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Small Group Market Expansion

For purposes of defining their large and small group health insurance markets, most states currently define a "small employer" as an employer that has 50 or fewer employees. The Affordable Care Act (ACA) called for the definition of a "small employer" to be expanded to include those that employed an average of between **one and 100 employees** on business days during the preceding calendar year and that employ at least two employees on the first day of the plan year. However, for plan years beginning before Jan. 1, 2016, a state could elect to define "small employer" as an employer that employed an average of between one and **50 employees** on business days during the preceding calendar year.

However, on Oct. 7, 2015, President Obama signed into law the **Protecting Affordable Coverage for Employees (PACE) Act**, which **repeals the ACA's small group market expansion requirement**. As a result, states now have the option, but are not required, to expand their small group markets to include businesses with up to 100 employees.

The expansion of the small group market was expected to have a significant effect on mid-size businesses. The ACA change means that some employers who had traditionally purchased policies in the large group market would have been shifted into the small group market for 2016 and beyond. Plans in the small group market must comply with a number of ACA requirements that do not apply in the large group market, such as the ACA's premium rating restrictions and the essential health benefits (EHB) requirement.

This Legislative Brief describes the impact of repealing the ACA's small group market expansion and outlines the ACA provisions that will apply when an employer moves into the small group market.

OVERVIEW OF THE SMALL GROUP MARKET

Most states have historically defined "small employers" as those with 50 or fewer employees for purposes of defining their small group health insurance market. The Department of Health and Human Services (HHS) indicated that it intended to issue guidance in the future about how to count employees in order to determine the market size of a group health plan. Currently, states use a variety of different methods to calculate employer group size.

An employer not in existence during the preceding calendar year must determine whether it is a small or large employer based on the average number of employees that it reasonably expects to employ on business days in the current calendar year. Also, the tax code's aggregation rules for controlled groups, companies under common control and affiliated service groups apply when determining an employer's size.

ACA's Small Group Market Expansion

Effective for 2016 plan years, the ACA called for the definition of a "small employer" to be expanded to include those that employed an average of between one and 100 employees. This requirement would have meant that employers with up to 100 employees would be required to purchase policies in the small group market, which is more heavily regulated than the large group market. This change was expected to increase premiums costs for employers and employees and reduce flexibility in plan design due to added small group market requirements.

However, **the PACE Act eliminates the ACA's new definition** and, instead, gives states the option of expanding their small group markets to include businesses with up to 100 employees.

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Some states have already amended their state laws to adopt the expanded small group market definition. In many cases, these states will have to take action to undo those changes.

Optional Transition Policy

Most states are already taking advantage of a transition policy provided by HHS that allows issuers in the individual and small group markets to renew health insurance policies that do not comply with certain ACA reforms that are effective for 2014. Originally, HHS announced that the transition policy would last one year; however, HHS later extended the transition policy for two additional years, to **policy years beginning on or before Oct. 1, 2016**.

Due to this transition policy, some insured group health plans for small employers may not include some of the ACA's requirements for small group market plans. If an issuer is using the transition relief, it is required to send a **notice** to the employer that explains which ACA reforms are not included in the health plan's coverage. This means that many employers have already been able to delay moving from the large group to the small group market. The PACE Act makes this relief permanent for all employers.

However, the transition policy is not available in every state. Because the insurance market is primarily regulated at the state level, state governors or insurance commissioners must allow issuers in their states to use the transition policy. Also, even if the transition policy is available in a state, health insurance issuers are not required to follow the transition relief and renew plans that do not comply with ACA reforms.

In addition, transition relief also applies to **large employers** that currently purchase insurance in the large group market, but that, as of Jan. 1, 2016, will be redefined by the ACA as small employers purchasing insurance in the small group market. At the option of the states and health insurance issuers, these large employers may renew their current policies through policy years beginning on or before Oct. 1, 2016, without their policies being considered as out of compliance with the specified ACA reforms that apply to the small group market but not to the large group market.

