What Employers Need to Know About the Healthcare Reforms

more Insight.

West Virginia Chamber Annual Meeting & Business Summit
August 30, 2012

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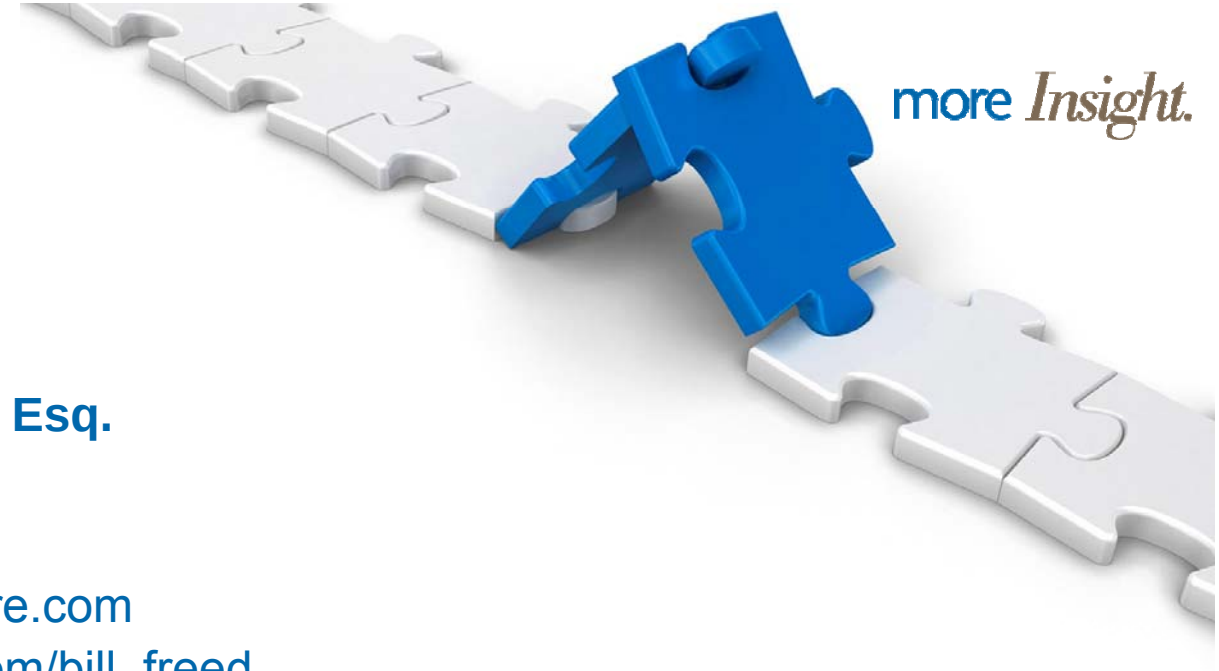

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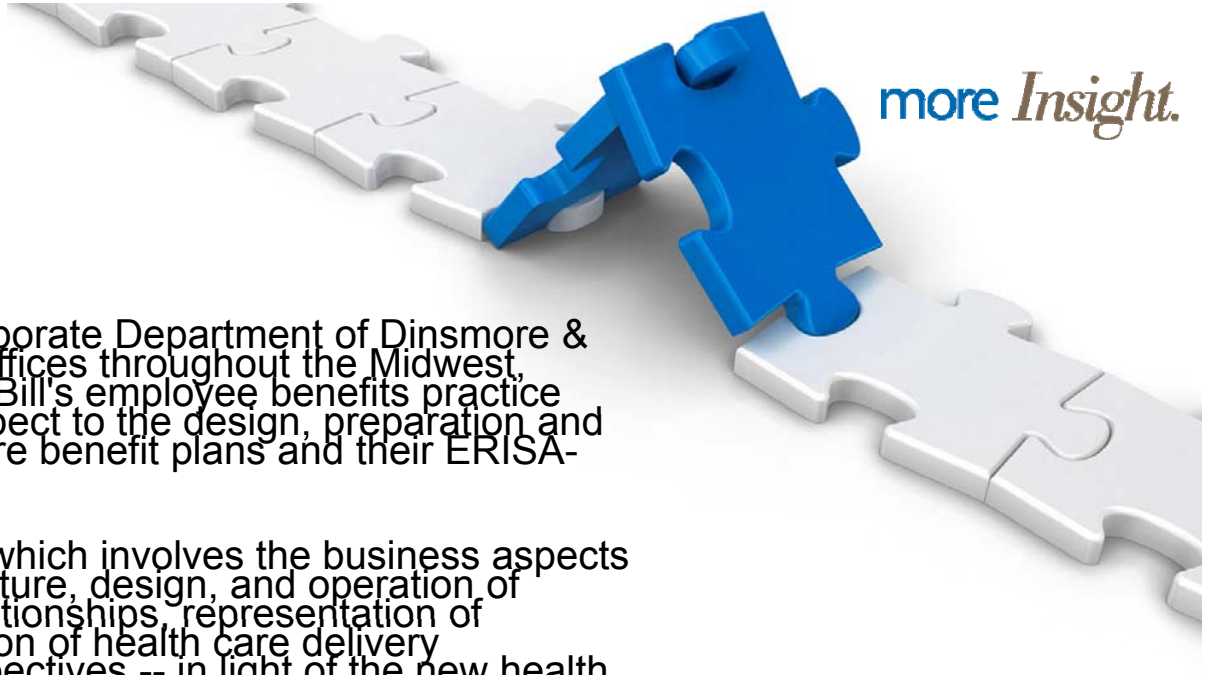

