Health Care Reform Update
PURMS Operations Committee – Additional Information

October 31, 2013

Barbara Wills
Seattle, WA
Agenda

Health Reform Update

- 2013 Requirements (a few)
- 2014 Requirements (a lot)
  - Individual Mandate/Exchanges/Tax Credits
  - Health Plan Standards
- 2015 Requirements (a pain)
  - Employer Shared Responsibility
- Health Reform Fees (a drain)
2013 REQUIREMENTS
Insurance Marketplace (Exchange) Notice

• Employers subject to FLSA must provide a notice to all employees, addressing:
  – Existence of public exchanges and subsidies
  – Impact of minimum value on subsidy eligibility
  – Potential loss of employer contribution if exchange coverage purchased

• **Provide to current employees by October 1, 2013 and then to new hires on and after that date**

• Notice has required and optional employer content

• Distribution methods:
  – First class mail or DOL electronic disclosure safe harbor
  – Hand delivery ok?

• COBRA election notice also updated to reference public exchanges

• **New guidance – no penalties or fines for not distributing!!**
SBCs

• Summaries of Benefit Coverage (SBCs)
  – Template for second year is updated to add a statement about Minimum Essential Coverage and Minimum Value
    - New template applies to coverage beginning on or after Jan. 1, 2014, and before January 1, 2015
    - Generally must send with annual enrollment materials to current employees
      - May send currently enrolled employee only the SBC for benefit package in which employee is enrolled
  – FAQs generally extend earlier safe harbors and enforcement relief to 2014
2014 Requirements At A Glance

- Health insurance exchanges
- Individual coverage mandate
- Financial assistance for exchange coverage of lower-income individuals
- States may expand Medicaid
- HIPAA wellness limit
- Employer shared responsibility
- Additional reporting and disclosure
- Dependent coverage to age 26 for any covered employee’s child
- No annual dollar limits

- No pre-existing condition limits
- No waiting period over 90 days
- Additional standards for new or “non-grandfathered” health plans, including limited cost-sharing and deductibles, provider nondiscrimination, and cover routine medical costs of clinical trial participants
- Health insurance industry fees begin
- Temporary reinsurance fees
- Auto enrollment some time after 2014
Implications of the Individual Mandate

- The requirement that individuals have insurance coverage or pay a penalty remains
- Penalties are modest:

<table>
<thead>
<tr>
<th>Year</th>
<th>Greater of</th>
<th>Penalty</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>$95 per person (cap of $285 per family)</td>
<td>or 1.0% of household income</td>
</tr>
<tr>
<td>2015</td>
<td>$325 per person (cap of $975 per family)</td>
<td>or 2.0% of household income</td>
</tr>
<tr>
<td>2016</td>
<td>$695 per person (cap of $2,085 per family)</td>
<td>or 2.5% of household income</td>
</tr>
</tbody>
</table>

- Family members under age 18 get one-half the penalty
- Total penalty is capped at the national average of the annual cost of a bronze level health insurance plan, for the applicable family size, offered through the state health care exchanges

- Exemptions
  - Those who spend more than 8% of income to get health coverage
  - Those who don’t have to file income tax returns. Those not required to file income tax in 2011 earning less than: 1. single under age 65 - $9500: 2. head of household under 65 - $12,200 and 3. married filing jointly both spouses under 65 - $19,000
Public Exchanges

- Insurance plan options available on exchanges that are operated by states or the Federal government (or a State/Federal partnership)

- Exchanges will conduct open enrollment from October 1, 2013 – March 31, 2014

- Generally, if household income is between 138%-400% of the federal poverty level (FPL), and individual does not have access to affordable or minimum value employer coverage, the Federal government will provide subsidies to buy insurance on public insurance exchanges

Note: Most employers provide “affordable” coverage to all benefit-eligible employees. Those employees won’t be eligible for exchange subsidies.

However, employees will be confused and expect guidance regarding choices.
Applying for Exchange Coverage – How will it really work?

