must make reinsurance contributions for major medical coverage, with certain exceptions.
- For this purpose, HSAs, health FSAs, expatriate health plans, and prescription drug plans are expressly excluded
- **For fully-insured plans**, carriers are responsible to pay the fees.

The Amount of the Fee

- HHS will establish a national reinsurance contribution rate each year.
- The annual per capita contribution rate for 2014 announced by HHS is **$63 and $44 for 2015**.
- HHS will collect all contributions and allocate reinsurance payments on a national basis.
- The same contribution rate applies to self-insured group health plans, although those plans are excluded from receiving reinsurance payments under the program.
  - Enrollment data must be provided to HHS by December 5 (generally calculated based on January through September data, even for non-calendar-year plans).

The Amount of the Fee

- Contributions may be paid in two installments—under a bifurcated contribution collection schedule—with the first installment reflecting the actual reinsurance contribution (plus HHS's administrative costs) and the second reflecting payments allocated to the U.S. Treasury.

- The first installment is invoiced by December 15 of the benefit year (i.e., the calendar year for which coverage is provided), and the second installment in the fourth quarter of the following calendar year, with payment for each installment due within 30 days after the invoice date.

- Both installments are based on the same enrollment count.

Health Insurance Industry Fee

(a.k.a. Annual Insurance Fee)

What is it?

- Health care reform imposes an annual fee to insurers beginning in 2014 for the purpose of funding federal and state Exchanges.

- The total fee collected in the first year, 2014, will be $8 billion; gradually increasing to $14.3 billion in 2018 and indexed for rate of premium growth in 2019 and thereafter.

- The fee applies to fully-insured plans including dental and vision plans; but self-funded plans are excluded from this requirement.

Who Pays it and When?

- **Who pays the fees?**

  Insurers

  (Note: Self-insured employers are exempt from this requirement.)

- **When is the fee due?**

  Each insurer will make its payment by September 30 of each applicable calendar year to the Secretary of the Treasury.

- **Will the fee have any impact on fully-insured group health plan premiums?**
  - YES. It is expected that this requirement will increase group health premiums in coming years.
  - Some insurers have already indicated that the full amount of about 2 - 2.5% of premium would be added upon the upcoming renewal as early as February 2013; and may be increasing to 3 - 4% of premium in future years.
  - Each insurer is expected to have its own calculation method to allocate its insurer's fee into the groups' premiums.

The Amount of the Fee

- **How is the fee determined?**
  - Each insurer's fee will be determined based on its respective market share of premium revenue from the previous calendar year.
  - For example, the 2014 fee will be based on an insurer's 2013 premium revenue and the percentage of the market it represents among all health insurers of US health risks.
  - Then, the market share of the insurer is used to determine its share of the total $8 billion (for 2014).
  - Fee payments are due no later than September 30 of the calendar year for which the fee is due (the "fee year"), so the first fee payment is due by September 30, 2014

- **What types of coverage does the fee apply to?**
  - The fee applies to most health insurance coverage including dental and vision plans.
  - However, self-insured plans, accident, disability income, specific disease and illness, and long-term care are not subject to this requirement.

90 Day Waiting Periods

Effective Date

- Effective as of plan years beginning on or after January 1, 2014, group health plans and insurers are prohibited from applying a waiting period that exceeds 90 days.
- This prohibition applies to group health plans and insurers but not to certain “excepted benefits.”
- Grandfathered health plans must also comply with the waiting period requirements.
- Can impose a 30 day orientation period before the waiting period begins.

What is it?

- **Definition of "Waiting period":** the period that must pass before coverage for an employee or dependent who is otherwise eligible to enroll under the terms of a group health plan can become effective.

- **Cumulative service requirement**

  If a group health plan or health issuer conditions eligibility on an employee having a completed a number of cumulative hours of service, up to 1,200 hours may be required; more than 1,200 hours would be considered designed to avoid compliance with the 90-day waiting period limitation.

- **Counting days**

  All calendar days are counted beginning on the enrollment date, including weekends and holidays.

Examples

- **Example 1**: A group health plan provides that full-time employees are eligible for coverage under the plan. Employee Bill begins employment as a full-time employee on January 19.

  Conclusion. Any waiting period for Bill would begin on January 19 and may not exceed 90 days. Coverage under the plan must become effective no later than April 19 (assuming February lasts 28 days).

