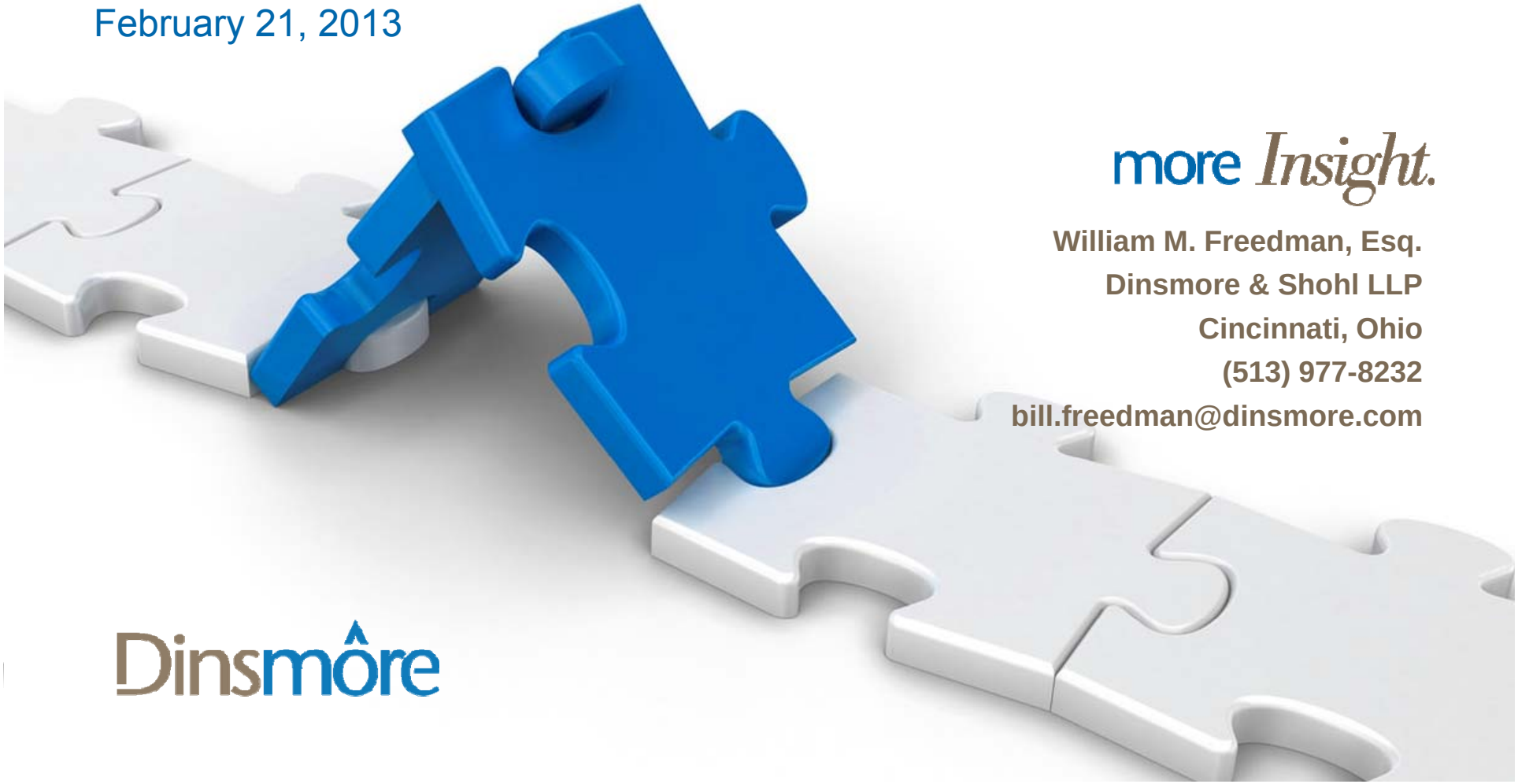
Healthcare Reform--Status Update

Greater Cincinnati Human Resources Association Legal Briefing
February 21, 2013



more Insight.

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Dinsmore

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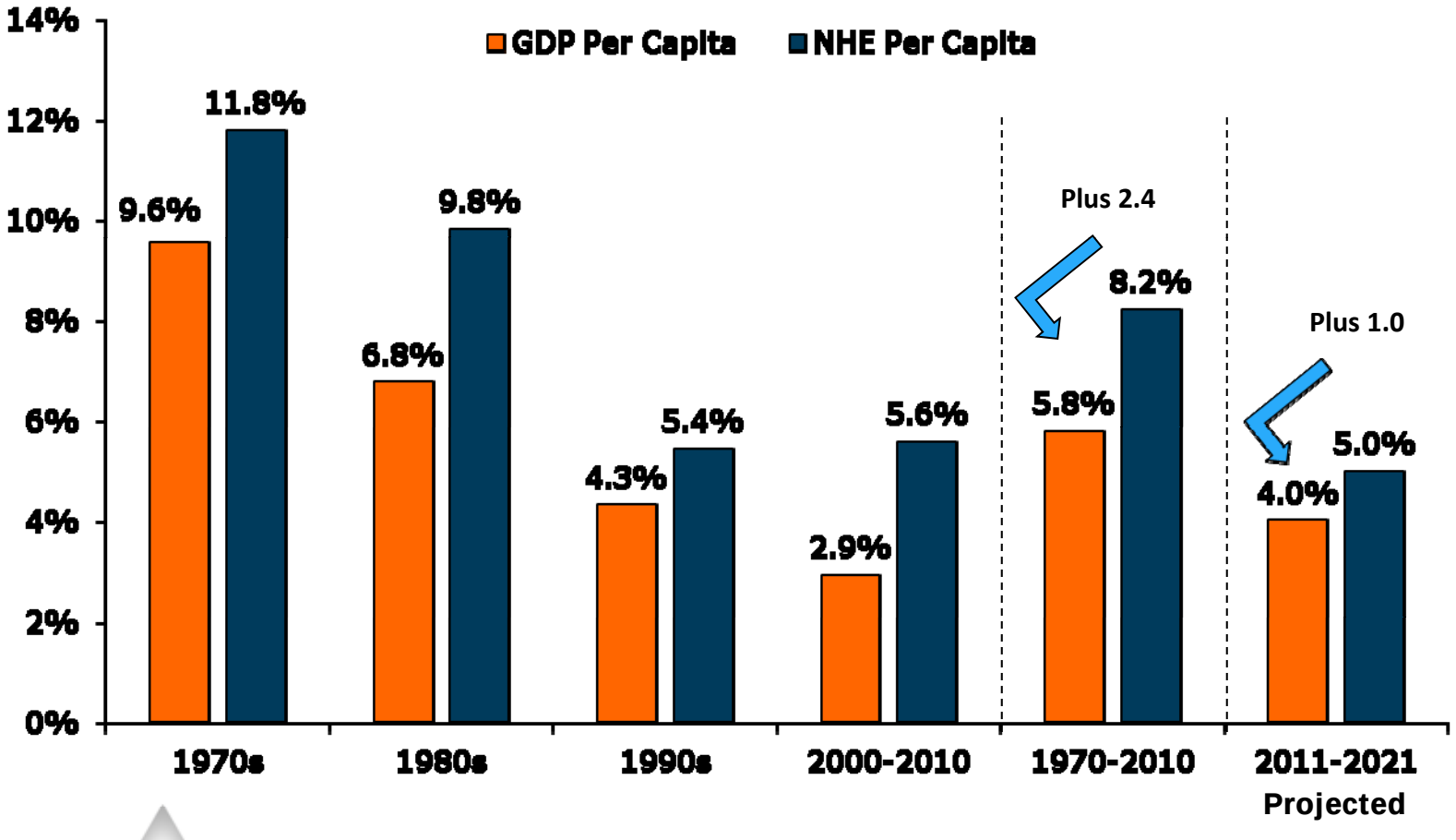
Bill's employee benefits practice serves a diverse client base with respect to the design, preparation and implementation of pension and welfare benefit plans and their ERISA-related issues. He counsels clients regarding the effect of laws such as ERISA, the Internal Revenue Code, the Age Discrimination in Employment Act, the Older Workers Benefit Protection Act, COBRA requirements, and HIPAA health care coverage.

Bill earned his J.D. from Harvard Law School. He is actively involved in myriad community and professional organizations, including the American Bar Association's Employee Benefits Committee of the Section of Taxation.

Bill's knowledge and service have been recognized by peers and clients alike. His is currently listed in The Best Lawyers in America®, Ohio Super Lawyers®, Cincy Leading Lawyers and Chambers USA Guide to America's Leading Business Lawyers.

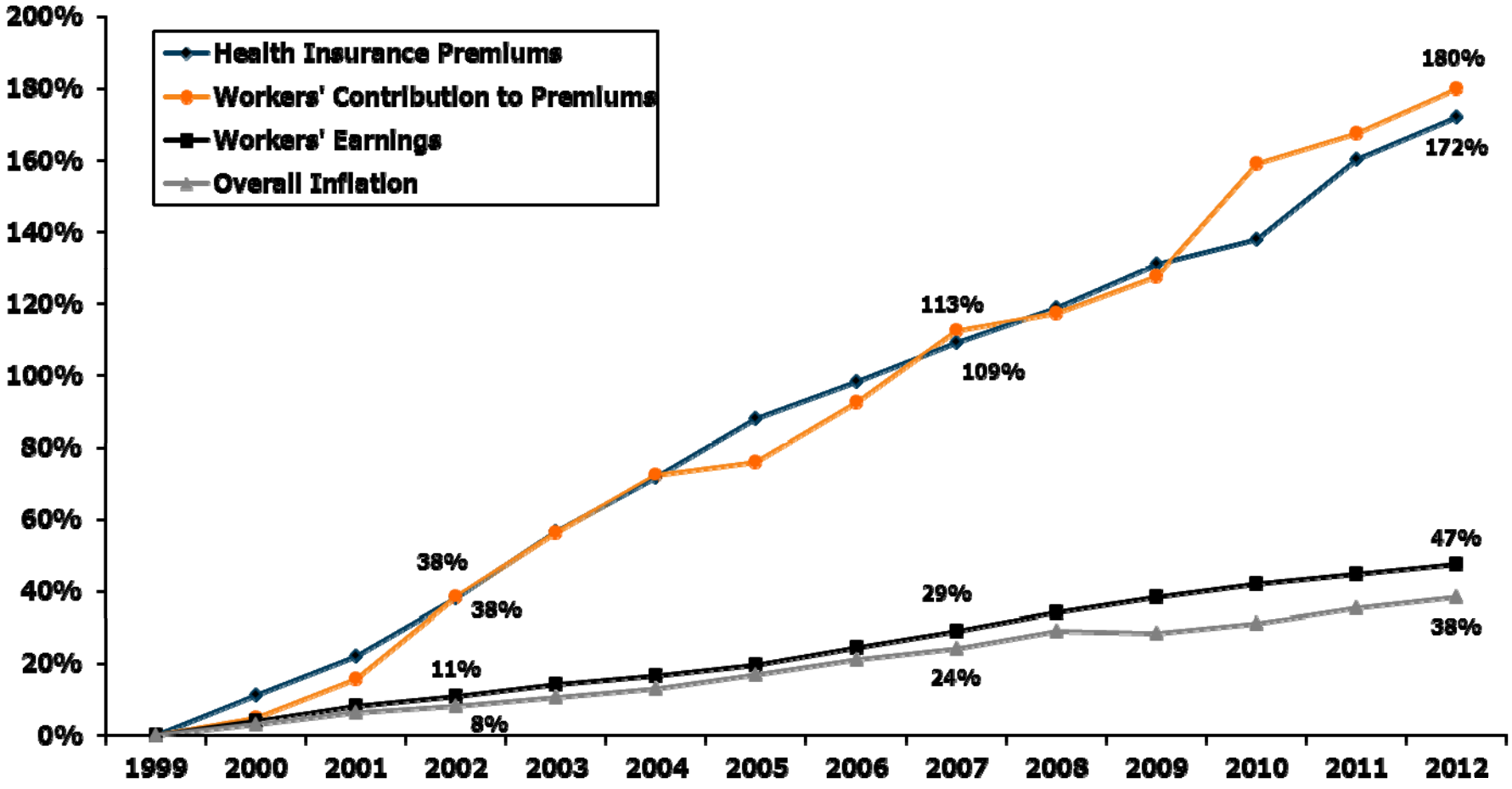
Introduction:
Trends in Health Care Costs

Average Annual Growth Rates for Health Spending and GDP Per Capita



Source: Historical data from Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group.

Cumulative Increases in Health Insurance Premiums, Workers' Contributions to Premiums, Inflation, and Workers' Earnings, 1999-2012



Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2012. Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation (April to April), 1999-2012; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 1999-2012 (April to April).

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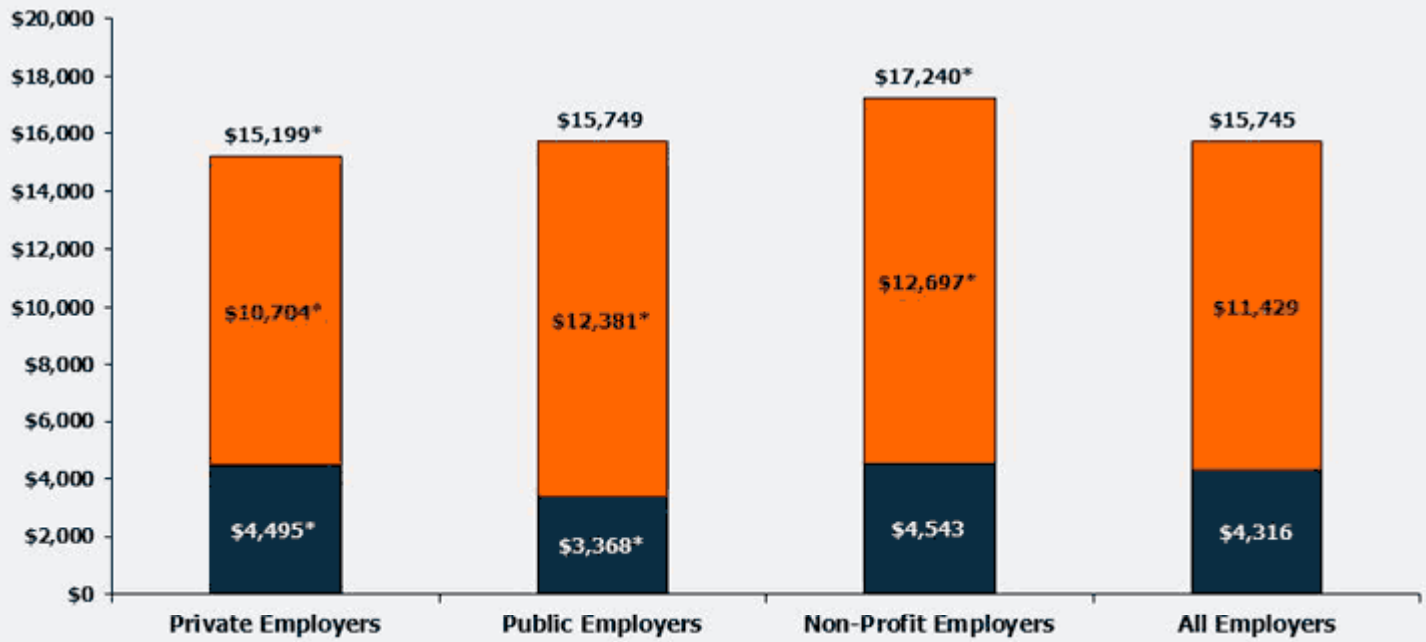
THE HENRY J. KAISER FAMILY FOUNDATION -AND- HRET HEALTH RESEARCH & EDUCATIONAL TRUST

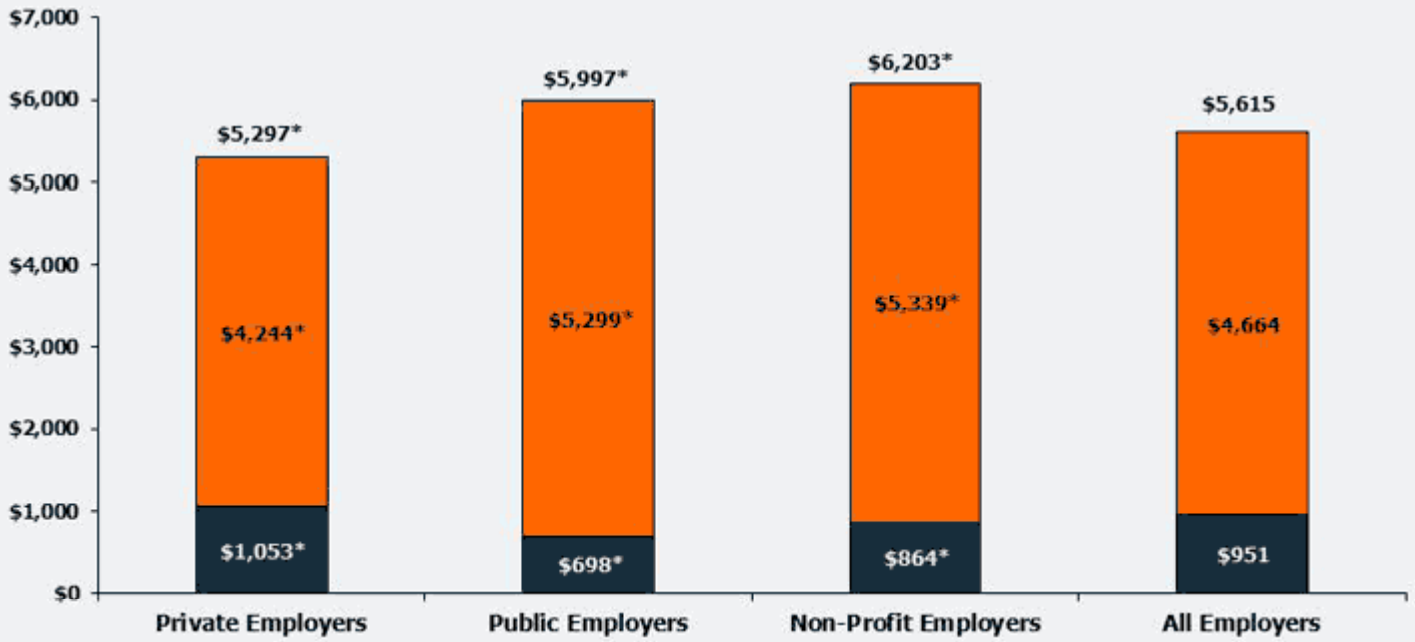
Worker and Employer Premium Contributions for Family Coverage, by Firm Ownership Category, 2012



* Estimate is statistically different from firms not in the indicated ownership category (p<.05).

