THE AFFORDABLE CARE ACT AND YOU

An Overview for Large Groups

EmblemHealth®

WHAT CARE FEELS LIKE.

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Find Answers to Your Questions About ...

The Affordable Care Act (ACA) includes protections, requirements and opportunities for large businesses, defined as those with an average of 50 or more full-time equivalent employees. With this booklet, we at EmblemHealth hope to explain the most important things you need to know.*

The ACA can mean different things for different groups. For example, certain transition rules apply to groups with fewer than 100 full-time equivalents. So please consult your legal counsel or tax professional for a closer look at how the law may affect your business and employees.

Visit **emblemhealthreform.com** for more information.

*The information in this booklet is current as of August 2014 and may not reflect changes made after publication. It is not meant to provide tax or legal advice. For specific questions, please speak with your legal counsel or tax professional.

What This May Mean for Your Group

Please consult your legal counsel or tax professional for specific guidance on how the employer mandate affects your group. Visit **www.irs.gov** for federal guidance on the mandate.

EMPLOYER MANDATE

The Affordable Care Act (ACA) includes shared responsibility provisions — often called the "employer mandate."

New Minimum Coverage Requirements

Starting in 2015, the employer mandate will require large groups (those with 50 or more full-time equivalents) to offer affordable, adequate health coverage to all their full-time employees and those employees' children, or pay a penalty. View the section on "Coverage Changes" in this booklet to see how the ACA defines affordable and adequate.

Time Frame

For most large businesses, the mandate takes effect in 2015 at the start of their plan year. In certain circumstances, employers with between 50 and 99 employees may be exempt from certain noncompliance penalties until 2016.

Reporting Requirements

During tax time in 2016, the IRS will require large employers to report on all the individuals they covered under their group plan in 2015. This is commonly called the 6056 report. For more information, please see the "Administrative Needs" section of this booklet.

What This May Mean for Your Group

The ACA legally protects your group from being denied or dropped from health coverage due to the health status of your employee population.

ACCESS TO COVERAGE

The Affordable Care Act (ACA) ensures that group health plans can access health coverage for their employees and renew their plans.

Guaranteed Issue

All health insurance companies offering coverage in a state's large group market must accept every large group that applies for such coverage. Some exceptions are if:

- A group moves outside a service area
- A group cannot pay the premium costs
- The insurance issuer withdraws from the market

Guaranteed Renewability

All health insurance issuers (for example, EmblemHealth's New York underwriting companies GHI, HIP and HIPIC) that offer coverage in a state's large group market must renew or continue such coverage at the option of the plan sponsor.

Nondiscrimination

Effective January 1, 2014, large groups must offer uniform benefits packages, regardless of the group's compensation structure.

What This May Mean for Your Group

With these changes, your employees will be more protected from the costs of health care. Encourage your employees to read and understand their Summary of Benefits & Coverage so they know how best to use their benefits.

COVERAGE CHANGES

The Affordable Care Act (ACA) protects equal access to quality, affordable health insurance.

Adequate, Affordable Coverage

Effective January 1, 2015, the health insurance coverage that large groups offer their employees must meet the ACA standards for both:

- **Adequacy**: A plan must be of minimum actuarial value, meaning it covers at least 60 percent of the total cost of the health benefits.
- **Affordability**: A plan must cost employees no more than 9.5 percent of their yearly household income.

Out-of-Pocket Maximum

Effective January 1, 2014, an absolute limit (out-of-pocket maximum, or MOOP) will apply to members' annual out-of-pocket costs for health care. The MOOP will be adjusted annually based on IRS guidelines, to account for changes in health care costs.

MOOPs for 2014 and 2015		
	Self-Only Coverage	**Couple/Family Coverage**
2014	$6,350	$12,700
2015	$6,600	$13,200

- **Included in MOOP**: In-network deductibles, coinsurance and copays paid toward covered essential health benefits
- **Not Included in MOOP**: Monthly premiums, out-of-network charges (charges for non-participating providers), services not covered under a plan, and services not considered essential health benefits, such as adult vision and dental services

Annual or Lifetime Dollar Limits Lifted

As of January 1, 2014, health insurers cannot place annual or lifetime maximum dollar limits on how much they'll pay for services covered under an employee's benefit plan. Benefit limits can still apply to most covered services (for example, a limit on the number of visits) — just not a dollar limit.