1. Individual applies to exchange
   - Provides income data
   - Certifies no access to minimum coverage from employer that is affordable

2. Exchange reviews
   - Reviews for Medicaid or tax credit eligibility
   - Possible spot check to confirm no employer coverage
   - Notifies individual if eligible

3. Individual enrolls
   - Enrolls for subsidized coverage in exchange
   - Tax credits are advanced to carrier; individual pays the remainder

4. Exchange notifies employer and IRS

5. IRS and employer reconcile (2016)
# Health Reform Premium Tax Credit Eligibility

<table>
<thead>
<tr>
<th>Federal Poverty Level %</th>
<th>Not Eligible for Subsidy</th>
<th>Not Eligible for Subsidy*</th>
<th>Eligible for Subsidy*</th>
<th>Medicaid Eligible**</th>
<th>No Employer Penalties</th>
<th>Employer Penalties Apply</th>
</tr>
</thead>
<tbody>
<tr>
<td>0% to 138%</td>
<td></td>
<td></td>
<td></td>
<td>0% - 9.5%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>138% to 400%</td>
<td>Not Eligible for Subsidy*</td>
<td>Eligible for Subsidy*</td>
<td>Employer Penalties Apply</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>400%+</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Employees between 138% - 400% of FPL also eligible for subsidies if employer does not offer coverage (employer penalties will apply).

** Presumes state has elected expansion of Medicaid to 138% of FPL.
Appealing Exchange Premium tax Credit Determinations

• Exchanges must notify an employer when one of its employees is found eligible for subsidies
  – notice will identify the subsidy-eligible employee, note the employer’s potential shared-responsibility assessment, and explain how the employer can appeal the exchange’s decision.
  – the notice will presumably indicate what the employee reported about the employer’s health coverage

• If an employee is found subsidy-eligible after an appeal, the employer’s only recourse will be to use a separate IRS appeals process to challenge the resulting shared-responsibility assessment (in 2016)

• Third-parties are allowed to help employers with the appeals process.

• Although shared-responsibility assessments for employers have been delayed until 2015, employers should prepare to appeal 2014 subsidy determinations that are based on incorrect information about their plans.
  – Subsidy-eligibility decisions made for 2014 could carry forward into 2015 and potentially trigger assessments.
## Who Is Eligible For Subsidized Government Insurance?
Assumes States Expand Medicaid To 138% FPL

<table>
<thead>
<tr>
<th>Household income ≤ 138% FPL</th>
<th>Eligible for Medicaid*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Household income ≤ 400% FPL</td>
<td>Could be eligible for subsidized exchange coverage</td>
</tr>
</tbody>
</table>

### Federal Poverty Level (FPL)

<table>
<thead>
<tr>
<th>Family size of</th>
<th>2013</th>
<th>Medicaid 138% FPL</th>
<th>Exchange 400% FPL</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 (single)</td>
<td>$11,490</td>
<td>$15,856</td>
<td>$45,960</td>
</tr>
<tr>
<td>2</td>
<td>$15,510</td>
<td>$21,403</td>
<td>$62,040</td>
</tr>
<tr>
<td>3</td>
<td>$19,530</td>
<td>$26,951</td>
<td>$78,120</td>
</tr>
<tr>
<td>4</td>
<td>$23,550</td>
<td>$32,499</td>
<td>$94,200</td>
</tr>
<tr>
<td>5</td>
<td>$27,570</td>
<td>$38,046</td>
<td>$110,280</td>
</tr>
<tr>
<td>6</td>
<td>$31,590</td>
<td>$43,594</td>
<td>$126,360</td>
</tr>
<tr>
<td>7</td>
<td>$35,610</td>
<td>$49,141</td>
<td>$142,440</td>
</tr>
<tr>
<td>8</td>
<td>$39,630</td>
<td>$54,689</td>
<td>$158,520</td>
</tr>
</tbody>
</table>

* Health reform legislation specifies income threshold of 133% FPL but also requires states to apply an “income disregard” of 5% of FPL in meeting income test; effective income threshold for eligibility is 138%

** Based on 2013 FPL.

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Plan options in public exchange are named after metals

<table>
<thead>
<tr>
<th>Features</th>
<th>Public exchanges</th>
<th>ER</th>
<th>Group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Bronze</td>
<td>Silver</td>
<td>Gold</td>
</tr>
<tr>
<td>Plan value</td>
<td>60%</td>
<td>70%</td>
<td>80%</td>
</tr>
</tbody>
</table>

- Silver – second-lowest cost plan – is baseline for calculating government subsidy
- Government subsidy and member contribution requirement calculated based on income, vary by level between Medicaid eligibility and 400% FPL
- Once subsidy determined for silver plan, can use for gold plan (pay more) or bronze plan (pay less)

