Strategic Considerations in Health Insurance

Walking Through Changes and Options for 2014 and Beyond

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National Association of Health Underwriters

September 2013
Recap/Political Overview

What’s About to Change

For Individuals
What’s About to Change in the Marketplace
What’s About to Change for Employers
What’s About to Change for Agents/Brokers
Resources and Questions
Political Landscape

Washington’s political dynamic is fractured
House actions are tempered by conservative pressure and tight Democratic majority in the Senate and President Obama
“Show Me” mentality when it comes to the health reform law.
Demonstrating business impact extraordinarily important

States are dealing with a host of health reform issues
Exchanges
Medicaid Expansion
Budget Concerns
Lack of Information from the Federal Government
Extreme variances in attitudes about implementation including amongst branches of state government
Preparing for the Big Year Ahead!

- 2014 is going to bring great changes to the world of health benefits
- The kinds of coverage available will change, as will the requirements and options for individuals, employers and employees
- Change can be scary but it’s also a time of great opportunity
# Health Reform Implementation

<table>
<thead>
<tr>
<th>Already Implemented</th>
<th>Being Implemented This Year</th>
<th>Still to Come</th>
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<tbody>
<tr>
<td>Grandfathered plan requirements and consumer-directed plan changes</td>
<td>Summary of coverage requirements for all plans</td>
<td>Individual mandate</td>
</tr>
<tr>
<td>Small business tax credits for purchasing private coverage</td>
<td>Exchange notification requirements for all employers</td>
<td>Employer responsibility/minimum value requirements for 50+ groups</td>
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</tbody>
</table>
| **Sept. 23rd reforms- all plans**  
Dependent coverage to 26  
No pre-ex for children  
Restrictions on rescissions and annual/lifetime limits | Employee FSA contributions capped at $2,500 | Health insurance exchanges, private coverage subsidies and Medicaid expansion in willing states |
| **Sept. 23rd reforms for non-grandfathered plans**  
Preventive care  
105h nondiscrimination rules (*enforcement delayed*)  
New coverage appeals process | Comparative effectiveness research funding tax impacts all plans | Insurance market reforms and new coverage standards for individual/small group market plans |
| Medical loss ratio requirements | Expanded W2 reporting | New national premium tax for fully-insured plans |

The “Cadillac” 40% excise tax goes into effect for all high-value group plans, including self-insured plans.
CHANGE AHEAD

EXPECT DELAYS?
What Has Actually Been Delayed So Far?

- Employer Mandate PENALTIES
- Mandatory Employer Reporting to Exchanges
- SHOP employee choice and premium aggregation (for FFM and Partnership States)
- Other Federal Exchange “Pare-Downs”
- Out-of-pocket Limit Transition
What Happened With OOP Limits?

- Rules on how health reform’s out-of-pocket limit provision would be implemented were announced in February, but they just got a lot of national coverage due to a New York Times story about them on August 13th.
- OOP Limits apply to all non-grandfathered group plans, including large groups and self-funded plans.
- New rules call for a limit calculation that is stricter than what is traditionally applied today—all individual copays count toward the total.
- The February rules include transition relief for health plans with more than one benefits administrator. These plans don't have to combine their tallies of members’ out of pocket spending into one total until 2015.
- If a plan does not impose an OOP maximum for RX, they do not need to apply one until 2015.
- An exception to the new rule is for plans that use a separate provider to run their behavioral health benefits. Under the Mental Health Parity and Addiction Equity Act of 2008, health plans can’t apply separate out-of-pocket maximum limits for those benefits.
- This is not a true delay, but more of a phase-in that applies to certain carriers and employer-sponsored plans.
What is still happening?