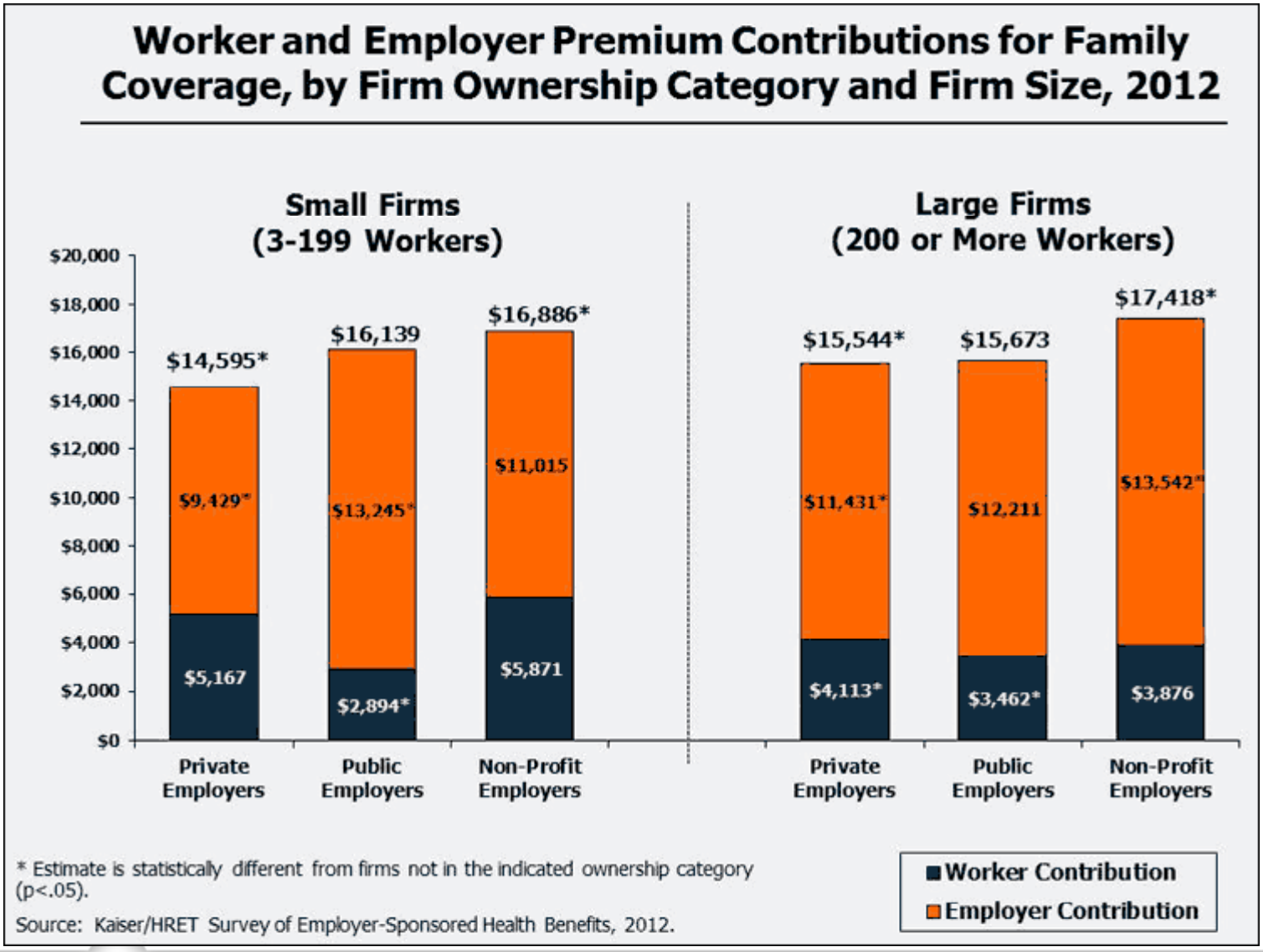
Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2012.

Worker and Employer Premium Contributions for Single Coverage, by Firm Ownership Category, 2012

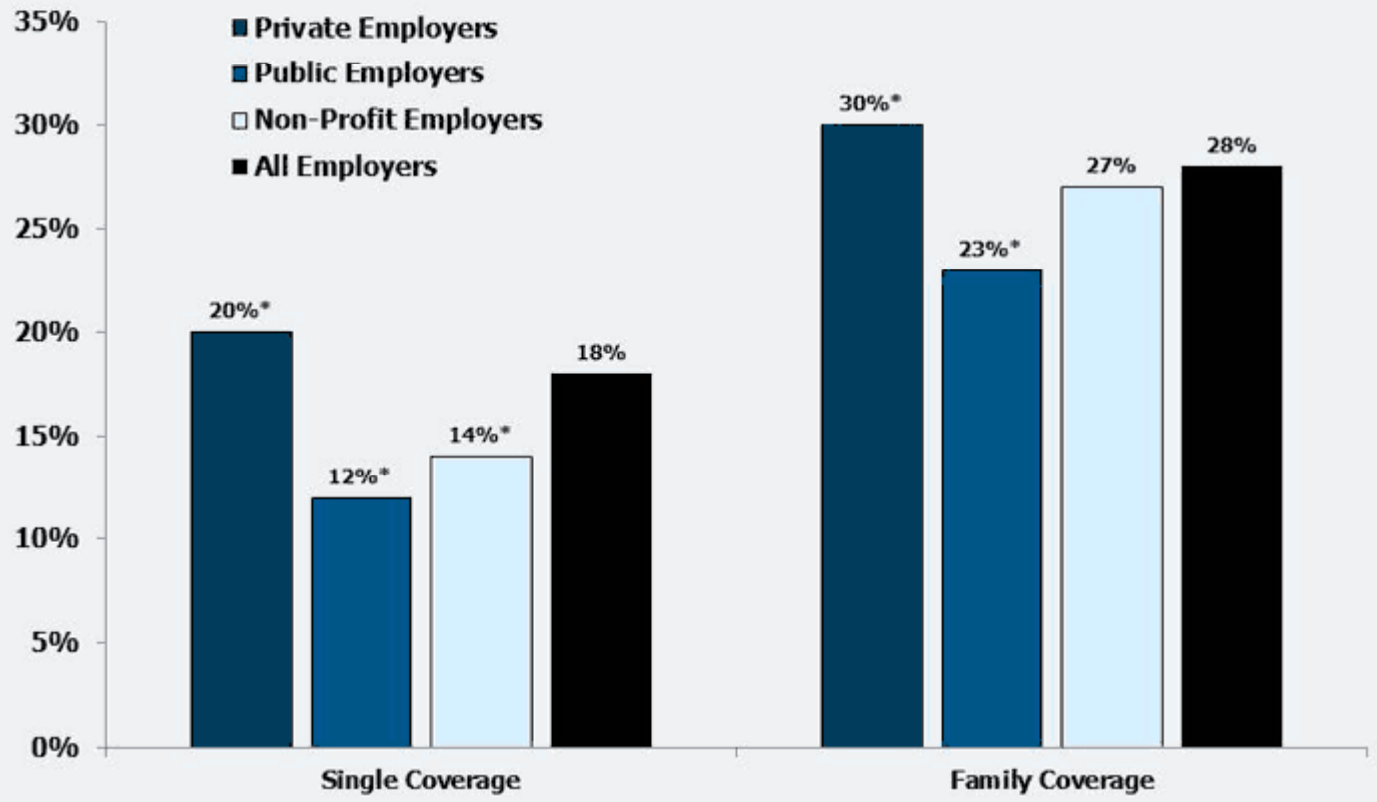


* Estimate is statistically different from firms not in the indicated ownership category (p<.05).

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2012.


Worker and Employer Premium Contributions for Family Coverage, by Firm Ownership Category and Firm Size, 2012
Small Firms (3-199 Workers)
Large Firms (200 or More Workers)
$20,000
$18,000
$16,000
$14,000
$12,000
$10,000
$8,000
$6,000
$4,000
$2,000
$0
$14,595*
$9,429*
$5,167
$16,139
$13,245*
$2,894*
$16,886*
$11,015
$5,871
$15,544*
$11,431*
$4,113*
$15,673
$12,211
$3,462*
$17,418*
$13,542*
$3,876
Private Employers
Public Employers
Non-Profit Employers
Private Employers
Public Employers
Non-Profit Employers
* Estimate is statistically different from firms not in the indicated ownership category (p<.05).
Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2012.
Worker Contribution
Employer Contribution

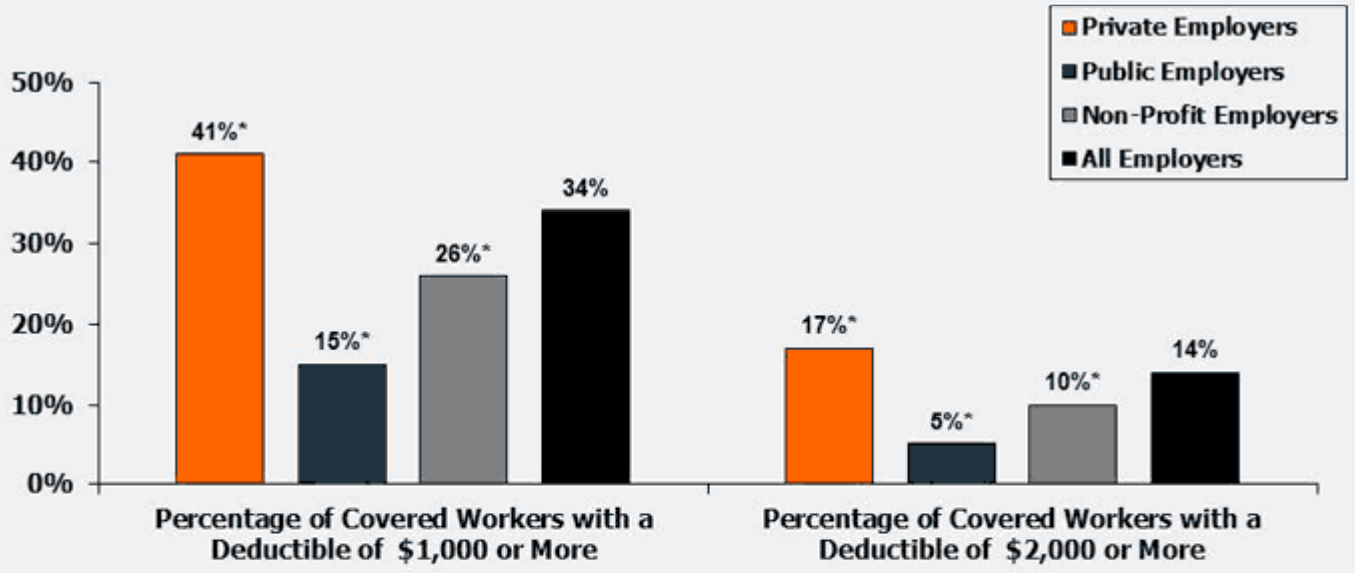
Average Percentage of Premium Paid by Covered Workers for Single and Family Coverage by Firm Ownership Category, 2012



* Estimate is statistically different from firms not in the indicated ownership category (p<.05).

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2012.

Percentage of Covered Workers Enrolled in a Plan with a High General Annual Deductible for Single Coverage, by Firm Ownership Category, 2012



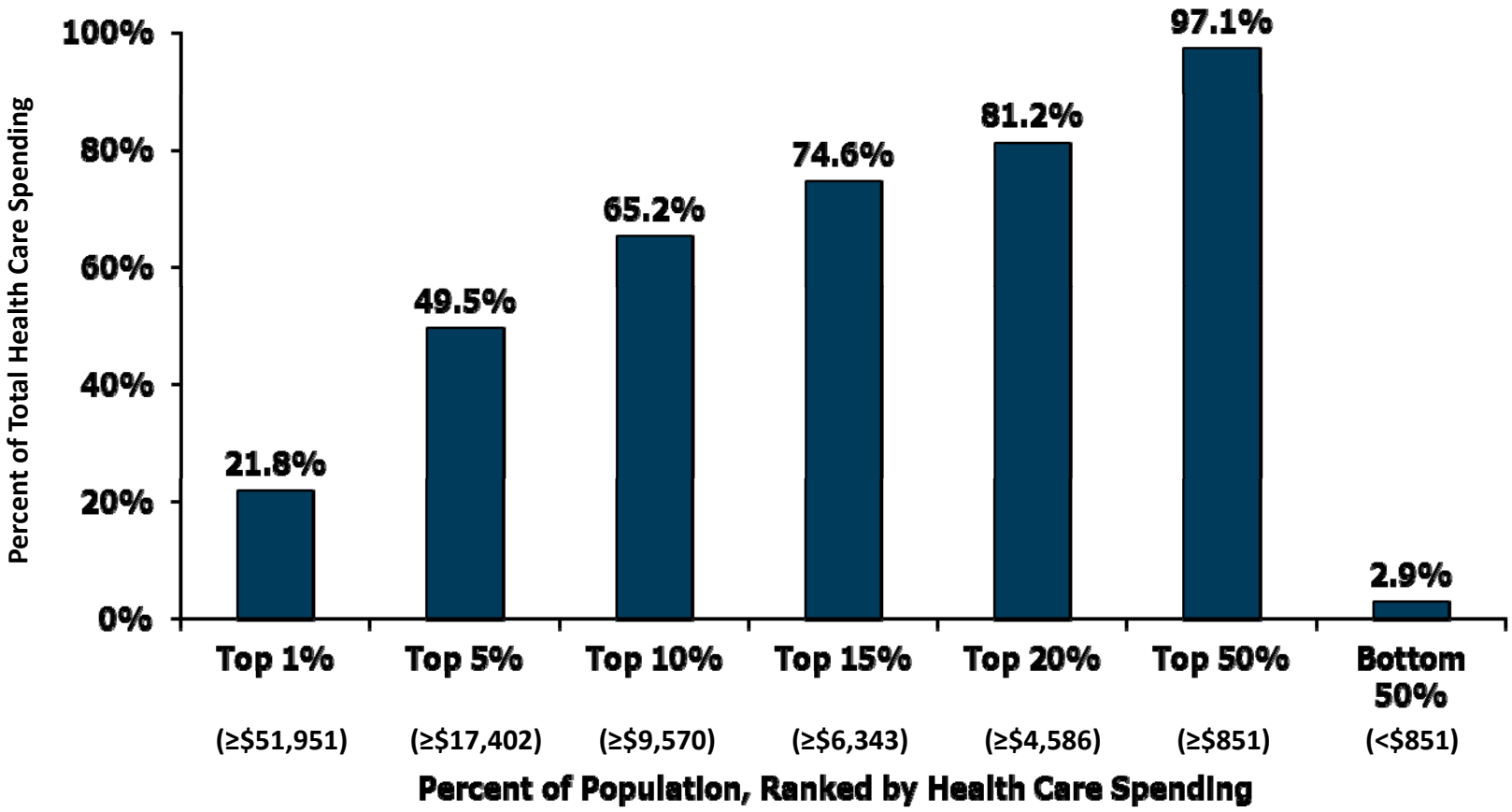
* Estimate is statistically different from firms in a different ownership category (p<.05).

Note: These estimates include workers enrolled in HDHP/SO and other plan types. Because we do not collect information on the attributes of conventional plans, to be conservative, we assumed that workers in conventional plans do not have a deductible of $1,000 or more. Because of the low enrollment in conventional plans, the impact of this assumption is minimal. Average general annual health plan deductibles for PPOs, POS plans, and HDHP/SOs are for in-network services.

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2012.

Introduction:
How Do “We” Spend Our Health Care Dollars?

Concentration of Health Care Spending in the U.S. Population, 2009

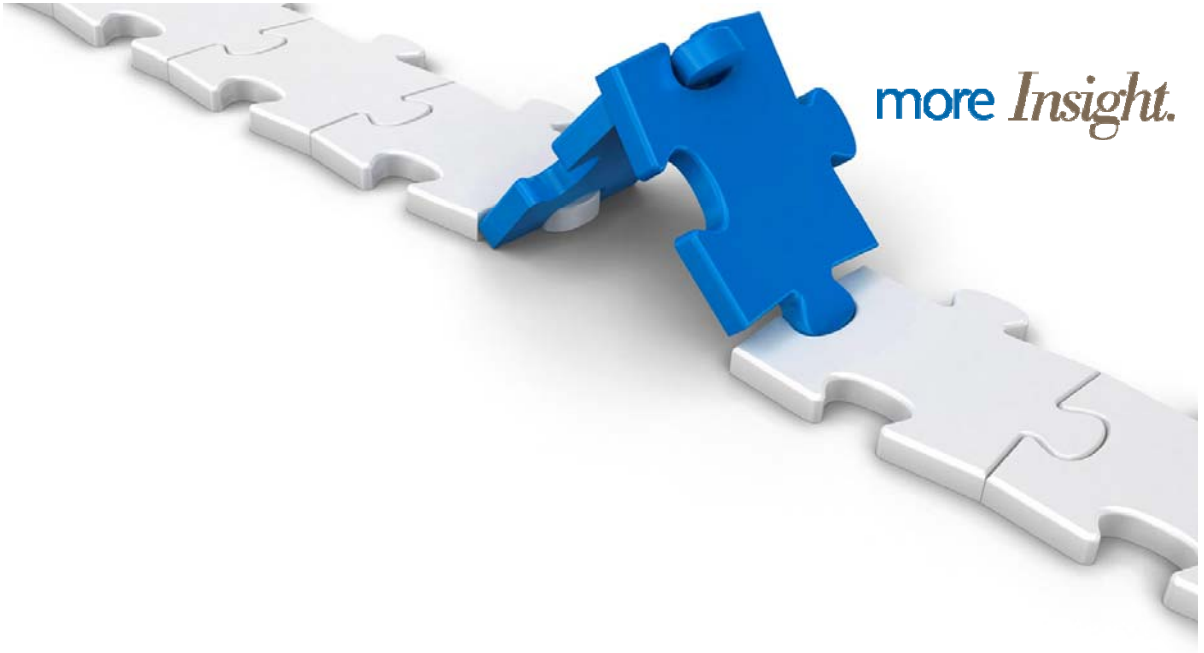


Note: Dollar amounts in parentheses are the annual expenses per person in each percentile. Population is the civilian noninstitutionalized population, including those without any health care spending. Health care spending is total payments from all sources (including direct payments from individuals and families, private insurance, Medicare, Medicaid, and miscellaneous other sources) to hospitals, physicians, other providers (including dental care), and pharmacies; health insurance premiums are not included.

Source: Kaiser Family Foundation calculations using data from U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey (MEPS), Household Component, 2009.

How Do “We” Spend Our Health Care Dollars?

- A small proportion of the U.S. population accounts for half of all U.S. health care spending
- The 5% of the population with higher health care expenses (≥$16,336 annually) was responsible for nearly half (47.5%) of total health care spending, while the 50% of the population with the lowest expenses (<$825) accounted for only 3.1% of total spending.