¹Some provisions apply differently for grandfathered and non-grandfathered plans
Eligibility For Medicaid, Subsidies, Cost-sharing Credit Based On Second-lowest Cost Silver Plan In 2014

**Individual in 2014** (Based on 2013 FPL of $11,490)

<table>
<thead>
<tr>
<th>% Poverty level</th>
<th>Annual household income</th>
<th>Plan value with cost-sharing credit</th>
<th>% Household income</th>
<th>Dollars</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;100%</td>
<td>&lt;$11,490</td>
<td>Medicaid / Access gap</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>&lt;138%</td>
<td>&lt;$15,856</td>
<td>Medicaid (if expanded)</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>138%</td>
<td>$15,856</td>
<td>+24% to 94%</td>
<td>3.00%</td>
<td>$40</td>
</tr>
<tr>
<td>150%</td>
<td>$17,235</td>
<td>+17% to 87%</td>
<td>4.00%</td>
<td>$58</td>
</tr>
<tr>
<td>200%</td>
<td>$22,980</td>
<td>+3% to 73%</td>
<td>6.30%</td>
<td>$121</td>
</tr>
<tr>
<td>250%</td>
<td>$28,725</td>
<td>70%</td>
<td>8.05%</td>
<td>$193</td>
</tr>
<tr>
<td>300%</td>
<td>$34,470</td>
<td>70%</td>
<td>9.50%</td>
<td>$273</td>
</tr>
<tr>
<td>400%</td>
<td>$45,960</td>
<td>70%</td>
<td>9.50%</td>
<td>$364</td>
</tr>
<tr>
<td>&gt;400%</td>
<td>&gt;$45,960</td>
<td>70%</td>
<td>No maximum</td>
<td>Full cost</td>
</tr>
</tbody>
</table>
2014 HEALTH PLAN STANDARDS
## 2014 Health Plan Standards
### Summary

<table>
<thead>
<tr>
<th>For all plans—plan years beginning on or after January 1, 2014</th>
<th>Additional standards for non-grandfathered plans for plan years starting on or after Jan. 1, 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>No waiting periods exceeding 90 days</td>
<td>Annual cost sharing limits</td>
</tr>
<tr>
<td>Offer coverage to dependent children to age 26 with no limitations</td>
<td>Provider nondiscrimination rules</td>
</tr>
<tr>
<td>No annual dollar limits on essential health benefits</td>
<td>Cover routine care for patients in clinical trials</td>
</tr>
<tr>
<td>Changed wellness incentives</td>
<td></td>
</tr>
<tr>
<td>No preexisting condition exclusions</td>
<td></td>
</tr>
</tbody>
</table>

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Annual or lifetime dollar limits and Essential Health Benefits (EHBs)

- Ten Essential Health Benefits categories listed in ACA statute:
  - Preventive & wellness services & chronic disease management.
  - Mental health & substance use disorder benefits, including behavioral health treatment.
  - Pediatric services, including oral & vision care.
  - Rehabilitative & habilitative services & devices.
  - Ambulatory patient services.
  - Emergency services.
  - Hospitalization.
  - Maternity & newborn care.
  - Prescription drugs.
  - Laboratory services.

- Self-funded plans and large insured plans are not required to cover EHBs.
  - Plans cannot place a dollar limit on a covered EHB.

- Options:
  - Eliminate all dollar limits — replace with visit limits, treatment limits, etc.
  - Determine what is an EHB and eliminate the dollar limits on those benefits only.
How do self-funded and large insured plans determine EHBs?

- For 2014–15, the federal government gave each state authority to develop its own detailed definition of EHBs, subject to federal guidelines.
  - Each state has a “benchmark” plan for determination of EHBs.

- The state benchmark plans are posted on the CMS website.
  - The summaries may not contain all of the details necessary to determine what benefits are covered.
  - Use the state benchmark plans in conjunction with the CMS Guide for Reviewing Essential Health Benefits.

- Certain state benchmarks are less rich, potentially allowing plans to retain a greater number of dollar limits.
What are some services or treatments that frequently have annual or lifetime dollar limits?

- Infertility treatments.
- Chiropractic care.
- Reconstructive surgery.
- Applied behavioral therapy.
- Acupuncture.
- Bariatric surgery and related treatments.
- Temporomandibular joint disease (TMJ).
- Prescribed drugs for nicotine addiction.
- Hearing aids.
- Durable Medical Equipment.