SMALL GROUP MARKET RULES

A number of ACA requirements apply to plans in the small group market only, and do not apply in the large group market. These provisions include:

Essential Health Benefits	Rating Restrictions	Metal Levels

These small group rules apply to fully insured plans, regardless of whether they are purchased through or outside of the Small Business Health Options Program (SHOP) Exchange. Self-insured plans in the small group market are not subject to these requirements.

Essential Health Benefits Package

Beginning in 2014, the ACA requires non-grandfathered health insurance plans in the individual and small group markets to offer comprehensive health coverage, known as the **essential health benefits package**. This comprehensive coverage requirement does not apply to grandfathered health plans, self-insured group health plans and health insurance plans offered in the large group market.

Under the essential health benefits package, a health insurance plan is required to:

- Cover a core set of items and services, known as essential health benefits (EHB);
- Limit cost-sharing for EHB; and
- Provide either a bronze, silver, gold or platinum level of coverage (or a catastrophic plan in the individual market).

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The ACA requires EHB to reflect the scope of benefits covered by a typical employer and to cover at least the following **10 general categories** of items and services:

- Ambulatory patient services (outpatient care)
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder benefits, 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

HHS developed a state-specific **benchmark approach** to more specifically define the items and services that comprise EHB. Under this approach, each state selected a benchmark insurance plan that reflects the scope of services offered by a typical employer plan in the state. If a state did not select a benchmark plan, HHS selected the small group plan with the largest enrollment in the state as the state's default benchmark plan. **As a general rule, the items and services included in a state's benchmark plan comprise the EHB that insured health plans in the state's individual and small group markets must cover**.

More information on the benchmark plans, including the benchmark plan for each state, is available on the Center for Consumer Information & Insurance Oversight (CCIIO) website.

Rating Restrictions for Health Insurance Premiums

Beginning in 2014, the ACA reforms the rating practices of health insurance issuers in the individual and small group markets by limiting the factors that can vary premium rates. These rating restrictions do not apply to grandfathered plans, large group plans or self-funded plans.

Under the ACA's rating restrictions, issuers may vary the premium rate charged to a non-grandfathered plan in the individual or small group market from the rate established for that particular plan only based on the following factors:

Age (within a ratio of 3:1 for adults)	**Geography** (rating area)
Family size (individual or family)	**Tobacco use** (within a ratio of 1.5:1)

All other rating factors are prohibited. This means that several factors commonly used by issuers to set higher premiums prior to 2014, such as health status, claims history, duration of coverage, gender, occupation, small employer size and industry, can no longer be used.

Per-member Rating Methodology

A **final rule** implementing the ACA's rating restrictions for health insurance premiums directs issuers to use the **per-member rating methodology** in the small group market. According to HHS, per-member rating ensures compliance with the requirement that age and tobacco rating only be apportioned to an individual family member's premium, enhances employee choice inside the SHOP Exchange and promotes accuracy of the ACA's risk adjustment methodology.

> Under the per-member rating methodology, the total premium charged by an issuer to a group health plan in the small group market is generally determined by adding up the premiums of each individual enrolled in the plan based on their age and tobacco use. This methodology is also referred to as "**list billing**."

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Also, according to HHS, the age bands—as implemented by the per-member rating methodology—are consistent with the Age Discrimination in Employment Act of 1967 (ADEA).

Composite Premium Methodology

The final rule allows issuers in the small group market to charge a group an amount for enrollees based on the average premium per member of the group (referred to as "**composite premiums**"), rather than their own specific per-member amount. An issuer may offer composite premiums in connection with a small group health plan as long as the total group premium calculated at the time of enrollment at the beginning of the plan year equals the amount that is derived from per-member rating.

Effective for plan years beginning on or after Jan. 1, 2015, an issuer that offers composite premiums generally must:

- Ensure that an average enrollee premium amount calculated based on enrollment of participants and beneficiaries at the beginning of the plan year does not vary during the plan year;
- Calculate the average enrollee premium amount for:
    - Covered individuals age 21 and older; and
    - Covered individuals under age 21; and
- Apply any rating for tobacco use on a per-member basis, and not as part of the average enrollee premium amount.