Part One: Affordable Care Act's Major Features With Pre-2013 Effective Dates That Are in Effect and Will Affect Employers in 2013

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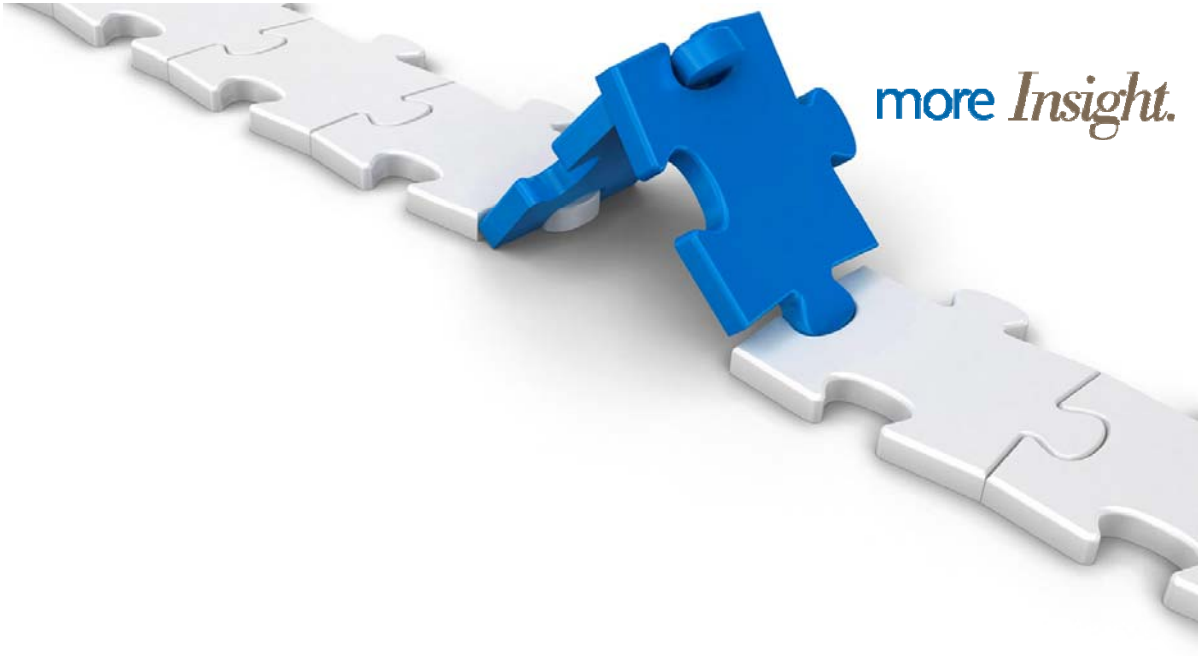

Medical Loss Ratio Rebates

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A Quick Overview of the Affordable Care Act's Major Features That Concern Employers Today

- Medical Loss Ratio Rebates

Carrier	Anthem	Humana	United
OH Small Group	-	-	✓
OH Large Group	-	-	-
KY Small Group	-	✓	
KY Large Group	✓	✓	✓
IN Small Group	✓	-	-
IN Large Group	-	-	-
WA Small Group	-	-	-
WA Large Group	-	-	✓
WV Small Group	-	-	✓
WV Large Group	-	-	-

A Quick Overview of the Affordable Care Act's Major Features That Concern Employers Today

- Medical Loss Ratio Rebates

Carrier	Anthem	Humana	United
OH Small Group	-	-	✓ ($904,629)
OH Large Group	-	-	-
KY Small Group	-	✓ ($4,119,316)	
KY Large Group	✓ ($4,972,534)	✓ ($5,690,771)	✓ ($310,546)
IN Small Group	✓	✓ ($1,642,431)	-
IN Large Group	-	✓ ($2,167,939)	-
WA Small Group	-	-	✓ ($362,303)
WA Large Group	-	-	-
WV Small Group	-	-	✓
WV Large Group	-	-	-

A Quick Overview of the Affordable Care Act's Major Features That Concern Employers Today

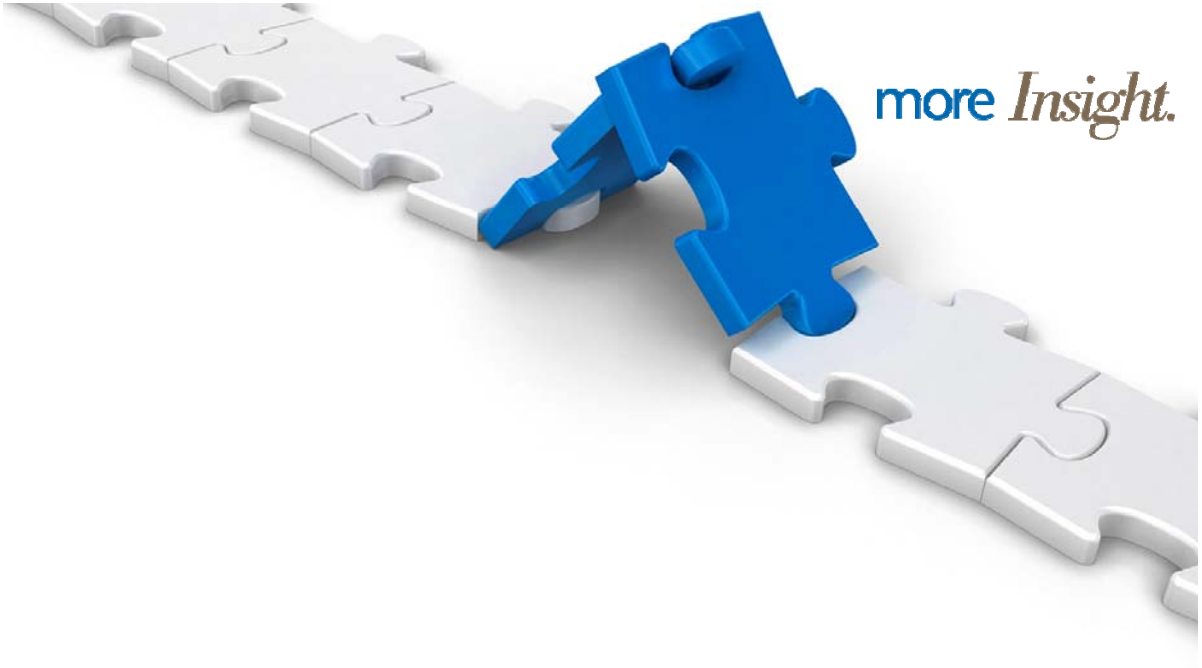
- Medical Loss Ratio Rebates

Estimated MLR Rebates: Small Group Market						
State	Total Amount of Rebates	Enrollment in Plans Paying Rebates	Number of Plans Paying Rebates	Average Rebate Per Enrollee	% of Enrollees in Plans Paying Rebates	Average Rebate Per Enrollee in Plans Paying Rebates
Georgia	$13,383,273	217,653	5	$21.48	35%	$61.49
Indiana	$10,944,576	231,577	5	$29.16	62%	$47.26
Kentucky	$3,253,008	34,007	1	$16.43	17%	$95.66
Ohio	$2,912,828	72,430	5	$2.97	7%	$40.22
Washington	$142,505	3,107	1	$.45	1%	$45.87
W. Virginia	$774,554	6,134	2	$10.83	9%	$86.88

"Insurer Rebates under the Medical Loss Ratio: 2012 Estimates," Kaiser Family Foundation, http://www.kff.org/healthreform/upload/8305.pdf

Medical Loss Ratio Rebates

- How Do You Share Rebates?
  - In cash to employee/participants and employer in proportion to percentage of premium paid
    - Can limit rebates to active employees/participants if costs outweigh providing benefit to terminated employees/participants
    - Rebate refund is taxable to the employee
  - Utilize the rebate to fund a premium holiday or for a benefit enhancement (if rebating the premium in cash is not cost effective)
  - De minimis exception? Possible if the administrative costs of making refund outweigh the benefit
  - Government plans are generally limited to reducing premium for the subsequent policy year or providing a cash refund to subscribers



New Notices and Summaries of Benefits Coverages to Employer-Sponsored Plan Enrollees

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Notices and Summaries of Benefits Coverages to Employer-Sponsored Plan Enrollees

- February 14, 2012: Final Regulations
- Purpose
  - Provide plans, participants and beneficiaries with a concise, uniform Summary of Benefits and Coverage (SBC) options for comparative purposes
  - Four pages – front and back
  - 12 point font
  - Model form provided: http://www.dol.gov/ebsa/pdf/SBCSampleCompleted.pdf

New Notices and Summaries of Benefits Coverages to Employer-Sponsored Plan Enrollees

- When?
  - To participants and beneficiaries who enroll or re-enroll in group health coverage during an open enrollment period that begins on or after September 23, 2012
  - New enrollees: upon initial application for coverage, either with any written application materials or on the first day the individual was eligible to enroll, if there were no written application materials
  - Open Enrollment: to participants renewing coverage, with written application materials, if any, otherwise at least 30 days prior to the effective date of coverage
  - Within seven days upon request; or
  - Within seven days of a special enrollment request

Insurance Company 1: Plan Option 1

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2013 – 12/31/2013

Coverage for: Individual + Spouse | **Plan Type:** PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.[insert] or by calling 1-800-[insert].

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$500** person / **$1,000** family Doesn't apply to preventive care	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.
Are there other deductibles for specific services?	Yes. **$300** for prescription drug coverage. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes. For participating providers **$2,500** person / **$5,000** family For non-participating providers **$4,000** person / **$8,000** family	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See www.[insert].com or call 1-800-[insert] for a list of participating providers.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about excluded services.

Questions: Call 1-800-[insert] or visit us at www.[insert].
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.[insert] or call 1-800-[insert] to request a copy.

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146

Corrected on May 11, 2012

- Copayments are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- Coinsurance is *your* share of the costs of a covered service, calculated as a percent of the allowed amount for the service. For example, if the plan's allowed amount for an overnight hospital stay is $1,000, your coinsurance payment of 20% would be $200. This may change if you haven't met your deductible.
- The amount the plan pays for covered services is based on the allowed amount. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the allowed amount is $1,000, you may have to pay the $500 difference. (This is called balance billing.)
- This plan may encourage you to use participating providers by charging you lower deductibles, copayments and coinsurance amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$35 copay/visit	40% coinsurance	none
	Specialist visit	$50 copay/visit	40% coinsurance	none
	Other practitioner office visit	20% coinsurance for chiropractor and acupuncture	40% coinsurance for chiropractor and acupuncture	none
	Preventive care/screening/immunization	No charge	40% coinsurance	
If you have a test	Diagnostic test (x-ray, blood work)	$10 copay/test	40% coinsurance	none
	Imaging (CT/PET scans, MRIs)	$50 copay/test	40% coinsurance	none

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.[insert].	Generic drugs	$10 copay/ prescription (retail and mail order)	40% coinsurance	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription)
	Preferred brand drugs	20% coinsurance (retail and mail order)	40% coinsurance	——————none——————
	Non-preferred brand drugs	40% coinsurance (retail and mail order)	60% coinsurance	——————none——————
	Specialty drugs	50% coinsurance	70% coinsurance	——————none——————
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	——————none——————
	Physician/surgeon fees	20% coinsurance	40% coinsurance	——————none——————
If you need immediate medical attention	Emergency room services	20% coinsurance	20% coinsurance	——————none——————
	Emergency medical transportation	20% coinsurance	20% coinsurance	——————none——————
	Urgent care	20% coinsurance	40% coinsurance	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	——————none——————
	Physician/surgeon fee	20% coinsurance	40% coinsurance	——————none——————

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture (if prescribed for rehabilitation purposes)
- Bariatric surgery
- Chiropractic care
- Hearing aids
- Most coverage provided outside the United States. See www.[insert]
- Weight loss programs

Your Rights to Continue Coverage:

**** Individual health insurance sample –**

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your premium. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at [contact number]. You may also contact your state insurance department at [insert applicable State Department of Insurance contact information].

OR

**** Group health coverage sample –**

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at [contact number]. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact: [insert applicable contact information from instructions].

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,490
- **Patient pays** $2,050

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	$7,540

Patient pays:

Deductibles	$700
Copays	$30
Coinsurance	$1320
Limits or exclusions	$0
Total	$2,050

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $3,520
- **Patient pays** $1,880

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	$5,400

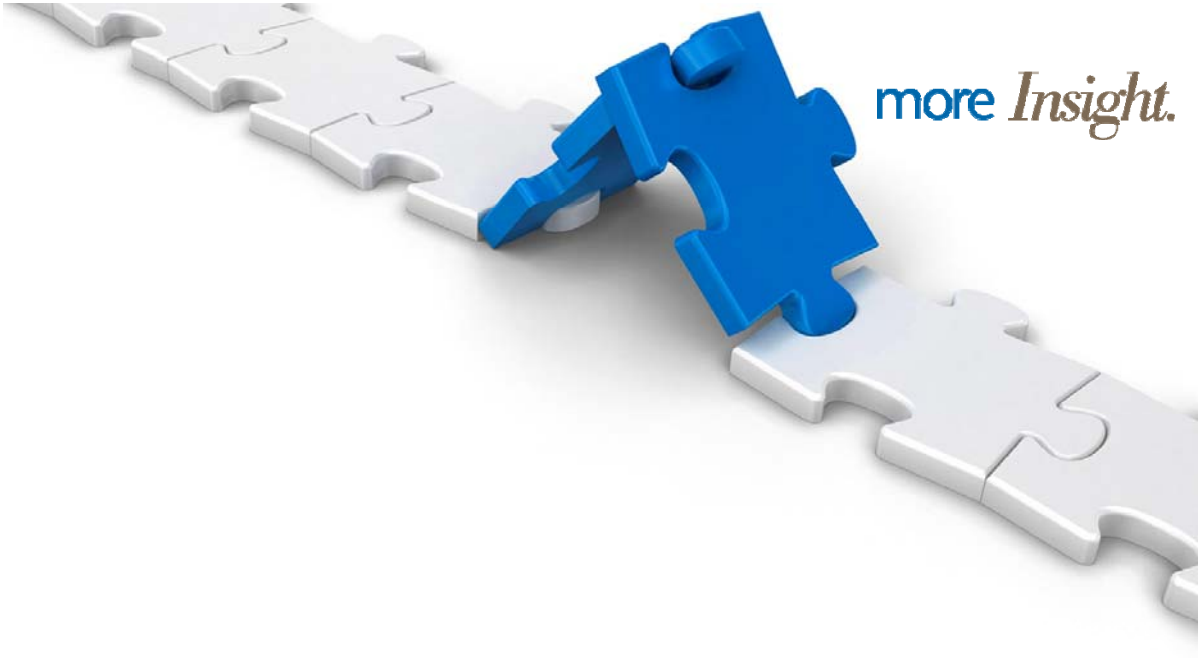
Patient pays:

Deductibles	$800
Copays	$500
Coinsurance	$500
Limits or exclusions	$80
Total	$1,880

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: [insert].

New Notices and Summaries of Benefits Coverages to Employer-Sponsored Plan Enrollees

- Benefits scenarios: HHS supplies costs of care to be used – and a downloadable macro-enabled spreadsheet to generate the data to be inserted in the examples
- How many SBCs must be distributed if employer offers > 1 plan coverage option? As to each option – one for each category of coverage (single, family)? Does the # differ depending on enrollment vs. re-enrollment? Tri-Agency FAQs issued 3-19-2012: combine information in one SBC



W-2 Reporting of Cost of Health Care Coverage

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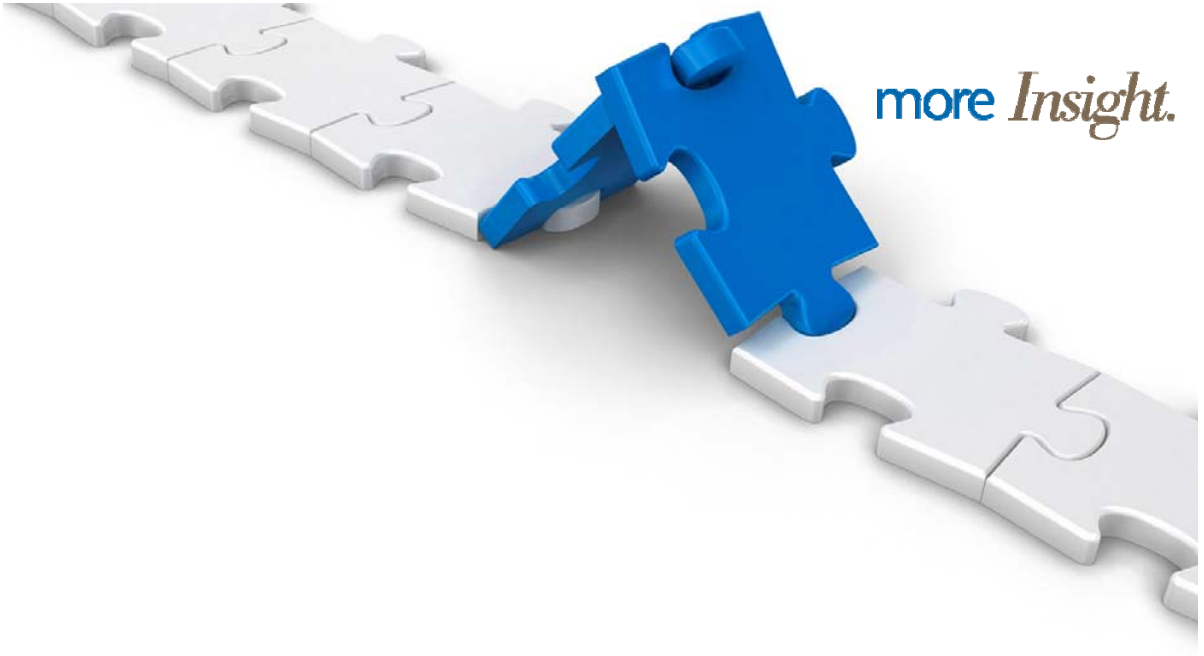
W-2 Reporting of Cost of Health Coverage

- When? 2012 W-2s That Will Be Issued in 2013
- Who Must Report? Employers That Issued 250 or More W-2s in 2011
- What is Reported?
  - Coverage under any group health plan provided by an employer who issued more than 250 W-2s last year
- Not reported:
  - Stand alone dental and vision plans, health savings account (HSA's) contributions, health reimbursement arrangements (HRA's) contributions, pre-tax salary reductions to a health flexible spending account (HFSA) (with no employer contributions to the HFSA accounts)
  - Retirees that receive health care coverage
- How to Calculate Premium?
  - Self-Insured Plans: COBRA premium
  - Fully Insured Plans: Actual premium charged



Preventive Health Services

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Preventive Health Services

- Who: All non-grandfathered plans
- When: plan years beginning on or after August 1, 2012
- What:
  - must provide coverage for a range of preventive services and may not impose cost-sharing (such as copayments, deductibles, or co-insurance) on patients receiving these services.
  - Four broad categories: evidence-based screenings and counseling, routine immunizations, childhood preventive services, and preventive services for women.