Coverage of the above services/treatments differs among the benchmarks
## Taking action on EHBs and annual and lifetime dollar limits

<table>
<thead>
<tr>
<th>Step</th>
<th>Plan Actions</th>
</tr>
</thead>
</table>
| □ 1. | Does the plan have an annual or lifetime dollar limit?  
       | - List the annual and lifetime dollar limits and benefits to which they apply.  
       | - Confirm listing with third party administrator/insurer.  
       | - Complete steps 2, 3, and 4. |
| □ 2. | Do you want to retain the dollar limit on each benefit?  
       | - What is the cost of eliminating the dollar limit for each of these benefits?  
       | - Are there permitted alternatives that would achieve the same results, e.g., visit limits? |
| □ 3. | Identify the annual and lifetime dollar limits that are important to you and, if there is more than one, consider their relative importance. |
| □ 4. | Examine logical benchmark plans for whether they treat the benefit with a dollar limit as an EHB.  
       | - State in which headquartered or in which employees are located.  
       | - Federal Employees Health Benefit Plan.  
       | - Other states.  
       | - Identify the benchmark plan(s) that allow the plan sponsor to retain the maximum number of key annual limits. |
Maximum 90-day waiting period

- For plan years beginning on or after January 1, 2014, the ACA prohibits group health plans and health insurers from imposing a waiting period for coverage that exceeds 90 days.
  - All calendar days count — strict 90 days (not first of month following or three months).

- The waiting period may begin after an employee or a dependent has met a plan’s other eligibility conditions for coverage.
  - i.e., eligible position, complete certain training.

- Eligibility conditions that are based solely on the lapse of a time period would be permissible for no more than 90 days.
Maximum 90-day waiting period (cont.)

- Plan may require employees to complete a specific number of hours of cumulative service to be eligible for coverage on a one time basis, as long as the total hours required do not exceed 1,200.

- Variable Hour Employees
  - Plan may use a measurement period of up to 12 months to determine whether an employee is eligible if a specified number of hours of service per period is a plan eligibility condition and it cannot be determined that a newly hired employee is reasonably expected to regularly work that number of hours per period.
  - But if hours of service can be reasonably predicted, 90 day rule applies.
    - Risk for employers that apply a measurement period to employees who are not variable hour.
Health Plan Standards – Non-Grandfathered Plans only
Annual Cost Sharing and Deductible Limits

• Annual cost sharing and deductible limits for all new and non-grandfathered plans, for plan years beginning on or after Jan. 1, 2014
  – Initially limited to the out-of-pocket maximum for HDHPs used with Health Savings Accounts ($6,350/individual, $12,700/family in 2014), then after 2014 indexing formula differs from HDHPs
  – Appears that only in-network, essential health benefits are subject to this limit—following in-network costs combined must not exceed OOP maximum limits:
    - Deductibles
    - Copayments
    - Coinsurance
    - Any other enrollee payments for covered in-network EHBs, but not premium payments
  – Cost sharing for integrated benefits (i.e., Rx) must generally accumulate to the OOP max (subject to transition relief)
Health Plan Standards – Non-Grandfathered Plans only

Annual Cost Sharing and Deductible Limits

• Transition Relief for 2014 for carved-out benefits:
  – A plan may have separate OOP maximums for benefits administered by different claims payers if each maximum, viewed alone, doesn’t exceed limit
  – Appears that a plan may have no OOP maximum for non-major medical coverage administered by a different claims payer if major medical coverage complies with OOP maximum limit
    - Relief does not apply to mental health benefits due to mental health parity

• Full compliance required in 2015

• Insured Plans, small market: Only non-grandfathered insured plans in the small market must cover essential health benefits with limited deductibles (initially $2,000/individual, $4,000 family)
Health Plan Standards
Wellness Plans

• Final rules released May 29, 2013, applicable for plan years beginning on or after Jan. 1, 2014
  – Employer-sponsored wellness plans should be reviewed for compliance with the final rules
  – Rules apply to grandfathered/non-grandfathered plans
  – Compliance with these rules doesn’t determine compliance with other applicable laws, such as the ADA or GINA

• Limit on the maximum size of wellness reward/penalty for wellness programs other than participation-only
  - Increased from 20% to 30% of the cost of coverage, and up to 50% for tobacco programs
Health Plan Standards
Wellness Plans