- **Example 2**: A group health plan provides that only employees who have completed specified training and achieved specified certifications are eligible for coverage under the plan. Employee Lisa is hired on May 3 and meets the plan's eligibility criteria on September 22.

  Conclusion. Lisa becomes eligible for coverage on September 22, but for the waiting period. Any waiting period for Lisa would begin on September 22 and may not exceed 90 days. Coverage under the plan must become effective no later than December 21.

Examples (Cont.)

- **Example 3**: A group health plan provides that employees are eligible for coverage after one year of service.

  Conclusion. The plan's eligibility condition is based solely on the lapse of time and, therefore, is NOT allowed because it exceeds 90 days.

- **Example 4**: A group health plan is a calendar year plan. Prior to January 1, 2014, the plan provides that full-time employees are eligible for coverage after a 6-month waiting period. Employee Sarah begins work as a full-time employee on October 1, 2013.

  Conclusion. The first day of Sarah's waiting period is October 1, 2013 because that is the first day Sarah is otherwise eligible to enroll under the plan's eligibility rule. Beginning January 1, 2014, the plan may not apply a waiting period that exceeds 90 days. Accordingly, Sarah must be given the opportunity to elect coverage that begins no later than January 1, 2014 (which is 93 days after Sarah's start date) because otherwise, on January 1, 2014, the plan would be applying a waiting period that exceeds 90 days. The plan is not required to make coverage effective before January 1, 2014 under the rules of this section.

Pre-existing Conditions

Overview

- Effective as of plan years beginning on or after January 1, 2014, a plan may not impose any pre-existing condition exclusion.

- This will be the case whether or not an individual has prior creditable coverage and whether or not the individual is a late enrollee.

- The prohibition includes both denial of enrollment and denial of specific benefits based on a preexisting condition.

- A PCE also includes any limitation or exclusion based on information relating to an individual's health status, “such as a condition identified as a result of a pre-enrollment questionnaire or physical examination given to the individual, or review of medical records relating to the pre-enrollment period.”

Out-of-Pocket Limits

Overall Cost-Sharing Limitations (Out-of-Pocket Maximum)

- A plan must not impose cost-sharing in excess of the maximum out-of pocket amount in effect for high deductible health plans for 2014.

- For 2014, the HDHP maximum out-of-pocket expense limit (that is, the sum of the plan's annual deductible and other annual out-of-pocket expenses (other than premiums) that the insured is required to pay, such as co-payments and co-insurance for an HDHP) cannot exceed $6,350 for self-only coverage and $12,700 for family coverage.

- For 2015, the limit can not exceed $6,600 for self-only coverage and $13,200 for family coverage.

- It does not apply to grandfathered plans.

Wellness Programs

Overview

- A new set of rules governing standard based wellness programs.
- Rules are similar to those set forth in current HIPAA current regulations (Participation and standard based programs), but with refinements.
- HIPAA wellness program incentive limit will increase from 20% to 30% of total cost of coverage.
- The reward limit may be increased to 50% of the cost of coverage for smoking cessation programs.

Approved Clinical Trials

Overview

- Group health plans providing coverage to a qualified individual may not deny the individual participation in an approved clinical trial, deny (or limit or impose additional conditions on) coverage of routine patient costs for items and services furnished in connection with the trial, or discriminate against the individual based on participation in the trial.
- A group health plan may not:
  - deny any qualified individual the right to participate in a clinical trial as described below;
  - deny, limit, or impose additional conditions on the coverage of routine patient costs for items and services furnished in connection with participation in the clinical trial; and
  - may not discriminate against any qualified individual who participates in a clinical trial.
- It does not apply to grandfathered plans

Cafeteria Plans & HRAs

Reimbursing Premiums for Individual Policies

- IRS Notice 2013-54 prohibits the reimbursement of premiums for individual medical policies from health reimbursement arrangements and premium only plans.

- Premiums for other types of individual coverages can be reimbursed.

- Rules are effective for plan years beginning in 2014.

Free Standing HRAs

- IRS Notice 2013-54 requires that HRAs be integrated with group health plans for plan years beginning in 2014.

- Rules vary depending on whether the group health plan is of minimum value.

- Free standing HRAs can still reimburse premiums and expenses for “excepted benefits.”