Preventive Health Services

- Current Controversy: Preventive Services for Women
  - Statute: These preventive health services include preventive care and screening provided for in the comprehensive guidelines supported by the Health Resources and Services Administration
  - HRSA Guidelines issued on August 1, 2011: require coverage, without cost sharing, for "[a]ll Food and Drug Administration [(FDA)] approved contraceptive methods, sterilization procedures, and patient education and counseling

Preventive Health Services

- Current Controversy: Contraceptive Services for Women
  - Tri-Agency February 6, 2013 Proposed Rule-Exemption For "Religious Employers": a "religious employer" need not offer coverage for contraceptive services.
    - "Religious employer" an employer described in IRC §§6033(a)(1) and 6033(a)(3)(A)(i) or (iii) (churches, their integrated auxiliaries, and conventions or associations of churches, and the exclusively religious activities of any religious order)
    - Result: the exemption is limited to houses of worship

Preventive Health Services

- Current Controversy: Contraceptive Services for Women
  - Tri-Agency February 6, 2013 Proposed Regulations: Special Accommodation for "Eligible Organizations" – Their Plan Need Not Provide Contraceptive Coverage But Their Insurer/TPA Must Arrange for Issuance of No-Cost Individual Insurance Policies Covering Contraceptive Services
    - "Eligible organizations." Must satisfy all four of these requirements:
      - Opposes providing coverage for some or all of the otherwise required contraceptive services
      - Organized and operated as a nonprofit entity
      - Holds itself out as a religious organization
      - Self-certifies compliance with the preceding three requirements

Preventive Health Services

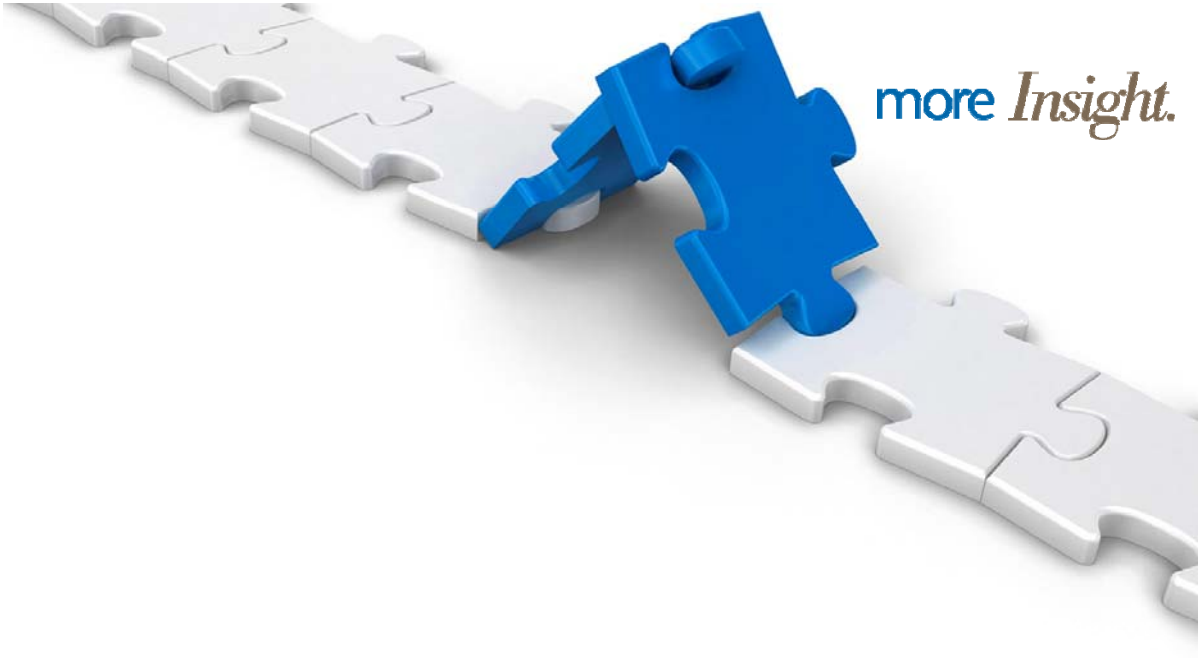
- Current Controversy: Contraceptive Services for Women
  - Tri-Agency February 6, 2013 Proposed Regulations: Special Accommodation for "Eligible Organizations" – Their Plan Need Not Provide Contraceptive Coverage But Their Insurer/TPA Must Arrange for Issuance of No-Cost Individual Insurance Policies Covering Contraceptive Services
    - If plan is fully insured: insurer issues individual policies to enrollees that covers contraceptive services at no charge to employer and no cost to enrollee
    - Self-insured: TPA arranges for insurer to issue the policies
    - Insurer gets a reduction in the access fees it must otherwise pay to federally facilitated Exchanges.

Preventive Health Services

- Current Controversy: Contraceptive Services for Women
  - Tri-Agency February 6, 2013 Proposed Regulations: No exemption or accommodation for for-profit employers

Preventive Health Services

- Current Controversy: Contraceptive Services for Women
  - Recent litigation:
    - O'Brien v. United States Dep't of Health and Human Servs., No. 4:12-CV-476 (CEJ) (E.D. Mo. Sept. 28, 2012)
      - For profit company whose owners are Catholic argued that the Act/regulations' contraceptive services requirement violated the Religious Freedom Restoration Act, the First Amendment, and the Administrative Procedure Act.
      - Court: refused to enjoin the Act/regulations
    - Legatus v. Sebelius, No. 12-12061 (E.D. Mich. Oct. 31. 2012): Court grants injunction to Daniel Weingartz and Weingartz Supply Company (owner and sponsor of plan); denied as to Legatus (a non-profit advocacy organization)



Patient-Centered Outcomes Research Institute (PCORI) Fee

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Patient-Centered Outcomes Research Institute (PCORI) Fee

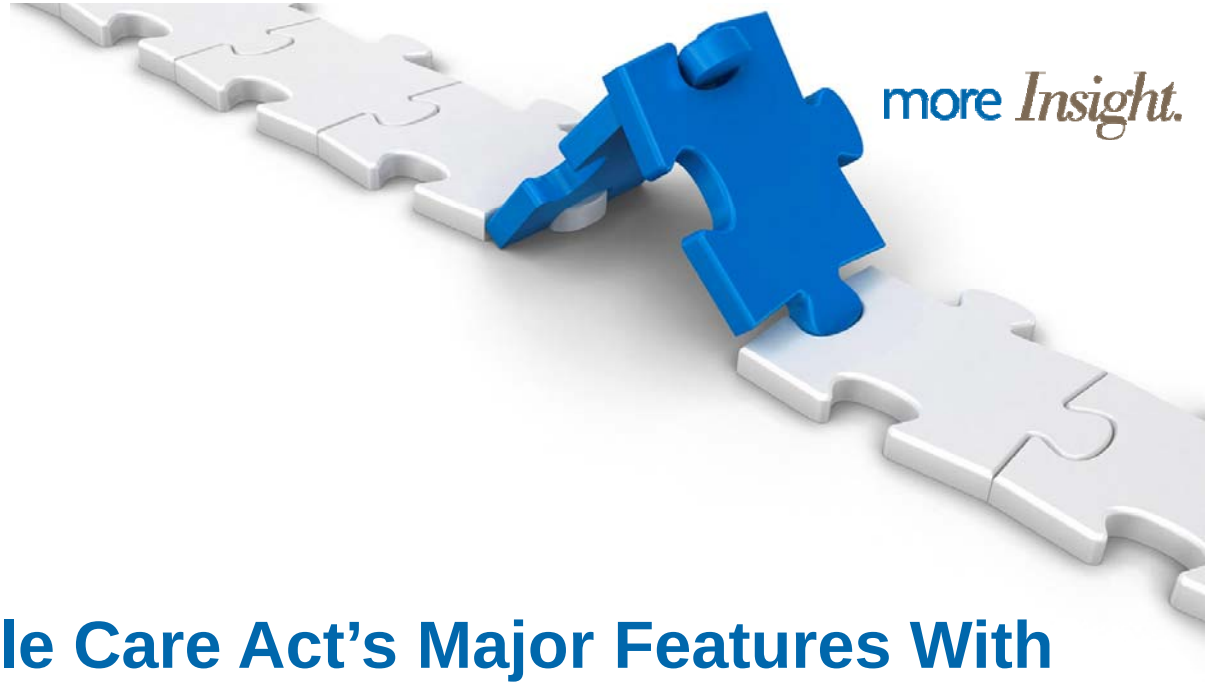
- When? The fee begins in 2012 and the phases out in 2019.
- How much? The fee is equal to the average number of covered lives for the policy year times the applicable dollar amount.
  - For policy years ending on or after Oct. 1, 2012, and before Oct. 1, 2013 - the applicable dollar amount is $1.
    - For policy years ending on or after Oct. 1, 2013, and before Oct. 1, 2014 - the applicable dollar amount is $2.
    - For policy years ending in any fiscal year beginning on or after Oct. 1, 2014 - the applicable dollar amount is the prior fiscal year's dollar amount plus an adjustment for medical inflation.

Patient-Centered Outcomes Research Institute (PCORI) Fee

- Which Plans Must Pay the Fee? "Specified health insurance policies" and plan sponsors of "applicable self-insured health plans."
  - "Specified health insurance policies" includes medical policies, retiree-only policies, and any accident or health insurance policy (including a policy under a group health benefit plan) issued to individuals residing in the United States. "Applicable self-insured health plans" includes MEWAs, VEBAs and multiemployer plans, as well as employer-sponsored health plans.
- Which Plans are Exempted?
  - HIPAA "excepted benefits" (e.g., stand-alone vision or dental plans)
  - HRAs integrated into a self-insured plan → treated as a single plan; don't double count members (HRA plus a fully insured plan → both must pay fee)
  - EAPs that do not provide significant benefits in the nature of medical care or treatment
  - FSAs: integrated with self-insured plan or restricted to excepted benefits → FSA and plan treated as a single plan; don't double count members

Patient-Centered Outcomes Research Institute (PCORI) Fee

- How is the fee paid?
  - IRS April 17, 2012 proposed regulations:
  - Insurance issuers and self-insured plan sponsors annually file federal excise tax return (Form 720)
  - File and remit annually
    - Due date: For policy or plan years that end during a calendar year: July 31 of the following calendar year
    - Special rule for fully insured plans using two of the four proposed methods for determining the number of members (NAIC member months or state form methods): Returns for each calendar year are due on July 31 of the following calendar year.



Part Two: Affordable Care Act's Major Features With Pre-2013 Effective Dates That Have Been Postponed But Will Affect Employers in 2013 or For Which Employers Must Plan in 2013

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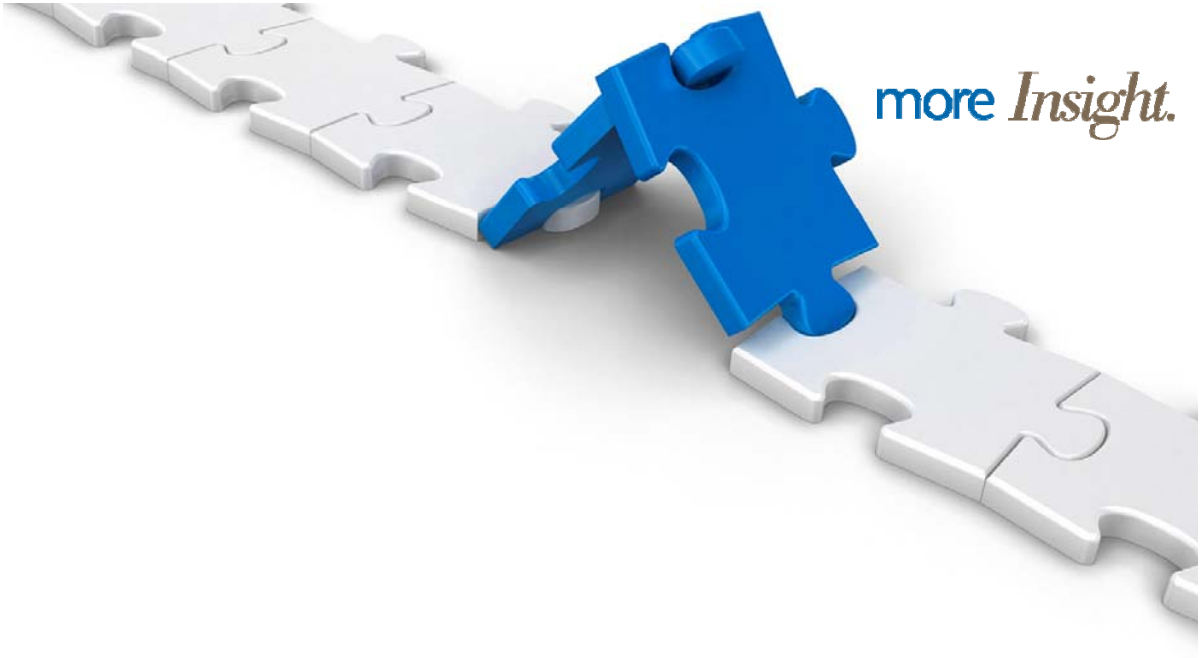

Auto Enrollment

Auto Enrollment

- **Will apply to employers with more than 200 full-time employees**
- **Original effective date: March 1, 2013**
- IRS Notice 2012-17: DOL – which is in charge of auto-enrollment says:
  - Auto-enrollment will not become effective until DOL issues regulations
  - "Automatic enrollment guidance will not be ready to take effect by 2014"
- Stay tuned: auto enrollment requires planning
  - Affected employers should begin planning sooner rather than later
  - Remember: will need to choose default plan package if employer offers more than one package (PPO, low deductible, high deductible) and default coverage (single, 2 party, or family)
  - This will require lots of communication to employees and data collection
- Check online enrollment options

The Fully Insured Plan Nondiscrimination Requirement

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Planning for the Fully Insured Plan Nondiscrimination Requirement

- §2716 of the Act (Incorporated in IRC §9815): Prohibits Discrimination in Eligibility or Benefits in Fully Insured Plans Using Rules "Similar" to Those that Already Apply to Self-Insured Plans
- Original Effective Date: Plan years beginning after September 23, 2010
- Effective Date delayed until issuance of comprehensive guidance (IRS Notice 2011-1)
- November 19, 2012 Department of the Treasury 2012-2013 Priority Guidance Plan: The Plan does not contain a project for this guidance
- Why do we care? Because historically, fully insured plans **could** discriminate – and many do discriminate.
  - This provision of the Affordable Care Act requires immediate attention: many small employers who although not subject to the Act's "employer mandate" penalties may still find themselves incurring substantial new costs to cover heretofore excluded employees

Planning for the Fully Insured Plan Nondiscrimination Requirement

- Highly compensated employee:
  - Expansive definition, when compared to that used in retirement plans:
    - The five highest paid officers
    - A 10% or more shareholder
    - An individual who is among the highest paid 25% of all employees

Planning for the Fully Insured Plan Nondiscrimination Requirement

- Excludable Employees:
  - Employees who have not completed 3 years of service
  - Part-time employees whose customary weekly employment is less than 35 hours
  - Seasonal employees,
  - Employees subject to a collective bargaining agreement
  - Employees who have not attained age 25
  - Nonresident Aliens

Planning for the Fully Insured Plan Nondiscrimination Requirement

- The Eligibility Test (from the IRS 1981 §105(h) regulations):
  - The plan benefits at least 70% or more of all employees,
  - 70% of all employees are eligible to benefit under the plan, and at least 80% or more of those eligible in fact benefit; or
  - The plan benefits a nondiscriminatory class of employees (the "nondiscriminatory classification test")
    - IRS §105(h) regulations incorporate the pre-1986 TRA qualified retirement plan §410(b) nondiscriminatory classification test

Planning for the Fully Insured Plan Nondiscrimination Requirement

- The Benefits Test
  - All benefits provided for highly compensated employees must be provided for all other participants.
  - This test applies based on benefits subject to reimbursement, not to actual payments of claims.
  - Result: The benefits test prohibits a lower deductible or copayment for highly compensated employees.
  - Test does not look at utilization: it only looks at availability.
- That's good for employers that offer different options within a plan: the §105(h) regulations provide that, as long as all eligible participants may elect a benefit package and the required employee contributions are the same, the benefits test is satisfied.

Planning for the Fully Insured Plan Nondiscrimination Requirement

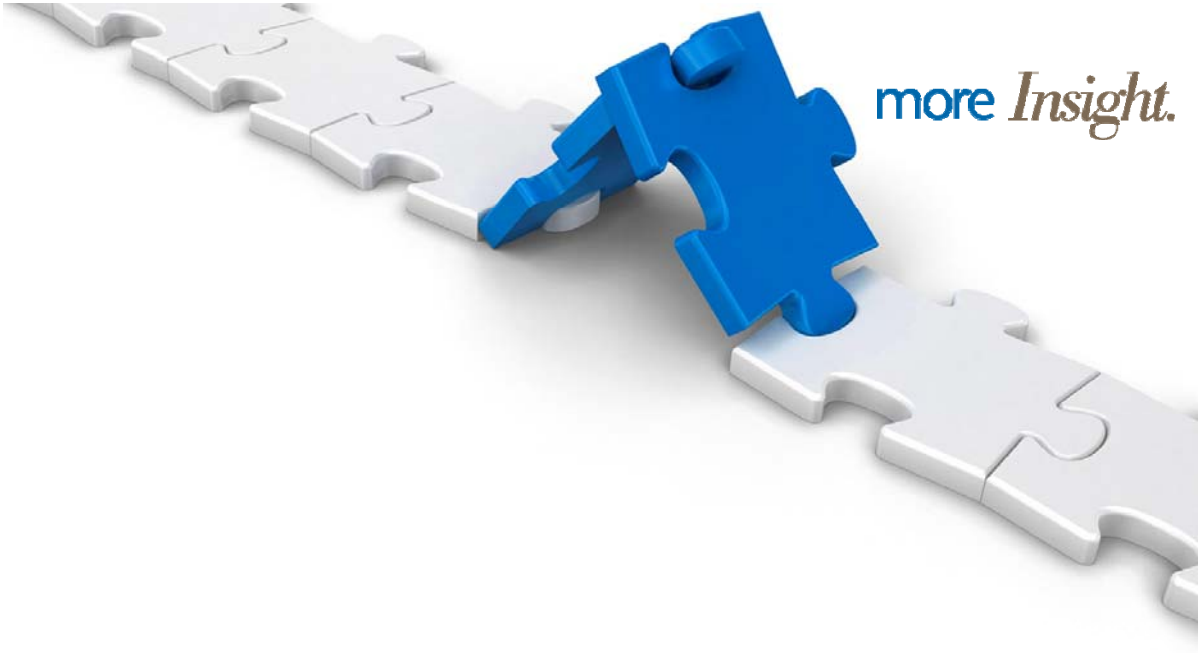
- Questions:
  - How should the eligibility test **really** be applied? Based on those eligible to participate? Or those who actually elect to participate?
  - How may we test different benefit packages?
  - How do we test multiemployer plans?
  - How do we test packages that have differing employee premium obligations? Must each be tested separately (the benefits test says we can combine certain packages – how about the eligibility test?)

