Warehouse Employees Union Local No. 730 Health and Welfare Trust Fund

Affordable Care Act Compliance—Current Status and Update on Pending Issues for 2013 and 2014

August 2013

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August 8, 2013

Board of Trustees
Warehouse Employees Union Local No. 730 Health and Welfare Trust Fund
911 Ridgebrook Road
Sparks, Maryland 21152-9451

Re: **Affordable Care Act Compliance – Current Status and Update on Pending Issues for 2013 and 2014**

Dear Trustees:

The Affordable Care Act ("ACA") applied to the Fund beginning on January 1, 2011.

On September 10, 2010, we issued our initial ACA report for the Fund.

This report provides an opportunity to discuss the Fund's current ACA compliance status, pending compliance issues for 2013 and 2014, and the health care system's structural changes that take effect in 2014.

It is based on our interpretation of the regulations issued to date and is subject to guidance from Fund Counsel. We anticipate supplementing this report periodically as additional information and guidance emerge.

We look forward to presenting this report and answering any questions you may have.

Sincerely,

Joshua Timm
Vice President and Benefits Consultant

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Introduction

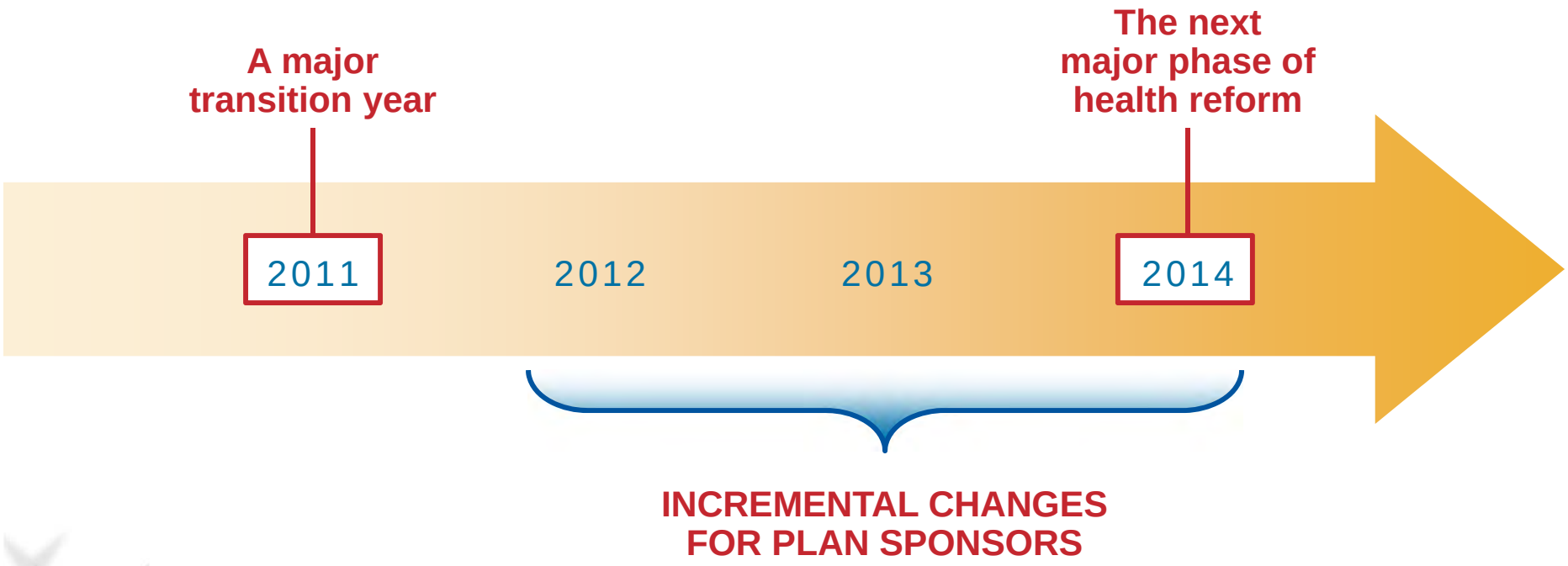
- ACA applied to the Fund effective January 1, 2011
- On September 10, 2010, we issued an initial ACA Report that provided information about significant issues affecting the Fund
- This report provides the following:
  - An opportunity to discuss the Fund's current ACA compliance status,
  - Description of compliance issues that will affect the Fund for 2013 and 2014, and
  - Overview of major structural changes coming in 2014

As always, plan sponsors should rely on Legal Counsel for authoritative advice on the interpretation and application of federal laws and regulations.

Affordable Care Act (ACA)

Where We've Been and Where We're Heading

- The Act's three-year anniversary: March 23, 2013



Early Changes for Multiemployer Plans

- **Small business tax credit:** IRS allows contributing employers to apply for tax credit through 2013 *if health coverage is insured*
- **W-2 reporting:** IRS exempts employers contributing to multiemployer plans from need to include cost of coverage on W-2s (transitional rule)

Latest Changes for Multiemployer Plans

- Proposed rule on how contributing employers are affected by the **Employer Shared Responsibility Penalty** (published January 2, 2013)
- Overview of **Employer Shared Responsibility Penalty** ***(Delayed)***
  - Purpose is to encourage employers to continue providing health coverage
  - Applies to employers with 50 or more full-time employee equivalents
  - Will be assessed only when one full-time employee obtains subsidized coverage through one of the ACA-required health insurance Exchanges
  - Penalty calculated differently depending on whether employer offers health coverage or does not offer coverage

Multiemployer Rule through 2014 *(Delayed)*

- A large contributing employer will not have to pay the penalty in 2014 if:
  - The employer is required by a collective bargaining agreement to make contributions, with respect to some or all of its employees, to a multiemployer plan,
  - The multiemployer plan offers coverage to individuals who meet the plan's eligibility conditions, and
  - The coverage is affordable and provides minimum value, and is offered to dependent children under 26.
- Employer determines whether an employee is a full-time employee by looking at hours worked for that contributing employer (not for all contributing employers combined)
- Any penalty owed would be paid by the contributing employer, not by the plan

Affordability and Minimum Value

- **Special transition rule for contributing employer to measure affordability**
  - Affordable if employee's contribution for self-only coverage (if any) does not exceed 9.5% of the wages reported by the contributing employer to the multiemployer plan for that full-time employee
  - Wages may be determined based on actual wages or an hourly wage rate under the applicable bargaining agreement
- Other safe harbor measures of affordability that employers may use:
  - W-2 wages (Box 1)
  - Rate of pay (monthly rate would equal 130 hours multiplied by the employee's hourly rate of pay)
  - Federal Poverty Level for a single person
- Minimum value is the 60% test: is the plan's share of total costs of benefits 60% or greater (on average)?