• When reasonable alternative must be offered
  – Activity-based: individual has to perform activity related to a health factor to obtain a reward, but individual doesn’t need to achieve a specific health outcome (Examples: walking, diet, or exercise programs)
    - May restrict alternative to individuals for whom it would be unreasonably difficult or medically inadvisable to attempt to satisfy the standard
    - Can require physician’s verification of condition, if reasonable
  – Outcome-based: individual must achieve specific health outcome to obtain reward
    - Alternative (or waiver) must be available to any individual who does not meet the standard based on a measurement test or screening
      - Cannot require physician’s verification of condition
  – If individual’s personal physician states that the plan standard is not medically appropriate, the plan must provide a reasonable alternative that accommodates the physician’s recommendations
  – If standard or alternative achieved, reward must be retroactive to beginning of year
Health Plan Standards – Non-Grandfathered Plans only
Clinical Trials

• As of first day of 2014 plan year, plans must permit participation in approved clinical trial treating cancer or other life threatening disease or condition, and:
  – May not deny, limit, or impose additional conditions on routine patient costs for items and services provided in connection with clinical trial
  – May not discriminate against participation in clinical trial

• No regulations will be issued before effective date
  – Plans to use good faith, reasonable interpretation of law
  – Regulators to work with plans toward compliance
Health Plan Standards – Non-Grandfathered Plans only

Clinical Trials

• What can plans continue to exclude under the ACA?
  – The investigational item, device, or service, itself
  – Items/services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient
  – A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis
Health Plan Standards – Non-Grandfathered Plans only
Provider Nondiscrimination

• As of first day of 2014 plan year, plans can’t discriminate against providers acting within scope of license concerning participation in the plan or coverage
  – Not any willing provider requirement
  – Ok to have different reimbursement rates based on quality or performance measures

• Intended scope unclear, but no regulations will be issued before effective date—look to ACA itself until guidance is issued

• Plans to use good faith, reasonable interpretation of law
  – Regulators to work with plans toward compliance
  – Review requirement with third party administrator
Health Plan Standards
Annual Limits/HRAs

• DOL FAQs address interaction of annual limits with HRAs
  – Future guidance expected requiring HRAs with annual limits to be integrated with other coverage that satisfies the annual and lifetime limits on essential health benefits
    - Unless otherwise exempt from market reform mandates—so stand-alone retiree-only HRAs are permissible
  – “Integrated” means HRAs must be limited to employees who actually enroll in the employer group coverage
  – Eliminates most stand-alone HRAs for active employees effective in 2014, with some transition relief
  – HRAs used to purchase individual coverage (whether or not through public exchanges) also impermissible
2015
EMPLOYER MANDATE TO COVER FULL-TIME EMPLOYEES OR “SHARED RESPONSIBILITY”
Shared Responsibility Employer Mandate Delayed Until 2015

Employers should continue to prepare for implementation

- The delay gives employers a realistic timeframe to implement tracking, measuring and monitoring processes for full-time status
- Additional guidance could provide clarifications, but major provisions expected to remain intact
- Many employers will want to commence assessment of employee full-time status later this year
Penalties can be triggered for employers with 50 or more FTEs beginning January 1, 2015.

**Determining 50 FTEs and “large employer” status**

Step 1: Calculate the number of full-time employees (30 hours/wk) for each calendar month in the preceding calendar year.

Step 2: Calculate the number of full-time equivalents for each calendar month in the preceding calendar year (total part time hours per month divided by 120)

Step 3: Add the number of full-time employees and full-time equivalents obtained in Steps 1 and 2 for each month of the preceding calendar year.

Step 4: Add up the 12 monthly numbers from Step 3 and divide the sum by 12. This is the average number of full-time employees for the preceding calendar year.

Step 5: If the number obtained in Step 4 is less than 50, then the employer is not subject to shared responsibility in the current calendar year. If the number obtained in Step 4 is 50 or greater, the employer is a large employer and subject to the law.
## Employer Shared Responsibility

### NON-OFFERING EMPLOYER PENALTY

- Assessed when an employer does *not offer* minimum essential coverage to 95% of its full-time employees and the children of those full-time employees *and* at least one full-time employee receives income-based assistance to buy coverage from the public exchange.
  - Monthly penalty: $166.66 times the number of full-time employees minus the first thirty during that month ($2,000 annualized)
Employer Shared Responsibility

What does it mean to “offer” coverage?