Bill Freedman is a Partner in the Corporate Department of Dinsmore & Shohl, LLP, a regional law firm with offices throughout the Midwest, Pennsylvania and Washington, D.C. Bill's employee benefits practice serves a diverse client base with respect to the design, preparation and implementation of pension and welfare benefit plans and their ERISA-related issues.

Bill's extensive health care practice, which involves the business aspects of health care law, including the structure, design, and operation of hospital and health care provider relationships, representation of physician practices, and representation of health care delivery organizations, gives Bill unique perspectives -- in light of the new health reform mandates in the Affordable Care Act -- to advise clients on the structure and design for eligibility and benefits for group health benefits plans, health reimbursement arrangements, and cafeteria plans.

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.

The Supreme Court's Decision in National Federation of Independent Business v. Sebelius

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The Supreme Court's Decision in National Federation of Independent Business v. Sebelius

- Is the Individual Mandate Constitutional?
  - Yes – leaving in place the majority of the Affordable Care Act
- Is the Medicaid Expansion Mandate Constitutional?
  - No – Congress cannot attach too many "strings" to funding dollars for certain programs
- 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
- Exchange Subsidies
  - Premium subsidies on the Exchange begin for individuals that have household income of more than 100% of the FPL but less than 400% of the FPL
  - Cannot obtain premium subsidy if you have:
  - Affordable employer provided coverage; or
  - Medicaid

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

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

- 2014: 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

- 2011-2014: No lifetime or annual limits
- 2014: Nongrandfathered fully insured plans will live with nondiscrimination rules "similar" to those that already apply to self-insured plans
- 2014: New underwriting requirements for fully insured nongrandfathered plans: adjusted community rating instead of individualized rating --shifts costs from older workers to younger workers
- 2014: The Individual "Pay or Play" Mandate
- 2014: Tax Subsidies to Encourage Individuals to "Play" via the Exchanges Rather Than "Pay"
- 2014: The Employer "Pay or Play" Mandate

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

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

- Medical Loss Ratio Rebates

Estimated MLR Rebates: Large 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	$13,174,803	365,960	5	$14.39	40%	$36.00
Indiana	$3,554,709	63,065	5	$9.35	17%	$56.37
Kentucky	$5,300,147	212,664	4	$14.30	57%	$24.92
Ohio	-	-	0	-	-	-
Washington	$1,665,341	51,229	2	$1.36	4	$32.51
W. Virginia	-	-	0	-	-	-

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

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

- 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

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

- New 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

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

- 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

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- 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].

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

- 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

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

- 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"

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

- W-2 Reporting of Cost of Health Coverage
  - When? 2012 W-2s That Will Be Issued in 2013
  - 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)
    - Employers that issued fewer than 250 W-2's in 2011
    - Retirees that receive health care coverage
  - How to Calculate Premium?
    - Self-Insured Plans: COBRA premium
    - Fully Insured Plans: Actual premium charged

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

- 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.

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

- 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

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

- 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.

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

- 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

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

- Limitations on Cost Sharing (Deductibles and Co-Insurance ≡ 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 ($6500 single/$12,000 family for 2012)(Act §1302(c)(1))
      - Maximum **deductible:** $2,000 single/$4,000 family (Act §1302(c)(2))
    - Plans sponsored by employers who employ 101 or fewer employees (plans in the "large group market" (Act §1304):
      - Maximum **aggregate cost-sharing obligation:** HSA limits ($6500 single/$12,000 family for 2012)(Act §1302(c)(1))
      - Maximum **deductible:** no limit (Act §1302(c)(2) only applies to health plans offered in the "small group market")