In addition, as a general rule, an issuer offering composite premiums with respect to a particular product offered in the small group market in a state must do so uniformly for all group health plans enrolling in that product, giving those group health plans the option to pay premiums based on a composite premium methodology. Plan sponsors selecting a product that offers composite premiums may then decide whether to pay premiums based on a per-member or composite premium methodology.

These composite premium rules are included in the 2015 Notice of Benefit and Payment Parameters Final Rule, which was released by HHS on March 11, 2014.

Uniform Family Tiers

States that do not permit rating for age and tobacco use may require health insurance issuers in the individual and small group markets to use **uniform family tiers** and corresponding multipliers established by the state.

Metal Levels

Non-grandfathered plans in the individual and small group markets outside of the Exchanges must offer coverage that matches up to the Exchanges' levels of actuarial value (referred to as metal levels—bronze, silver, gold and platinum). Actuarial value is calculated as the percentage of total average costs for EHB that a plan will cover.

A health plan's actuarial value tells consumers how generous the plan's coverage is based on its cost-sharing provisions (that is, deductibles, copayments and coinsurance). Plans with higher actuarial values provide coverage that is more generous. For example, if a plan has an actuarial value of 70 percent, on average, a consumer would be responsible for 30 percent of the costs of covered benefits. If a plan has an actuarial value of 80 percent, on average, a consumer would be responsible for 20 percent of the cost of covered benefits.

HHS has provided an Actuarial Value Calculator that issuers of non-grandfathered health plans in the individual and small group markets, both inside and outside of the Exchanges, must use to determine their metal levels. The Actuarial Value Calculator is available on the Center for Consumer Information & Insurance Oversight (CCIIO) website.

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Each metal level is based on a specified share of the actuarial value of the plan's EHB. Bronze plans have the least generous coverage, while platinum plans have the most generous coverage. Coverage levels are as follows:

Bronze Level	Silver Level	Gold Level	Platinum Level
60 percent actuarial value	70 percent actuarial value	80 percent actuarial value	90 percent actuarial value

HHS allows for small variations (plus or minus two percentage points) in the actuarial value used to determine levels of coverage. For example, under HHS' guidance, a silver plan could have an actuarial value between 68 percent and 72 percent.

SHOP EXCHANGE ELIGIBILITY

The ACA required each state to establish an online competitive marketplace, called an Exchange, where individuals and small businesses may purchase health insurance, beginning in 2014. The SHOP is the Exchange component for small businesses. According to HHS, the SHOP gives small businesses the same purchasing power as large businesses and will allow small employers to provide their employees with a choice of health plan options.

Although states could limit SHOP participation prior to 2016 to businesses with **up to 50 full-time equivalent (FTE) employees**, small employers with up to 100 employees will be eligible to participate in the SHOP in all states beginning in 2016. Beginning in 2017, states may allow businesses with more than 100 FTE employees to participate in the SHOP.

For purposes of SHOP eligibility, FTEs are calculated using the most recent year, and excluding seasonal employees (those working fewer than 120 days per year). Employers will:

- Count the number of people who worked an average of 30 or more hours per week; and
- Add to this amount the number of hours worked per week by non-full-time employees, divided by 30.

To participate in a SHOP, an employer must qualify as a "small employer" for purposes of Exchange participation. In addition, the employer must:

- Elect to offer, at a minimum, all full-time employees coverage in a qualified health plan through a SHOP; and
- Either have its primary office in the Exchange service area and offer all of its employees coverage through that SHOP, or offer coverage to each eligible employee through the SHOP servicing the employee's primary worksite.

In the SHOP, there are no residency standards for either the employer or employee. Small employers must either offer employees coverage through the SHOP serving the employer's primary business address or offer coverage to an employee through the SHOP serving the employee's primary worksite.

The SHOP's eligibility rules permit an employer to participate in more than one Exchange. Thus, multi-state employers may participate in multiple SHOPs. However, an employer may only establish one federal SHOP (FF-SHOP) account per state. In addition, issuers will not be required to determine employee counts for FF-SHOP eligibility purposes. Employers will attest that they employ 50 or fewer employees through information provided directly to the FF-SHOP.