Health FSAs

- For health FSAs to avoid the requirements of Health Care Reform, they must meet the requirements of an “excepted benefit.”

- Free standing health FSAs are still possible if reimburse excepted benefits.

- What requirements apply if a Health FSA is not an excepted benefit?

Health FSAs

- Allow up to $500 carryover to 2014 and later
- Carryover can allowed to be used for alll or the next plan year
- Many unanswered questions from guidance
- Cafeteria plan must be amended to allow

Participation in Cafeteria Plan

- Notice 2014-55 addresses cafeteria plan elections in two specific situations related to the availability of coverage through a Health Insurance Exchange (or Marketplace).

- An employee may want to revoke an election under his or her employer's plan in order to purchase coverage through an Exchange if:

  - The employee's hours of service are reduced so that the employee is expected to average less than 30 hours of service per week, but the reduction does not affect eligibility for coverage under the employer's group health plan; or

  - The employee would like to cease coverage under the employer's group health plan and purchase coverage through an Exchange, without having a period of either duplicate coverage or no coverage.

- In each of these situations, Notice 2014-55 permits a cafeteria plan to allow an employee to prospectively revoke his or her election for coverage under the employer's group health plan during a period of coverage.

Insurance Mandates

Transition Policy

- In November 2013, CMS announced a one-year transition policy allowing insurers in the individual and small group markets to renew health insurance policies that would otherwise have been canceled due to noncompliance with certain insurance market mandates under health care reform scheduled to take effect for policy years starting on or after January 1, 2014.

- In March 2014, HHS announced a two-year extension of this policy—indicating that it will consider the impact of the two-year extension of the transitional policy in assessing whether an additional one-year extension is appropriate.

Transition Policy

- Under the transition policy, individual and small group policies that are renewed for a policy year starting between January 1 and October 1, 2014 will not be considered to be out of compliance with six “specified” reforms, including premium rating rules, guaranteed availability and renewability , and the requirement to provide essential health benefits provided that certain conditions are satisfied.

- These policies are considered to be minimum essential coverage even though they do not comply with some aspects of health care reform.

Guaranteed- Availability

- Each health insurance issuer that offers health insurance coverage in the individual or group market (regardless of whether the coverage is offered in the large or small group market) is required to accept every employer and individual in the state that applies for such coverage.

- Enrollment may be restricted to open or special enrollment periods.

- Insurers in the small group market to apply minimum participation rules other than during the annual open enrollment period from November 15 to December 15 of each year.

Guaranteed- Renewability

- To the extent permitted under state law, an insurer can discontinue all products in the small group market without having to also discontinue all products in the large group market.
- When renewing a product, insurers in the small group market must provide each plan sponsor a written notice of renewal at least 60 calendar days before the renewal date.
- An insurer may refuse to renew a group policy for certain specified exceptions.
  - These include nonpayment of premiums, fraud, or material misrepresentation; employer's failure to meet minimum contribution and participation requirements; insurer's discontinuance of a particular product or all coverage in market; no enrollees in service area; and uniform modification of small group market coverage

Guaranteed- Renewability

- An issuer can refuse to renew a group policy if the plan sponsor fails to comply with a material plan provision relating to employer contribution or group participation rules, pursuant to applicable state law.

- For this purpose, an “employer contribution rule” means a requirement relating to the minimum level or amount of employer contributions toward the premium for enrollment of participants and beneficiaries.

- The term “group participation rule” means a requirement relating to the minimum number of participants or beneficiaries that must be enrolled in relation to a specified percentage or number of eligible individuals or employees of an employer.

Fair Health Insurance Premiums (Individual & Small Group Markets)

- Premiums charged by insurers in the individual & small group market may vary with respect to a particular plan or coverage only by:
  - whether the plan or coverage covers an individual or family,
  - the rating area, as established under state standards,
  - age, except that the rate may not vary by more than a factor of 3 to 1 for adults, and
  - tobacco use, except the rate may not vary by a factor of more than 1.5 to 1.

Comprehensive Health Coverage Requirement

- Effective for plan years beginning on or after January 1, 2014, health insurance insurers offering coverage in the individual or small group market must ensure that such coverage includes the “essential health benefits package.”
- This requirement does not apply to “excepted benefits.”
- Insurance coverage and health plans that qualify as grandfathered health plans are not required to comply with comprehensive health coverage requirement.