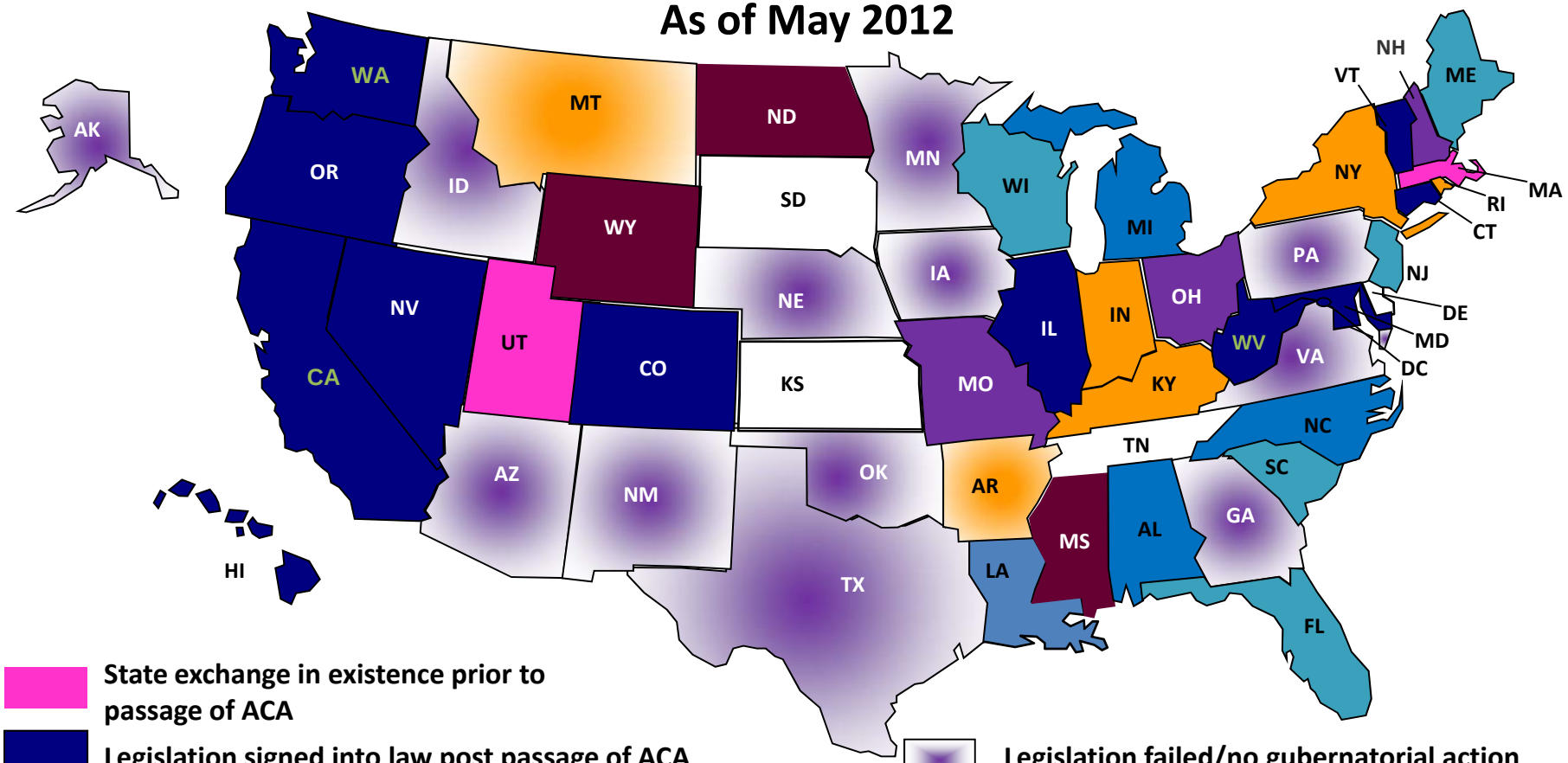
A Quick Overview of the Affordable Care Act's Major Features That Concern Employers Today

- Limitations on Cost Sharing (Deductibles and Co-Insurance ≡ 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

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

- New Taxes on Highly Compensated Employees -- Tax Years Beginning On Or After January 31, 2013
  - 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
    - Applies to the employee portion of the tax only. The employer portion does not change.
    - Employee portion goes from 1.45% to 2.34%

Status of State Legislation to Establish Exchanges, As of May 2012



- State exchange in existence prior to passage of ACA
- Legislation signed into law post passage of ACA
- Legislation signed: intent to establish an exchange, creation of study panel or appropriation
- Legislation passed one or both houses
- Legislation pending in one or both houses
- Legislation failed/no gubernatorial action
- Governors pursuing non-legislative options
- Governors working with HHS on options
- Governor veto or decision not to establish exchange
- No legislative activity to date