Employer Penalty

Key Action Items for Fund

- Review dependent eligibility rules and contribution strategies
- If there are employee contributions for self-only coverage, determine whether affordable
- Calculate minimum value
  - Minimum Value (MV) Calculator
  - Design-Based Safe Harbors
  - Certification by Actuary if above methods not suitable due to plan design
- Even though employer penalty has been delayed, multiemployer plans will need to:
  - Determine minimum value for the Summary of Benefits and Coverage (SBC) for the plan year beginning on January 1, 2014, and
  - Provide contributing employers with information about minimum value and affordability so that employers can send notices to employees about the health insurance Exchanges (discussed later in this report)

Overview of Compliance Status

Grandfathered Plan

- Fund Counsel has determined that the Fund remains grandfathered; the Fund has included a notice of grandfathered status in its 2011-2013 Summaries of Material Modifications (SMMs)
- The Fund's definition of "Eligible Dependent" was amended effective January 1, 2011 to extend coverage to participants' children under age 26 who are not eligible for their own employment-based health coverage (including coverage available through the dependent's spouse, if any)
- Special enrollment of adult children under age 26 (who do not have access to their own employer-sponsored health coverage) was conducted in February 2011. Eligibility is continuing without a cut-off date, with coverage effective on the first day of the month following the date of the request and enrollment by the Fund Office
- The Fund's Class E Plan eliminated its pre-existing condition exclusion on children under age 19 effective January 1, 2011

Overview of Compliance Status

Grandfathered Plan

- The Fund's Class E Plan eliminated its $1,000,000 lifetime benefit maximum effective January 1, 2011 and adopted an escalating annual dollar limit on Essential Health Benefits. Eligibility for enrollment was extended to any individuals whose coverage ended previously because they reached the former lifetime benefit maximum. The annual dollar limit for 2013 is $2,000,000
- Effective January 1, 2011, the Fund's Class E Plan's $100,000 lifetime dollar limit on organ transplant benefits was eliminated
- According to information available on the Early Retiree Reimbursement Program (ERRP) website, the Fund did not participate in ERRP

Group Health Plan Mandates

Key Action Items Remaining

- Continue to review potential changes for impact on grandfathered status; while the Fund remains grandfathered, continue to include notice of grandfathered status in materials about the Fund's benefits; if the Fund loses its grandfathered status, it will need to begin complying with the group health mandates that apply to non-grandfathered plans, including the latest FAQ guidance (*e.g.*, preventive services without cost sharing, emergency room services, internal claims and appeals, and external review)
- Review the Fund's process for determining if adult children have their own employment-based health coverage to confirm that it is being administered consistently and fairly; eliminate this exclusion as of January 1, 2014
- Issue the Fund's Year 2 Summaries of Benefits and Coverage (SBCs) at least thirty (30) days prior to the start of the 2014 Plan Year

Group Health Plan Mandates

Key Action Items Remaining

- Ensure that the Fund's Class E Plan's $2,000,000 annual maximum benefit is eliminated effective January 1, 2014
- The Fund's Class E Plan's pre-existing condition exclusion on adults must be eliminated effective January 1, 2014
- The Fund's self-insured Class E Plan does not have annual dollar limits on specific benefits, but it does have a $1,500 lifetime limit on TMJ. The Fund's Optimum Choice HMOs have annual dollar limits on Chiropractic Services ($500/policy year), Durable Medical Equipment ($2,500 per policy year), Ostomy and Urological Services ($2,500/policy year), and Prosthetic Devices ($2,500/policy year).
  - The Fund's health insurance carrier and TPA should confirm that the above list of specific benefits subject to lifetime or annual dollar limits is complete, and the carrier should explain its rationale for keeping the annual dollar limits listed above
  - To the extent that dollar limits apply to specific benefits, the Fund will need to identify a benchmark health plan for defining Essential Health Benefits (EHBs)

Group Health Plan Mandates

Key Action Items Remaining

- The Fund should then compare its specific benefits with dollar limits against the EHBs in its benchmark plan to determine whether the identified dollar limits are still permissible

- The Fund's Summary Plan Description (SPD) should be updated for the many Plan changes made since the SPD was last issued (*i.e.*, the Class C and Class E SPD was last updated in September 2007). The Fund's Evidence of Coverage Booklets should also be reviewed and updated as necessary

- The Fund's insurance carrier, United Health Care, should confirm that the Fund's insured Optimum Choice HMO for active Class C employees and its insured Optimum Choice HMO for pre-Medicare Class E retirees fully complies with all ACA requirements for grandfathered health plans effective to date and that no changes have been made that would affect the Fund's grandfathered status

- Review guidance on the ACA's ban on waiting periods over 90 days to assess extent of impact, if any, on the Fund's eligibility rules

Group Health Plan Mandates

Key Action Items Remaining

- The Fund's self-funded vision plan (provided through Group Vision Associates on an ASO basis) covers several types of services subject to annual dollar limits (*i.e.*, eye examinations - $35.00; single vision lenses - $9.00; bifocal or trifocal lenses - $14.00; contact lenses - $55.00; and frames - $15.00). The Fund should review with Fund Counsel whether these annual dollar limits should be eliminated on coverage provided to individuals under age 19 in view of the ACA's prohibition on annual dollar limits on pediatric vision coverage
- Fund Counsel should confirm that the Fund's retroactive termination policy is consistent with the ACA's prohibition of rescission of coverage unless due to fraud or material misrepresentation of fact
- Fund Counsel should confirm that changes made to the Fund's health plan options to comply with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) did not affect the Fund's grandfathered status under the ACA

New Requirements for 2013

All Plans (grandfathered and non-grandfathered):