- Individual mandate.
- The law’s health insurance market reforms that go into effect as of the first day of the plan year that begins in 2014.
- Health insurance exchanges.
- The marketplace notice. All employers subject to the Fair Labor Standards Act (not just PPACA’s employer mandate provisions) are required to send a marketplace notice to all employees by October 1, 2013.
- The affordability/minimum value tests. These terms don't just relate to the mandate, they are concepts relevant to ANY employee if ANY employer (regardless of size) who is eligible for employer sponsored coverage and who wishes to apply for a subsidy in the exchange.
- Summaries of Benefit and Coverage
- PCORI Fee.
- The transitional reinsurance fee, the new national health insurance premium tax and other new taxes
- W-2 Reporting requirements.
- The limit on Health FSA salary reductions.
Recap/Political Overview

What’s About to Change

For Individuals

What’s About to Change in the Marketplace

For Employers

What’s About to Change for Agents/Brokers

Resources and Questions
Individual Mandate

Are you:
• Part of a religious group with an exception
• Incarcerated
• Undocumented resident
• American Indian
• Pay more than 8% of take-home pay for employer coverage
• So low-income you don’t pay federal income taxes
• Someone who fall into a Medicaid expansion coverage hole
• Some other hardship exemption

Do you have:
• Coverage through a job
• Coverage through an exchange/at least bronze individual coverage
• Medicaid, Medicare, CHIP
• Tricare or VA Care
• Student Health Plan
• Grandfathered plan

People will need to demonstrate that they have minimum essential coverage or meet an exception.

Penalty
• 2014—Greater of 1% family income or $95 adult/$285 family maximum
• 2015—Greater of 2% family income or $325 adult/$975 family maximum
• 2016—Greater of 2.4% family income or $695 adult/$2085 family maximum

No Penalty

YES

or

NO
### Proposed Rule on Minimum Essential Coverage

<table>
<thead>
<tr>
<th>Minimum Essential Coverage Includes:</th>
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<tbody>
<tr>
<td>• Insurance policies sold in the small or large group market</td>
</tr>
<tr>
<td>• Employer-sponsored group health plans (a group health plan is a welfare arrangement under ERISA that provides medical care to employees or dependents through insurance, reimbursement or otherwise)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Minimum Essential Coverage Does Not Include:</th>
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<tbody>
<tr>
<td>• Stand-alone HRAs that are not integrated with a group health plan</td>
</tr>
<tr>
<td>• HIPAA-excepted benefits such as: stand-alone vision or dental, cancer-only policies, indemnity plans (hospital or disease), accident or disability plans, on-site medical clinics and other types of coverage listed in PHSA §2791(c)</td>
</tr>
</tbody>
</table>
The new availability of tax credits for qualified low income people purchasing individual coverage through exchanges could be a game changer.

QUALIFIED individuals with family incomes between 100-400% of the federal poverty level will be eligible for sliding scale premium tax credits that will cap the amount they may pay for coverage. Individuals with family incomes at or below 250% of the FPL also qualify for reduced cost-sharing.
The Congressional Budget Office estimates that individual market premiums are going to be between 27-30% higher in 2014.

The CBO says “[new health care law market reforms will] have a much greater effect on premiums in the nongroup [individual] market than in the small group market, and they would have no measurable effect on premiums in the large group market.”

On average, Exchange subsidies will only cover approximately 2/3 of premiums.

Fifty-six percent of Individual Exchange Consumers Will Get A Subsidy

- Subsidized Consumers
- Unsubsidized Consumers
48 percent of those who are currently buying insurance on the individual market will be able to collect tax credits if they enroll on the exchanges.

Source: Kaiser Family Foundation analysis.
<table>
<thead>
<tr>
<th>Subsidy Eligible?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single individual who works for a company with 30 FTE employees that offers an “affordable” bronze plan.</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Spouse and children of an individual who work for a company with 30 FTE employees that offers the whole family “affordable” bronze coverage even though the cost of the family coverage is too much for them because their family income is 275% FPL</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Spouse of an individual who works for a large employer with a spousal carve-out. Family income is 350% FPL</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Employee and family who are offered family coverage by a company with 30 FTE employees, but even the single employee premium for the low-cost bronze plan is unaffordable.</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Individual with income of 85% FPL in a state that does not expand Medicaid.</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Single 25 year old male with no employer coverage and an income of 125% of FPL that wants to buy the exchange’s “young and invincible” catastrophic plan.</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>
## Premium Tax Credit’s Varying Impact

