

The Patient Protection and Affordable Care Act of 2010 (PPACA)

April 29, 2010

Presenters:

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Today's Agenda

Mike Suttman

- Overview of the PPACA (and Reconciliation)
- Emphasis on the next 12-18 months
- Additional items through 2013

Paul Routh

- 2014 and Beyond
- Health Exchanges
- Employer Penalties
- Individual Mandates



Opening Remarks

- PPACA & Reconciliation is now law
- Devil is in the Details – Regulations forthcoming
- McGohan Brabender communication plan
- Eating the elephant one bite at a time



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McGohan Brabender Communication Plan

Time sensitive information available via MB Flash Updates and MB Semi-Monthly Compliance Updates.

Archive of Prior Flash Updates and Legislative Updates available at mcgohanbrabender.com.

Future group seminar meetings and individual client planning sessions.

2010 Rules

3 Programs that May Benefit Targeted Employers or Individuals

1. Small Business Tax Credit
2. Early Retiree Reinsurance Program
3. Individual High Risk Pool For Uninsured



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Each has impact to targeted employers or individuals in 2010.

See more detailed information on following slides.

2010 Rules

1. Small Business Tax Credit - Retroactive to January 1, 2010

Eligibility

Small Employer (25 or fewer full time employees)

and

Average Annual Salary of less than \$ 50,000

and

Employer Pays at Least 50% of Premiums
for Single Coverage



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1. Small Business Tax Credit

There is a tax credit available to small business (i.e. less than 25 employees) whose average annual salary is less than \$50,000 per year. The maximum credit in 2010 is 35% (25% for tax exempt organizations) and is available to employers with 10 or fewer full time employees with average annual salary of less than \$25,000.

For a more in depth discussion of the qualifications for the SBTC please refer to the McGohan Brabender legislative update from April 15, 2010. The link to this document is:

<http://www.mcgohanbrabender.com/documents/content/665.pdf>

To be eligible for the credit the employer (1) must be small (i.e., 25 or fewer full-time employees) (2) whose employees' average annual salary is less than \$50,000 and (3) the employer must pay at least 50 percent of the cost of single coverage. The maximum credit for 2010 is 35 percent of the amount of premiums the employer paid. The tax credit is phased out if the employer has more than 10 full-time employees and/or their annual average salary exceeds \$25,000.

2010 Rules

1. Small Business Tax Credit

Maximum Credit	Reduced Credit
10 or fewer full time employees and Average Annual Salary < \$ 25,000	10 to 25 full time employees and/or Average Annual Salary >\$ 25,000 and < \$50,000



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Small Business Tax Credit will be modified beginning January 1, 2014 due to Health Care Exchanges (HCE).

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<http://www.mcgohanbrabender.com/documents/content/665.pdf>

2010 Rules

2. Early Retiree Reinsurance Program – June 21, 2010

- Pays 80% of Individual's claims between \$15,000-\$90,000
- Reimbursements are tax free **BUT** money must be used to reduce plan costs
- Total amount available is \$5 Billion – Program ends January 1, 2014 or earlier if money runs out



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“Early Retiree” (i.e. age 55 through 64).

Reduction of plan costs (e.g. reduce premiums, co-payments, etc.).

2. Reinsurance for Early Retirees – Effective June 23, 2010

Reimburse health plans for 80% of early retiree's claims between \$15,000 and \$90,000. Money must be used to benefit participants not employer (i.e. reduce premiums, co-payments, etc.).

2010 Rules

3. Individual High Risk Pool – June 21, 2010

- Program for individuals with pre-existing conditions
- Anti-Dumping – no incentives – Cash Out Plans?
- Must be uninsured for prior six months
- Ends on January 1, 2014



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3. High Risk Pools

HHS to establish high risk pools effective June 21, 2010 for individuals with pre-existing conditions **and** no creditable coverage for prior 6 months. High Risk pools are set to end on January 1, 2014 when Health Exchanges replace the High Risk Pools.

Employers cannot dump individuals in the pool. HHS to develop rules as to what constitutes dumping. If this happens the employer must reimburse the pool for the person's claims.

NOTE: Having a "cash option to coverage" type plan to allow those waiving the employer provided plan should be OK as long as all employees are offered the same cash-out incentives.

Comment: Does this really solve one of the key problems? That is, if you have poor coverage, high cost coverage, or coverage that recently expired (less than 6 months prior to June 21, 2010) the High Risk Pool may not offer a solution.

2010 Rules

Step 1 - ALL Employers

Is Your Plan Grandfathered or Non-Grandfathered?