Planning for the Fully Insured Plan Nondiscrimination Requirement

- Why This is Important:
  - Employers will attempt to design a plan that meets the affordability and minimum value test to satisfy the employer mandate
  - Can the employer also offer a richer plan with higher premiums that is not affordable?
  - One possible answer: that combination will satisfy the employer mandate—but the “rich plan” may not satisfy the nondiscrimination requirement
  - This requirement applies to small employers, too: watch out for small employers that sponsor a fully insured health plan but have excluded a significant number of employees. That may not work once the nondiscrimination requirements take effect.

Planning for the Fully Insured Plan Nondiscrimination Requirement

- Why This is Important: Affected employers must determine:
  - Can my plan pass what is likely to be the nondiscrimination requirement
  - If not, what costs am I likely to incur under my present plan design as the result of having to add heretofore excluded employees?
  - Am I willing to pay that additional cost? If not –
    - Should I discontinue the plan and provide pay increases to a select group (and should I add a cafeteria plan flexible spending account to allow that select group to avoid paying current tax)? Can I do so without violating the cafeteria plan nondiscrimination requirements? And, don't forget the 2013 $2,500 limit on FSAs.
    - Can I increase employee premium sharing and out-of-pocket limits to reduce my cost? Don't forget the 2014 limit on deductibles for employers who employ less than 100 employees



Part Three: Affordable Care Act's Major Features With 2013 Effective Dates For Which For Which Employers Must Plan in 2013

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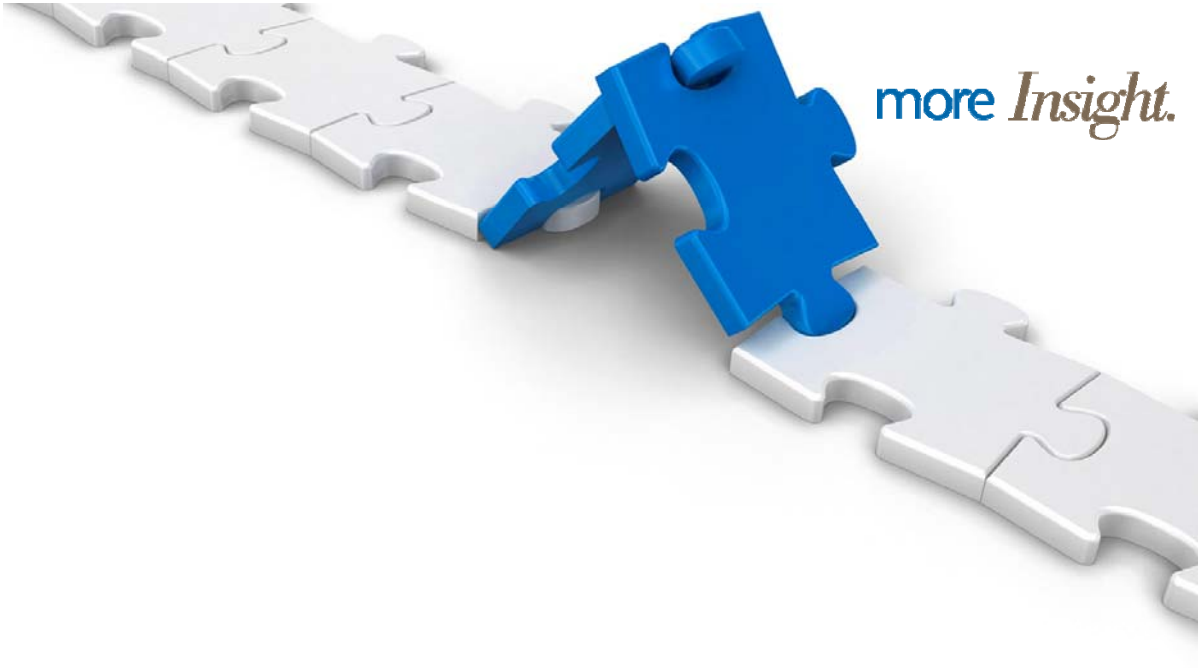

Two New Taxes on Highly Compensated Employees

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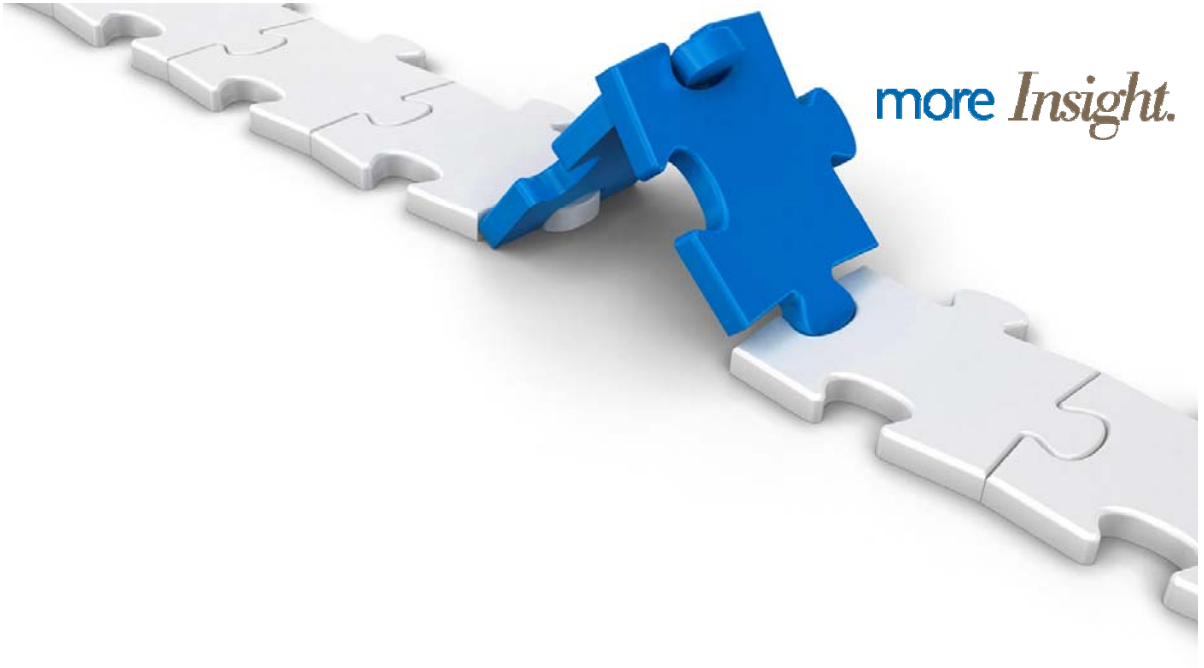
Two New Taxes on Highly Compensated Employees

- Two New Taxes on Highly Compensated Employees -- Tax Years Beginning On Or After January 31, 2013
  - Additional 0.9% Medicare Tax On Earned Income In Excess Of $200,000 Single Or $250,000 Joint
    - Applies to the employee portion of the tax only. The employer portion does not change.
    - Employee portion goes from 1.45% to 2.34%
  - 3.8% surtax on investment income for individuals with Modified Adjusted Gross Income (AGI) over $200,000 Single or $250,000 Joint
    - Net income from interest, dividends, annuities, royalties, rents, gain from the sale of property other than in a business, and passive flow-through income



Additional 0.9% Medicare Tax On Earned Income In Excess Of $200,000 Single Or $250,000 Joint

Additional 0.9% Medicare Tax On Earned Income In Excess Of $200,000 Single Or $250,000 Joint

New Guidance: IRS Proposed Regulation and Fact Sheet Issued on November 30, 2012

- What wages are subject to Additional Medicare Tax?
  - All wages that are currently subject to Medicare Tax are subject to Additional Medicare Tax if they are paid in excess of the applicable threshold for an individual's filing status. For more information on what wages are subject to Medicare Tax, see the chart, Special Rules for Various Types of Services and Payments, in section 15 of Publication 15, (Circular E), Employer's Tax Guide.
- Will Additional Medicare Tax be withheld from an individual's wages?
  - An employer must withhold Additional Medicare Tax from wages it pays to an individual in excess of $200,000 in a calendar year, without regard to the individual's filing status or wages paid by another employer.

Additional 0.9% Medicare Tax On Earned Income In Excess Of $200,000 Single Or $250,000 Joint

- If my employer withholds Additional Medicare Tax from my wages in excess of $200,000, but I won't owe the tax because my spouse and I file a joint return and we won't meet the $250,000 threshold for joint filers, can I ask my employer to stop withholding Additional Medicare Tax?
  - No. Your employer must withhold Additional Medicare Tax on wages it pays to you in excess of $200,000 in a calendar year. Your employer cannot honor a request to cease withholding Additional Medicare Tax if it is required to withhold it. You will claim credit for any withheld Additional Medicare Tax against the total tax liability shown on your individual income tax return (Form 1040).

Additional 0.9% Medicare Tax On Earned Income In Excess Of $200,000 Single Or $250,000 Joint

- What should I do if I have two jobs and neither employer withholds Additional Medicare Tax, but the sum of my wages exceeds the threshold at which I will owe the tax?
  - If you anticipate that you will owe Additional Medicare Tax but will not satisfy the liability through Additional Medicare Tax withholding (for example, because you will not be paid wages in excess of $200,000 in a calendar year by an employer), you should make estimated tax payments and/or request additional income tax withholding using Form W-4. For information on making estimated tax payments and requesting an additional amount be withheld from each paycheck.

Additional 0.9% Medicare Tax On Earned Income In Excess Of $200,000 Single Or $250,000 Joint

- When must an employer withhold Additional Medicare Tax?
  - The statute requires an employer to withhold Additional Medicare Tax on wages it pays to an employee in excess of $200,000 in a calendar year, beginning January 1, 2013. An employer has this withholding obligation even though an employee may not be liable for Additional Medicare Tax because, for example, the employee's wages together with that of his or her spouse do not exceed the $250,000 threshold for joint return filers. Any withheld Additional Medicare Tax will be credited against the total tax liability shown on the individual's income tax return (Form 1040).

Additional 0.9% Medicare Tax On Earned Income In Excess Of $200,000 Single Or $250,000 Joint

- Is an employer liable for Additional Medicare Tax even if it does not withhold it from an employee's wages?
  - An employer that does not deduct and withhold Additional Medicare Tax as required is liable for the tax unless the tax that it failed to withhold from the employee's wages is paid by the employee. Even if not liable for the tax, an employer that does not meet its withholding, deposit, reporting, and payment responsibilities for Additional Medicare Tax may be subject to all applicable penalties.
- Is an employer required to notify an employee when it begins withholding Additional Medicare Tax?
  - No. There is no requirement that an employer notify its employee.
- Is there an “employer match” for Additional Medicare Tax (as there is with the regular Medicare tax)?
  - No. There is no employer match for Additional Medicare Tax.

Additional 0.9% Medicare Tax On Earned Income In Excess Of $200,000 Single Or $250,000 Joint

- If an employee's annual Medicare wages are expected to be over $200,000, will an employer withhold Additional Medicare Tax from the beginning of the year or only after Medicare wages are actually paid in excess of $200,000 year-to-date?
  - An employer is required to begin withholding Additional Medicare Tax in the pay period in which it pays wages in excess of $200,000 to an employee.

Additional 0.9% Medicare Tax On Earned Income In Excess Of $200,000 Single Or $250,000 Joint

- I have two employees who are married to each other. Each earns $150,000, so I know that their combined wages will exceed the threshold applicable to married couples that file jointly. Do I need to withhold Additional Medicare tax?
  - No. An employer should not combine wages it pays to two employees to determine whether to withhold Additional Medicare Tax. An employer is required to withhold Additional Medicare Tax only when it pays wages in excess of $200,000 in a calendar year to an employee.

Additional 0.9% Medicare Tax On Earned Income In Excess Of $200,000 Single Or $250,000 Joint

- What should an employer do if an employee receives wages that are not paid in cash, such as taxable fringe benefits, from which Additional Medicare Tax cannot be withheld?
  - If an employee receives wages from an employer in excess of $200,000 and the wages include taxable noncash fringe benefits, the employer calculates wages for purposes of withholding Additional Medicare Tax in the same way that it calculates wages for withholding the existing Medicare tax. The employer is required to withhold Additional Medicare Tax on total wages, including taxable noncash fringe benefits, in excess of $200,000. The value of taxable noncash fringe benefits must be included in wages and the employer must withhold the applicable Additional Medicare Tax and deposit the tax under the rules for employment tax withholding and deposits that apply to taxable noncash fringe benefits. Additional information on how to withhold tax on taxable noncash fringe benefits is available in Publication 15 (Circular E), section 5, and Publication 15-B, section 4.

Additional 0.9% Medicare Tax On Earned Income In Excess Of $200,000 Single Or $250,000 Joint

- Should an employer combine an employee's wages for services performed for all of its subsidiaries if it has an employee who performs services for more than one subsidiary in its company, but the payroll is paid through one of the subsidiaries?
  - An employer is required to withhold Additional Medicare Tax on wages paid to an employee in excess of $200,000 in a calendar year. When an employee is performing services for multiple subsidiaries of a company, and each subsidiary is an employer of the employee with regard to the services the employee performs for that subsidiary, the wages paid by the payor on behalf of each subsidiary should be combined only if the payor is a common paymaster. Publication 15-A, section 7 contains more information on common paymasters. The wages are not combined for purposes of the $200,000 withholding threshold if the payor is not a common paymaster.

Additional 0.9% Medicare Tax On Earned Income In Excess Of $200,000 Single Or $250,000 Joint

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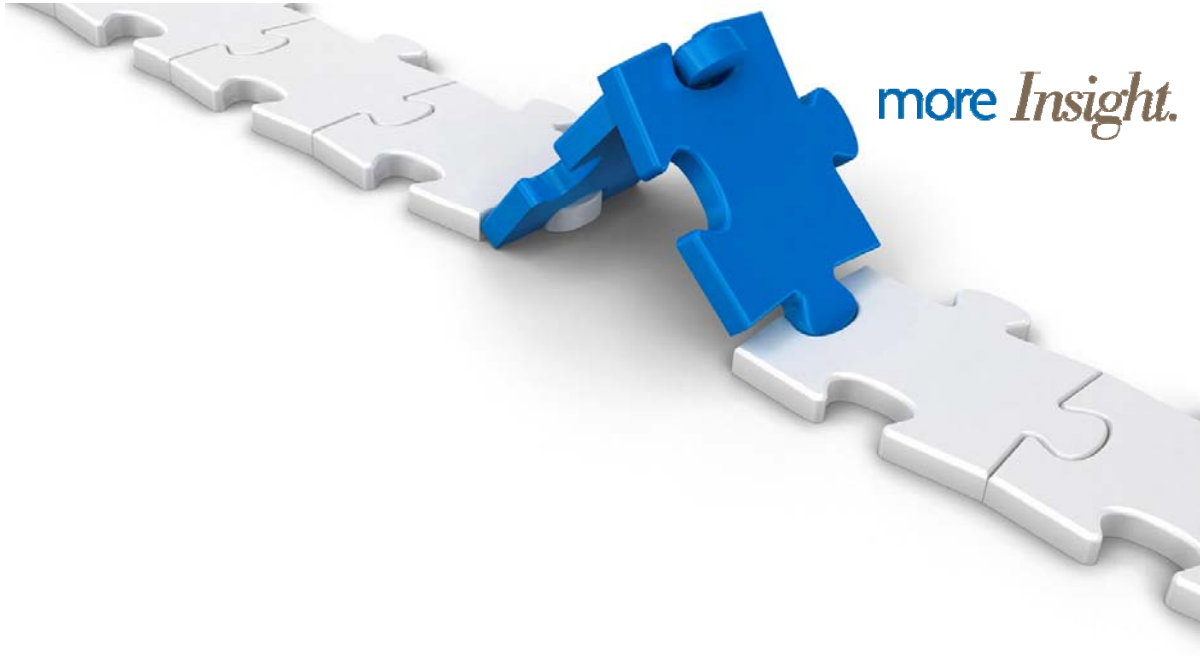

3.8% Surtax On Investment Income For Individuals With Modified Adjusted Gross Income (AGI) over $200,000 Single or $250,000 Joint

3.8% Surtax On Investment Income For Individuals With Modified Adjusted Gross Income (AGI) over $200,000 Single or $250,000 Joint

- New Guidance: IRS Proposed Regulation and Frequently Asked Questions, released on November 30, 2012, published in December 5, 2012 Federal Register

3.8% Surtax On Investment Income For Individuals With Modified Adjusted Gross Income (AGI) over $200,000 Single or $250,000 Joint

- What is included in Net Investment Income?
  - In general, investment income includes, but is not limited to: interest, dividends, capital gains, rental and royalty income, non-qualified annuities, income from businesses involved in trading of financial instruments or commodities, and businesses that are passive activities to the taxpayer (within the meaning of IRC section 469).
- Does this tax apply to gain on the sale of a personal residence?
  - The Net Investment Income Tax will not apply to any amount of gain that is excluded from gross income for regular income tax purposes. The pre-existing statutory exclusion in IRC section 121 exempts the first $250,000 ($500,000 in the case of a married couple) of gain recognized on the sale of a principal residence from gross income for regular income tax purposes and, thus, from the NIIT.

3.8% Surtax On Investment Income For Individuals With Modified Adjusted Gross Income (AGI) over $200,000 Single or $250,000 Joint

- Does Net Investment Income include interest, dividends, and capital gains of my children that I report on my Form 1040 using Form 8814?
  - The amounts of Net Investment Income that are included on your Form 1040 by reason of Form 8814 are included in calculating your Net Investment Income. However, the calculation of your Net Investment Income does not include (a) amounts excluded from your Form 1040 due to the threshold amounts on Form 8814 and (b) amounts attributable to Alaska Permanent Fund Dividends.