- What does it mean to “offer coverage” such that “non-offering” penalty does not apply?
  - Offering coverage to all but 5% (or, if greater 5) of its full-time employees
  - Offering coverage to employee’s children to age 26
    - Children must include biological, adopted, step and eligible foster children
    - Not spouses or domestic partners
  - Coverage must be “minimum essential coverage” (MEC), which includes employer-sponsored self-insured or fully insured coverage, except for certain “excepted” benefits
  - Employers might offer MEC-only (i.e., unaffordable or not minimum value) coverage to avoid paying “non-offering employer penalty”
    - Recent WSJ article explored “preventive care-only” option
  - Effective opportunity to enroll at least once per year

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Employer Shared Responsibility

OFFERING EMPLOYER PENALTY

- Assessed when an employer offers minimum essential coverage to 95% of its full-time employees and the children of those full-time employees but that coverage is unaffordable or does not satisfy the 60% minimum value requirement and the employee receives income-based assistance to buy coverage from the public exchange.
  - Monthly penalty could also apply if a full-time employee in the 5% or less not offered coverage receives income-based assistance to buy coverage from the public exchange.
  - Monthly penalty: $250.00 times the number of full-time employees who receive income-based assistance to buy coverage on the public exchange for that month ($3,000 annualized)
## Employer Shared Responsibility
### 30-hour Work Week Requirement

<table>
<thead>
<tr>
<th>Who Is A Full-Time Employee?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anyone employed on average at least 30 hours of service per week during a month</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>How Do We Determine Full-Time Employee Status?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Likely more guidance to come – IRS safe harbor under current guidance:</td>
</tr>
<tr>
<td>– For ongoing employees, employers can choose a period from three to 12 months and determine average hours worked during that period – called the measurement period</td>
</tr>
<tr>
<td>– Subsequent “stability period” must be at least six consecutive months thereafter and cannot be shorter than the look back period</td>
</tr>
<tr>
<td>– Individualized measurement/stability period for new hires</td>
</tr>
<tr>
<td>– If the employee was full-time/not full-time during the measurement period, the employee is treated as full-time/not full-time during the stability period</td>
</tr>
<tr>
<td>– 90-day maximum “administrative” interval between the measurement and stability period (i.e., could have 10/15-10/14 measurement period and 1/1–12/31 stability period)</td>
</tr>
</tbody>
</table>
Employer Shared Responsibility
Hours of Service

Hours of Service

- **Hours of Service** include all hours for which an employee is paid or entitled to payment, including:
  - Vacations
  - Holidays
  - Leaves for illness, disability or other incapacity
  - Jury or military duty

Averaging Rules for Special Unpaid Leaves of Absence

- Special rules may be applied when a lookback period includes an unpaid leave of absence for FMLA, jury duty, or military leave under USERRA
  - **Option 1:** Exclude the period of the leave in determining the average number of hours of service per week during the Measurement Period
  - **Option 2:** Credit the employee with Hours of Service for the weeks of unpaid leave at a rate equal to the employee’s average weekly rate during weeks when no special unpaid leave was taken
**Illustration 1: The Basic Structure of the Look-Back Rule**

<table>
<thead>
<tr>
<th>CYCLE 1</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>STANDARD</td>
<td>ADMIN</td>
<td>STABILITY</td>
</tr>
<tr>
<td>CYCLE 2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>STANDARD</td>
<td>ADMIN</td>
<td>STABILITY</td>
</tr>
</tbody>
</table>

1. Between three months to 12 months in length, at employer’s choice

2. Up to 90 days in length

3. No shorter than Cycle 1 measurement period, and at least six full calendar months long for eligible employees

4. No shorter than Cycle 2 measurement period, and at least six full calendar months long for eligible employees
Illustration 2: Look-Back Period for Ongoing Employees
Calendar Year Plan

- Employer has selected a Standard Measurement Period of 12 months.
- Employer has selected an Administrative Period of 2 1/2 months which starts at the end of the Standard Measurement Period and ends immediately before the first day of the Plan Year.
- A variable hour employee works an average of 30 Hours of Service per week during each Standard Measurement Period.
- The variable hour employee must be offered coverage for each Stability Period.
- Employer offers affordable, minimum-value coverage for all of 2014 to ongoing employee who meets full-time status during Cycle 1’s standard measurement period and/or for all of 2015 to ongoing employee who meets that status during Cycle 2’s standard measurement period.
Employer Shared Responsibility

• New Full-Time or Non-Seasonal Employees
  – If reasonably expected to work full-time, must be offered ability to enroll by the beginning of the fourth calendar month of employment, but no more than 90 days