- Comparative Effectiveness Research Fees (final rule published December 6, 2012) (discussed later in “Fees” section)
- Plans to Certify Compliance with Certain HIPAA Electronic Data Interchange (EDI) Standards (certification not required until certification process is developed by government)

Summary of Benefits and Coverage (SBC)—Year Two

- SBCs must be distributed at the following times:
  - Annually. If no open enrollment materials, 30 days before the start of the plan year (*i.e.*, for this Fund, by December 2, 2013)
  - Upon request (within 7 business days following receipt of request)
  - To new enrollees, with written application materials (if any); if no such materials, then no later than first day individual is eligible for coverage
  - To special enrollees (such as new spouse added mid-year) (within 90 days of enrollment)
- Government's policy of not enforcing penalties has been extended through Year Two to plan sponsors making good faith effort to comply
- Template for Year Two released April 23, 2013
  - Must state whether the plan meets the 60 percent minimum value standard

Advanced Notice of Material Modification

- Notice of material modification to terms of plan/coverage reflected in the SBC must be provided at least 60 days *prior* to the date the modification becomes effective
- Applies only to mid-year changes that affect content of the SBC

Ban on Waiting Period of More than 90 Days

For All Plans (grandfathered and non-grandfathered), beginning with plan year on/after January 1, 2014:

- Proposed rule applicable through at least 2014 published March 21, 2013
- Waiting period is the time period that must pass before coverage for an employee or dependent *who is otherwise eligible to enroll* becomes effective
- Rule doesn't require coverage for someone not eligible under the terms of the plan
- Under proposed rule, 90 days means 90 calendar days, not three months

90-Day Waiting Period: General Rules

1. "Variable hour employees": those who need to work specified number of hours **over a period of time** to be eligible for coverage, and it cannot reasonably be determined at start date if hours requirement will be met
   - Plan sponsor can take up to one year to determine if eligible for coverage, provided coverage is effective (if eligible) no later than 13 months (plus fraction) from employee's start date, and
   - If plan sponsor uses a shorter measurement period (i.e., less than one year), any waiting period after the measurement period cannot exceed 90 calendar days
2. Cumulative service requirement (up to 1,200 hours):
   - Set number of hours without a time limit during which hours must be worked
   - Plan may require employees to complete up to 1,200 hours of service in order to become eligible, provided coverage is effective no later than 91st day after hours requirement met
3. Eligibility requirements based on earnings/residuals are allowed

Other Group Health Plan Mandates Effective in 2014

For All Plans (grandfathered and non-grandfathered), beginning with plan year on/after January 1, 2014:

- Ban on preexisting condition exclusions (regardless of age)
- No annual dollar limits on essential benefits (no more waivers)
  - Individual spending accounts that the IRS calls “Health Reimbursement Arrangements” (HRAs) are subject to the annual limits rules and need to be “integrated” with primary group coverage that complies with the annual limits rules

Fees

- Comparative Effectiveness Research Fees
- Temporary Reinsurance Program Fees
- Insured Plans Only: Annual Fee on Health Insurance Providers Paid by Carriers in 2014 and Beyond
  - Will be reflected in carrier's rates

Comparative Effectiveness Research Fees

- All plans (insured and self-insured) must pay a fee to fund comparative effectiveness research
  - Plan sponsor pays if coverage is self-insured; issuer pays if coverage is insured
- First effective for plan year beginning January 1, 2012
- First year — $1.00 per average number of covered lives
  - Second year— $2.00 per covered life (indexed starting in third year)
  - Sunsets in 2019
- Paid by July 31 of the calendar year after last day of plan year
  - For this Fund, first year was to be paid by July 31, 2013

Comparative Effectiveness Research Fees

Counting Average Number of Covered Lives

1. Actual Count Method:
   - Add the totals of covered lives for each day of the plan year and divide by number of days in plan year
2. Snapshot Method
   - Add the totals of covered lives on one or more dates during the first, second, or third month of each quarter of the plan year and divide by the number of dates on which a count was made
   - Can do actual count on each of these days, or count participants and use a dependency factor of 2.35 to count family members
3. Form 5500 Method (if 5500 is filed by due date for fees)
   - If plan only offers self-only coverage: sum of participants at beginning and end of plan year, divided by 2
   - If plan also offers family coverage: same as above but do not divide by 2

For plan years beginning before July 11, 2012 (and ending on/after October 1, 2012), a plan sponsor may use any reasonable method to count covered lives.

Payments to Temporary (2014-2016) Reinsurance Programs

- Goal of reinsurance programs is to stabilize the individual insurance market in 2014 – 2016
- Self-insured plans will have to pay fees to help finance these reinsurance programs
- Health insurance issuers will also have to pay fees
- Fees will be based on a per capita (i.e., per person) contribution rate set by federal government
  - Final rate for 2014 is $5.25 per person per month (i.e., $63 per person per year)
  - Per person (not per employee)
- Fees apply to “major medical coverage”

New Requirements for 2013

Non-Grandfathered Plans

Non-Grandfathered Plans Only:

- Preventive Services for Women (apply to plan year beginning on or after August 1, 2012)
- Nondiscrimination Rules for Insured Plans (standards and effective date to be determined in regulations)
- Quality Reporting (awaiting guidance)

Additional Preventive Services

Non-Grandfathered Plans

- More preventive services will be added over time
- Once appropriate governmental body releases new or updated recommendations, plan must provide coverage beginning with the plan year that begins one year later
- For example, for plan year beginning on/after May 21, 2011, new recommendations relating to newborn screening took effect
- Check website at least once each year for updates
  - http://www.healthcare.gov/law/features/rights/preventive-care/index.html
- Plans may use reasonable medical management techniques to control costs

Additional Preventive Services for Women

Non-Grandfathered Plans

- Apply to non-grandfathered plans with the plan year beginning on/after August 1, 2012
- Based on guidelines issued August 1, 2011 by the Health Resources and Services Administration (part of HHS) based on recommendations from the Institute of Medicine