Pre-Existing Conditions Covered

As of January 1, 2014, no one can be denied health insurance or pay higher premiums due to a pre-existing condition (a health condition someone had before their coverage start date). Health insurance issuers also cannot deny claims based on a pre-existing condition.

What This May Mean for Your Group

A healthier and more productive work force means fewer sick days, less stress and a better ability to manage time and workloads. Consider ways to encourage preventive care and incorporate incentive-based wellness programs into your employee benefits package.

HEALTH AND WELLNESS BENEFITS

The Affordable Care Act (ACA) increases consumer access to preventive care and gives groups new opportunities to encourage employees to participate in wellness programs.

Preventive Care Access

Effective January 1, 2014, group plans must cover certain in-network preventive care services for adults, children and infants at no out-of-pocket cost. This includes regular checkups, vaccinations, a yearly flu shot and screenings such as a colonoscopy, prostate screening and mammogram.

For a full list of preventive services that must be covered, visit **www.hhs.gov/healthcare** and select Prevention & Wellness.

Workplace Wellness Incentives

Effective January 1, 2014, businesses may choose to encourage their employees to participate in health-contingent wellness programs, subject to certain rules, by offering to pay:

- Up to 30 percent of an employee's monthly premium contribution for participating in such a workplace wellness program **and**
- An additional 20 percent of the employee's monthly premium contribution for participating in a tobacco-cessation program.

The total reward for participation cannot, however, exceed 50 percent of the employee's total annual premium.

What This May Mean for Your Group

The ACA fees and taxes may increase your premiums or self-insured program costs, but the impact may vary by group. So it's important to consult your legal counsel or tax professional for specific guidance.

FEES AND TAXES

Under the Affordable Care Act (ACA), the federal government will levy new fees and taxes on some large businesses. The following fees and taxes apply to plan sponsors and administrators of self-insured plans. They also apply to insurers of fully insured plans and **are included in premium costs**.

Patient-Centered Outcomes Research Institute Fee ("PCORI" or "CER" fee):

- **Purpose**: To support research of effective, efficient medical prevention, treatment and care
- **Time Frame**: 2013 through 2019; does not apply to plan years ending after September 30, 2019
- **Cost**: Assessed annually per covered life; adjusted yearly for inflation

Transitional Reinsurance Assessment Fee

- **Purpose**: To help stabilize premiums in the individual market as new high-cost individuals enter the health insurance market
- **Time Frame**: 2014 through 2016; paid on quarterly basis
- **Cost**: Assessed annually per covered life

High-Cost Health Insurance Tax ("Cadillac Tax")

(For more information, see the "Cadillac Tax" section of this booklet.)

- **Purpose**: To help support the cost of health care reform and the reduction of medical costs
- **Time Frame**: 2018 and beyond
- **Cost**: An excise tax of 40 percent on plan costs that exceed the defined thresholds