• New Variable Hour or Seasonal Employees
  – If it cannot be determined that the employee is reasonably expected to work 30 hours per week, employer can apply measurement/stability period to employee and not offer coverage until employee meets full-time average
  – Employee who is determined to be full-time during measurement period must be offered ability to enroll no later than the first day of second month after the employee’s one year anniversary date (13 months and a fraction of a month)
Employer Shared Responsibility

- “Seasonal” not defined – reasonable, good faith interpretation of the term required if initial measurement period will be applied to an employee working more than 30 hours per week
  - Proposed regulations use an example of a ski instructor working 50 hours per week from November – March

- Temporary employees or employees working for a limited duration cannot automatically be considered seasonal or variable hour employees
  - Beginning in 2015, employers cannot take into account that an employee may terminate prior to the end of the initial measurement period unless truly seasonal
If Sam meets full-time status in his initial measurement period, his employer will offer him affordable, minimum-value coverage during his entire initial stability period.

If Sam meets full-time status during the standard measurement period, his employer will offer him affordable, minimum-value coverage during the entire standard stability period, regardless of whether Sam met that threshold during his initial measurement period.
Employer Shared Responsibility
Overview of Strategy Options for Variable Hour Populations

1. Adopt Safe-Harbor Look Back/Stability Period
2. Adopt Other Measurement Period – risk of rejection by the IRS
3. Manage Employee Hours to Under 30
4. Do nothing - High risk of penalties

Remember: The ultimate goal is to be able to defend against an employee claim of full-time status with no offer of coverage.

Do you have a process for tracking full-time status that meets that goal?
Employer Shared Responsibility
Affordability

Do you have an affordable plan?

Coverage is considered affordable as long as an employee’s required contribution for self-only coverage does not exceed 9.5% of the employee’s household income for an employer plan’s lowest-cost option.

- Affordability safe harbors:
  - **W-2 wages** – employee’s contribution does not exceed 9.5% of the employee’s wages reported in Box 1 of Form W-2.
  - **Rate of pay** – employee’s contribution is equal to or lower than 9.5% of monthly wages. An employer would multiply each eligible hourly employee's rate of pay at start of plan year by 130 hours per month. For salaried employees, monthly salary would be used.
  - **Federal poverty line** – employee’s contribution does not exceed 9.5% of FPL for a single individual.

Wellness Incentives—cannot treat reduced premiums available through wellness program as earned, except for wellness programs related to tobacco use.

- Mercer estimates that a plan will be affordable for all participants with a self-only contribution of $129 or less (in states where Medicaid expansion is adopted) or $94 or less (in states where Medicaid expansion is not adopted).
What is the “minimum value” test?

- The plan must be designed to pay at least 60% of covered benefit
- Approach for determining minimum value
  - HHS calculator
  - Safe harbor checklists
  - Actuarial certification
- Most plans offered today are significantly over the 60% threshold; But employers may move closer to the minimum in the future

Does the minimum value test require coverage of specific benefits?

- Coverage of essential benefits appears to be incorporated into MV calculations
HEALTH REFORM FEES/TAXES
## Health Care Reform Fees
### Summary

<table>
<thead>
<tr>
<th>Fee</th>
<th>Effective Year</th>
<th>Who Pays</th>
<th>Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Manufacturers of Branded Prescription Drugs</strong></td>
<td>2011 and continues thereafter</td>
<td>Companies who manufacture or sell branded prescription drugs to certain government programs</td>
<td>Fees likely to be passed through indirectly to employers (impact unclear)</td>
</tr>
<tr>
<td><strong>Patient-Centered Outcomes Research Institute (PCORI) Fee</strong></td>
<td>Policy or plan year that ends on or after Oct. 1, 2012, and before Oct. 1, 2019</td>
<td>Insurer for fully insured plans; group health plan sponsor for self insured plans (e.g., employer maintaining a single-employer plan)</td>
<td>$1.00 PMPY for policy or plan years ending on or after Oct. 1, 2012 but before Oct. 1, 2013, increasing in subsequent years</td>
</tr>
<tr>
<td><strong>Manufacturers of Medical Devices</strong></td>
<td>2013 and continues thereafter</td>
<td>Companies who manufacture or sell medical devices</td>
<td>2.3% of every sale</td>
</tr>
<tr>
<td><strong>Fee on Health Insurance Providers</strong></td>
<td>Begins in 2014 and continues thereafter</td>
<td>Health insurance companies offering fully insured coverage</td>
<td>Estimated 1.9% - 2.3% in 2014</td>
</tr>
<tr>
<td><strong>Transitional Reinsurance Fee</strong></td>
<td>2014 and sunsets in 2016</td>
<td>Insurance providers; self-insured plan is liable (but TPA or ASO may transfer fee at plan’s discretion)</td>
<td>Estimated $63 PMPY for 2014, decreasing in subsequent years</td>
</tr>
</tbody>
</table>
Health Care Reform Fees
Transitional Reinsurance Fee