Grandfathered Plan	Non-Grandfathered Plan
In Existence on March 23, 2010	Plan Created <i>(or Changed)</i> after March 23, 2010



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These are the dates used when determining if your plan is considered a GF plan or a Non-GF Plan. The March dates are NOT the dates you must comply with the new rules.

2010 Rules

Is Your Grandfathered Plan Status in Jeopardy?

You will maintain your Grandfathered status if:

- Plan adds family members of current participants
- Plan adds new employees and family members



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How a plan can ensure it maintains its' Grandfathered Plan status is Unclear

There are a couple of specific actions cited in the law which DO NOT result in loss of GF status. They are:

- A GF plan can add family members for current participants
- A GF plan can add new employees and their family members

2010 Rules

Grandfathered status May or May Not Remain if:

- Add existing employees – previously declined coverage
- Make plan design changes – (e.g. Deductible & Coinsurance)
- Add new category of employees (e.g. Union or Part-Time Employees)
- Change carriers
- Merge with another plan



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Impact on GF/N-GF status as a result of some activities is Unknown:

There are no clear guidelines within the current law for the impact to a plan's GF status when making some other common changes.

Regulations expected in June 2010.

2010 Rules

Grandfathered vs. Non-Grandfathered

Grandfathered Plan	Non-Grandfathered Plan
Must comply with one set of rules	Comply with the same rules PLUS additional provision



Grandfathered Plans

Plan Years on or after September 23, 2010

(i.e. January 1, 2011 for Calendar Year Plans)

- No lifetime limits on "Essential Benefits"
- Restricted annual limits on "Essential Benefits"
(Until 1-1-2014)



Lifetime & Annual Limits Effective Dates Vary as Indicated

No lifetime limits on essential health benefits for a Plan Year after September 23, 2010.

Can have annual limits on essential health benefits as permitted by regulations not yet issued until plan year beginning on January 1, 2010.

On or after January 1, 2014 can not have annual limits on essential health benefits.

Can, at anytime, have annual and lifetime limits on non-essential health benefits.

It appears you can still have per occurrence, per visit and other similar limitations.

Grandfathered Plans

“Essential Benefits” Include:

- Ambulatory
- Emergency
- Preventive
- Mental Health & Substance Abuse
- Rehabilitative
- Laboratory
- Wellness
- Pediatric
- Hospitalization
- Maternity & Newborn Care
- Prescription Drug
- Disease Management.



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This is the current list of Essential Benefits. The Government will expand this list. Lifetime and Annual Limits are still Permitted on “Non-Essential Benefits.”

Grandfathered Plans

Plan Years on or after September 23, 2010
(i.e. January 1, 2011 for Calendar Year Plans)

- **Prohibition Against Rescissions** – *Except for fraud or intentional misrepresentation*
- **Mandates Plans Cover Dependent Coverage to Age 26**
Regardless of marital status; but not required to provide coverage if eligible for other employer provided coverage
- **Elimination of Pre-Existing Condition for Anyone Under Age 19**



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Recessions Effective Plan Years Beginning after September 23, 2010 – All Plans

Can not rescind coverage unless fraud or intentional misrepresentation of material fact.

Employers must give prior notice of the cancellation and the cancellation must be in accordance with the terms of the plan. This means that the plan must specifically state coverage can be rescinded and it appears that the coverage can be retroactively taken away if plan language provides for retroactive rescissions.

Coverage for Older Children Effective Plan Year Beginning after September 23, 2010 (Except as Noted) – All Plans.

Employer plans must cover children up to age 26 regardless of marital or tax dependent status (e.g. living outside employee's home). Do not have to cover grandchildren. Failure to comply can be excise tax of up to \$100 per day per failure. Note the IRC was amended to say no imputed income to employee for value of the coverage. If Grandfathered Plan then if the child has other group coverage available then the employer does not have to cover the child until Plan Year beginning January 1, 2014. ***When it is a Non-Grandfathered Plan and the child has other group coverage available, the child is still eligible to be covered under the plan.***