*Source:  Kaiser Family Foundation’s Subsidy Calculator*

<table>
<thead>
<tr>
<th>Individual</th>
<th>Family Status</th>
<th>Income</th>
<th>Percentage of income dedicated to premium</th>
<th>Estimated value of the employee’s annual tax credit in 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>30 year old with qualified employer coverage</td>
<td>Married, two children</td>
<td>$35,000</td>
<td>9.5% of household income</td>
<td>No one in the family qualified to buy subsidized exchange coverage</td>
</tr>
<tr>
<td>30 year old with no employer coverage</td>
<td>Single</td>
<td>$35,000</td>
<td>9.5% of household income</td>
<td>$945 (based on Kaiser Family Foundation’s projection of a $3,426 annual single nonsmoker premium in 2014) Individual’s annual premium costs would be $2480</td>
</tr>
<tr>
<td>30 year old with no employer coverage</td>
<td>Married, two children</td>
<td>$35,000</td>
<td>2% of household income</td>
<td>$9,269 (based on the Kaiser Family Foundation’s projection of a $9869 annual family nonsmoker premium in 2014) Family’s annual premium costs would be $600</td>
</tr>
<tr>
<td>45 Year old with qualified employer coverage</td>
<td>Married, three children</td>
<td>$55,000</td>
<td>9.5% of household income</td>
<td>$0 -- No one in the family qualified to buy subsidized exchange coverage</td>
</tr>
<tr>
<td>45 year old with no employer coverage</td>
<td>Single</td>
<td>$55,000</td>
<td>N/A</td>
<td>$0 – Individual may buy coverage in the exchange but would not qualify for subsidy Individual’s annual premium payments would be $5,609 based on Kaiser Family Foundation’s projection of 2014 single premium</td>
</tr>
<tr>
<td>45 year old with no employer coverage</td>
<td>Married, two children</td>
<td>$55,000</td>
<td>7.36% of household income</td>
<td>$6059 (based on Kaiser Family Foundation’s projection of a $10,108 annual family premium in 2014) Family’s annual premium costs would be $4,049</td>
</tr>
</tbody>
</table>
How Will the Subsidies Work?

Individuals and their dependents who have been offered coverage through an employer that meets an affordability and minimum value test are not eligible to purchase coverage through an exchange and get a subsidy.

Qualified individuals with family incomes between 100-400% of the federal poverty level are eligible for a premium tax credit. Individuals with family incomes at or below 250% of the FPL also qualify for reduced cost-sharing.

While consumers can buy any type of policy, the amount of the tax credit received is based on the premium for the second lowest cost silver plan in the rating area where the individual is eligible to purchase coverage.

The law requires consumers to contribute a specific percentage of income to the premium. It’s a sliding scale based on the federal poverty level. The subsidy then makes up the difference between that amount and the cost of the benchmark plan.

The premium subsidy will come in the form of a refundable and advanceable tax credit paid directly to the individual’s insurer.
What About Income Verification?

Individual applies for exchange coverage. Self-reports current household income.

Income is verified with most recent data from IRS and Social Security. If there is more than a 10% income disparity, further checking ensues. Federal exchanges will check every case. State exchanges may double-check a sample.

Additional verification will come through voluntarily reported employer data and Equifax. If needed, the individual may be asked to provide more substantiation data. If none is provided, the tax credit advance payments will be halted.

Individuals will have to claim their credit on their annual income tax filings. If income doesn’t match-up with what was reported, there will be tax consequences.

Inappropriate subsidies must be repaid. Amount is capped based on income, but if you make more than 400% of FPL the full subsidy must be repaid. Exception is there will be no repayment of cost-sharing subsidies.
In states that do not expand Medicaid, people making less than 100% of FPL won’t be eligible for a premium tax credit subsidy.

Kaiser Family Foundation
statehealthfacts.org
Your source for state health data
The elephant in the room is how is health reform going to impact premium rates and the amount people actually pay for coverage? Right now rate and price predictions are all over the map.
Why can no one agree about the rate/price impact of health reform?