Comprehensive Health Coverage Requirement

- To provide the essential health benefits package, a plan must—
  - provide essential health benefits,
  - limit cost-sharing, and
  - provide either bronze, silver, gold, or platinum level coverage (that is, benefits that are actuarially equivalent to 60%, 70%, 80%, or 90% (respectively) of the full actuarial benefits provided under the plan), as or a catastrophic plan (also known as “young invincibles” coverage).

Comprehensive Health Coverage Requirement

- What precisely constitutes “essential health benefits” is to be defined by regulations, but they include minimum benefits in ten general categories and the items and services covered within those categories—
  - Ambulatory patient services
  - Emergency services
  - Hospitalization
  - Maternity and newborn care
  - Mental health and substance use disorder services, including behavioral health treatment
  - Prescription drugs
  - Rehabilitative and habilitative services and devices
  - Laboratory services
  - Preventive and wellness services and chronic disease management
  - Pediatric services, including oral and vision care.

Cost Sharing Limits

Cost Sharing Requirements

- Health care reform requires that “cost-sharing” be limited.
- This requirement applies to all individual and small nongrandfathered group insured health plans
- Cost-sharing includes deductibles, co-insurance, co-payments or similar charges, and any other required expenditure which is a qualified medical expense with respect to essential health benefits covered under the plan.
- Cost-sharing does not include premiums, balance billing amounts for non-network providers, or spending for noncovered services.

Cost Sharing Requirements

- **Limit on Annual Deductible:**
  - For non grandfathered plans, the annual deductible must not exceed:
    - $2,000, in the case of a plan covering a single individual, or
    - $4,000 in the case of any other plan.
  - This requirement was repealed
  - The maximum deductible amounts may be increased by the maximum amount of reimbursement reasonably available to a participant under a “flexible spending arrangement.”
  - This It does not apply to grandfathered plans.

New Law Repeals Deduction Limits for Small Employer Insured Health Plans

- Section 213 of "Protecting Access to Medicare Act of 2014" repeals the annual deductible limit requirement for small employer insured health plans that was to be effective for plan years beginning on or after Jan. 1, 2014.
- The repeal of the Affordable Care Act's (ACA) deductible limit is retroactively effective to the date of the ACA's enactment in March 2010.
- President Obama signed the Protecting Access to Medicare Act of 2014 into law on April 1, 2014.
- Section 1302(c)(2)(A) of the ACA provided that deductible limits for 2014 could not exceed $2,000 for a plan covering a single individual, or $4,000 for any other plan.
- The proposed deductible limits for 2015 would be $2,150 for self-only coverage and $4,300 for other than self-only coverage.

Which Employers are eligible for the Marketplace?

Employers Eligible for the Exchange

- Beginning in 2014, small employers can offer coverage to their employees through an Exchange.

- A “small employer” is an employer that employed an average of at least one but not more than 100 employees on business days during the preceding calendar year, and employs at least one employee on the first day of the plan year.

- Before 2016, a state will have the option to define “small employer” by substituting 50 for 100 in the standard definition.

Small Business Health Options Program ("SHOP")

Small Business Health Options Program (SHOP)

- SHOPs are intended to allow small employers to offer their employees a choice of QHPs, the way large employers can—giving the small employer and its employees more bargaining power, a bigger risk pool, and more choices.

- HHS has posted a paper and online SHOP application for employers, and an application for their employees.

- For 2014, small employers enrolling through the FF-SHOP, and some state-based SHOPs, must use a "direct enrollment" process, submitting a paper application rather than applying online. Most employers will work with an agent, broker, or insurer to submit the application.

- HHS has announced that for the first time, starting November 15, 2015, small employers will be able to enroll in SHOP coverage entirely online.

- Direct enrollment will cease to be an option as of November 15, 2014, when employers wanting 2015 plan year coverage in the FF-SHOP must use the online system available at HealthCare.gov

SHOP Functions

- A SHOP is required to carry out all of the functions of an Exchange, but is not required to carry out certain requirements related to individual coverage.

- A state may choose to merge its individual and small group market risk pools and operate the Exchange and SHOP through the same structure, and may allow individuals and employees of small businesses to have the same plan options.