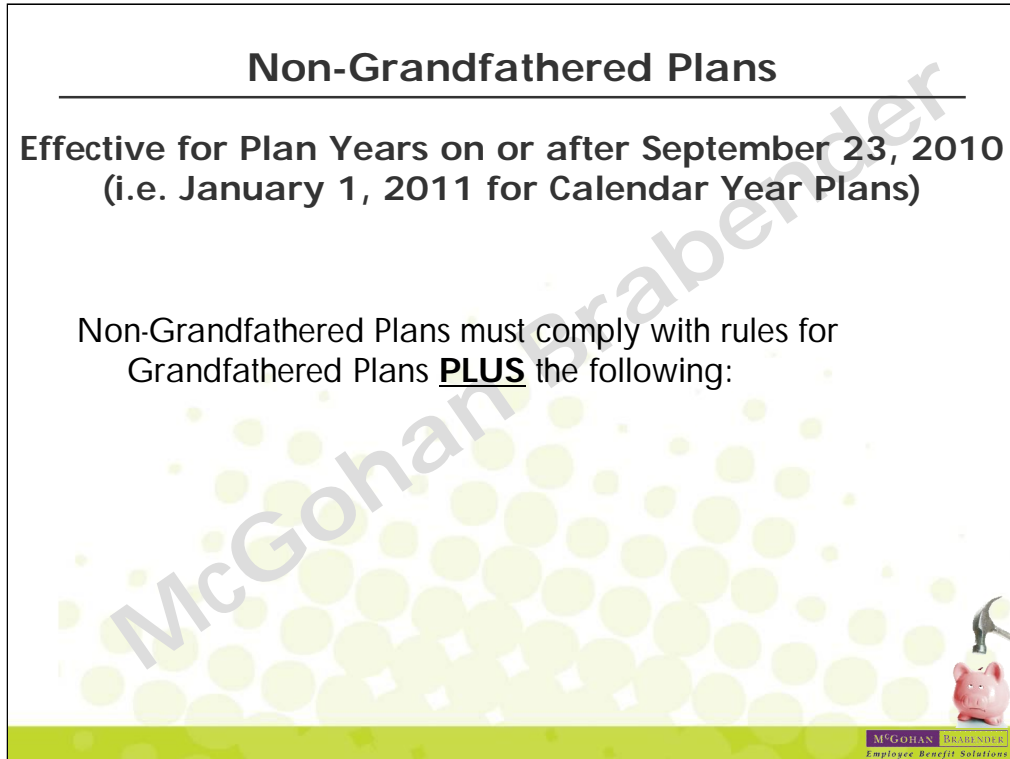
For a more in depth discussion of the Co-ordination of the Federal and Ohio qualifications for the dependant age eligibility provisions please refer to **The April 30, 2010 MB Compliance Update.**

Must have language in plan documents to enforce.

Non-Grandfathered Plans

Effective for Plan Years on or after September 23, 2010
(i.e. January 1, 2011 for Calendar Year Plans)

Non-Grandfathered Plans must comply with rules for
Grandfathered Plans **PLUS** the following:



If a plan loses Grandfather Status the plan will be subject to the rules for Non-Grandfathered Plans.

Non-Grandfathered Plans

Plan Years on or after September 23, 2010
(i.e. January 1, 2011 for Calendar Year Plans)

- Emergency Services
- Open Provider Choice - *Does not mean plan has to accept any willing provider*
- New Appeals Procedures – *Must continue benefits during process*



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Emergency Services – Must provide coverage without prior authorization and must treat out-of-network providers the same as network providers.

Open Provider Choice – Plan cannot restrict participant's right to select a Primary Care Provider. Plans CAN still have PPO networks.

For those plans that require the designation of a Primary Care Provider the plan must allow a Pediatrician to be a Primary Care Provider for a child.

A plan that provides coverage for obstetric or gynecology care and requires the designation of a Primary Care Provider the plan must allow direct access to OB-GYN (i.e. no referral required).

Appeals Process

Does not replace but supplement current claims processes under ERISA. Must have both internal and external procedures. Must continue coverage during the review process. This should help speed up the appeals process.

Non-Grandfathered Plans

Plan Years on or after September 23, 2010 (i.e. January 1, 2011 for Calendar Year Plans)

Mandate Plans Provide Dependent to Age 26 – (Married or unmarried)
Even if dependent has other employer provided coverage available

- No Annual Limits on “Essential Benefits”
- Discrimination Rules – *Fully Insured Plans*
- Preventive Care & Screening – *Must be first \$ coverage*



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Coverage for Older Children Effective Plan Year Beginning after September 23, 2010 – All Plans

Must cover children up to age 26 regardless of marital status. Do not have to cover grandchildren. Failure to comply can be excise tax of up to \$100 per day per failure.

For a more in depth discussion of the Co-ordination of the Federal and Ohio qualifications for the dependant age eligibility provisions please refer to **The April 30, 2010 MB Compliance Update.**

Self Funded plans have been subject to IRC discrimination rules. The penalties for violating the discrimination rules are different. If plan is Self Funded – highly compensated employees are penalized. If plan is Fully Insured – Employer is penalized.

Preventive Care

Plans must provide for preventive services and must provide 1st dollar coverage.