- Rate comparisons with present-day policies may be hard because in many cases rating factors, plan design requirements, mandated benefit requirements and more will substantially different than what is required today. In most cases, particularly in the individual market, benefit packages will be richer, but networks may be reduced.
- Many rate analyses do not take into consideration new taxes and fees that will be included in premiums moving forward.
- Most of the pricing impact will hit the individual and small group markets. There are risk-sharing protections built into those markets to protect against adverse-selection costs, but they are untested.
- While rates have to be actuarially justified, carriers are making big assumptions about market impact when developing 2014 rates and there are wide variances.
- Subsidized individuals will be shielded from price impact because the amount they must spend is limited by income. But even though the subsidized consumer won’t personally absorb an increase, prices remains the same.
Recap/Political Overview
What’s About to Change
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Resources and Questions
Exchange Marketplace

- As envisioned, “streamlined, easy to use, consumer friendly, neutral online marketplace for health insurance” with one-stop shopping for Medicaid, CHIP, subsidized coverage and other individual coverage
- Subsidized coverage will only available for individuals purchasing through an exchange, not those in an employer group
- People with adequate and affordable group coverage cannot leave group plan for subsidized individual exchange coverage
- Obama Administration is attempting to rebrand Exchanges as “Marketplaces”
- Three Governance Options:
  - State-Owned and Operated
  - State-Federal Partnership Model
  - Federal Fallback Exchange
State Exchange Decisions

- Coverage through the exchanges will begin in every state on January 1, 2014, with enrollment beginning October 1, 2013.
- State decisions and blueprints on oversight of the exchanges were required by January 1, 2013 for a state-based exchange and by February 15, 2013 for a partnership exchange or federally-facilitated exchange.
- Even if a state elects a state-based exchange, if they are not able to make the exchange operational for consumers in time, or if their efforts are not sufficient for certification by HHS, the federal government will assume operations.
- Status of state exchange marketplaces
  - Sixteen states plus the District of Columbia declared that they intend to establish a state-based marketplace and have received conditional approval from HHS
    - Mississippi’s application was rejected due to conflict between the elected Insurance Commissioner and Governor
    - Utah has received conditional approval for a state-based SHOP exchange only
  - Seven states are planning to pursue a state-federal partnership marketplace
  - Twenty-six states will have a federally-facilitated exchange in 2014
<table>
<thead>
<tr>
<th>State</th>
<th>Decision</th>
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<tbody>
<tr>
<td>Alabama</td>
<td>Default to Federal Exchange</td>
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<td>Alaska</td>
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<tr>
<td>Arizona</td>
<td>Default to Federal Exchange</td>
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<tr>
<td>Arkansas</td>
<td>Planning for Partnership Exchange</td>
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<tr>
<td>California</td>
<td>Declared State-based Exchange</td>
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<td>Colorado</td>
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<tr>
<td>Connecticut</td>
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<tr>
<td>Delaware</td>
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<tr>
<td>District of Columbia</td>
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<td>Florida</td>
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<td>Georgia</td>
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<td>Idaho</td>
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<td>Tennessee</td>
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<td>Texas</td>
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<td>Utah</td>
<td>State-based SHOP and Default to Federal Individual Exchange</td>
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<td>Vermont</td>
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<td>Virginia</td>
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<td>Washington</td>
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<td>Wisconsin</td>
<td>Default to Federal Exchange</td>
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<tr>
<td>Wyoming</td>
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SHOP Exchange Update

- Statute gives great flexibility to states regarding SHOP exchanges, but there are requirements for states in the new final exchange rules. On May 31, 2013 HHS released final rule on SHOP exchange establishment
  
  http://www.ofr.gov/OFRUpload/OFRData/2013-13149_PI.pdf

- The final rule delays the provision of the law that would allow a small employee to choose multiple health plans to offer its employees, as well as the required premium aggregation.

- Until 2015, the federal SHOP Exchange will, instead, assist small employers in choosing a single qualified health plan to offer their employees.