- And starting in 2017, an Exchange could choose to allow insurers in the large group market to offer QHPs inside the SHOP.)

- If a state does not merge the individual and small group market risk pools, the SHOP must permit each qualified employee to enroll only in QHPs in the small group market.

SHOP Functions

- Different structures have been established for state-operated SHOPs and FF-SHOPs.
- Health care reform requires a SHOP to allow a qualified employer to choose a “metal” level of coverage (i.e., bronze, silver, gold, platinum band make all QHPs within that level available to its qualified employees.
- This is referred to as the “employee choice model.”
- State-operated SHOPs are not required to offer the employee choice model for plan years beginning before January 1, 2015, and FF-SHOPs will not start offering the employee choice model until plan years beginning on or after January 1, 2015.

SHOP Functions

- State-operated SHOPs have flexibility to allow a qualified employer to make QHPs available to employees by other methods in addition to the employee choice model.

- For example, according to HHS, some health insurers expressed openness to allowing an employee to “buy up” to certain plans at the next higher metal level above the one specified by the employer.

- This would give employees access to a broader range of health plans.

- While this may be a feature of some state-operated SHOPs, it will not be offered through the FF-SHOPs, at least in the first year of SHOP operation.

SHOP Functions

- A SHOP must provide a premium calculator to help employees determine their cost of coverage after any employer contribution.

- The calculator must compare available QHPs after the application of any applicable employer contribution in lieu of any advance payment of the premium tax credit and any cost-sharing reductions.

- Bills provided by a SHOP must contain, in addition to the total amount due by the employer, the portion of each employee's premium for which the employer is responsible and the portion for which the employee is responsible.

- A SHOP may also include an average premium on the billing statement to assist employers in smoothing premium costs between employees

SHOP Functions

- A state-operated SHOP may have minimum participation requirements so long as they are based on the rate of employee participation in the SHOP, not on the rate of employee participation in any QHP of a particular issuer.

- Under final insurance market reform regulations, insurers cannot deny coverage for failure to meet minimum participation requirements.

- The default minimum participation rate for the FF-SHOP is 70%, also calculated at the level of the participation of the employees of the employer in the FF-SHOP and not enrollment in a single QHP.

SHOP Functions

- Federally facilitated SHOPs (FF-SHOPs) are expected to provide a number of tools and resources to help employers, employees, agents, and brokers evaluate coverage options.

- They will allow employers to model scenarios, for instance by changing the employer contribution percentage, before selecting coverage.

- FF-SHOPs will collect a single, aggregated payment from each employer and distribute the payment to QHP insurers based on participating employee plan selections.

SHOP Functions

- FF-SHOPs are expected to offer additional administrative support, including employer billing, receipt of payments, disbursements to plans, and payment reconciliation.

- Multi-state employers participating in the FF-SHOP will offer coverage to all eligible employees either through the FF-SHOP serving the employer's primary place of business or through the state-based or the FF-SHOP serving each employee's primary worksite.

SHOP Functions

- State-operated SHOPs have flexibility to allow a qualified employer to make QHPs available to employees by other methods in addition to the employee choice model.

- For example, according to HHS, some health insurers expressed openness to allowing an employee to “buy up” to certain plans at the next higher metal level above the one specified by the employer.

- This would give employees access to a broader range of health plans.

- While this may be a feature of some state-operated SHOPs, it will not be offered through the FF-SHOPs, at least in the first year of SHOP operation.

Employers and Employees Eligible for a SHOP

- A SHOP must permit qualified employers to purchase coverage for qualified employees through the SHOP. A qualified employer is defined as an employer that meets three requirements:
  - is a small employer;
  - elects to offer, at a minimum, all full-time employees coverage in a QHP through a SHOP; and
  - either has its primary office in the Exchange service area and offers all its employees coverage through that SHOP, or offers coverage to each eligible employee through the SHOP servicing the employee's primary worksite.

Employers and Employees Eligible for a SHOP

- A “small employer” is an employer that employed an average of at least one but not more than 100 employees on business days during the preceding calendar year, and employs at least one employee on the first day of the plan year.

- A qualified employee is an individual employed by a qualified employer who has been offered health insurance coverage by such qualified employer through the SHOP.

Qualified Employer Participation Rules

- The SHOP must permit a qualified employer to purchase coverage for its small group at any point during the year.