Required services:
• Well-woman visits (described as including prenatal care) • Screening for gestational diabetes • Human papillomavirus (HPV) testing every 3 years beginning at age 30 • Counseling for sexually transmitted infections • Counseling and screening for HIV (includes testing) • Contraceptive methods and counseling for all FDA-approved methods and sterilization (includes barrier and hormonal methods and implanted devices) • Breast feeding support, supplies and counseling (including equipment rental or purchase) • Screening and counseling for interpersonal and domestic violence

FAQs on Preventive Services

Non-Grandfathered Plans

- Released February 20, 2013
  - http://www.dol.gov/ebsa/faqs/faq-aca12.html
- Clarify coverage requirements for certain services
- Following must be covered without cost sharing (in network):
  - Aspirin and other OTC recommended items and services when prescribed by health care provider
  - OTC contraceptives such as sponges and spermicides if prescribed by health care provider (but not male methods)
  - Services related to follow-up and management of side effects from contraceptives, counseling for continued adherence, and device removal
  - Removal of polyps during screening colonoscopy
  - BRCA genetic counseling and genetic testing if recommended by health care provider
- Coverage must be provided out of network if there is no in-network provider

Cost-Sharing Limit Effective in 2014

Non-Grandfathered Plans

For Non-Grandfathered Plans, beginning with plan year on/after January 1, 2014:

- Plan must have out-of-pocket maximum that does not exceed $6,350 individual/$12,700 family (amounts indexed in future years)
- Deductibles, coinsurance, copayments and similar charges must count toward this maximum
- FAQ published February 20, 2013 provides transition rule for first year for plans that use multiple service providers
  1. Plan's "major medical coverage" must comply, and
  2. If plan has a maximum for other coverage (*e.g.*, Rx), that limit must comply
- Likely to apply only to in-network cost sharing

Agencies have released an FAQ on this requirement, but not proposed rules.

Other Group Health Plan Mandates Effective in 2014

Non-Grandfathered Plans

For Non-Grandfathered Plans, beginning with plan year on/after January 1, 2014:

1. Coverage relating to routine costs associated with approved clinical trials
2. Provider nondiscrimination
3. Reporting relating to transparency in coverage – effective no sooner than when comparable standards apply to Qualified Health Plans in the Exchanges (*i.e.*, not before 2015)
4. Protection of employees

Regulations are unlikely before 2014, so the federal Departments have announced that plan sponsors are expected to implement clinical trial and provider nondiscrimination requirements using a good faith, reasonable interpretation of the law.

New *Employer* Requirements for 2012-2013

Applicable to Employers:

- W-2 Reporting (for now, contributing employers are exempt)
- Protection of Employees (interim final rule effective February 27, 2013)
- Employer Exchange-related Notices

Form W-2 Reporting

- Informational reporting of aggregate cost of employer-sponsored health care coverage
  - Does not cause employer-sponsored coverage to become taxable
- Generally applies to all employers that provide applicable employer-sponsored coverage
  - Transition rule: IRS exempts employers contributing to multiemployer plans
- First applied to 2012 Form W-2s issued January 2013