- State-operated SHOP Exchanges may, but are not required to, apply the same restrictions.
Inside and Outside Exchanges Changes Are Looming that Will Impact Premiums

**Pricing Changes**
- Community rating that limits rate variability to age, family status, smoker status and geographic area with an overall variation of 3 to 1 meaning that the highest rate offered for a product may be no more than three times the lowest rate.
- Impacts Individual and Small Group plans

**New Tax Burden**
- New national premium tax, reinsurance fees, and comparative effectiveness tax will impact rates in 2014 and beyond.
- Average tax cost will be over $500 for a family premium in 2014
- Premium tax impacts all fully insured plans.
- Other insurer taxes and fees hit all plans
- Other looming taxes like the medical device and RX taxes will impact all consumers
**Plan Design Changes**

- Qualified individual and small group plans will have to meet:
  - Essential health benefit requirements
  - Actuarial value requirements
  - Cost-sharing limitations
  - Separate small group deductible cap of $2000/$4000
  - HHS may provide some relief, on the deductible cap, but details are still unclear

- Recent HHS decision means all plans, including large group and self-funded, will have to meet Out-of-pocket limits tied to the HSA deductible limits with transition relief for 2014

**Subsidies**

- Qualified individual market purchasers with family incomes between 100-400% of FPL through the new exchanges.
- Subsidies are not available to Medicaid-eligible individuals.
Participation Requirements

- HHS rules have prohibited participation and contribution requirements for large group market issuers and required small group carriers to have a requirement-free open enrollment period from Nov 15-Dec 15 annually.
- Unknowns right now include:
  - Will carriers limit small group participation/contribution requirement reprieves to the one month November 15-December 15 open enrollment window?
  - Will exchange coverage be counted as a valid waiver?
  - If the stop-loss market is affected and in any case how will it react?
Does A Renewal Date Change Help?

- Employers and carriers have contemplated the idea of changing renewal dates to delay PPACA compliance and related costs.
- Changing a renewal date is a complicated decision and a responsible broker needs to help clients weigh all involved factors.
  - Market reforms are generally implemented on a plan-year basis, but individual mandate is not.
  - There are some employer mandate transition relief options for non-calendar year plans, but a renewal date switch generally negates them. It’s still unclear how transition relief will work with the mandate penalty delay.
  - There may be Cafeteria plan considerations.
  - Current rules require documentation of a sound business reason for a renewal date change and a switch may trigger a DOL audit.
  - Recent HHS changes to participation and contribution requirements and the creation of a November 15-December 15 open enrollment period could be a business reason for a change.
What about Self-Funding?

- Increased interest in self-funding amongst smaller and midsized groups
- Increased interest in the integration of self-funded options with other group coverage options
- Participation requirement changes in the fully-insured market could change dynamics
- DOL requested more information about small group self-funding last year and is conducting annual market studies
- Market interest in self-funded workarounds has already resulted in DOL guidance about changes for HRAs. They need to be attached to a group chassis.
- Some states are looking at regulation of attachment points as a way of limiting smaller group self-funding
- More increased interest may bring even more increased regulatory scrutiny
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Resources and Questions
What are employers talking about?
Employer Responsibilities Regarding Exchanges

All employers that offer group health benefits are going to have responsibilities regarding the exchanges, even if they do not want to purchase exchange-based coverage or isn’t eligible to purchase exchange coverage.

- Exchange Notices
- Coverage Verification
  - Individual Mandate
  - Employer Mandate
  - Subsidies
- Quality reporting
Coverage Concepts All Employers (and Employees) Need to Know

- The concepts of minimum essential coverage, affordable coverage and minimum value coverage aren’t just important for employers who are subject to the law’s shared responsibility requirements.
- All employers of all sizes who offer any type of coverage will need to know if the coverage they offer meets these concept tests.
- All employees of all types (FT, PT, seasonal, etc.) will need to know what kinds of coverage has been offered to them (if they if they seek a subsidy through the exchanges.
### Coverage Tests

