HEALTH CARE REFORM SERIES

The small business guide

What is it?

Health care reform made big changes to small employee benefits for plans starting on or after Jan. 1, 2014. Don't worry, we've got you covered. You can count on HealthPartners to help you understand these changes. Here's a quick reference guide to how the Affordable Care Act (ACA) impacts small employers like you.

First things first – are you a small employer?

The changes in this guide apply to employers considered "small" for the purposes of plans and rates.

Section 1304 (b) (2) of the Patient Protection and Affordable Care Act (42 U.S. Code 18024 (b)(2)) was amended by the Protecting Affordable Coverage for Employees Act or "PACE Act" (Public Law 114-60) to now read:

> *The term "small employer" means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 1, but not more than 50 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year.*

Generally speaking, employers with 2–50 employees are considered small. Additional guidelines apply. Be sure to talk to your broker or account manager if you have questions.

Essential Health Benefits (EHB)

The ACA sets mandates for the types of services that small employer plans must cover. These guidelines, called Essential Health Benefits (EHBs), include preventive services, pregnancy and childbirth, hospital stays, emergency care and more.

Plans must also offer dental coverage for children (dental benefits for adults are optional). All HealthPartners small employer plans include pediatric dental coverage. That includes 100 percent coverage for preventive services like cleanings and exams for children through age 19. All basic, major and medically necessary orthodontic benefits are subject to the medical plan's deductible and coinsurance provisions, including out-of-pocket maximums.

For a full list of essential health benefits, visit **healthcare.gov**.

Actuarial Value (AV)

Actuarial Value (AV) is a way to estimate the percentage of health care expenses that a health plan will cover in a given year.

Example: A plan with an AV of 60 percent means that the plan would pay 60 percent of covered health care expenses while the member would pay an average of 40 percent out-of-pocket in the form of copayments, coinsurance and deductibles.

All small employer plans must meet one of four AV levels or tiers in order to comply with the law: 60 percent (bronze); 70 percent (silver); 80 percent (gold); and 90 percent (platinum).

Cost sharing limits

Under reform, there are no annual or lifetime limits on health care services. However, the ACA does set limits for consumer spending on in-network essential health benefits. These out-of-pocket limits are for costs paid by the consumer, like deductibles, copays or coinsurance, for in-network services. This doesn't include health care premiums or out-of-network costs.

For standard deductible plans, all copays and deductibles must meter to the out-of-pocket limit and be no more than $7,900 for individuals and $15,800 for families (2019 limits). Qualified high deductible health plans (HDHP) and health saving account (HSA) cost sharing and contribution limits are different and are determined by the IRS. The 2019 HDHP out-of-pocket limit is $6,750 for individuals and $13,500 for families.

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Adjusted community rating

The ACA requires an adjusted community rating to determine premiums for small employers buying insurance in and outside the public marketplace or exchange. Premiums are calculated using these factors: family size, geographic location, age and tobacco use (tobacco use is optional and HealthPartners does not apply a tobacco rating factor).

Principal business address

The ACA requires that the rating area for small employers is determined using the group policyholder's principal business address. If the employer has registered an in-state principal business address with the state, that location is the principal business address. However, an address registered solely for purposes of service of process will not be considered the employer's principal business address unless it is also a substantial worksite for that business.

If an in-state principal business address isn't registered with the state or is only registered for purposes of service of process and is not a substantial worksite, then the principal address is the business address within the state where the greatest number of employees work in the applicable state.

In the case of a network plan with limited service areas, if the principal business address isn't in the service area, the principal business address will be the business address within the plan's service area where the greatest number of employees work as of the beginning of the plan year. In addition, the rating area for the network plan is the rating area that reflects where the greatest number of employees within the plan's service area live or reside as of the beginning of the plan year.

Open enrollment

Employers may continue to purchase coverage at any time during the year. However, insurers may limit enrollment to Nov. 15 through Dec. 15 for employers who fail to comply with state laws on participation and contribution requirements.

Late and special enrollment

The ACA allows employees to enroll in coverage 31 days after the date of eligibility, determined by the employer, and after completing applicable new hire waiting periods. Employees who don't enroll within 31 days will need to wait until the next open enrollment or a 30 day special enrollment period to obtain coverage. Termination, divorce and death of a covered employee are a few examples of qualified events for a special enrollment period. For a full list, see section 603 of ERISA. HealthPartners small employer open enrollment must occur within 31 days prior to the group's effective date.

90 Day maximum waiting period

Starting on Jan. 1, 2015, as groups renew, waiting periods for small employers can be no longer than 90 days.

Marketplaces

Public exchanges, or "marketplaces" are a growing distribution channel for buying and selling health plans to individuals and small employers. Minnesota's marketplace is called MNsure, and Wisconsin uses the federally facilitated marketplace.

Guaranteed availability of coverage

Reform requires all health plans to offer non-grandfathered small employers all approved products. Any applicant, with certain exceptions (e.g. the group is not located in the product or network service area), will be accepted.

Guaranteed renewal

The ACA requires insurers to renew or continue coverage if employers choose. Exclusions include non-payment of premium, fraud and failure to comply with state laws on participation and contribution requirements.

MORE INFORMATION

To learn more, visit **healthpartners.com/employer**.

HealthPartners has produced this series to promote general understanding of key topics in health care reform. This information is not a legal opinion or tax advice and should not be relied upon as a legal opinion or tax advice. You should seek advice based on your particular circumstances from an attorney or independent tax advisor.

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