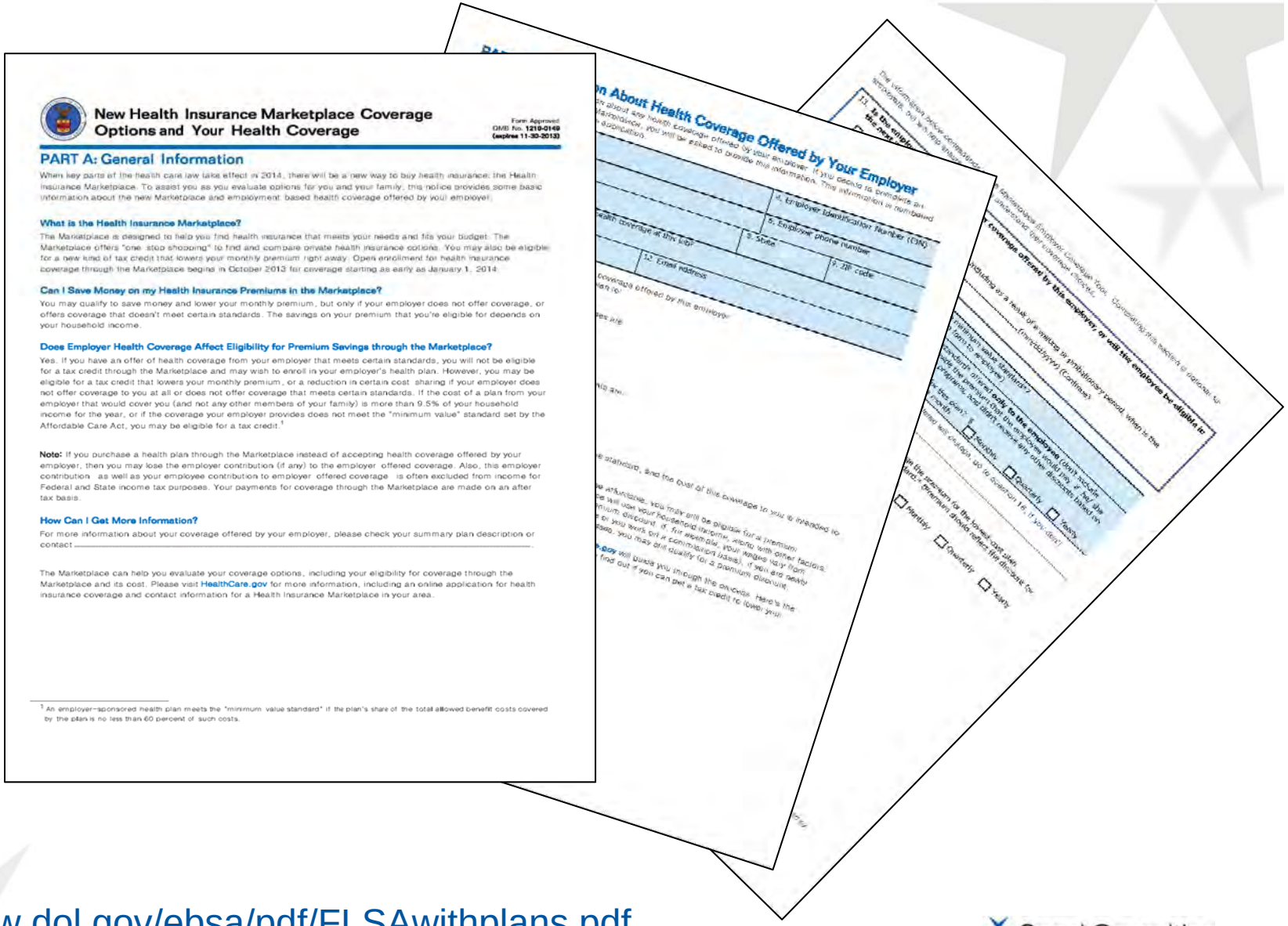
Protection of Employees

- Employer cannot discharge or otherwise retaliate against employee with respect to compensation, terms, conditions or privileges of employment because the employee:
  - Received a tax credit or a cost-sharing subsidy in a health insurance Exchange;
  - Provided information to the employer or to a government official about something the employee reasonably believes is a violation of the ACA;
  - Testified, assisted or participated in a proceeding concerning such violation; or
  - Objected to or refused to participate in any activity or assigned task that the employee reasonably believes violates the ACA
- Statutory provision effective when ACA enacted; interim final rule published by OSHA on February 27, 2013 effective on publication
- Complaints to be filed with OSHA and investigations handled by OSHA
- Can result in reinstatement, back pay, compensatory damages (including attorneys' fees)

Notice/Reporting Requirements

- Employers must provide notice to employees of the following:
  - The existence of the Exchanges and the services they offer
  - How to enroll/request information
  - If the employer's group health plan does not meet certain standards, a tax credit may be available to purchase Exchange coverage
  - If the employee purchases an Exchange plan, the employee may lose the employer contribution (if any) to health coverage offered by the employer
- Employers must provide notice to current employees and start providing to new hires by October 1, 2013 (model notice provided)
- Contributing employers will need information from the multiemployer plan in order to complete the model notice (minimum value and affordability)

Model Employer Notice



New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 11-30-2013)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution - as well as your employee contribution to employer-offered coverage - is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact _____.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

http://www.dol.gov/ebsa/pdf/FLSAwithplans.pdf

What Lies Ahead?

- Auto Enrollment
- Individual Mandate/Penalty
- Health Insurance Exchanges
- Individual Subsidies
- Medicaid Expansion
- Employer Shared Responsibility Penalty *(Delayed)*
- Excise Tax

Automatic Enrollment

- Applies to employers with more than 200 full-time employees and that offer health coverage
- Must automatically enroll employees in the plan and provide notice to employees
- Employees may opt out
- Compliance will not be required before regulations are issued
  - FAQ issued February 9, 2012 states that regulations will not be ready to take effect by 2014 as initially contemplated
- Not clear how this will affect contributing employers or multiemployer plans

Individual Mandate

- Individuals must have *minimum essential coverage* (including employer-sponsored coverage) or pay a monthly penalty
- Individual penalty accounted for as an additional amount of federal tax owed
- Phases in—$95 or 1% of income in 2014 (whichever is higher) to $695 or 2.5% of income (whichever is higher) in 2016
- No penalty if:
  - Cost of coverage exceeds 8% of household income
  - Short coverage lapses (3 months or less)
  - Other exemptions apply
- Supreme Court upheld the constitutionality of the individual mandate on June 28, 2012

State Health Insurance Exchanges

- **2014:** State Health Insurance Exchanges will allow individuals and small employers to choose from a menu of insurance products
  - Exchange plans must offer "essential health benefits"
  - Rating restricted to geography, family size, age rated 3:1; tobacco use 1.5:1
  - Federal subsidies will be available to help people buy coverage
- **2017:** States may allow large employers to buy through Exchanges

maryland health connection

COVERED CALIFORNIA

HealthConnector
Health Insurance for Massachusetts Residents

COVER OREGON

Core Functions of the Exchange

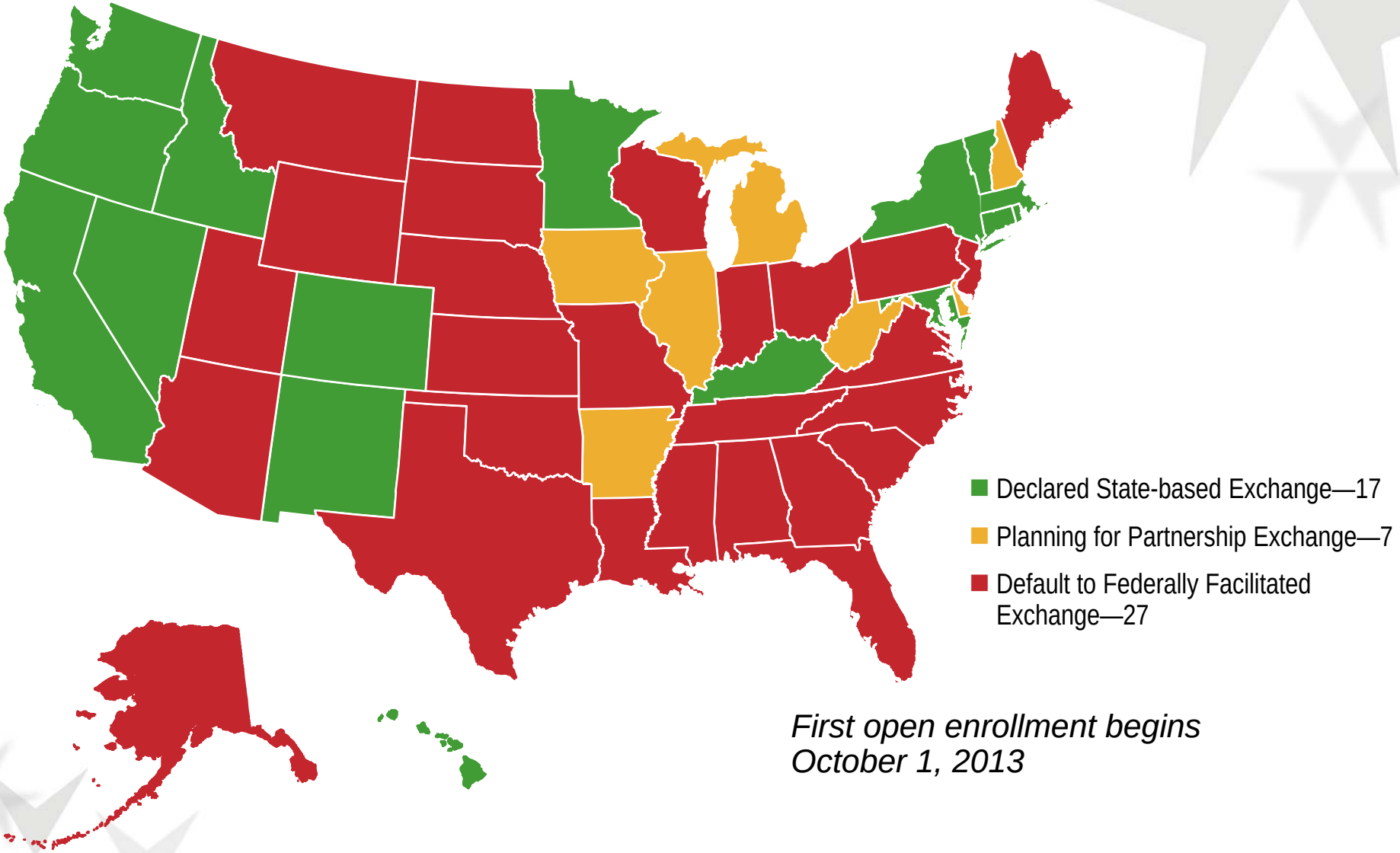
- **Consumer Assistance:** Toll-free information line; Internet comparison tool; Navigator program
- **Plan Management:** Certify and rate qualified health plans; conduct monitoring and oversight of plans
- **Eligibility:**
  - Verify eligibility, including for premium assistance tax credits and cost-sharing subsidies; connect applicants to Medicaid and CHIP if eligible
  - Use HHS-managed data services hub to connect to federal data sources (IRS, Social Security, Homeland Security)
- **Enrollment:** Facilitate enrollment in qualified health plans
- **Financial Management:** Process premiums; ensure stabilization of premiums through reinsurance and risk adjustment