2010 Rules

Miscellaneous Items

Retiree Plans (i.e. No Active Employees) Subject to HIPAA Portability Provisions & Mental Health Parity Act

States are to Develop Ombudsman to help people with insurance issues

Unreasonable Premiums Increases to be monitored by federal and state

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These provisions are not subject to plan status (i.e. grandfathered vs non-grandfathered)

Ombudsman Program

State agencies are to help individuals with plan issues. Not clear but could help even if the person is in a self funded health plan.

Monitor Premium Increases

HHS and states will begin monitoring "unreasonable" rate increases.

"Unreasonable" is not defined. Carrier must submit justification for the increase prior to implementing the increase.

January 1, 2011 - Hard Date for All Employers

Elimination of Reimbursement from FSA, HRA and HSA for Over the Counter Drugs – UNLESS the OTC is prescribed by physician or is insulin

Penalty for Non-Medical HSA Distribution Increased from 10% to 20%

SIMPLE Cafeteria Plan for Small Employer (Fewer than 100 employees)



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Effective date for these provisions are not dependent upon plans status (i.e. grandfathered or non-grandfathered).

FSA, HRA and HSA - Elimination of Reimbursement of over the counter drugs – Health FSA, HSA and HRA can no longer reimburse over the counter drug UNLESS prescribed by physician or the drug is insulin.

Simple Cafeteria Plans – Effective January 1, 2011

Small employers (i.e. averages less than 100 employees during either of the 2 preceding years) can establish a “simple” cafeteria plan and have a safe harbor from the discrimination rules.

January 1, 2011 - Hard Date for All Employers

Advanced Notice Requirements – Must provide sixty day advanced notice of plan change – penalty can be up to \$1,000 per participant

Form W-2 Requirements – Must report aggregate amount of health coverage

Insurance Companies' Cost Ratio

85% Threshold for Large Employer Plans

80% Threshold for Small Employer Plans

Voluntary Long Term Care Program (CLASS)



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Advanced Notice Requirements – Must provide sixty day advanced notice of plan change – Dependent on regulations – Penalty can be up to \$1,000 per participant.

W-2 reporting requirements exclude salary deferrals to Health Flexible Spending Accounts (FSAs).

Insurance Companies' Cost Ratio

For large employer plans 85% of premiums must be spent on medical services

For small employer plans 80% of premiums must be spent on medical services

Cost Ratio – if insurer fails to comply, they rebate participants.

CLASS Effective 1/1/2011

Similar to a long-term care program. Employers can (but do not have to) enroll in program which permits employees to make payroll deductions for the coverage. Employee must be enrolled in the program for five years and the minimum benefit will be \$50 per day.

Plan Years On or After January 1, 2012

Non-Grandfathered Plans

Annual Reports to Department of Health & Human Services and Participants - RE: Plan's Quality of Care

Government is to Develop Standardized Definitions –
Must be used for Insured Plans – Unclear if Self Funded
Plans must use them

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Annual Reports to Department of Health & Human Services and Participants: By March 23, 2012 The Secretary of Health and Human Services is to develop requirements for plans to report on a variety of issues including information related to (1.) improving health outcomes through quality reporting, (2.) activities to prevent readmissions, (3.) safety promotion and medical error reduction, and (4.) health promotion and wellness activities.

Government is to Develop Standardized Definitions – The new law requires the Secretary of HHS to issue regulations providing for the development of terms to be used in Fully Insured Plans it is unclear if self funded plans must use them. The purpose is to enable participants to better understand and compare coverage.

January 1, 2013 Hard Date

Health FSA Cap – Maximum Amount of Salary Deferrals is \$2,500

Medicare Tax (FICA) Increases .9% on Certain Income

Medicare Tax (FICA) of 3.8% on Investment Income

Comparative Effectiveness Research Fee

- \$1 in 2013
- \$2 in 2014 through 2019



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Note: The Health FSA Cap is on salary deferrals BUT, seems to allow employer contributions to exceed \$2,500 limit.

Increased Medicare Tax on High Income Individuals Effective January 1, 2013

Adds another .9% FICA tax on wages above \$200,000 for single taxpayers and \$250,000 for married taxpayers.

New Tax on Investment Income Effective January 1, 2013

New 3.8% tax on investment income based on lesser of (1) net investment income or (2) the excess of modified AGI above the threshold (\$200,000 for single, \$250,000 for married).