3.8% Surtax On Investment Income For Individuals With Modified Adjusted Gross Income (AGI) over $200,000 Single or $250,000 Joint

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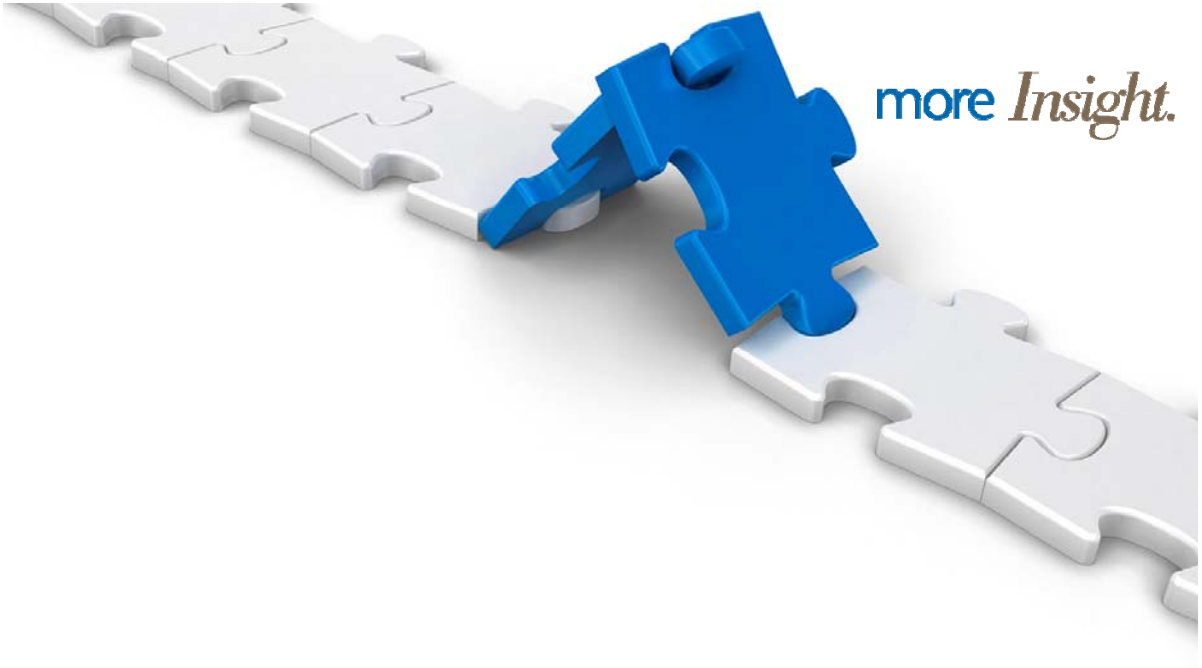
- What are some common types of income that are not Net Investment Income?
  - Wages, Unemployment Compensation; Operating Income from a Nonpassive Business, Social Security Benefits, Alimony, Tax Exempt Interest, Self-employment Income, Alaska Permanent Fund Dividends (see Rev. Rul. 90-56, 1990-2 CB 102), and Distributions from certain Qualified Plans (those described in sections 401(a), 403(a), 403(b), 408, 408A, or 457(b)).

3.8% Surtax On Investment Income For Individuals With Modified Adjusted Gross Income (AGI) over $200,000 Single or $250,000 Joint

- Proposed Regulations address exception in New Code §1411(c)(1)(A): the net investment income tax does not apply to income derived in the ordinary course of a trade or business.
- The Ordinary Course Exception for Business Conducted by Passthrough Entities
  - The ordinary course of business exception does NOT include business that constitute passive activities under §469 or a trade or business of trading in financial instruments or commodities (as defined in section 475(e)(2)). Result: to avoid attracting the NIIT, the passthrough entity must not be either of these two types of entities.
  - Determination of whether the trade or business from which the income is derived is a passive activity with respect to the taxpayer is determined at the taxpayer (individual, estate, or trust) level in accordance with the general principles of section 469.
  - Determination of whether the trade or business from which the income is derived is a trade or business of trading in financial instruments or commodities is made at the passthrough entity level (the partnership or S corporation level). If the passthrough entity is engaged in a trade or business of trading in financial instruments or commodities, income from such trade or business retains its character as it passes from the entity to the taxpayer.

3.8% Surtax On Investment Income For Individuals With Modified Adjusted Gross Income (AGI) over $200,000 Single or $250,000 Joint

- The material participation rules of section 469 will apply for purposes of determining whether a taxpayer materially participates in a section 162 trade or business for purposes of determining whether such trade or business is described in section 1411(c)(2)(A).



$2,500 Limit on Cafeteria Plan Flexible Spending Accounts

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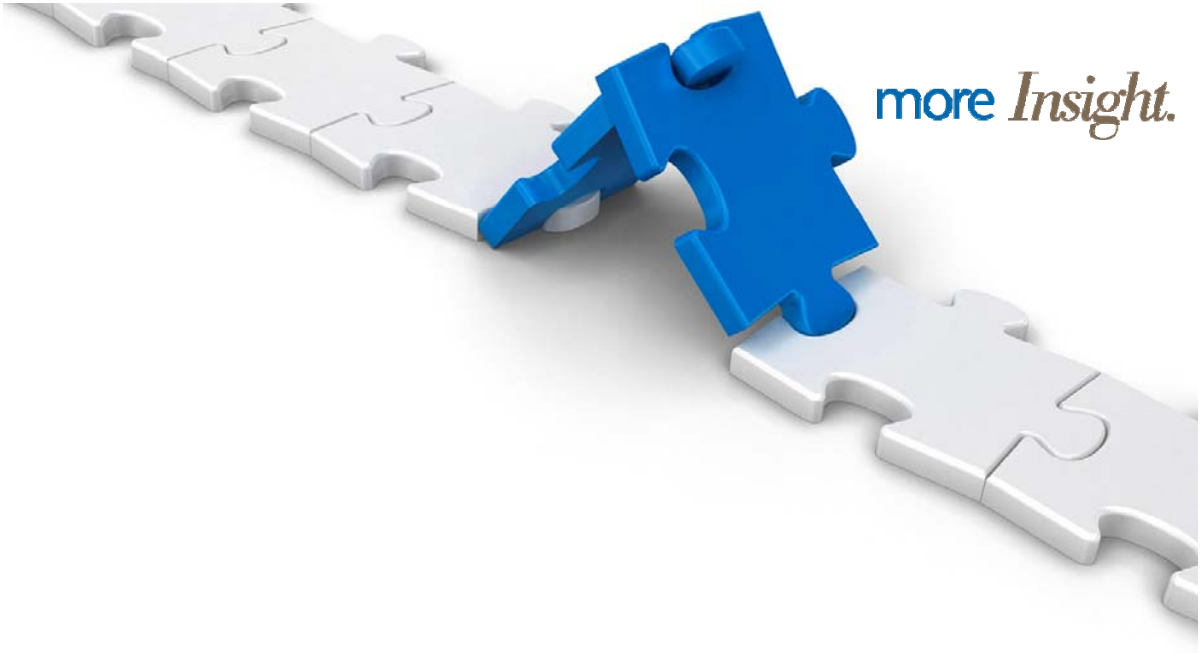
$2,500 Limit on Flexible Spending Accounts

- The $2,500 Limit is Effective for Taxable Years Beginning After December 31, 2012.
- The maximum amount available for reimbursement of incurred medical expenses of an employee, the employee's dependents, and any other eligible beneficiaries with respect to the employee, under a health flexible spending arrangement that is part of a cafeteria plan for a plan year (or other 12-month coverage period) must not exceed $2500.
- The $2,500 limitation is indexed to CPI-U beginning after December 31, 2013. ACA §9005.
- A cafeteria plan that does not include this limitation on the maximum amount available for reimbursement under any flexible spending arrangement will not qualify as a cafeteria plan under IRC §125.

$2,500 Limit on Flexible Spending Accounts

- Planning Steps
  - Cafeteria plan flexible spending arrangements must be amended to limit permissible salary reductions/employer contributions to flexible spending arrangements to $2,500 (indexed for inflation) for 2013.
  - Failure to effect this change means employees may lose the pre-tax treatment of their salary deferrals and will be required to include in income the entire deferral plus any employer contributions.
  - Problem: FSA elections for 2013 must be circulated and completed prior to 2013
  - Make sure plan enrollment materials notify eligible employees of the $2,500 limit and make sure plan administrators can intercept excess elections.



Part Three: Planning That is Required in 2013 to Comply with the Affordable Care Act's 2014 Effective Date Changes

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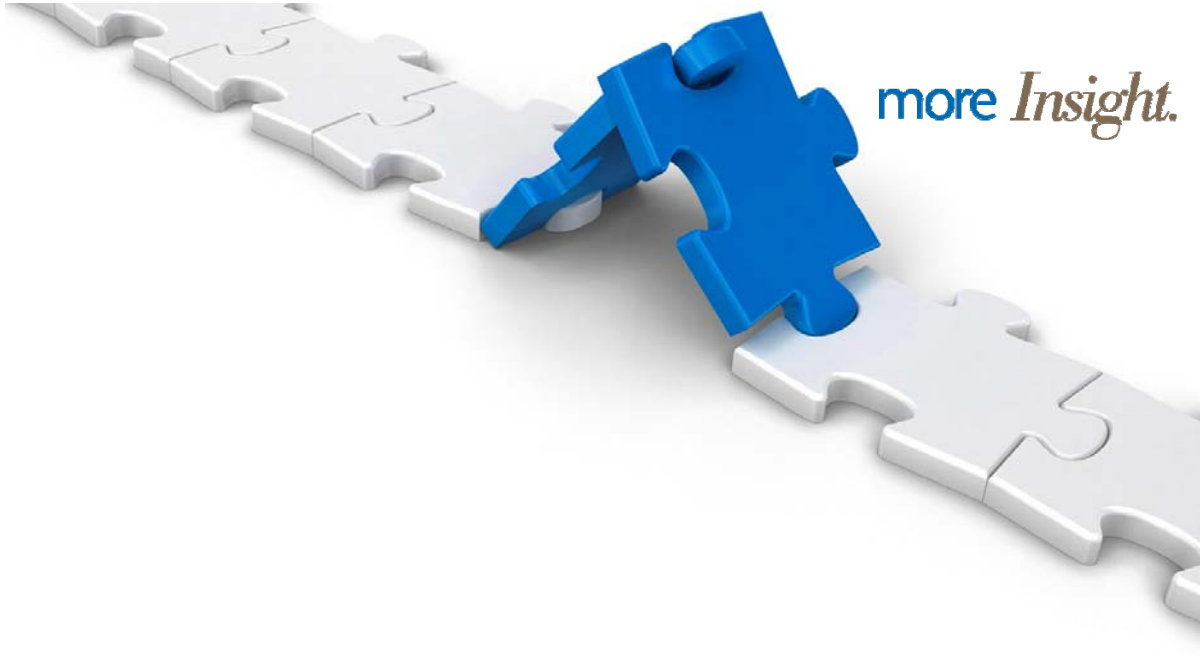

A Quick Overview of the Affordable Care Act's 2014 Effective Date Major Features Employers Must Plan For in 2013

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A Quick Overview of the Affordable Care Act's 2014 Effective Date Major Features Employers Must Plan For in 2013

- State-Based Health Care Exchanges
  - "Qualified Health Plans"
    - "Essential Benefits Package"
      - 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, as well as pediatric services, including oral and vision care
      - Determined Based on What is Included in the State Exchange's Benchmark Plan

A Quick Overview of the Affordable Care Act's Major Features That Concern Employers Today

- Expanded Medicaid Eligibility
- Transitional Reinsurance Program
- Limitation on Cost Sharing (Deductibles and Out of Pocket Expenses)
- New underwriting requirements for fully insured nongrandfathered plans: adjusted community rating instead of individualized rating --shifts costs from older workers to younger workers
- The Individual "Pay or Play" Mandate
- 90 Limit on Eligibility Waiting Periods
- Tax Subsidies to Encourage Individuals to "Play" via the Exchanges Rather Than "Pay"
- The Employer "Pay or Play" Mandate

Expanded Medicaid Eligibility

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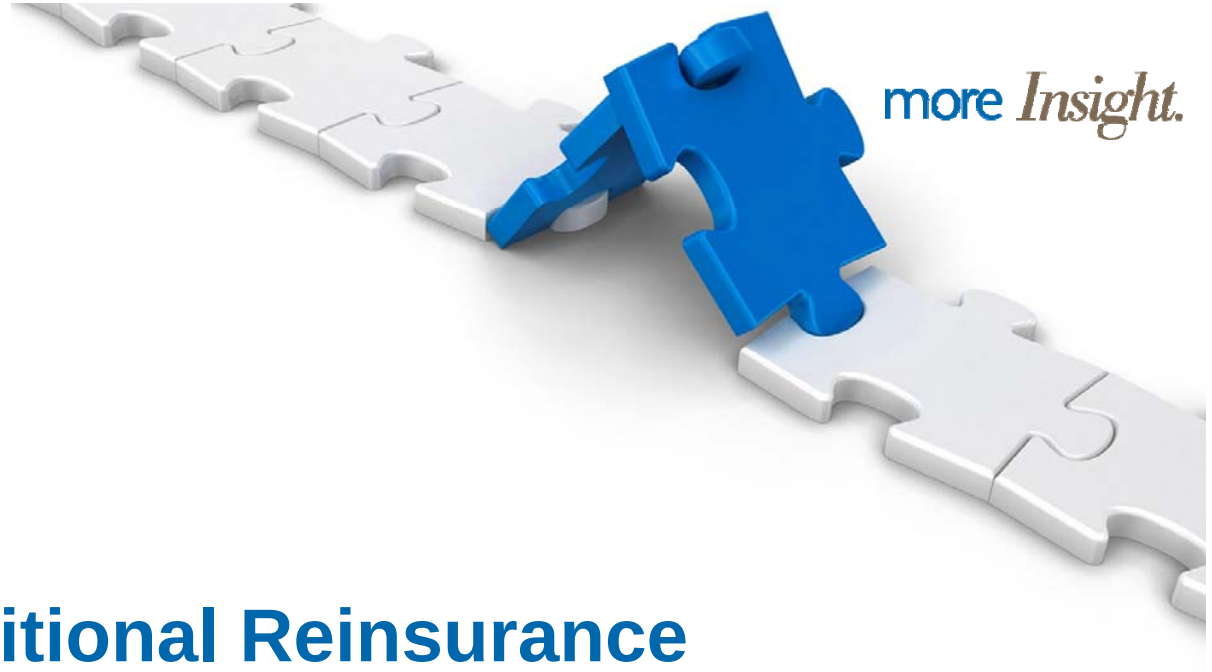
Expanded Medicaid Eligibility

- The ACA Attempted to Expand Medicaid's Mandatory Coverage:
  - A participating state must cover nearly all non-disabled adults under age 65 with household income between 100% and 133% of the Federal Poverty Level (FPL), beginning in January 2014
  - Currently, some states do not cover adults without dependent children or cover parents only at income levels far below 100% of FPL
- ACA: Federal government pays 100% of the states' increased cost through 2016, decreasing to 90% by 2020
- Is the Medicaid Expansion Mandate Constitutional?
  - The Supreme Court's Decision in National Federation of Independent Business v. Sebelius: No – Congress cannot attach too many "strings" to funding dollars for certain programs.

Expanded Medicaid Eligibility

- Effect on Employers
  - If a state expands Medicaid eligibility, then –
    - Employees who become Medicaid eligible can enroll in Medicaid (which has no premium or out of pocket obligations)
    - Their employer avoids having to include them in the employer's group health benefit plan
      - That relieves the employer of an expense
      - Eliminates a group of employees from the employee "count" that will otherwise determine the employer's exposure to the employer mandate penalties
      - Eliminates employees for small employers who are not subject to the employer mandate penalties but who are subject to the fully insured nondiscrimination requirements



Transitional Reinsurance Program

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Transitional Reinsurance Program

- Affordable Care Act §1341: establishes transitional reinsurance program, beginning in 2014 and ending at the conclusion of 2016
- Purpose: reduce the uncertainty of insurance risk in the individual market by partially offsetting risk of high cost enrollees. Will provide increased payments to health insurance issuers that attract higher-risk populations, such as those with chronic conditions, and reduce the incentives for issuers to avoid higher-risk enrollees.
  - Funds collected by the will be transferred from issuers with lower-risk enrollees to issuers with higher-risk enrollees.

Transitional Reinsurance Program

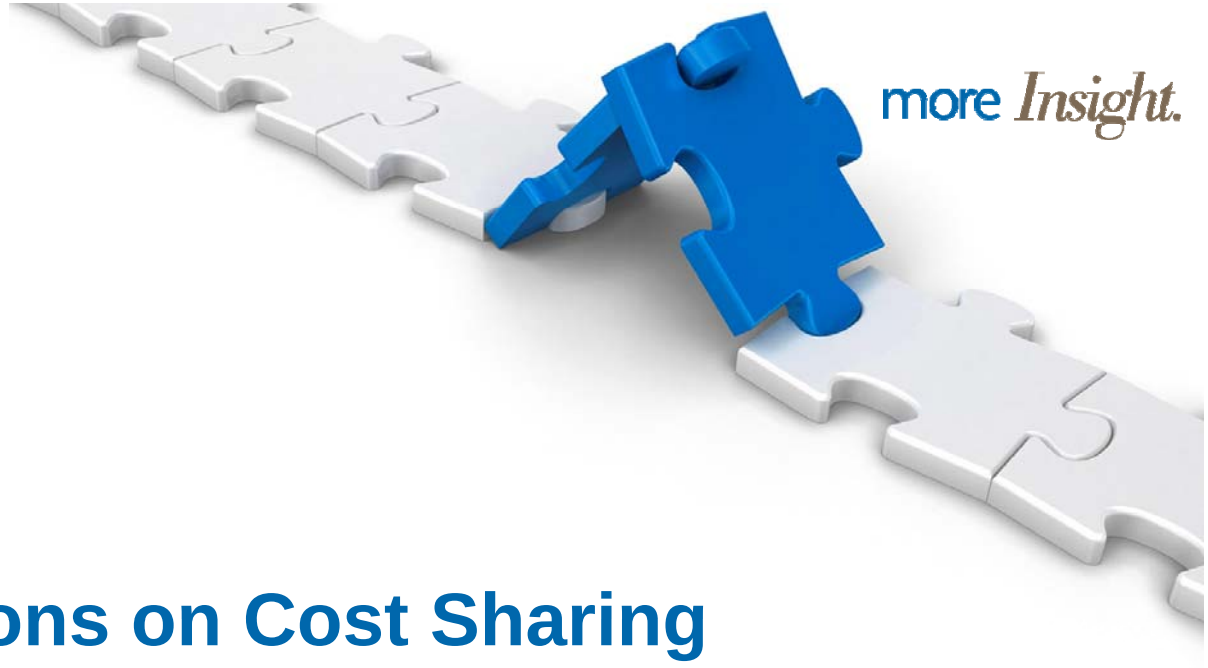
- Who contributes to the program? Health insurance issuers and third party administrators on behalf of group health plans must make payments.
  - Insured coverage: issuers are liable for and must make the reinsurance contributions.
  - Self-insured group health plans: the plan is liable, although a third-party administrator or administrative-services-only contractor may be utilized to transfer reinsurance contributions on behalf of a self-insured group health plan, at that plan's discretion.

Transitional Reinsurance Program

- Plans that are subject to this new obligation: plans that offer “major medical coverage” – coverage
  - Plans that are therefore exempt:
    - Plans with coverage that is limited in scope (for example, dread disease coverage, hospital indemnity coverage, stand-alone vision coverage, or stand-alone dental coverage) or extent (for example, coverage that is not subject to the Public Health Service Act section 2711 and its implementing regulations)
    - HRAs that are part of a major medical plan are exempt
    - FSAs and HSAs are exempt

Transitional Reinsurance Program

- How large is the contribution? November 30, 2012 Guidance:
  - HHS will administer the program on a nationwide basis
  - Plans will pay HHS one nationally determined, uniform per participant rate
  - Projected rate for 2014: $5.25 per participant per month
- Planning: remember to budget this cost – it's not peanuts.