- The employer's plan year must consist of the 12-month period beginning with the qualified employer's effective date of coverage.

- The SHOP must provide qualified employers with a period of no less than 30 days prior to the completion of the employer's plan year and before the annual employee open enrollment period (discussed below), in which the qualified employer may change its participation in the SHOP for the next plan year.

- If an employer remains eligible for coverage and does not take action during the annual employer election period, the employer will continue to offer the same plan, coverage level, or plans selected the previous year for the next plan year unless the QHP or QHPs were no longer available.

Qualified Employer Participation Rules

- Qualified employers are required to provide the SHOP with information about individuals or employees whose eligibility to purchase coverage through the employer has changed.

- This notice would apply both to newly eligible employees and dependents as well as to those no longer eligible for coverage.

- The employer would retain all notice responsibilities under state and federal law for these individuals (including, for example, COBRA election notices).

Qualified Employer Enrollment Rules

- HHS regulations established standards for annual and special enrollment periods for individuals enrolled through an Exchange or SHOP.

- SHOPs are required to adhere to the open enrollment period requirements for Exchanges and provide the special enrollment periods of an Exchange, with a few exceptions.

- The SHOP must establish a standardized annual open enrollment period of no less than 30 days for qualified employees prior to the completion of the applicable qualified employer's plan year and after that employer's annual election period.

Qualified Employer Enrollment Rules

- SHOPs also must allow qualified individuals and enrollees to enroll in a QHP or change from one to another as a result of the following triggering events:
  - A qualified individual or dependent loses minimum essential coverage;
  - A qualified individual gains a dependent or becomes a dependent through marriage, birth, adoption, or placement for adoption;
  - A qualified individual's enrollment or non-enrollment in a QHP is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of the Exchange or HHS;
  - An enrollee adequately demonstrates to the Exchange that the QHP in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee;
  - A qualified individual or enrollee gains access to new QHPs as a result of a permanent move;
  - An Indian may enroll in a QHP or change from one to another one time per month; and
  - A qualified individual or enrollee demonstrates to the Exchange that the individual meets other exceptional circumstances (as defined by the Exchange).

Employer Contributions

- Employers in the SHOP may elect a variety of ways to contribute toward health coverage.
- Because employees in the SHOP may be choosing their own coverage and will need to know the net cost to them after the employer's contribution, each employer must choose a contribution method before its employees select coverage.
- To facilitate this, each SHOP will define one or more standard methods by which employers contribute toward employee coverage.
- In the FF-SHOP, the employer will be required to define a percentage contribution toward premiums for employee-only coverage under a specific reference plan and, if dependent coverage is offered, a percentage contribution toward premiums for dependent coverage under the reference plan.

Employer Credits

- For tax years beginning in 2014 and later, the maximum small business health care tax credit available to eligible small employers increases to 50% of nonelective contributions, but the requirements for the contribution arrangement are different from those applicable to earlier tax years.

- The nonelective contributions for 2014 and later tax years must be made on behalf of employees who enroll in a qualified health plan offered to employees by the employer through an Exchange.

What is a Small Employer?

- In order to qualify to receive a small business health care tax credit in any tax year, an employer must be either an eligible small employer or a tax-exempt eligible small employer, as defined in Code § 45R.
- **Definition of Eligible Small Employer**
  - There are three requirements that an employer must satisfy to be an "eligible small employer." With respect to any tax year—
  - the employer must have no more than 25 full-time equivalent (FTE) employees for the tax year;
  - the employer's FTEs must have average annual wages that do not exceed $50,000 (for 2010 through 2013); and
  - the employer must have a contribution arrangement in effect that meets the requirements of Code § 45R(d)(4).

Reporting

Form 1099-B

- Employers who are not subject to the employer mandate requirements, health insurance issuers, self-insured multiemployer plans, and providers of government-sponsored coverage, will report on Form 1095–B (or a substitute form).

- Filers will be required to submit a single Form 1094-B as a “transmittal form” to the IRS with the Forms 1095-B.

- The timelines track the Form W-2 rules.

Form 1095-B

- The form is generally filed with the IRS by Feb. 28 (March 31 for electronic filing), and furnished to full-time employees or responsible individuals by January 31.