Comparative Effectiveness Research Fee

- Paid based on average number of lives
- Insured plans - paid by the carrier
- Self-insured plans paid by employer

Plan Years On or After January 1, 2012

Grandfathered Plans

Four Page Uniform Plan Description – When the coverage is applied for and prior to coverage

Auto Enrollment for Large Employers - (200 or more full time employees) Effective date will be the date regulations are issued

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By March 23, 2011 The Secretary of HHS is required to develop standards for plans to use in summarizing plan benefits to its participants. It seems that this is to be a benefits highlights description of the plan. Not to exceed 4 pages in length, cannot use font smaller than 12 point. It must be presented to a “culturally and linguistically appropriate manner”

Auto Enrollment Unclear Effective Date –After Regulations – All Plans

Must have automatic enrollment for new full time employees and continue the enrollment for current employees. Applies to employers with more than 200 full time employees.

Administrative Issues – how do you get employee to complete enrollment forms?

Plan Years on or after January 1, 2014

Grandfathered Plans

Mandates Plans Provide Dependent Coverage to Age 26 –
(Married or Unmarried) Even if Dependent **is** Eligible for Other
Employer Provided Coverage

No Pre-Existing Conditions Exclusions for Anyone

**Wellness Programs Maximum Reward/Penalty Raised
to 30% (from 20%) – Potentially up to 50%**

Maximum Waiting Period is 90 Days

No Annual Limits on “Essential Health Benefits”



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Mandates Plans Provide Dependent Coverage to Age 26

A Grandfathered plan will be compelled to expand the eligibility to include the plan to dependents up to age 26 **even if** they are eligible for another employer's coverage.

Maybe do it now – not worth the hassle to keep track of them.

Plan Years on or after January 1, 2014

Non-Grandfathered Plans

Fully Insured Health Plan for Small Employers Must Provide Essential Health Benefits

Limits on Cost Sharing (i.e. Out-of-pocket \$2,000 Single Coverage/ \$4,000 Family Coverage)

Coverage for Qualified Clinical Trials

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Clinical Trials - Effective Plan Years after December 31, 2013

Plans must pay for the cost associated with qualified individuals in a clinical trial. A person is a qualified individual if is recommended for the treatment by a participating provider or the person presents medical and scientific information saying the treatment is appropriate. The rules do not require a plan to pay for out of network providers but if the plan does pay for out of network benefits, then must pay for clinical trials by out of network facilities.

Insurance Company Mandates

Limits on Small Group Premium Differentiations -

- Age 3:1
- Tobacco 1.5:1

Guaranteed Issue for All Groups -

Currently just small groups

Guaranteed Renewability for All Groups

No Provider Discrimination -

Plan does not have to accept "Any Willing Provider"

Small Group Insured Plan – Maximum annual deductible - \$2,000 single coverage/\$4,000 family coverage



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For small employers with insured plans the annual deductibles cannot exceed \$2,000 for single coverage and \$4,000 for family coverage. These amounts can be increased if in conjunction with a Health FSA.

Part 2 - Paul Routh

Most Significant Change - January 1, 2014

Three Interrelated Topics:

- I. Health Insurance Exchanges
- II. Individual Mandates
- III. Penalties for Large Employer

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Most significant penalty provisions will begin on January 1, 2014. This date will apply regardless of your plan year.

I. Health Care Exchanges (HCE)

What is a Health Care Exchange?

- State run (as opposed to single federal exchange)
- Clearing House of Information
- Certify Plan Options – 4 Options
- Can offer stand alone dental plan
- Co-op plan – Not government option plan



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Previous proposals had one Federal exchange.

State government or non-profit entity. The statute allows the HCE to contract with “navigators” to perform various functions.

One of the key functions of the HCE is the transfer of information between Government, employers and employees.

Exchanges also can offer stand alone dental plan.

Co-op plan – Not for profit plan to compete with private carriers \$6 billion seed money.

I. Health Care Exchanges (HCE)

What Options Are Available Through the Health Care Exchange?

- 4 Options – Bronze, Silver, Gold & Platinum
- Maximum Out-of-Pocket Based on High Deductible Health Plan (\$5,950/Single \$11,900/Family) and Maximum Deductibles can not exceed \$2,000/single and \$4,000/family
- Catastrophic plan – for individuals up to age 30 or If individual is exempt from individual mandates



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Bronze = covers 60% of benefit costs, silver = 70% of benefit costs, gold = 80% of benefit costs and platinum = 90% of benefit costs.

Carrier must offer at least silver and gold options.

The Maximum Out of Pockets Based on HDHP amounts which are indexed.

Deductible amounts will also be indexed.

Catastrophic plan is just for individuals up to age 30 and those exempt from the penalty for not having coverage. Provides three primary care visits a year + benefits above HDHP Out of Pocket Limits.

I. Health Care Exchanges (HCE)

What Do Exchanges Do?