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

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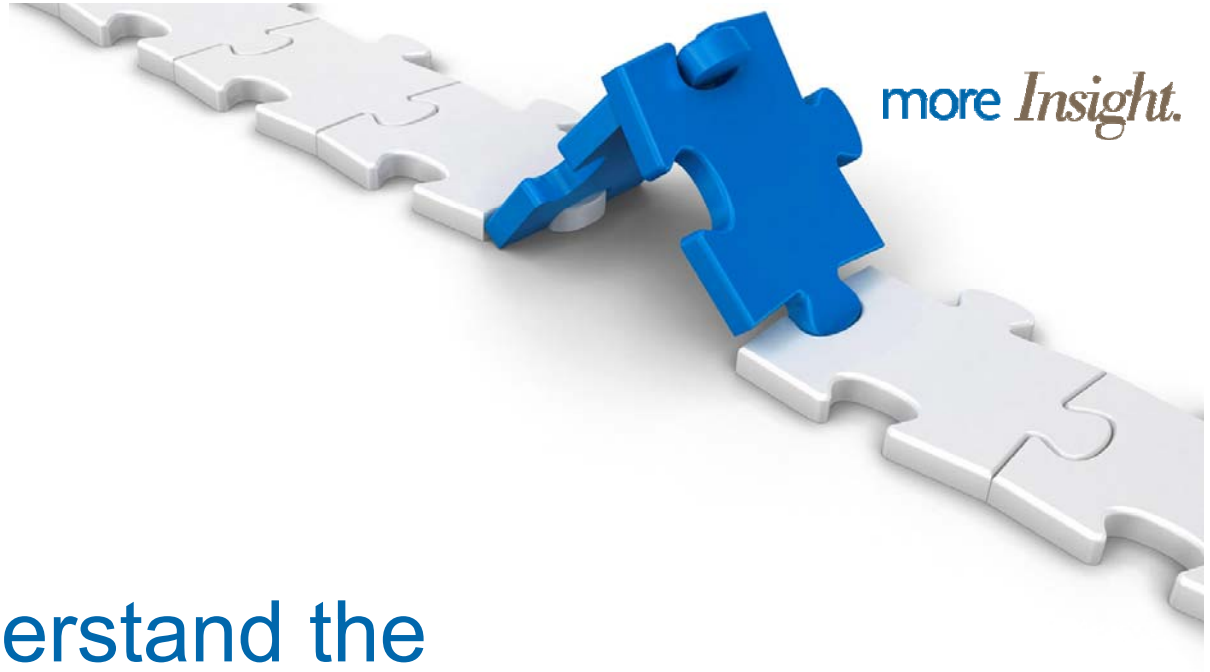
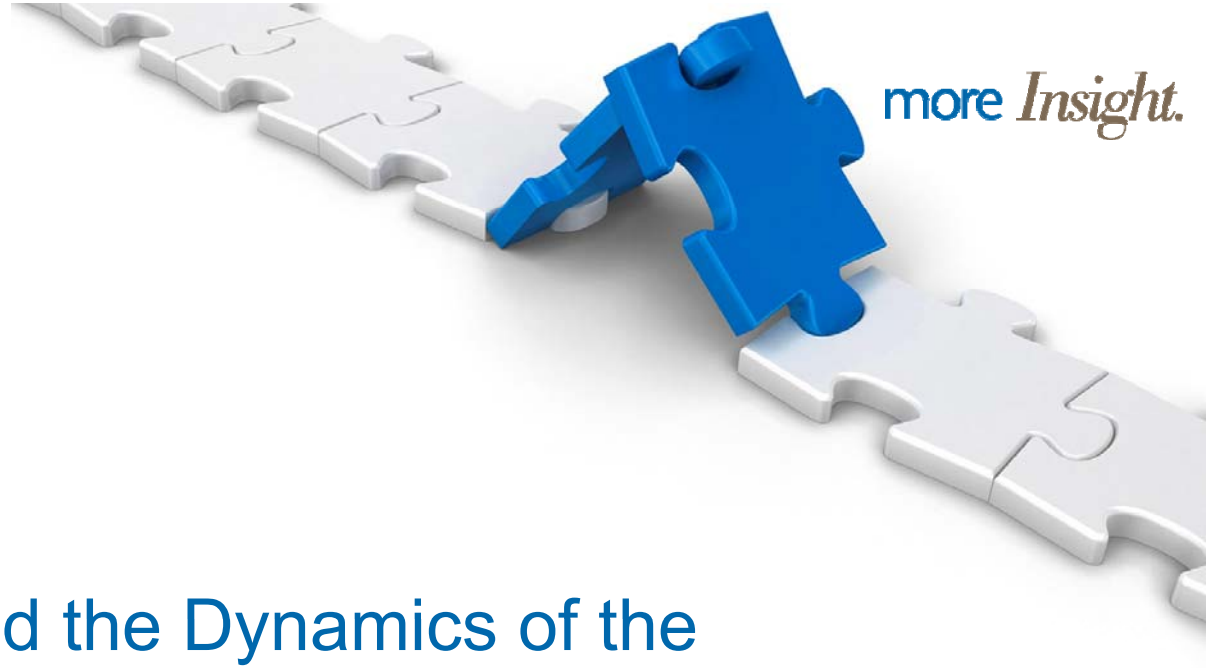