Exchange Options

- **State Exchange:** State establishes and runs the Exchange, but communicates with federal government on certain issues like eligibility
- **Federally Facilitated Exchange (FFE):** Federal government runs the state Exchange
- **Partnership Exchange:** A form of FFE, with division of eligibility, enrollment, plan management, consumer assistance, and financial management functions between State and Federal governments. Federal government is ultimately responsible

Status of Health Insurance Exchanges

(as of June 20, 2013)



First open enrollment begins October 1, 2013

Data Source: Kaiser Family statehealthfacts.org

Individual vs. Small Business Exchanges

Two separate Exchanges but states can merge into one.

Individual Exchange

- Open to individuals who are citizens or legal immigrants
- Not open to undocumented individuals
- Buy through home state exchange
- **Federal subsidies are available to help individuals/families buy coverage**
- People who are eligible for decent, affordable coverage – for example, through a multiemployer plan – do not qualify for these subsidies

Small Business (SHOP) Exchange

- Initially, open only to small businesses
- States may allow large employers to buy beginning in 2017
- Employer buys through:
  - Exchange where employer has principal place of business, or
  - Exchanges in the states where employees have their principal worksite
- **No federal subsidies to help employees buy coverage**
- At this point, it appears that multiemployer plans cannot purchase SHOP coverage on behalf of small contributing employers

Multiemployer Plans vs. SHOP Coverage

	Typical Fund Coverage	SHOP Coverage
Self-insured and cost-effective	✓	Must be insured $$$
Benefits tailored to meet needs of workforce	✓	Off-the-shelf
Broad range of benefits (even non-health)	✓	Only medical/Rx + pediatric dental/vision
Maintains health coverage connection to local union	✓	Connection severed
Employers track hours and write one check	✓	Employers hassled with benefits coverage decisions

Who May Buy Exchange Coverage

- Qualified Individuals (see next slide)
- Qualified Employers
  - ACA's default: employer with 100 or fewer employees
  - States may limit access to employers with 50 or fewer employees before January 1, 2016
  - States may open access to employers with over 100 employees in 2017

Qualified Individuals

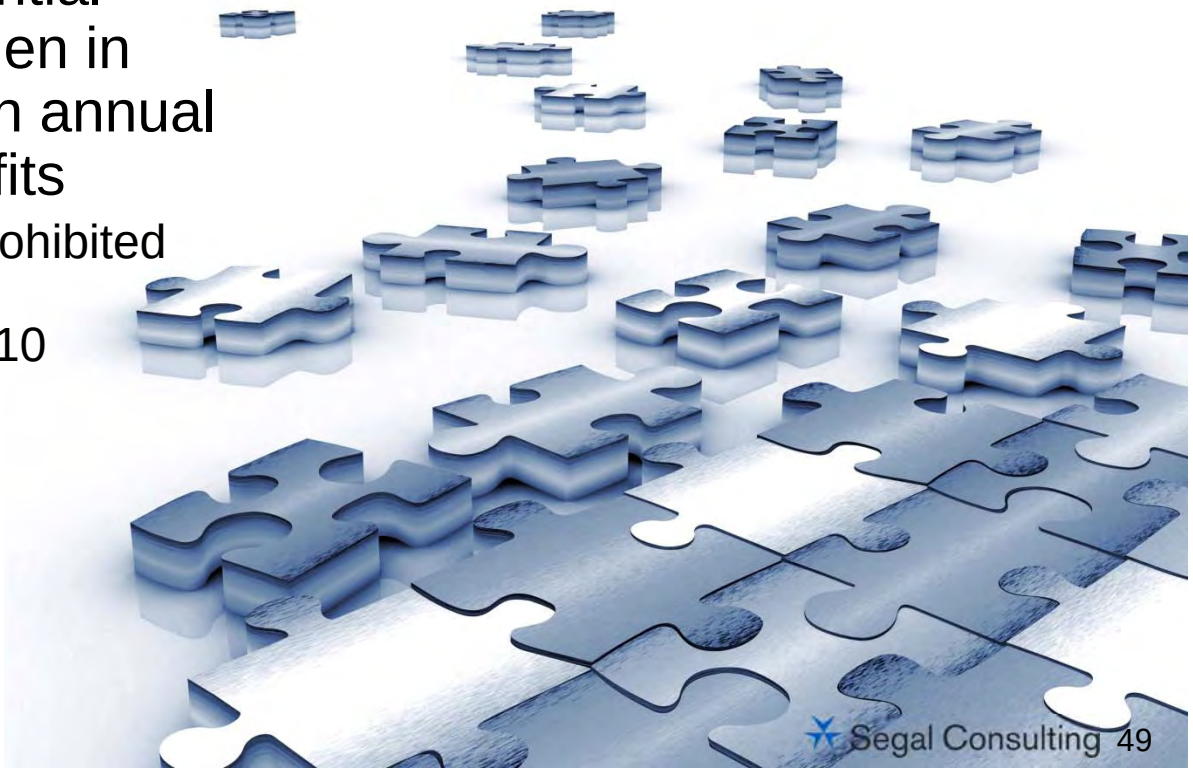
- Only qualified individuals may purchase coverage through the Exchanges
  - Residents of the state where the Exchange is established
  - Non-incarcerated persons
  - Citizens and legal immigrants
- Non-documented individuals cannot get subsidies or buy on the Exchange. This is critically important to some plans.
- Multiemployer plan eligibility rules do not include this eligibility screen