<table>
<thead>
<tr>
<th>Affordable</th>
<th>Minimum Value</th>
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</thead>
<tbody>
<tr>
<td>Employee’s share of the premium cannot exceed 9.5% of household income.</td>
<td>Lowest tier plan must be at least a 60% actuarial value</td>
</tr>
<tr>
<td>Affordability test is based on the cheapest minimum value plan the employer offers.</td>
<td>Actuarial value is based on cost-sharing and out-of-pocket expenses, not premiums</td>
</tr>
<tr>
<td>HRA contributions under certain circumstances are factored into the affordability calculation.</td>
<td>Employer contributions to account-based plans will factor into actuarial value</td>
</tr>
<tr>
<td>Proposed rule only allows nondiscriminatory tobacco cessation programs, not other wellness programs to count towards affordability</td>
<td>Proposed rule only allows nondiscriminatory tobacco cessation programs, not other wellness programs to count towards actuarial value, with some transition relief for 2014</td>
</tr>
<tr>
<td>Test is also based on the employee-only rate, regardless of whether or not the employee selects family or dependent coverage</td>
<td>Administration has a calculator and there are other safe harbors employer can use</td>
</tr>
<tr>
<td></td>
<td>Small groups that offer Bronze QHPs or higher meet the minimum value standard</td>
</tr>
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Minimum Essential Coverage

Minimum essential coverage is the standard individuals need to meet to complete the individual mandate requirements and employers need to meet to avoid a “no coverage” penalty. It includes the following:

- Employer-sponsored coverage (including COBRA coverage and retiree coverage)
- Coverage purchased in the individual market
- Medicare Part A coverage and Medicare Advantage
- Most Medicaid coverage
- Children's Health Insurance Program (CHIP) coverage
- Certain types of veterans health coverage administered by the Veterans Administration
- TRICARE
- Coverage provided to Peace Corps volunteers
- Coverage under the Nonappropriated Fund Health Benefit Program

Minimum essential coverage does not include coverage providing only limited benefits, such as coverage only for vision care or dental care, Medicaid covering only certain benefits such as family planning, workers' compensation, or disability policies.

The Department of Health and Human Services (HHS) has authority to designate additional types of coverage as minimum essential coverage.
Employers Will Also Have To Help The Exchanges Verify Coverage

HHS will use data from insurance exchange markets to determine whether people have coverage when the individual mandate takes effect in 2014.

Determining whether an individual has coverage for individual mandate enforcement will involve getting information from both employees and employers.

These procedures are separate from the IRS procedures for determining employer penalties under the employer play-or-pay mandate.

Mandatory employer reporting for both the individual and employer mandates will not begin until 2015.

In 2014, employees will be able to present a voluntary reporting form to employers to assist with verification.

Voluntary reporting will help preserve the stability of employer groups and help prevent employees from being awarded subsidies inappropriately that will eventually have to be paid back.
Who has to be Offered Coverage?

- Full Time Employees (30 hours or more a week)
- Dependents who are defined as employee’s children under age 26 (IRC §152(f)(1))

Employers will not face tax penalties for electing not to offer coverage to spouses.
If a spouse has no other source of affordable employer-sponsored coverage, he/she could get an exchange subsidy.

Other Key Points About Coverage Offers
• A large employer will be considered as offering coverage to full-time employees if they offer coverage to 95% of their full-time employees and dependents (or, if greater, to 5 employees). Note: if any of the 5% of full-time employees who are not offered coverage receive premium tax credits from an Exchange, the employer will be required to pay an annual penalty of $3,000 for each of those employees.
Other Points to Consider About Offering Coverage

- There are no penalties or employer responsibility requirements now, yet most employers offer coverage today.
- Penalties may increase over time as more employers choose to pay penalties rather than provide coverage. Penalties do not fully offset coverage costs in exchange, adding incentive for increases in penalty amounts.
- If employer increases salary to make up for lost benefits, employer FICA tax obligations will also increase; whereas employer-sponsored benefits are excluded from income.
- Employers who offer coverage rarely, if ever have a 100% take-up rate. However, employers who fail to offer coverage pay penalties for 100% of eligible workers.
- If employees choose to remain uninsured rather than seek coverage, increased absenteeism and presentee-ism may result. Furthermore, workers compensation costs may go up for what are actually non-work related health costs.
- Employers that drop coverage generally must drop it for all—in all likelihood management carve outs will be tough to maintain post-2014
- Competitors may seek an advantage by offering coverage
- There may be a PR back-lash for not offering coverage
Recap/Political Overview

What’s About to Change

For Individuals

What’s About to Change in the Marketplace

What’s About to Change for Employers

Resources and Questions
### Which Provisions Apply?