- Share information between employer, employees & government
- Provide information about plans, Medicaid and CHIP
- Provide cost calculator – Kaiser Family Foundation has sample calculator

<http://healthreform.kff.org/SubsidyCalculator.aspx>

- Provide information re: carriers' plans, premium trends, etc.
- Certify individuals exempt from having to buy insurance (i.e. not subject to penalty)



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Share data and handle administrative details for health care reform.

This includes facilitating transfer of information between the government, employers and employees.

Provide information to individuals about available plans and premiums.

Make information more understandable, use standardized formats and forms to make it easier to compare plans .

Provide information to employers about which of their employees have purchased coverage and received premium tax credit or cost sharing subsidy.

Provide information to the government regarding individual receiving premium tax credits or cost sharing subsidy.

This information will help identify employers who may be subject to penalties.

I. Health Care Exchanges (HCE)

Who Can Participate in Exchanges?

- Allows individuals to purchase coverage
- Allows small employers to offer employees coverage through the HCE
- Small employer is defined as employer with less than 100 employees
- States have option to define "small employer" as employers with less than 50 employee for 2014 and 2015
- States have option to open exchanges to larger employer beginning in 2017



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Individuals must be U.S. Citizens or legal immigrants not incarcerated.

Small employers can elect to allow all full time employees the opportunity to elect HCE plans.

Once the small employer makes this election, the employer remains a "small employer" for these purposes regardless of size.

The federal legislation defines small employers as those with fewer than 100 full time employees.

However, for the first two years the states may define small employers as those with less than 50 employees.

II. Individual Mandates

- Requires all U.S. citizens and legal residents have qualifying coverage or pay a penalty
- Qualifying coverage is Medicare, Medicaid, TRICARE, all employer sponsored grandfathered plans and plans sold through Health Care Exchanges
- Qualifying coverage also includes employer sponsored plans that are not grandfathered as long as the plan provides essential benefits
- Those without coverage pay a penalty unless otherwise exempted from penalty



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One of main components of health care reform was to provide coverage for the uninsured.

II. Individual Mandates

Penalty Exemptions

- Financial hardship = (1) if lowest cost option exceeds 8% of individual's income or (2) income is below tax filing requirements (i.e. 2009 - \$9,350 for single filers and \$18,700 for married filers)
- Religious objections
- Those without coverage for less than 3 months
- Incarcerated Individuals and American Indians



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If an individual falls under one of these category he/she is not penalized for not having coverage.

II. Individual Mandates

Two forms of financial assistance to help pay for coverage

1. Premium Tax Credits – used to purchase coverage through health care exchanges
2. Cost Sharing Subsidies – used to reduce maximum out-of-pocket amounts



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Premium tax credit – reduces the cost to buy the coverage.

Cost sharing subsidies – reduces the out of pocket maximum associated with the plan
– Remember Out of Pocket limits are the HDHP Limits.

Only available to individuals whose income is less than 400% of Federal Poverty Level (FPL).

If household income is more than 400% of FPL than the individual is not eligible for premium tax credit and cost sharing subsidies.

IMPORTANT NOTE: It is likely to be another administrative burden for an employer to identify and track the employee's HOUSEHOLD income.

II. Individual Mandates

- Premium Tax Credits – amount of credit varies based on income
- Premium Tax Credits – limit amount of income individual or family can be required to pay for coverage – based on cost of Silver Plan
- If income is below 133% of FPL = Eligible for Medicaid



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Income limits place a maximum percentage of a person's income they can be required to pay towards coverage.

II. Individual Mandates

Premiums tax credits are as follows

<u>Income Level</u>	<u>Maximum % of Income To Spend for Coverage</u>
Up to 133% of FPL	2%
133% - 150% of FPL	3.0% - 4.0%
150% - 200% of FPL	4.0% - 6.3%
200% - 250% of FPL	6.3% - 8.05%
250% - 300% of FPL	8.05% - 9.5%
300% - 400% of FPL	9.5%

Based on cost of silver plan option



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Look up household income to determine percentage of income person can be required to spend of health care.

For example; Person's income is \$16,245 = 150% of FPL. Therefore, he or she can not be required to pay more than 4.0% of household income to buy health coverage.

Example: Employee's annual household income is \$16,245, therefore, the maximum amount the employee is required to pay for coverage is 4% of household income or \$650 per year.

Say the cost of the silver plan is \$3,600 per year. This means this person's premium tax credit will be $\$3,600 - \$650 = \$2,950$.

2 Individual Mandates

2010 Federal Poverty Levels

Size of Family	100% of Poverty	133% of Poverty	400% of Poverty
1	\$10,830	\$14,404	\$43,320
2	\$14,570	\$19,378	\$58,280
3	\$18,310	\$24,352	\$73,240
4	\$22,050	\$29,327	\$88,200
5	\$25,790	\$34,301	\$103,160
6	\$29,530	\$39,275	\$118,120
7	\$33,270	\$44,249	\$133,080
8	\$37,010	\$49,223	\$148,040



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For family units with more than 8 members, add \$3,740 for each additional person times applicable percentage.