- The information on the form pertains to the prior calendar year and the first forms are due in 2016 (reporting information for 2015).

Form 1095-C

- In 2015, employers with 50 or more full-time equivalent employees will be required to report information about health coverage offered during the prior year to full-time employees, including information about the lowest cost option offered and whether the minimum value requirements were satisfied.

- Form 1095–C (or a substitute form) will be used by self-insured employers to meet both the employer responsibility and the minimum essential coverage reporting requirements.

- An employer that provides insured coverage will also report on Form 1095–C, but will complete only the employer section.

- In addition, filers will be required to submit a single Form 1094-C as a “transmittal form” to the IRS with the Form 1095-C.

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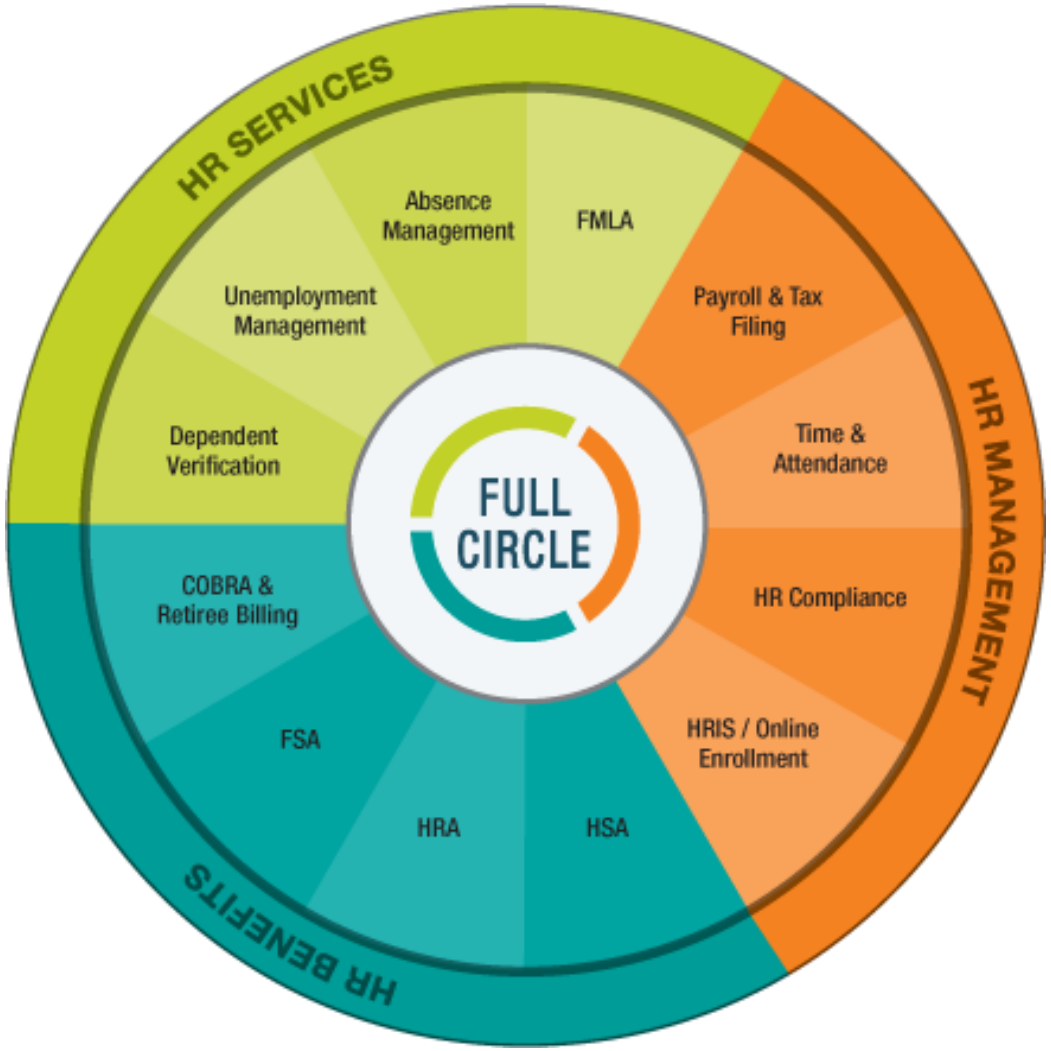

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