But First: Understand the Implications of the Individual Mandate

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).*

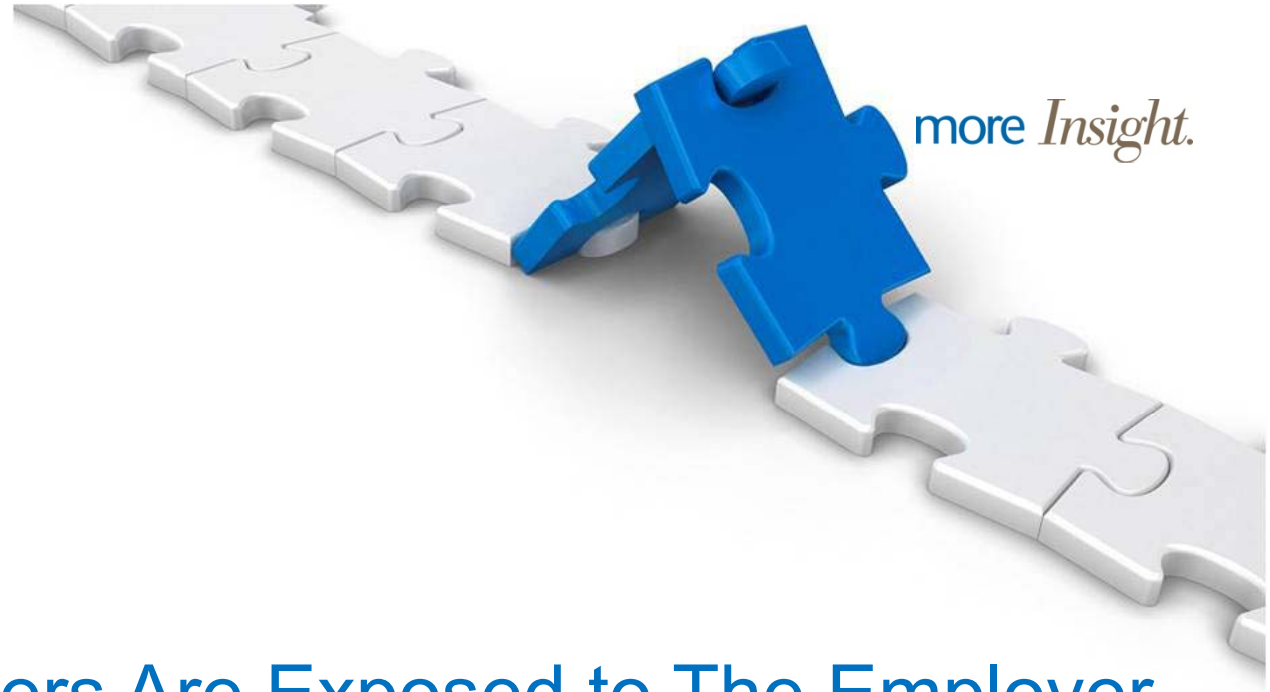
Income as % of FPL		224%
Expected family contribution	**$3,570**	
Premium for benchmark plan		$14,000
Premium tax credit		$10,430
		($14,000-$3,570)
Premium for plan family chose		$14,000
Actual family contribution		$ 3,570

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.
    - Notice 2011-36: 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"
    - Notice 2011-36: four calendar months is the equivalent of 120 days

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: Divide the total number of monthly hours worked by the part-time employees by 120.

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

The Employer Mandate, Auto Enrollment, and 90 Day Limit On Waiting Periods All Apply to Bona Fide Full Time Employees: Identifying Who They Are

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Determining Who is a Full-Time Employee

- Notice 2011-36: IRS Considering Lookback-Stability Period for **Current Employees**
  - Look back to previous year:
    - Three months up to 12 months (employer choice)
  - If full-time during measurement period: treated as full-time for current year for at least six months and in all events for a period equal to the selected measurement period
  - If part-time during measurement period: treated as part-time for current year for a period equal in length to the measurement period

Determining Who is a Full-Time Employee

- Notice 2012-17, Q&A 5: IRS Considering Testing Period for **New Employees**
  - Reasonably anticipated to work full-time as of date of hire?
    - Deemed full-time as of date of hire. Must be eligible within 90 days for employer to avoid penalty

Determining Who is a Full-Time Employee

- Notice 2012-17, Q&A 5: IRS Considering Testing Period for **New Employees**
  - Can't tell as of date of hire? Look back after first three months of employment
    - Worked full-time and hours are reasonably representative: must be eligible as of end of **following (second)** three month period. No penalty prior to end of second three month period
    - Worked part-time or hours not reasonably representative: use following (second) three month period as a second lookback period:
      - If at end of second lookback period, determined to be
        - Full-time: must be eligible as of the end of the **third** three month period
        - Part-time: part time for remainder of year

Determining Who is a Full-Time Employee

- Notice 2012-17, Q&A 5: IRS Considering Testing Period for **New Employees**
  - Warning: IRS officials have indicated that IRS is likely to jettison this methodology
  - Initial feedback from stakeholders: negative.

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 Penalty?
  - Do not offer group health benefit plan coverage to all bona fide full-time employees **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)
- 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?
  - 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

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**
  - Preamble to IRS August 17, 2011 Proposed Regulations on the premium tax credit (76 F.R. 50936) and Notice 2011-73:future regulations will create an affordability safe harbor
  - The affordability safe harbor: penalty will not apply for a year if the employee portion of the **self-only** premium for the employer's lowest cost plan that provides minimum value (60%) does not exceed 9.5 percent of the **employee's current W-2 wages from the employer**.

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**
  - Result: the safe harbor is **not** retrospective – no "lookback-stability period"
  - To guarantee access to the safe harbor in its current form: must revise plan to say that the employee's premium obligation for the plan year will not exceed 9.5% of W-2 wages
  - Business commenters: why not permit a lookback-stability period?