State Exchange Fees

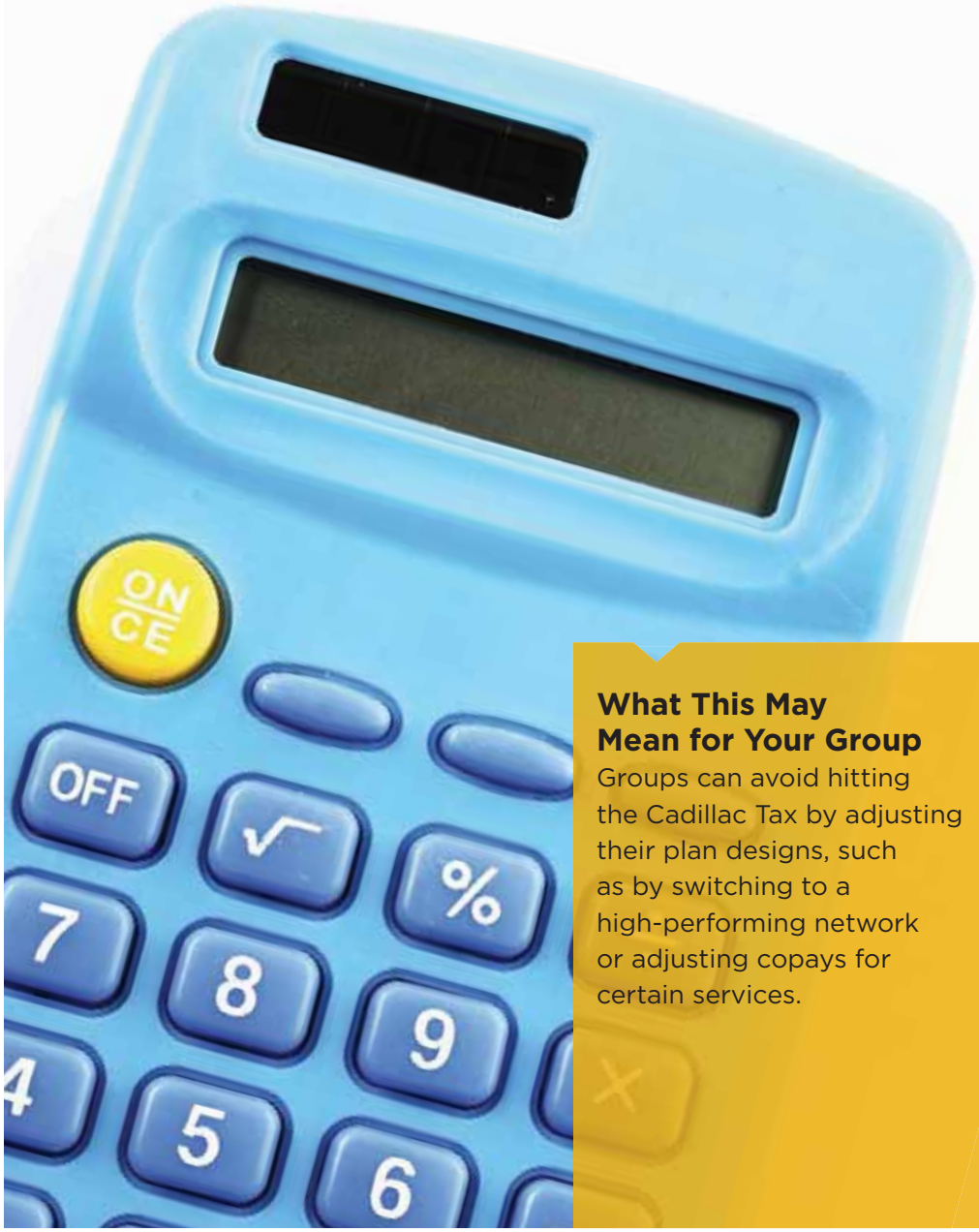
- **Purpose**: To support the administration of the state health insurance marketplaces
- **Time Frame**: To be determined and varies by state
- **Cost**: Does not apply in New York State for calendar year 2015

The following fee applies to insurers of fully insured plans, but **not** to self-insured plans:

Health Insurer Fee

- **Purpose**: To support the cost of health care reform
- **Time Frame**: 2014 and beyond
- **Cost**: Varies based on insurers' relative market share of all US health insurance business

Note: The fees and taxes listed on this page do not reflect potential shared responsibility penalties or other fees and taxes that may not directly impact employers, including the medical device tax and any other taxes repealed in future legislation.



What This May Mean for Your Group

Groups can avoid hitting the Cadillac Tax by adjusting their plan designs, such as by switching to a high-performing network or adjusting copays for certain services.

CADILLAC TAX

Starting in 2018, a high-cost health insurance tax — often called the Cadillac Tax — will be levied on high-cost employer-sponsored health coverage, as part of the Affordable Care Act (ACA).

How the Tax Works

A 40 percent tax will be applied only to the portion of employer-sponsored coverage that exceeds a given cost threshold. For 2018, the yearly cost threshold will be:

- $10,200 for self-only coverage
- $27,500 for couple/family coverage

The cost threshold(s) includes employer- and employee-paid premiums (or COBRA program cost for self-insured groups) and contributions to Health Savings Accounts (HSAs) and Flexible Spending Accounts (FSAs).

The tax is levied at the member contract level, not at the group contract level. For example, if an employee's plan is valued at $11,200, the group will pay a 40 percent tax on the $1,000 surplus, amounting to a $400 tax for that policy.