Limitations on Cost Sharing

Limitations on Cost Sharing

- Deductibles and Co-Insurance ≡ Cost Sharing
  - Where does this requirement appear in the Act? Act §1201, which adds §2707 to the PHSA and which incorporates the standards in Act §1302(c)(1) and (2)→ Incorporated into IRC §9815
  - Effective Date: Plan years beginning on or after January 1, 2014
  - Applies to non-grandfathered employer-sponsored plans and all plans offered on the exchanges

Limitations on Cost Sharing

- **What are the limits?**
  - Plans sponsored by employers who employ 100 or fewer employees (plans in the "small group market" (Act §1304):
    - Maximum **aggregate cost-sharing obligation:** HSA limits ($6,050 single/$12,100 family for 2012; $6,250 single/$12,500 family for 2013)(Act §1302(c)(1))
    - Maximum **deductible:** $2,000 single/$4,000 family (Act §1302(c)(2))
  - Plans sponsored by employers who employ 101 or more employees (plans in the "large group market" (Act §1304):
    - Maximum **aggregate cost-sharing obligation:** HSA limits ($6,050 single/$12,100 family for 2012; $6,250 single/$12,500 family for 2013) (Act §1302(c)(1))
    - Maximum **deductible:** no limit (Act §1302(c)(2) only applies to health plans offered in the "small group market")

Limitations on Cost Sharing

- Why do we care about these limits? To evaluate whether to offer an "affordable plan" and avoid the employer mandate penalty or whether to discontinue coverage
  - Employers with 50+ bona fide full time employees (30+ hours per week) but less than 100 employees are most affected:
    - Employer mandate: Employer must pay any portion of the premium > 9.5% of household income
    - Employer can suppress premium (and therefore employer's premium cost exposure) by increasing cost sharing obligation
    - But can't increase too much, because of the limit on cost sharing **and** deductible

Planning for Employer-Level "Pay or Play" Requirement – The Employer Mandate

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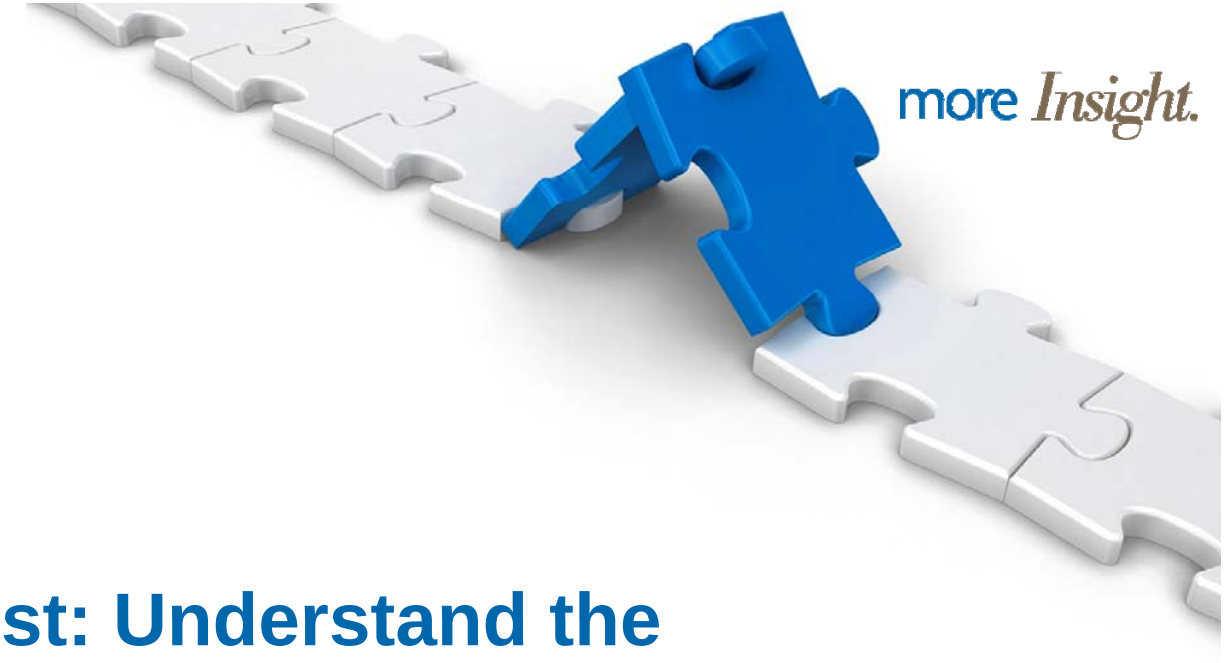

But First: Understand the Implications of the Individual Mandate

The Individual “Pay or Play” Mandate

- Every individual with household income >138% of the poverty level must
  - Enroll in a plan that offers “minimum essential coverage” or
  - Pay a penalty
- The Penalty:
  - 2014: 1% of household income>threshold or $95, whichever is more
  - 2015: 2% of household income>threshold or $325, whichever is more
  - 2016 and thereafter: 2.5% of household>threshold or $695, whichever is more.
  - Total household penalty cannot exceed 3x the individual penalty.
- Is the Penalty Onerous Enough to Cajole Younger Employees to Enroll?
  - The more who enroll, the lower the per member claims, the lower the employer’s exposure (and the more attractive the plan becomes to older workers)
  - The reverse is the problem.

Next: Understand the Dynamics of the Premium and Coinsurance Tax Subsidies Eligible Individuals Can Garner If and Only If They Enroll in an Exchange Plan

The Premium Tax Credit For Eligible Individuals Who Enroll in an Exchange Plan

- Individuals subject to the pay or play mandate are also eligible for a premium tax credit they can use to pay for a qualified health plan they purchase on the state health exchange (and may also be eligible for cost-sharing subsidies)
- Eligibility:
  - Can't be eligible for Medicare, Medicaid, or an "affordable" employer-sponsored health plan (more on that in a moment).
  - Household income must be between 100% and 400% of the federal poverty level
    - Will Congress or the Administration lower the 100% floor?

The Premium Tax Credit For Eligible Individuals Who Enroll in an Exchange Plan

- 2011-2014 Federal Poverty Level

	By Family Size			
	1	2	3	4
2011	$10,890	$14,710	$18,530	$22,350
2012	$11,065	$14,947	$18,828	$22,710
2013	$11,243	$15,187	$19,131	$23,075
2014	$11,425	$15,432	$19,439	**$23,447**

- **400% of FPL single (2014 projected) = $46,000**
- **400% of FPL family (2014 projected) = $94,000**

The Premium Tax Credit For Eligible Individuals Who Enroll in an Exchange Plan

- Credit Amount
  - The difference between the premium for the exchanges' "benchmark plan" and the taxpayer's "expected contribution"
  - Expected contribution: a % of taxpayer's household income
    - Percentage increases as household income increases
      - 2% of household income → 100% of FPL
      - 9.5% of household income → 400% of FPL
  - Benchmark plan: second lowest cost plan that can cover family at "silver" level

The Premium Tax Credit For Eligible Individuals Who Enroll in an Exchange Plan

- Credit Amount
  - Choose a plan that is less expensive than the benchmark plan? Since credit remains the same, family's out of pocket cost will be less than the expected contribution
  - Choose a plan that is more expensive than the benchmark plan? Since credit remains the same, family's actual out of pocket cost will exceed the expected contribution.

The Premium Tax Credit For Eligible Individuals Who Enroll in an Exchange Plan

- Example: Family of Four; $50,000 Household Income—Purchase Benchmark Plan

Income as % of FPL	224%
Expected family contribution	**$3,570**
Premium for benchmark plan	$9,000
Premium tax credit	$5,430 ($9,000-$3,570)
Premium for plan family chose	$9,000
Actual family contribution	$3,570

Examples are from IRS Fact Sheet, August 12, 2011, http://www.treasury.gov/press-center/Documents/36BFactSheet.PDF

The Premium Tax Credit For Eligible Individuals Who Enroll in an Exchange Plan

- Example: Family of Four; $50,000 Household Income; Parents are Between Age 55-64. *Affordable Care Act permits plans to base premiums on age (maximum spread – 3-1).*
  - Income as % of FPL 224%
  - **Expected family contribution** **$3,570**
  - Premium for benchmark plan $14,000
  - Premium tax credit $10,430 ($14,000-$3,570)
  - Premium for plan family chose $14,000
  - Actual family contribution $ 3,570

The Premium Tax Credit For Eligible Individuals Who Enroll in an Exchange Plan

- Example: Family of Four; $70,350 Household Income—Purchase Benchmark Plan
  - Income as % of FPL 300%
  - **Expected family contribution** **$6,680**
  - Premium for benchmark plan $9,000
  - Premium tax credit $2,320 ($9,000-$6,680)
  - Premium for plan family chose $9,000
  - Actual family contribution $6,680 ($557/month)

This example uses tables in August 17, 2011 Proposed Regulation

Which Employers Are Exposed to The Employer Mandate Penalties? An “Applicable Large Employer”

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Which Employers Are Exposed to The Employer Mandate Penalties? An "Applicable Large Employer"

- An Employer is an "Applicable Large Employer" for a calendar year if the employer employed at least 50 "full-time employees" during the preceding calendar year
  - "Full-time employees": working 30 or more hours per week.
    - IRS January 2, 2013 Proposed Regulations: IRS proposes an alternative measurement – 130 hours per month
  - Seasonal Exception. The number of full-time employees excludes those full-time seasonal employees who work for less than 120 days during the year.
    - If employer's work force is > 50 full-time + full-time equivalent employees for 120 days or less during a calendar year, and if the employees > 50 who were employed for not more than 120 were seasonal employees, the employer is NOT an "applicable large employer"
    - IRS January 2, 2013 Proposed Regulations : Good faith interpretation of "seasonal worker" is permitted

Which Employers Are Exposed to The Employer Mandate Penalties? An "Applicable Large Employer"

- Treatment of partners and sole proprietors:
  - IRS January 2, 2013 Proposed Regulations: sole proprietors, partners in a partnership, and 2-percent S corporation shareholders (excluding hours of service as an employee of an S corporation) are not "employees" for purposes of §4980H, the employer mandate section of the Internal Revenue Code
- Aggregation Rules Apply
  - IRS January 2, 2013 Proposed Regulations: All employees of a controlled group under §414(b) or (c), or an affiliated service group under §414(m), are taken into account in determining whether the members of the controlled group or affiliated service group together constitute an applicable large employer.

Which Employers Are Exposed to The Employer Mandate Penalties? An "Applicable Large Employer"

- Part-Time Employees Count -- But Only Determine If an Employer Constitutes an Applicable Large Employer
- To convert part-time employees into the equivalent number of full-time employees: For each month, divide the total number of monthly hours worked by the part-time employees by 120. Add that to the number of full-time employees. If a monthly number includes a fraction, preserve the fraction. Add the monthly numbers of full-time employees and full-time equivalent employees to produce an annual total; if the annual total includes a fraction, disregard the fraction.

Which Employers Are Exposed to The Employer Mandate Penalties? An "Applicable Large Employer"

- Determining the Number of Hours An Employee Worked
  - IRS January 2, 2013 Proposed Regulations:
    - The Proposed Regulations contain rules for determining the number of hours of service for both applicable large employer determinations and for the "look-back measurement method" that employers may use to determine exposure to the two "assessable payments" to which "applicable large employers" are subject
    - Hourly employees: the only acceptable method is the actual hours method.
    - Non-hourly employees: actual hours, or days-worked equivalency, or weeks-worked equivalency
    - The Proposed Regulations contain averaging methods for employment break periods for employees of educational institutions.
    - Proposed Regulations: Employees compensated on a commission basis, adjunct faculty, transportation employees, and analogous employment positions: reasonable good faith method.

The Two Employer Pay or Play Mandate Penalties

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The Two Employer Pay or Play Mandate Penalties

- ***Penalty #1:*** Penalty on the applicable large employer that **does not offer group health benefit plan coverage to all of its full time employees**

- ***Penalty #2:*** Penalty on the applicable large employer that offers coverage – but the coverage is

  - **not affordable --**The employee's share of the premium > 9.5% of household income

    OR

  - The plan's share of covered health benefit costs (the "actuarial value") does not offer **minimum value –** it is less than 60%,

The Two Employer Pay or Play Mandate Penalties

- Applicable Large Employers face these two different penalties *only if* at least one bona fide full time employee (> 30 hours per week) is eligible for the new premium tax credit
- One of the two penalties is calculated by reference to the number of bona fide full time employees – so, being able to identify who they are will be important
- IRS January 2, 2013 Proposed Regulations: For any calendar month, an applicable large employer member [each entity that is a member of a controlled group which, in the aggregate, constitutes an "applicable larger employer] may be liable for an assessable payment under §4980H(a) (failure to offer coverage to full-time employees) or under §4980H(b) (failure to offer affordable coverage that provides minimum value), but cannot be liable under both §4980H(a) and §4980H(b) for the same calendar month.

The Employer Mandate and Auto Enrollment Apply to Bona Fide Full Time Employees: Identifying Who They Are (The 90-Day Limit on Waiting Periods Applies Not Only to Full Time Employees But Also to All Other Eligible Participants)

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Determining Who is a Full-Time Employee

- IRS January 2, 2013 Proposed Regulations: Measurement, Administrative and Stability Periods to Determine Status as a Full Time Employee for Purposes of the Employer Mandate
  - Basic Rules: Ongoing Employees:
    - Standard measurement period: 3 months to 12 months. determine status during measurement period. That status then applies during the—
    - Subsequent stability period, regardless of employee's # of hours during the stability period. At least 6 calendar months; no shorter than measurement period.
    - Administrative period. Up to 90 days; overlaps prior stability period. (Example: 12 month measurement period begins on 10/15; stability period is the following calendar year; administrative period runs from 10/15 to January 1.

Determining Who is a Full-Time Employee

- IRS January 2, 2013 Proposed Regulations: Measurement, Administrative and Stability Periods to Determine Status as a Full Time Employee for Purposes of the Employer Mandate
  - Basic Rules: New Employee Reasonably Expected to Work 30+ Hours Per Week as of Start Date and Not a Seasonal Employee :
    - Employer must offer coverage at or before the end of this employee's initial three full calendar months of employment.

Determining Who is a Full-Time Employee

- IRS January 2, 2013 Proposed Regulations: Measurement, Administrative and Stability Periods to Determine Status as a Full Time Employee for Purposes of the Employer Mandate
  - Basic Rules: New "Variable Hour Employee" or New "Seasonal Employee"
    - Definition: can't determine as of start date whether employee is reasonably expected to work on average at least 30 hours per week over the initial measurement period
    - Example: new employee hired during holiday season – expected to work 30+ hours during that season but not sure thereafter
    - Special Rule for 2014 only for new employees who, although they will initially perform at least an average of 30 hours of service per week, are reasonably expected to be employed for a limited duration:
      - For 2014, only: employers can take into account take the likelihood of continued employment to determine whether a new employee is or is not a variable hour employee.
      - NB: the Proposed Regulations specifically decline to allow employers to take turnover into account in determining whether a new employee is or is not a variable hour employee:

Determining Who is a Full-Time Employee

- IRS January 2, 2013 Proposed Regulations: Measurement, Administrative and Stability Periods to Determine Status as a Full Time Employee for Purposes of the Employer
  - Basic Rules: Initial Measurement and Administrative Periods for New Variable Hour Employee and New Seasonal Employee
    - Initial measurement period: a period that begins on any date between the employee's start date and the first day of the first calendar month following the employee's start date and is between three and 12 months long (at the election of the employer).
    - Initial administrative period: not longer than 90 days
    - Initial measurement period plus initial administrative period can't extend beyond last day of first calendar month following first anniversary of employment start date

Determining Who is a Full-Time Employee

- IRS January 2, 2013 Proposed Regulations: Measurement, Administrative and Stability Periods to Determine Status as a Full Time Employee for Purposes of the Employer Mandate
  - Basic Rules: Initial Stability Period for New Variable Hour Employee
    - Initial Stability period: same as for similarly situated ongoing employee.
      - Perform on average 30 hours of service per week during the initial measurement period: stability period must be at least six consecutive calendar months but no shorter than the duration of the initial measurement period).
      - Fail to perform on average 30 hours of service per week during the initial measurement period: stability period during which this employee will not be treated as a full-time employee cannot be more than one month longer than the initial measurement period and cannot exceed the remainder of the standard measurement period + administrative period in which the initial measurement period ends.

Determining Who is a Full-Time Employee

- IRS January 2, 2013 Proposed Regulations: Measurement, Administrative and Stability Periods to Determine Status as a Full Time Employee for Purposes of the Employer Mandate and the Maximum 90-Day Waiting Period
  - Basic Rules: Subsequent Measurement and Stability Periods for New Variable Hour Employee
    - When a new variable hour employee completes an entire standard measurement period, then the new variable hour employee must be tested for that standard measurement period as an ongoing employee.
      - Result: New variable hour employee fails to qualify as a full-time employee during the initial measurement period but qualifies as a full-time employee during the overlapping (or immediately following) standard measurement period => employer must treat the variable hour employee as a full-time employee for the entire stability period that corresponds to the standard measurement period (i.e., just like an ongoing employee) -- and must do so even if that stability period starts before the end of the stability period associated with the employee's initial measurement period

Remember: The 90-Day Limit on Waiting Periods Applies to All Eligible Participants

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Remember: The 90-Day Limit on Waiting Periods Applies to All Eligible Participants

- IRS Notice 2012-59:
  - What is a “waiting period”? The period of time that must pass before coverage for an employee or dependent who is otherwise eligible to enroll under the terms of the plan is effective.
    - “Otherwise eligible to enroll”: the employee has met the plan’s substantive eligibility conditions, such as being in an eligible job classification.
  - Conditions for eligibility that are not based solely on the passage of time are permitted (e.g., employee must work full time or work a specified number of hours in a work period to earn coverage in an eligibility period.
    - The condition must not be designed to avoid compliance with the 90-day waiting period limitation.
    - Eligibility conditions that are based solely on the lapse of a time period are permissible for no more than 90 days.

Remember: The 90-Day Limit on Waiting Periods Applies to All Eligible Participants

- IRS Notice 2012-59:
  - An employer may use a measurement period permitted in Notice 2012-58 (and now incorporated in IRS January 2, 2013 Proposed Regulations) to determine when an employee satisfies the plan's full time eligibility condition and will not violate the 90 day limit on waiting periods **if** coverage is made effective no later than 13 months from the employee's start date, plus if the employee's start date is not the first day of a calendar month, the time remaining until the first day of the next calendar month.
  - Result:
    - If the measurement period for a variable hour employee is 12 months, the administrative period can't exceed one month.

Remember: The 90-Day Limit on Waiting Periods Applies to All Eligible Participants

- IRS Notice 2012-59:
  - If a plan wishes to cover part-time employees, but only after they complete a specified number of hours of service, how many hours of service may the plan require without violating the 90 day limit on waiting periods?
  - Notice 2012-59: a cumulative hours of service condition with respect to part-time employees is permissible as long as that condition does not require more than 1,200 hours.