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

- **Which Premium? Single? Or Family?**
  - IRS August 17, 2011 Proposed Regulations: Plan is affordable if premium the employee must pay for single coverage is < 9.5% of household income.
  - NB: 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
  - Employee advocates and GAO: for spouses and dependents, base the 9.5% requirement on coverage for which the employee enrolls – which means, **family coverage premium could not exceed 9.5% of household income either**

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

- **Which Premium? Single? Or Family?**
  - IRS Position may change: preamble to IRS May 23,2012 final regulations on eligibility for premium tax credit:

    "The proposed regulations provide that an eligible employer-sponsored plan is affordable for an employee and related individuals if the portion of the annual premium the employee must pay for self-only coverage does not exceed …9.5 percent of the taxpayer's household income. Commentators suggested that the affordability of coverage for related individuals should be based on the portion of the annual premium the employee must pay for family coverage…"***Future regulations concerning employer-sponsored coverage will provide final rules on determining affordability for related individuals and proposed rules on determining minimum value."***

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

- **Which Premium? Single? Or Family?**

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

- February 24, 2012 HHS CCIIO Actuarial Value and Cost-Sharing Reductions Bulletin:
  - Outlines guidelines for determining actuarial value for individual and small group health benefit plans that will be offered on the Exchanges and non-grandfathered individual and small group market plans
  - Standard method: CMS will develop a single set of data and assumptions for population, utilization, and health care pricing. Plans must use this data to calculate their plans actuarial value, using their own benefit design parameters (deductibles, copayments)
    - Option: state provided use of state standard populations
    - Option: geographic differences in pricing

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

- CCIIO Guidance:
  - Optional method: CMS will Develop a publicly available AV calculator that plans will use to determine AV.
    - Will incorporate a set of claims data weighted to reflect the expected standard population in the individual and small group markets for the year of enrollment.
    - Plans input information on cost-sharing parameters; calculator returns AV.

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 actuarial 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

Planning for 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)
- 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

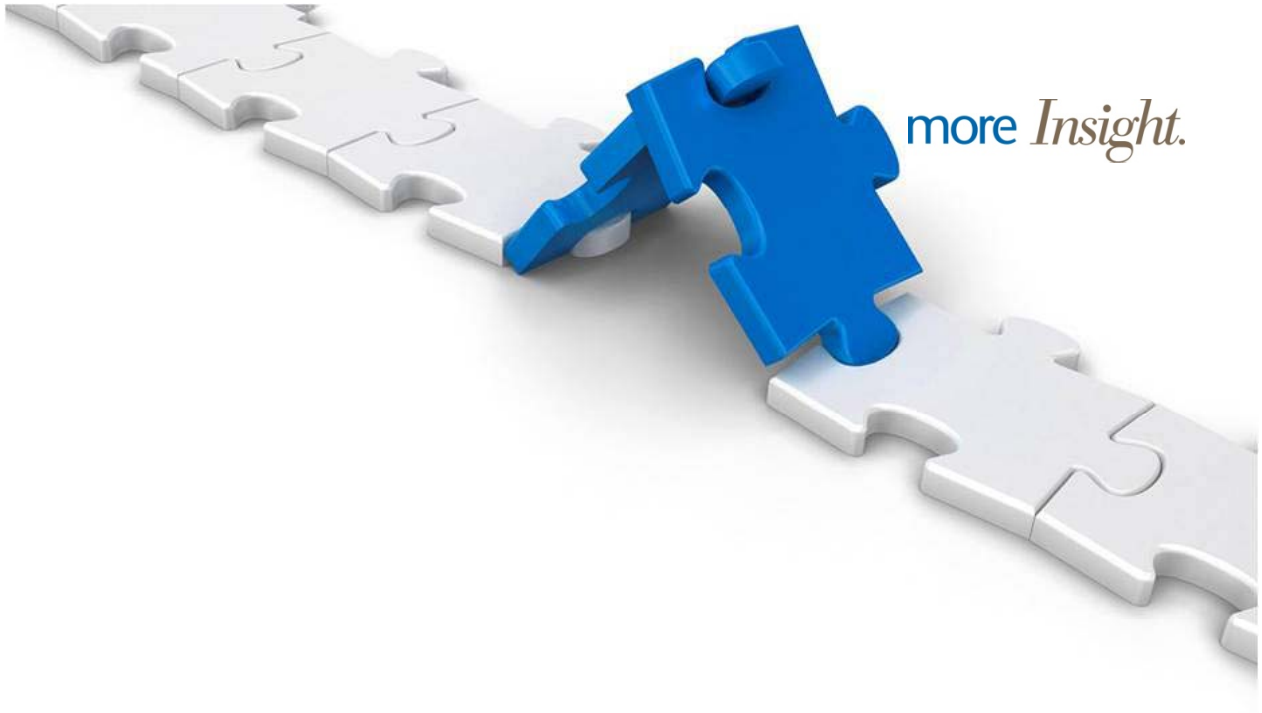
- The Benefits Test
  - All benefits provided for highly compensated employees must be provided for all other participants.
  - This test applies based on benefits subject to reimbursement, not to actual payments of claims.
  - Result: The benefits test prohibits a lower deductible or copayment for highly 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