Participation in a SHOP is voluntary for eligible small employers. However, beginning in 2014, a small employer that qualifies for the ACA's small business health care tax credit must purchase coverage through a SHOP in order to be eligible for the tax credit. For 2014, the maximum small business health care tax credit increases from 35 percent to 50 percent of employer contributions toward health coverage (from 25 percent to 35 percent for tax-exempt small employers).

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GUARANTEED RENEWABILITY

Effective Jan. 1, 2014, the ACA reaffirms existing protections that individuals and employers have with respect to coverage renewal. For example, these protections prohibit issuers from refusing to renew coverage because an individual or employee becomes sick or has a pre-existing condition.

A final rule issued by HHS on Oct. 30, 2013, clarifies that the ACA guarantees the employer the right to renew or continue in force the coverage it purchased in the small (or large) group market even if the employer ceases to be a small (or large) employer due to an increase (or decrease) in the number of employees. For example, an employer that originally purchased coverage in the small group market and that increases in size beyond the definition of a small employer has the option of keeping the product it purchased in the small group market.

However, the requirements of guaranteed renewability do not change the employer group's size for purposes of other reforms under the ACA. For example, the ACA's premium rating rules apply to health insurance coverage in the individual and small group markets, but generally do not apply to health insurance coverage in the large group market. Thus, the ACA's premium rating rules generally would not apply where an employer increases in size to become a large employer, even if the employer is renewing a product originally purchased in the small group market.

EARLY RENEWAL OPTION

As with past renewals, employers may see a premium increase, partially due to rising medical costs. To help mitigate the ACA's impact on health insurance premiums, some health insurance issuers have been encouraging employers to renew their coverage early for 2016.

The early renewal option gives employers the option to renew their coverage in late 2015 instead of waiting until their 2016 policy anniversary dates to renew. According to various issuers, renewing early could allow some employers to continue to purchase policies in the large group market, allowing them to postpone additional costs that are due to the ACA's premium rating and other reforms that apply in the small group market.

When considering an early renewal, keep in mind that the federal agencies implementing the ACA and other employee benefit laws have not addressed whether these early renewals are permissible. Because of this, employers should consult their benefit advisors or legal counsel to determine how an early renewal could impact them.

When an employer renews early, it may result in a change to the health coverage's plan year. The Internal Revenue Service (IRS) has limited plan year changes in a number of contexts. If an early renewal results in a change to the health coverage's plan year, the employer should consider the following:

- The IRS's final regulations on the ACA's employer shared responsibility penalty provide that once a plan year is established, it can only be changed for a valid business purpose. Applicable large employers, or ALEs (employers with 50 or more full-time and full-time equivalent, or FTE, employees) are prohibited from changing plan years to avoid the employer penalty under the final regulations. In addition, certain transition relief under the final regulations would not apply to ALEs that change their plan year. For example:
    - ALEs that have fewer than 100 full-time employees (including FTEs) generally will have an additional year, until 2016, to comply with the employer shared responsibility rules. However, **ALEs that change their plan year after Feb. 9, 2014, to begin on a later calendar date are not eligible for this delay**.
    - ALEs that maintain a non-calendar year plan may qualify for certain transition relief that would delay the employer shared responsibility rules until the beginning of the 2015 plan year. However, **ALEs that modified their plan year after Dec. 27, 2012, to begin on a later calendar date are not eligible for this transition relief**.
- The IRS's proposed cafeteria plan regulations provide that employers can only change a cafeteria plan's year based on a valid business purpose. Examples provided by the IRS of changes based on a valid business

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purpose include switching insurance carriers or experiencing a corporate merger, acquisition or other change in business operations.

- In Notice 2012-40, consistent with the proposed cafeteria plan regulations, the IRS states that a plan year is permitted to be changed only for a valid business purpose. If the principal purpose of changing the plan year of a health flexible spending account (FSA) is to delay the application of the ACA's $2,500 limit, the change is not for a valid business purpose.

In many of these contexts, the IRS has indicated that a plan year change that is not made for a valid business purpose will be disregarded and considered ineffective.

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