<table>
<thead>
<tr>
<th>Provision</th>
<th>Group Size</th>
</tr>
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</table>
| Employer Mandate (Must offer FT employees affordable and minimum value coverage to avoid penalty) | • 50+ FT Equivalents  
• Uses a new definition of FT employee of 30 hours/week  
• PT employees count on a pro-rata basis to determine applicability but do not need to be offered coverage  
• IRS Controlled Group Rules Apply |
| W2 Reporting (Must report value of health benefits—just reporting, no taxation) | • Requirement applicability is currently clear for 2012 (W2 issued in 2013) ONLY  
• Mandatory for groups that issue 250 or more W2s. Optional for other groups for 2012 but will eventually apply to all.  
• Applicability "based upon the rule in § 6011(e) that exempts employers from filing returns electronically if they file fewer than 250 returns."  
• Groups should verify with CPA but generally can apply on a separate employer basis unless the group uses a common paymaster. |
| Cadillac Tax (begins in 2018)                   | • All group health plans                                                   |
| Auto-Enrollment (effective date unclear but at least 2015) | • All groups of 200 or more employees                                      |
## Which Provisions Apply?

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| **Market Reforms**                 | • State definition of small group until December 31, 2015  
  (Required to buy a qualified health plan, EHBs, metal levels, MCR, etc.)  
  • Effective January 1, 2016 small group definition becomes 1-100 for all states  
  • If a state allows large groups in the exchange after 2017, then market rules apply to them too  
  • Grandfathered plans exempt                                                                                                                                 |
| **Small Group Deductible Cap**     | • State definition of small group until December 31, 2015  
  • Effective January 1, 2016 small group definition becomes 1-100 for all states  
  • Grandfathered plans exempt  
  • HHS has provided some relief to carriers for QHP offerings that cannot meet the cap and still offer a bronze plan through 2016 |
| **Maximum Out-of-Pocket Limits**   | • Tied to annual HSA limits and includes deductibles and other costs sharing  
  • New guidance suggests they apply to all non-grandfathered plans, including large group and self-funded plans |
| **Exchanges**                      | • Individual plans (only policies that are eligible for premium subsidy)  
  • State definition of small group for SHOP exchange until 2016  
  • Effective January 1, 2016 small group definition becomes 1-100 for all states  
  • Sole proprietors currently not SHOP eligible  
  • Post January 1, 2017 a state may elect to allow larger groups into the SHOP exchange  
  • Grandfathered plans exempt                                                                                                                                 |
<table>
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<tbody>
<tr>
<td>105 H Non Discrimination Rules</td>
<td>•All fully insured and self-funded group health plans except grandfathered plans&lt;br&gt;•Currently not enforced for fully insured plans, but rules specially designed for these plans expected to be promulgated in 2013</td>
</tr>
<tr>
<td>Summary of Benefits and Coverage</td>
<td>All individual and group plans</td>
</tr>
<tr>
<td>Age 26, Rescissions, Prohibitions on benefit limits</td>
<td>All individual and group plans</td>
</tr>
<tr>
<td>Preventive Care, Claims appeals and provider choice and out-of-network emergency care</td>
<td>All individual and group plans except grandfathered plans</td>
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<tr>
<td>New National Premium Tax</td>
<td>Individual and fully insured groups</td>
</tr>
<tr>
<td>Employer Reporting to Exchanges</td>
<td>All group plans—guidance pending</td>
</tr>
<tr>
<td>New National Reinsurance Fee</td>
<td>All individual and group plans</td>
</tr>
</tbody>
</table>
Health reform is complicated.