Employer Decision Points

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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

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 a Benchmark Plan Cost?
  - Remember:
  - To avoid the individual penalty, most individuals will be required to either possess coverage through an employer-sponsored plan or acquire coverage through a state health exchange that is at least the "bronze" level (a 60% actuarial value)
  - The premium tax credit for those with household incomes below 400% of the FPL is based on the premium for the second lowest cost "silver" plan (70% actuarial value)

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

- What Will a Benchmark Plan Cost? HHS Center for Consumer Information & Insurance Oversight December 16, 2011 Essential Health Benefits Bulletin and February 21, 2012 FAQs:
  - For exchange-offered qualified health plans: each state chooses a single benchmark plan type; that type's array of essential health benefits serves as the standard for all QHPs offered on the state's exchange.

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

- What Will a Benchmark Plan Cost? HHS Center for Consumer Information & Insurance Oversight December 16, 2011 Essential Health Benefits Bulletin and February 21, 2012 FAQs:
  - State chooses among these four options:
    - the largest plan by enrollment in any of the three largest small group insurance products in the State's small group market
    - any of the largest three State employee health benefit plans by enrollment
    - any of the largest three national FEHBP plan options by enrollment
    - the largest insured commercial non-Medicaid Health Maintenance Organization (HMO) operating in the State.

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

- What Will a Benchmark Plan Cost? HHS Center for Consumer Information & Insurance Oversight December 16, 2011 Essential Health Benefits Bulletin and February 21, 2012 FAQs:
  - Issuers may adjust benefits, including both the specific services covered and any quantitative limits ,provided—
    - offer coverage for all ten statutory EHB categories
    - Adjustments only permitted within a statutory EHB category

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

- What Will a Benchmark Plan Cost?
  - Do Sponsors of Self-Insured Plans or Grandfathered Plans Care How CMS Mandates the Structure of the Benchmark Plan?
  - Yes.
  - Why?
  - Because the Act prohibits **all** plans from imposing annual and lifetime dollar limits on essential health benefits – which are part of the benchmark plan design

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?

- Now We Know What the Benchmark Plan Will Cost
- 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
  - Watch out: if the 9.5% of household income requirement applies to family coverage → lots of new takers → significant new employer financial exposure
  - 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: Stay as is => How many bona fide employees will migrate to exchange plan (@ $3k per migrant). Which is cheaper: raise AV to 60% or pay the $3K x likely # of migrants
  - Choice #2: Raise to 60% => How much will this increase the employer's cost? > $3k per likely migrant? If so, don't increase

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**

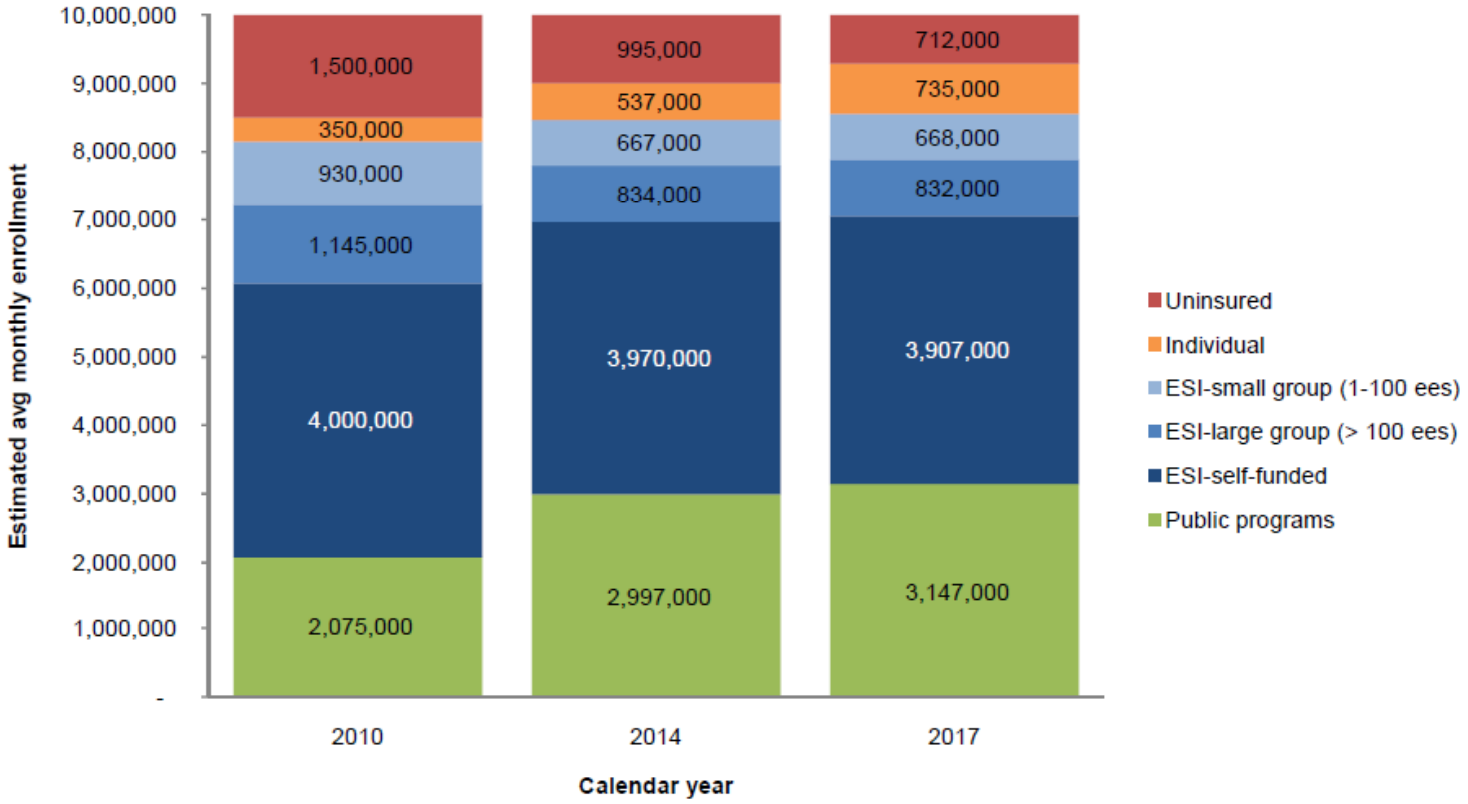
Planning for the Employer-Level "Pay or Play" Requirement: What Will the Benchmark Plan Cost an Employee? How Does that Compare to The Employee's Cost for Enrolling in the Employer's Plan?