Who Pays

Insurers pay on behalf of fully insured groups, and self-funded groups pay on their own behalf.

Adjustments to Thresholds

The cost threshold may be subject to adjustment for:

- Health care costs, age, gender and cost of living
- Retired individuals age 55 and older and covered employees in high-risk professions (adjusted to $11,850 for self-only coverage and $30,950 for couple/family coverage)

What This May Mean for Your Group

It's important to start consulting your legal counsel or tax professional now to make sure you're on track to comply with these requirements.

ADMINISTRATIVE NEEDS

The Affordable Care Act (ACA) requires certain actions from large groups. Speak with your legal counsel or tax professional for specific guidance.

Required Benefits Documents

Under the ACA, groups and health insurance issuers must provide plan members with:

1. **A Summary of Benefits & Coverage**: A federally standardized document describing benefits and cost-sharing responsibilities, in plain language and a simple format. It must be provided to employees when shopping for and enrolling in a plan, again at each new plan year, **and** within seven business days of requesting a copy from their group health plan or health insurer.
2. **A Uniform Glossary**: A standardized list of terms commonly used in health insurance coverage, such as copay and deductible.

Reporting Requirements

Under the ACA, your large group is required to report on the health coverage you offer to full-time employees. You must:

- **File Section 6056 information returns to the IRS**: While you can choose to report this for the 2014 plan year (in the 2015 tax season), you must report this for the 2015 plan year (in the 2016 tax season). Fully insured groups may be able to file the report with their insurance carrier. Speak with your legal counsel or tax professional about how to proceed.
- **Notify your employees**: You must also provide full-time employees a simplified version of the report you submit to the IRS, which will specify the months of the year they were offered minimum essential coverage.

90-Day Waiting Period

Effective January 1, 2014, large groups must allow employees to enroll in the group health plan no more than 90 days (including weekends and holidays) after they become eligible for such coverage.

Exchange Notices

Effective January 1, 2013, large groups must send notices to their employees each year stating they may opt to seek coverage through their state's health insurance exchange.

KEY TERMS

Affordable Care Act (ACA) — The bill President Obama signed into law in 2010 to reform the US health care system. It's also known as Obamacare.

Coinsurance — A percentage of the cost an insured person pays for a covered health service, often once they meet their deductible (if they have one).

Copay — The fixed dollar amount an insured person pays to a health care professional for covered services, typically at the time of the office visit.

Deductible — The fixed dollar amount an insured person pays toward covered services each year before an insurance company starts paying for covered health services.

Full-time employees — As defined by the ACA, employees who work an average of 30 or more hours per week.

Full-time equivalents — As defined by the ACA, employees who work the equivalent of a full-time employee. They must be counted as full-time employees in determining the total number of full-time employees a group employs.

Grandfathered plans — Plans that have been permitted to keep most of their pre-Obamacare health benefits subject to certain conditions. To qualify, the plan must have been effective on or before March 23, 2010 — the date of the ACA's enactment — and cannot be modified in a way that would cause a loss of grandfathered status.

Large group — As defined by the ACA, a business with an average of 50 or more full-time employees or full-time equivalents for over six months of the year.

KEY TERMS (CONTINUED)

Minimum actuarial value — The percentage the insurer pays for total health care costs versus what the member pays.

Minimum essential coverage — Health insurance that meets the national standards for health care coverage that all lawfully present US residents must obtain starting in 2014, if they want to avoid paying the individual penalty.

Network — The group of doctors, hospitals and other health care providers with whom a health insurer or self-funded plan contracts in order to deliver medical services to plan members.

Non-grandfathered plans — Plans that do not qualify as grandfathered plans and/or plans that became effective after March 23, 2010 — the date of the ACA's enactment. Non-grandfathered plans must meet all pertinent ACA requirements.

Out-of-pocket costs — Costs that plan members pay as part of their health coverage. This includes copays, coinsurance and deductibles.

Out-of-pocket maximum — The annual maximum dollar amount an insured person will have to pay in out-of-pocket costs for covered essential health benefits received in network.

Pre-Existing Condition — A health condition someone had before their coverage start date.

Premium — The amount an insured group and/or individual pays to their health insurance carrier each month for their health coverage.

NOTES

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