FPL amounts are indexed annually.

Individual Mandates

- Cost Sharing Subsidy – Reduces out-of-pocket amounts based on income
- Out-of-pocket amount = \$5,950/Single - \$11,900/Family – HDHP Limits Based on 2010 numbers
- Out-of-pocket maximum based on Income

Income Percentage of FPL	Single Coverage	Family Coverage
100%-200%	\$1,983	\$3,976
200%-300%	\$2,975	\$5,950
300%-400%	\$3,987	\$7,973



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Cost sharing subsidies based on household income and reduces the maximum out of pocket exposure.

The lower the household income the greater the cost sharing subsidies which reduces maximum out of pocket exposure.

Example 1: Single individual making \$50,000 per year. This person's income exceeds 400% of FPL= No cost sharing subsidy = His/her out of pocket maximum = \$5,950.

Example 2: Single individual making \$14,000 per year. This person's income is between 100%-200% of FPL = His or her maximum out of pocket maximum \$1,983.

II. Individual Mandates

If employer offers health coverage and makes employer contributions, the employer must offer Free Choice Vouchers (FCVs) – it's another way to pay for coverage

- FCVs are available to employees whose income is below 400% of FPL and employee's required contribution for employer coverage is between 8% and 9.8% of their income
- FCVs must equal employer contributions to employer's group health plan
- Employees can use FCVs to buy coverage through exchange
- FCVs are tax free to recipients if used to buy health coverage and excess amounts can be cashed in but the cash is taxable



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FCV = Another way for employees to pay for coverage offered through the Health Care Exchanges.

Take amount employer is willing to pay towards employer's health plan and contribute to Health Care Exchange on behalf of employees to purchase coverage through the Health Care Exchange.

The employee uses the FCV to help pay for coverage purchased through Health Care Exchange.

In practice there is very limited application since it is only available to employees with income below 400% FPL **AND** whose employee contributions to employer's health plan is between 8% - 9.8% of income – Very few will fall into this category.

FVC are tax free to employees if employee uses all the credits to buy coverage through the Health Care Exchange.

An individual is permitted to cash out any excess value of their FCV. The excess value of FCV that is cashed out is taxable income to the individual.

II. Individual Mandates

Penalty Is Phased In	Greater of	
	Flat Amount	% of Household Income
Year	Flat Amount	% of Household Income
2014	\$95	1.0%
2015	\$325	2.0%
2016	\$695	2.5%
2017+	\$695 + COL	2.5% + COL



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Note: When calculating the penalty based on the flat amount; the maximum penalty per family is limited to 3 members.

Those family members in excess of 3 are disregarded when calculating the Flat Amount penalty.

For example, the Flat Amount penalty in 2014 for a family of 2 is \$190 (i.e. 2 x \$95).

The Flat Amount penalty in 2014 for a family of 5 is \$285 (i.e. 3 x \$95).

The penalty is the greater of the flat amount or the percentage of household income.

III. Employer Penalties

2 Scenarios Resulting in a Large Employer Penalty

First Scenario

Penalty for employers who do not offer coverage, **OR**

Second Scenario

Penalty if an employer offers coverage but, it is not quality coverage or it is not affordable

AND

At least 1 full time employee receives
the Premium Tax Credit or Cost Sharing Subsidy



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“Large” employers are those 50 or full time employees.

No penalties will be assessed against small employers (i.e. those with fewer than 50 full time employees).

III. Employer Penalties

Defining “Large Employer”

- 50 or more full time employees
- Full time is defined as 30+ hours per week
- Exclude full time seasonal employees working less than 120 days per year
- Fractionalize part time employees by month, **BUT** **ONLY** for the large employer calculation (see *next slide*)



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For purposes of determining large employer status, employers should count employees during the previous calendar year.

Statute says “on average” and in the context of COBRA this means more than 50% of the employer’s business days.

III. Employer Penalties

Example of fractionalizing part time employees

Assume 20 employees

Each work 24 hours per week (96 hours per month)

20 employees @ 96 hours per month = 1,920 hours

1,920 hours / 120 hours per month =

16 Full Time Employees



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This calculation **is only used** to determine if the employer is a “large” employer for purposes of assessing the penalty.

No penalty assessed for part time employees that obtain coverage through the health care exchange and receive the premium tax credit and/or cost sharing subsidy.

III. Employer Penalties

When is an employer penalized?