Medicaid Expansion/Exchange Subsidies

- Expansion of Medicaid to 133% of the Federal Poverty Level (FPL)
  - Not all states will expand Medicaid
- Subsidies to individuals up to 400% of FPL to purchase Exchange coverage
  - In 2013: 400% FPL = $94,200 for family of 4
  - Subsidies on a sliding scale based on income
  - Premium assistance tax credit
    - Refundable and advanceable
    - Measured by cost of purchasing silver-level plan
  - Cost-sharing assistance also available

Essential Health Benefits

- Essential benefits must be offered by Exchange plans
- Each state will determine the essential benefits package by selecting among certain benchmark plans
- Self-insured group health plans do not have to offer essential benefits, but if they do, then in 2014 they cannot have an annual maximum on those benefits
  - lifetime maximums were prohibited effective for plan years beginning on or after 9-23-10



Essential Health Benefit Categories in Statute

1. Ambulatory patient services
2. Hospitalization
3. Emergency services
4. Maternity and newborn care
5. Mental health and substance use disorder services, including behavioral health treatment
6. Prescription drugs
7. Rehabilitative and habilitative services and devices
8. Laboratory services
9. Preventive and wellness services and chronic disease management
10. Pediatric services, including oral and vision care

Exchange Benefit Levels

Platinum: 90% of the full actuarial value

Gold: 80% of the full actuarial value

Silver: 70% of the full actuarial value (keyed to subsidies)

Bronze: 60% of the full actuarial value

Young Invincible (catastrophic plan for individuals under 30)

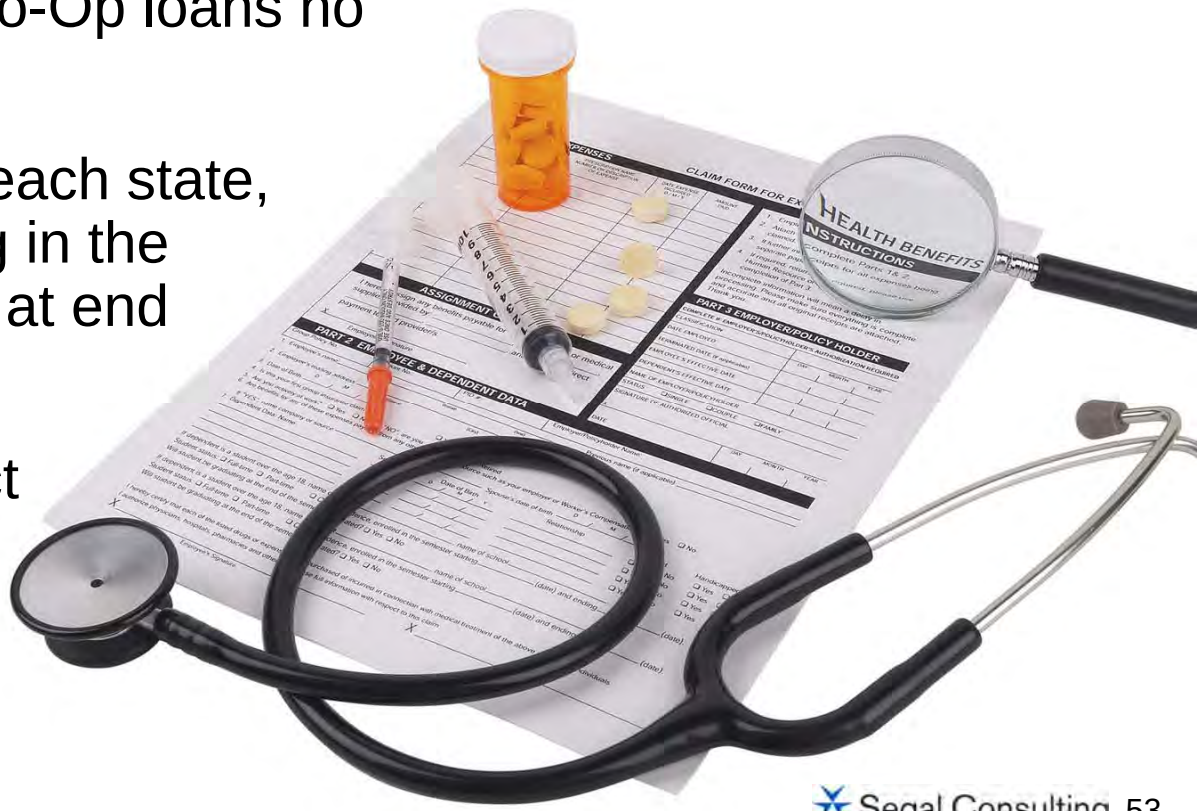
Multiemployer plans typically provide coverage at the gold to platinum levels.