Planning for the Employer-Level "Pay or Play" Requirement Penalty #1-Offer Coverage to all 30+ Hour Full Time Employees

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Planning for the Employer-Level "Pay or Play" Requirement Penalty #1-Offer Coverage to all 30+ Hour Full Time Employees

- What Triggers This First Penalty?
  - Do not offer group health benefit plan coverage to bona fide full-time employees (and their dependents) **AND** at least one of those full time employees enrolls in an exchange plan **AND** receives the premium tax subsidy (i.e., family income < 400% of FPL)
  - NB: Must offer coverage not only to full-time employees but also to their dependents
- Who is a "Dependent"?
  - IRS January 2, 2013 Proposed Regulations: "dependent" means "child," as defined in IRC §152(f)(1) who is under age 26
  - That definition includes adopted children and stepchildren—they do not have to qualify as tax dependents.
  - Spousal carve-outs ARE permitted

Planning for the Employer-Level "Pay or Play" Requirement Penalty #1-Offer Coverage to all 30+ Hour Full Time Employees

- How Much is This First Penalty?
  - In 2014, the annual penalty is equal to: the total number of full-time employees minus 30, multiplied by $2,000.
  - After 2014, the penalty payment amount will be indexed by a premium adjustment percentage for the calendar year.

Planning Options to Deal With Penalty #1Fail to Offer Group Health Plan Coverage

- How Many Additional Employees Must the Employer Offer Coverage?
  - IRS January 2, 2013 Prop. Reg. §54.4980H-5(a)Creates an Exception
    - Employer will be treated as offering coverage to its full-time employees (and their dependents) for a calendar month if, for that month, it offers coverage to all but five percent or, if greater, five of its full-time employees (provided that an employee is treated as having been offered coverage only if the employer also offered coverage to that employee's dependents).”
    - Applies to a failure to offer coverage to the specified number or percentage of employees (and their dependents), regardless of whether the failure to offer was inadvertent.

Planning Options to Deal With Penalty #1Fail to Offer Group Health Plan Coverage

- How Many Additional Employees Must the Employer Offer Coverage?
  - Does the employer currently exclude employees who constitute bona fide employees under the ACA's employer pay or play mandate provisions (30 hours per week or 130 hours per month)?
  - If the answer is yes, how big is the affected population?
    - Industries likely to be affected: food service, retail, construction
    - Staffing services: who will treat the long-service staffer as the employee?

Planning Options to Deal With Penalty #1Fail to Offer Group Health Plan Coverage

- Will the Employer's Cost of Coverage Be More – Or Less – than $2,000?
  - This depends upon:
    - The employer's share of plan costs
    - The average age-mortality of the heretofore excluded employees
  - The younger the age, the lower their cost
  - HHS 11-26-12 Proposed Regulations on Health Insurance Market Rules:
    - For group policies offered on state exchanges, allowable rating factors (such as age, tobacco use) must be associated with specific employees and dependents.
    - Issuers would be required to calculate per-member rates in order to develop a group premium.
    - The amount employers would then contribute to coverage of each group member: the Proposed Regulation explicitly leaves to employers (of all sizes) flexibility to base their contribution either on the per member average, ***or on each group member's specific factors.***

Distribution of Average Spending Per Person, 2009

	Average Spending Per Person
Age (in years)	
<5	$2,468
5-17	1,695
18-24	1,834
25-44	2,739
45-64	5,511
65 or Older	9,744
Sex	
Male	$3,559
Female	4,635

Note: Population is the civilian noninstitutionalized population, including those without any health care spending. Health care spending is total payments from all sources (including direct payments from individuals and families, private insurance, Medicare, Medicaid, and miscellaneous other sources) to hospitals, physicians, other providers (including dental care), and pharmacies; health insurance premiums are not included.

Source: Kaiser Family Foundation calculations using data from U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey (MEPS), 2009.

Planning for the Employer-Level "Pay or Play" Requirement Penalty #2- Fail to Offer a Plan That is Affordable and Which Offers Minimum Value

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Planning for the Employer-Level "Pay or Play" Requirement Penalty #2- Fail to Offer a Plan That is Affordable and Which Offers Minimum Value

- What Does it Take to Fall Prey to This Penalty?
  - **Employee's share of the premium is not affordable: at least 9.5% of household income**

OR

  - **Plan's share of covered health benefit costs (plan-paid benefits ÷ sum of plan-paid benefits plus copayments/deductibles) does not offer minimum value – it is less than 60%**

AND

  - **At least one bona fide full time employee enrolls in an exchange plan AND receives the premium tax subsidy**

Planning for the Employer-Level "Pay or Play" Requirement Penalty #2- Fail to Offer a Plan That is Affordable and Which Offers Minimum Value

- How Much is This Penalty?
  - **In 2014, the annual penalty is equal to:**
    - **the number of full-time employees who receive the tax subsidy when enrolling in an exchange plan, multiplied by $3,000.**
    - **But in any event not more than (total # of FTEs – 30) x $2,000**
  - **After 2014, the penalty payment amount will be indexed by a premium adjustment percentage for the calendar year.**

Planning for the Employer-Level "Pay or Play" Penalty #2- The "9.5%" Premium Affordability Requirement

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Planning for the Employer-Level "Pay or Play" Requirement Penalty #2- The "9.5%" Premium Affordability Requirement

- **The Affordable Plan Requirement: Premium Must Not Exceed 9.5% of Household Income**
  - IRS January 2, 2013 Proposed Regulations Create Three Safe Harbors
  - First Safe Harbor: Form W-2 Wage Safe Harbor.
    - At the end of the calendar year, determine whether 9.5% of the employee's actual Form W-2 wages for the year was less than the employee's cost of the lowest self-only coverage.
    - To guarantee compliance: structure plans to express the employee premium obligation as a percentage of Form W-2 wages.
    - Box 1 wages must be used -- Preamble rejects requests to add back income-excluded §125, 401(k) and 403(b) deferrals.
    - Good news: the Proposed Regulations contain an adjustment to Form W-2 wages if the employee was not a full-time employee for the entire calendar year: can pro-rate W-2 wages to include a fraction equal to the fraction of the year for which the employee was eligible for coverage

Planning for the Employer-Level "Pay or Play" Requirement Penalty #2- The "9.5%" Premium Affordability Requirement

- **The Affordable Plan Requirement: Premium Must Not Exceed 9.5% of Household Income**
  - Second Safe Harbor: Rate of Pay Safe Harbor
    - (1) Take the hourly rate of pay for each hourly employee who is eligible to participate in the health plan as of the beginning of the plan year, (2) multiply that rate by 130 hours per month, and (3) determine affordability based on the resulting monthly wage amount.
    - Employee's monthly contribution amount is affordable if it is equal to or lower than 9.5 percent of the computed monthly wages (i.e., the employee's applicable hourly rate of pay x 130 hours).
    - Salaried employees: monthly salary is used instead of hourly salary multiplied by 130.
    - Employer may use this safe harbor only if, with respect to the employees for whom the employer applies the safe harbor, employer does not reduce the hourly wages of hourly employees or the monthly wages of salaried employees during the year.
    - **Importance of this safe harbor: it fixes the amount of the employee's obligation, regardless of whether the employee works or is on an unpaid leave.**

Planning for the Employer-Level "Pay or Play" Requirement Penalty #2- The "9.5%" Premium Affordability Requirement

- **The Affordable Plan Requirement: Premium Must Not Exceed 9.5% of Household Income**
  - Third Safe Harbor: Federal Poverty Line Safe Harbor
    - Employer provided coverage offered to an employee is affordable if the employee's cost for coverage does not exceed 9.5 percent of the FPL for a single individual.
    - Remember: for households with families, the amount that is considered to be below the poverty line is higher, so using the amount for a single individual ensures that the employee contribution for affordable coverage is minimized.
    - Employers may use the most recently published poverty guidelines as of the first day of the plan year of the applicable large employer member's health plan.

Planning for the Employer-Level "Pay or Play" Requirement Penalty #2- The "9.5%" Premium Affordability Requirement

- Which Premium? Single? Or Family?
  - IRS January 2, 2013: use the lowest cost for self-only coverage
    - Employers like this
      - Plan satisfies affordability requirement – no penalty.
      - Employees with dependents must pay difference between (1) cost of family coverage and (2) 9.5% of household income
      - No credit if employee elects to go to Exchange
  - NB: This rule appears in these Proposed Regulations' definitions of the three affordability safe harbors
    - Does it apply only if the employer elects to use one of the three safe harbors?
    - How do health-contingency wellness program rewards/penalties affect determination of the cost of coverage?

Planning for the Employer-Level "Pay or Play" Requirement Penalty #2- The "9.5%" Premium Affordability Requirement

Why is Single vs. Family a Big Deal to Employers (and Employees Who Want Family Coverage)?

Affordability Based on Single Premium	Affordability Based on Family Premium
Employee Chooses Single Coverage	
Employee's share of the single premium cannot exceed $4,275	Same
Employee must pay up to 78% of the single premium ($4,275 divided by $5,500)	Same
Employee Chooses Family Coverage	
Employer could contribute what it would have contributed for single coverage – $5,550 minus $4,275, or **$1,225** Employee must pay balance of the family premium. Result: Employee pays **$13,050** for **family coverage** **Employer pays $2,450** ($15,500-$13,050)	Employee share of **family** premium cannot exceed $4,275 (9.5% of household income) Result: Employee pays **$4,275** for **family coverage** **Employer pays $11,225** ($15,500-$4,275)

Median national single premium:$5,500 Median national family premium: $15,500. Employee's household income: $45,000. 9.5% of Employee's household income: $4.275

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Planning for the Employer-Level "Pay or Play" Penalty #2- The "60%" Minimum Value Requirement

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Planning for the Employer-Level "Pay or Play" Penalty #2- The "60%" Minimum Value Requirement

- **IRS Notice 2012-31: Four possible choices that employer-sponsored plans may use to determine minimum value:**
  - **Choices #1 & #2: Use a "Calculator."**
    - Input plan design features; calculator returns the plan's actuarial value
    - The calculator will use standard populations and claims data. E**mployers will NOT use their own plans' claims data.**
    - NB: good for plans covering younger (or healthier) populations. Not so good for plans
  - **Choice #3: Design-Based Safe Harbor Checklist**
    - Plan design satisfies checklist features → plan deemed to provide minimum value
  - **Choice #4: Actuarial Certification-Must Use Standard Population & Claims Data**

Planning for the Employer-Level "Pay or Play" Penalty #2- The "60%" Minimum Value Requirement

- Should Employers Worry About Satisfying This Requirement?
  - Probably not:
  - 98 percent of individuals currently covered by employer-sponsored plans are enrolled in plans that have an actuarial value of at least 60 percent using methods and assumptions similar to those described in Notice 2012-31.*

*Actuarial Value and Employer-Sponsored Insurance, ASPE Research Brief, U.S. Department of Health and Human Services (November 2011) http://aspe.hhs.gov/health/reports/2011/AV-ESI/rb.shtml.

Planning for the Employer-Level "Pay or Play" Penalty #2- The "60%" Minimum Value Requirement

- Employers Should Keep In Mind Typical Correlations Among Deductibles, Actuarial Value and Premium Cost

Actuarial Value	Typical Total Premium (Single/Family) (2011)	Deductible	Co-Insurance	OOP Maximum
61%	$3,470/$8,564	$5,950	20%	$5,950
70%	$4,048/$9,991	$2,300	20%	$5,950
87%	$5,032/$12,418	$350	15%	$5,000

Employer Decision Points

Dinsmore

Planning for the Employer-Level "Pay or Play" Requirement

- Employer Decision Points
  - Employ 50 more full-time equivalents?
    - If not, no penalty exposure, regardless of whether the employer offers a plan or the cost of the plan
    - Don't forget the requirement not to discriminate. That may make continued sponsorship of an employer-subsidized group health plan very expensive
    - Don't forget the 90 day limit on waiting periods. Plans that use a longer period suppress claims and therefore premiums (and, therefore, the employer's cost to subsidize premiums). Shorter waiting period → either higher premiums or raise deductibles to offset the increased cost.

Planning for the Employer-Level "Pay or Play" Requirement

- Employer Decision Points
  - Employ 50 or more full-time equivalents? If the answer is, yes:
    - How many are credit-eligible?
    - Then, add together the premium tax credit and cost sharing subsidies to calculate employee's cost for a benchmark plan. Compare that to the employee's cost for employer-sponsored coverage. **Is the employer's plan a better deal?**
    - If the employer's plan is not a better deal, and if it is either not affordable or does not offer minimum value, will credit-eligible employees migrate to the exchange? If so, how many?

Planning for the Employer-Level "Pay or Play" Requirement: What Will the Benchmark Plan Cost an Employee? How Does that Compare to The Employee's Cost for Enrolling in the Employer's Plan?

Plan	Actuarial Value	Premium	Deductible	Co-insurance	OOP Maximum	Hospital Coinsurance (per admission)	Physician Visit Coinsurance (primary/ specialist)	Prescription Drug Coinsurance
Silver 2	70%	$4,048/ $9,991	$2,300	20%	$5,950	Yes	Yes	Yes
Bronze	61%	$3,470/ $8,564	$5,950	20%	$5,950	Yes	Yes	Yes
FEHBP BCBS Standard Option	87%	$5,032/ $12,418	$350	15%	$5,000	$250 copay	$20/$30	$10/$70/$70

- Source: Source: "Actuarial Analysis to Estimate Costs of a Model EHB Package" (National Health Council, August 2011)
- Caveat: 2011 data and pricing. Premium assumes worker under age 55

Planning for the Employer-Level "Pay or Play" Requirement: What Will the Benchmark Plan Cost an Employee? How Does that Compare to The Employee's Cost for Enrolling in the Employer's Plan?

- Is the Employer Plan's employee share of the premium < 9.5% of W-2 wages?
  - For most employer sponsored plans, the answer usually will be, yes. So far, so good.
  - If not: consider restructuring premium cost subsidies
    - Lots of employees with wages < $40,000?
      - If the employer's plan is not affordable, these employees are entitled to large premium and coinsurance subsidies on the exchanges. That increases exposure to the employer mandate penalty unless state expands Medicaid eligibility.

Planning for the Employer-Level "Pay or Play" Requirement: What Will the Benchmark Plan Cost an Employee? How Does that Compare to The Employee's Cost for Enrolling in the Employer's Plan?

- Must the plan expand its eligibility because of the 30+ hour definition of "full time employee" or in order to satisfy the nondiscrimination requirements?
- If the answer is, yes: that means more employer financial exposure
  - More employees → more claims → higher cost for the self-insured employer or higher future premiums for the fully insured employer [depending on average experience for the state's population]

Planning for the Employer-Level "Pay or Play" Requirement: What Will the Benchmark Plan Cost an Employee? How Does that Compare to The Employee's Cost for Enrolling in the Employer's Plan?

- How many newly eligible employees will enroll – even if the employee's share of the premium is < 9.5% of household income
  - 9.5% of $35,000 is $3,325
  - Few may take the offer of enrollment
  - They will **not** be eligible for premium/coinsurance subsidies on the exchanges because the plan is affordable
  - Result may be: theoretical cost exposure only – no takers
  - The smaller the employer, the lower the current employer contribution, the better dropping coverage will look

Planning for the Employer-Level "Pay or Play" Requirement: What Will the Benchmark Plan Cost an Employee? How Does that Compare to The Employee's Cost for Enrolling in the Employer's Plan?

- If the Employer Plan's Actuarial Value >60%, then:
  - Choice #1: Do nothing: No Penalty. Plan passes pay or play requirements.
  - Choice #2: Reduce AV to 60%. Still no penalty. But plan costs – premiums or employee cost sharing – decline.
  - Plan looks less expensive to employees.
  - Use savings for employer's own use (offset costs for any FTEs who heretofore have been excluded but now must be included)
  - Warning: is the employer in the small group market? Deductibles can only be increased to $2,000/$4,000
    - Result: need to shop for a plan with high coinsurance (i.e., more than the typical 20%) to boost the employee's share of plan costs and reduce the employer's exposure

Planning for the Employer-Level "Pay or Play" Requirement: What Will the Benchmark Plan Cost an Employee? How Does that Compare to The Employee's Cost for Enrolling in the Employer's Plan?

- Here's an Example
  - Employee "household income" = $55,800 (250% of FPL)
  - Family Coverage

Plan Type	(1) Employee Net Premium Cost After Subsidy	(2) Employee Cost Sharing Obligation	(3) Employee Total Financial Exposure (1)+(2)
Silver	$4,438	$5,950	$10,388
Bronze	$3,011	$5,950	$8,961
Employer (use FEHB standard option as proxy)	$7,450 (no subsidy; employee pays 60% of premium)	$350 deductible per individual x 4 = $1,400	$8,850+coinsurance

Planning for the Employer-Level "Pay or Play" Requirement: What Will the Benchmark Plan Cost an Employee? How Does that Compare to The Employee's Cost for Enrolling in the Employer's Plan?

- Have we described the typical employee?
- Yes
  - Plan does not owe any employer mandate penalties
  - Plan could reduce its actuarial value to 60% to save the employer $ -- which may be needed if employer must offer enrollment to bona fide FTEs who heretofore have been excluded or must re-configure eligibility to satisfy the new nondiscrimination requirements

Planning for the Employer-Level "Pay or Play" Requirement: What Will the Benchmark Plan Cost an Employee? How Does that Compare to The Employee's Cost for Enrolling in the Employer's Plan?

- Have we described the typical employee?
- No: our typical employee makes less – 150% of the poverty level
  - Let's look at an example that illustrates this employee's choices

Planning for the Employer-Level "Pay or Play" Requirement: What Will the Benchmark Plan Cost an Employee? How Does that Compare to The Employee's Cost for Enrolling in the Employer's Plan?

- The new example
  - Employee "household income" = $33,480 (150% of FPL)
  - Family Coverage

Plan Type	(1) Employee Net Premium Cost After Subsidy	(2) Employee Cost Sharing Obligation	(3) Employee Total Financial Exposure (1)+(2)
Silver with reduced cost sharing and higher AV (ACA cost sharing subsidies for employees <250% of FPL)	$1,323	$225 deductible per individual x 4 = $900	$2,230 + maximum coinsurance exposure of $600 (for maximum OOP of $1,500) = **$2,680**
Employer (use FEHB standard option as proxy)	$7,450 (no subsidy; employee pays 60% of premium)	$350 deductible per individual x 4 = $1,400	**$8,850+coinsurance**

Planning for the Employer-Level "Pay or Play" Requirement: What Will the Benchmark Plan Cost an Employee? How Does that Compare to The Employee's Cost for Enrolling in the Employer's Plan?

- In our example, our plan does not owe any employer mandate penalties because it's affordable and has an actuarial value of 87%
- But, if the plan must start covering a flock of heretofore ineligible bona FTEs, the employer will be staring at substantial additional costs
  - What's the likelihood that will occur?
    - Will the state expand Medicaid eligibility?
    - Even if the answer is no, will low wage employees choose the employer's plan? No! They'll go to the Exchange, because the Exchange plan is more highly subsidized.
- Plan could reduce its actuarial value to 60% to save the employer $ -- which the employer can use to partially offset the costs of offering enrollment to bona fide FTEs who heretofore have been excluded