• Begins in 2014 and sunsets in 2016
  – To fund reinsurance pools to help stabilize the individual insurance marketplace, and to provide revenue to the federal government
  – Total national amounts to be collected are highest in 2014, and decreasing in 2015 and 2016
  – Some guidance issued; more expected

Fee = Average number of covered lives (includes dependents) during benefit year x national contribution rate for benefit year

• “National contribution rate” will be released each year by HHS
• HHS estimates the monthly reinsurance fee will be $5.25 per enrollee for 2014 (PMPY fee of $63)
• Estimates not released for 2015, 2016
Health Care Reform Fees
Transitional Reinsurance Fee

• Paid annually by the “contributing entity”
  – Insured plans: insurance providers (carriers will likely build this fee/tax into renewal pricing)
  – Self-insured plans: the plan
    - HHS clarified that the self-insured group health plan sponsor (not TPA) is liable (TPA or ASO may transfer the fee on behalf of self-insured health plan, at plan’s discretion)

• Proposed timeline for 2014 payment
  – By Nov. 15, 2014 – contributing entity submits to HHS average number of covered lives (using counting methods similar to PCORI counting methods)
  – By Dec. 15, 2014 (or 30 days after submission of annual count, whichever is later) – HHS notifies contributing entity of amount due
  – 30 days after HHS notification – contributions due for the benefit year (i.e., generally first annual payment for the year 2014 will be due in late 2014 or early 2015)

• Which plans must pay the fee?
  – Self-insured and insured plans offering major medical coverage
  – For insured plans, state-approved coverage that is part of commercial book of business only
# Health Care Reform Fees

## Transitional Reinsurance Fee

<table>
<thead>
<tr>
<th>Year</th>
<th>Transitional Reinsurance Fund</th>
<th>US Treasury</th>
<th>Total</th>
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</thead>
<tbody>
<tr>
<td>2014</td>
<td>$10,000,000,000</td>
<td>$2,000,000,000</td>
<td>$12,000,000,000</td>
</tr>
<tr>
<td>2015</td>
<td>$6,000,000,000</td>
<td>$2,000,000,000</td>
<td>$8,000,000,000</td>
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<tr>
<td>2016</td>
<td>$4,000,000,000</td>
<td>$1,000,000,000</td>
<td>$5,000,000,000</td>
</tr>
</tbody>
</table>

**Estimated covered lives in US under private insurance**
- Based on 2010 Census: 196,100,000
- Adjusted for change in insurance market: 200,000,000

**Fee PMPY**

<table>
<thead>
<tr>
<th>Year</th>
<th>Fee PMPY</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>$63.00*</td>
</tr>
<tr>
<td>2015</td>
<td>$40.00**</td>
</tr>
<tr>
<td>2016</td>
<td>$25.00**</td>
</tr>
</tbody>
</table>

* Based on HHS estimate issued on March 11, 2013 in final rule
**Mercer estimates calculated based on 200,000,000 estimated covered lives
## What is the Excise Tax?

- 40% excise tax on “high cost” coverage, including medical, health FSA contributions, onsite medical clinics, and employer contributions to HSAs (including HSA contributions through payroll deduction)
  - Does not include stand-alone insured dental and vision coverage
- Initial cap set at $10,200/single and $27,500 family
  - Higher thresholds ($11,850/$30,950) for retirees and workers in high-risk professions
  - Higher threshold ($27,500) for single multiemployer plan coverage
  - Indexed to CPI (for 2019 only, CPI+1%)
- Aggregate cost determined using a methodology similar to that used for determining applicable COBRA premiums
- Employers must determine aggregate cost
  - Insurers responsible for tax for insured coverage
  - Benefit administrators responsible for tax for self-insured coverage
  - Employers responsible for tax for HSA contributions
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