- 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
- 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

What are the Current Estimates of the Effect of the Affordable Care Act's New Underwriting and Benefit Design Features and Availability of Individual Premium Credits on Individuals and Their Employers?

Dinsmore

Figure 2-1: Ohio non-elderly covered lives by source of coverage – changes from 2010 to 2014 and 2017



Assist with the First Year of Planning for Design and Implementation of a Federally Mandated Health Benefit Exchange in Ohio, Milliman Study for Ohio Department of Insurance, August 31, 2011

- The individual health insurance market increases by approximately 110% or 390,000 lives
- The public programs increase by approximately 52% or 1,070,000 lives
- The ESI-small group market decreases by approximately (28%) or (260,000) lives
- The ESI-large group market decreases by approximately (27%) or (310,000) lives
- The ESI-self-funded market decreases by approximately (2%) or (90,000) lives
- The uninsured population decreases by approximately (53%) or (790,000) lives

Assist with the First Year of Planning for Design and Implementation of a Federally Mandated Health Benefit Exchange in Ohio, Milliman Study for Ohio Department of Insurance, August 31, 2011

Details of the Study: Effects of Community Rating

- “Individual policyholders and ESI-group policy premiums will have significant variability as a result of the ACA requirement for adjusted community rating (ACR).”
- “Individuals and smaller employers will observe the greatest impacts since they are more likely to be at one extreme or the other of the total current premium range (i.e. health status tier, age band, and gender category).”

Details of the Study: Effects of Community Rating

- "In the individual market, a healthy young male (with benefit coverage at the market average actuarial value pre and post-ACA) may experience a **rate increase of between 90% and 130%.** However, a 60 year old with chronic health conditions may experience a significant premium decrease.

- "In the **ESI-small group market**, rating changes may result in **a premium increase of 150% or a premium decrease of nearly 40% for groups at opposite ends of the current rating structure."**

How Competitive is the Marketplace for Employer-Sponsored Group Health Insurance?

Background:

Herfindahl-Hirschman Index ("HHI") values range from 0 to 10,000, with a value closer to zero indicating a more competitive market and values closer to 10,000 indicating a less competitive market. As a rule of thumb, an HHI index below 1,000 indicates a highly competitive market, and a value between 1,000 and 1,500 indicates an unconcentrated market. Values between 1,500 and 2,500 suggest moderate concentration, and markets with results above 2,500 are generally considered highly concentrated.

"How Competitive are State Insurance Markets" [A single insurer accounted for at least half of the market share for group insurance in 26 states and D.C.] (Kaiser Family Foundation October 13, 2011)

How Competitive is the Marketplace for Employer-Sponsored Group Health Insurance?

Small Group Insurance Market Competition 2010			
State	Number of Insurers with > 5% Market Share	Market Share of Largest Insurer	Herfindahl-Hirschman Index (HHI
Alabama	1	96%	9175
Illinois	4	52%	3262
Indiana	4	54%	3313
Kentucky	3	63%	4807
Louisiana	3	80%	6532
Mississippi	3	80%	6498
Ohio	4	35%	2153
Oregon	7	24%	1579
Tennessee	3	70%	5299
Texas	4	40%	2429
Washington	6	50%	3067
West Virginia	3	50%	3671

"How Competitive are State Insurance Markets" [A single insurer accounted for at least half of the market share for group insurance in 26 states and D.C.] (Kaiser Family Foundation October 13, 2011)