Employers are penalized when one or more full time employees obtain coverage through the Health Care Exchange **AND** receives a Premium Tax Credit **OR** Cost Sharing Subsidy

Note: Employers **ARE NOT** penalized when part time employees receive a PTC

Employers **ARE NOT** penalized if employee receives FCV



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As a general rule a full time employee is not entitled to premium tax credit or cost sharing subsidy (i.e. employer will not be penalized) if:

- (1) There is employer provided coverage that is sufficient (i.e. 60% of cost of benefits are covered);
- (2) The employee's share of the premiums does not exceed 9.5% of household income; or
- (3) The employee's household income exceeds 400% of the FPL.

3 Employer Penalties

Example:

ABC Company has 140 employees and 105 are full time employees (i.e. work at least 30 hours per week) and 35 part time employees.

1st Scenario – ABC Company does not offer any health coverage

2nd Scenario – ABC Company offers health coverage but 25 full time employees receive Premium Tax Credit



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This example assumes the employer had more than 50 full time employees during the previous calendar year.

This example also assumes that at least one full time employee does receive coverage and the premium tax credit through the health care exchange.

Employer Penalties

1st Scenario

If an employer does not offer any coverage **AND** at least 1 full time employee receives the Premium Tax Credit (PTC), **THEN**

The Penalty = (the # of full time employees) MINUS (30) TIMES (\$2,000)

ABC Company

Penalty is \$ 150,000 = (105 full time employees – 30) x \$ 2,000

Note that the 35 part time employees for the ABC Company are disregarded when calculating the penalty.

The penalty is calculated on a monthly basis (i.e. \$166.67 / mo.)



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The example shows the penalty on an annual basis BUT the penalty must be calculated on a monthly basis which will be administratively challenging.

A large employer that does not offer coverage has the following government reporting obligations:

- A statement that it does not offer coverage
- The number of full time employees, PLUS
- Anything else the government may require

Employer Penalties (Cont.)

2nd Scenario

If an employer offers any coverage BUT it is not 60% actuarial value, OR the employee's cost exceeds the 9.5% of the employee's household income threshold,

THEN the penalty is the lesser of:

The number of full time employees receiving the Premium Tax Credit times \$3,000

OR

(the # of full time employees) MINUS (30) TIMES (\$2,000)

ABC Company

\$ 75,000 = 25 Full Time Employees Receiving PTC x \$3,000

OR

\$ 150,000 = (105 full time employees) 75 x \$2,000

Penalty is lesser of \$75,000 or \$150,000

The penalty is calculated on a monthly basis (i.e. \$250 or \$167 /month).



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A large employer that offers coverage has the following government reporting obligations:

- Name of each individual who can enroll in employer's plan
- The waiting period
- The # of months plan was available
- The monthly premiums of lowest cost option
- The plan's share actuarial value
- The number of full time benefit
- The number of months the employees were covered, **PLUS**
- Anything else the government may require

3 Employer Penalties

	Large employer = 50 or more full-time employees			
	Does not offer coverage		Offers coverage	
	A	B	C	D
<i>Not a large employer: less than 50 full-time employees</i>	No full-time employees receive credits for exchange coverage	1 or more full-time employees receive credits for exchange coverage	No full-time employees receive credits for exchange coverage	1 or more full-time employees receive credits for exchange coverage
<i>No penalty</i>	No penalty	Number of full-time employees minus 30 multiplied by \$2,000	No penalty	Lesser of: Number of full-time employees minus 30 multiplied by \$2,000 Number of full-time employees who receive credits for exchange coverage multiplied by \$3,000

Government prepared chart.

Government publication on penalties at:

<http://www.ncsl.org/documents/health/EmployerPenalties.pdf>.

Cadillac Tax - January 1, 2018

40% excise imposed on insurers if aggregate value of employer sponsored coverage

2010 thresholds are:

\$10,200* single coverage

\$27,500* family coverage

* Adjusted for inflation



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Any coverage under multiemployer plan is automatically considered family coverage. The threshold amounts can be adjusted for age, gender and high risk professions.

Cadillac Tax – January 1, 2018

Notes: Threshold amounts include:

- All employer provided coverage such as:
 - Health FSAs
 - HRAs
 - Employer HSAs
- Excise tax assessed against carrier if full insured and against plan sponsor if self funded
- Penalty is pro-rated if more than one plan (e.g. HDHP and HRA)



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The value of all employer provided health coverage that is excludable from employee's gross income is counted towards the threshold amount.

This includes pre-tax salary deferrals for premiums and FSA contributions.

The excise tax is nondeductible.

Even though paid by the insurer or plan administrator cost will be passed on in the form of higher premiums.

Questions & Answers

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Questions

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