Multi-State Plans

- Director of the Office of Personnel Management (OPM) will enter into contracts with at least two multi-state qualified health plans that will be offered through each Exchange in every state
- OPM will establish the criteria that plans will need to meet to become a multi-state plan
- At least one multi-state plan must be offered by a non-profit entity

Consumer Operated and Oriented Plans (CO-OP)

- Co-Ops may offer qualified health plans in the individual and small group markets (inside or outside the Exchange)
- Member-run non-profit health insurers must meet state insurance requirements (solvency, licensure, network adequacy, rate, etc.)
- HHS required to make Co-Op loans no later than July 1, 2013
- Goal was one Co-Op in each state, but Congress cut funding in the "fiscal cliff" deal reached at end of 2012
- Funding cut will not affect the 24 Co-Ops already approved by HHS



Premium Assistance Tax Credit Eligibility

Individuals must:

- Not be eligible for coverage through an employer-sponsored plan
- Not be in Medicare, Medicaid, CHIP, TRICARE, the VA or any other coverage named by HHS
- Be a resident of the state where the Exchange is established
- Not be incarcerated at the time of enrollment
- Be a citizen or legally documented immigrant currently residing in the United States
- Have household income between 100% and 400% of FPL
- Not be claimed as a dependent on anyone's tax return

Can Individuals with Employer-Sponsored Coverage Receive the Premium Assistance Tax Credit?

- Generally, no
- However, employees may apply for the premium assistance tax credit when the employer-sponsored coverage for which they are eligible is:
  - Below 60% of actuarial value, or
  - Not affordable (*i.e.*, the employee premium for self-only coverage exceeds 9.5% of household income)

Employer Shared Responsibility Penalty—2014 *(Delayed)*

- Applies to employers with 50 or more full-time employees
  - Must aggregate hours of part-time employees to create total number of full-time employees
  - Full-time = works on average at least 30 hours per week
  - Proposed rule published Jan. 2. 2013 addresses how to determine if employees are full-time employees
- If the employer **does not** offer coverage (and one full-time employee receives a tax credit in the Exchange)
  - Penalty is $2,000 (annualized) times the **total #** of full-time employees (minus first 30 workers)
- If the employer **does** offer coverage (and one full-time employee receives a tax credit in the Exchange)
  - Penalty is $3,000 (annualized) times **# of full-time employees getting tax credit** in Exchange (penalty max)
  - Tax credit would only be available if group coverage is unaffordable or actuarial value is less than 60%

Notice/Reporting Requirements Applicable to Large Employers *(Delayed)*

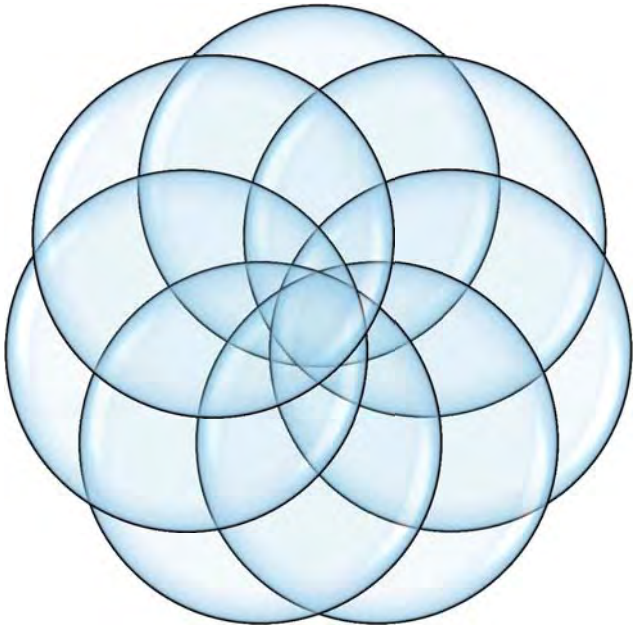
- Report to IRS beginning in 2015 regarding coverage options offered to all full-time employees in 2014:
  - Employer information
  - Whether minimum essential coverage is offered
  - The length of the waiting period
  - The months during the year that it was offered
  - Monthly premium for the lowest cost option in each enrollment category
  - Employer's share of the total allowed costs of benefits
  - The number of full-time employees each month
  - Name, address, and TIN of each full-time employee during the year and the months during year covered under plan
- Notices also provided to full-time employees by January 31 of the year following the year in which employer files the IRS return

Unknowns About the Exchanges

Will fully operational Exchanges be in place for open enrollment on October 1, 2013?

Will the subsidies and/or employer penalties change in future years?

Will enough health insurers participate to make these robust marketplaces?



Will subsidies continue to be available in the Exchanges that are operated by the federal government?

Will it be possible to buy a competitively priced gold or platinum plan?

Will the Exchanges provide stable coverage, with consistent offerings year to year?

What premiums will be charged across and within the metal levels?

Retirees

- Exchanges will not be offering Medicare supplemental plans, but early retirees can purchase coverage on the Exchanges
- Age rating limitations applicable beginning in 2014 may make Exchange coverage more attractive compared to current options in the individual market
- Employer shared responsibility penalty is not triggered if retirees obtain premium assistance tax credits in the Exchanges

Multiemployer Plans and the Exchanges

- Can plans buy coverage through the Exchanges?
- What types of supplemental coverage will plans be able to provide?
- Will plans be able to leverage the subsidies that will be available to purchase Exchange coverage?
- Can plans act as intermediary between Exchanges and contributing employers?
- How will the ACA affect collective bargaining around health benefits?

Federal regulations will establish general rules, but states will fill in the gaps.

Modeling Impact

- Segal can model the impact of the premium assistance tax credit and the employer penalty on specific groups
- Model can include impact of moving from plan with high actuarial value to silver plan (70%)
- Need data such as cost of current plan, wage rates (to estimate household income), amount of employee contributions, if any, employer's tax rate, etc.

Excise Tax—2018

40% Excise Tax on Health Plans that Cost Above a Certain Threshold

- Threshold $10,200/$27,500 indexed to the CPI-U
- Adjustments due to age/gender; increased thresholds for high-risk professions and retirees
- Thresholds increased in 2018 if CBO projections incorrect
- Appears to exclude most dental and vision; includes health FSAs and HRAs
- Multiemployer plans treated as family coverage for all participants; therefore, the threshold is $27,500 for multiemployer plans

How to Prepare for 2014 & Beyond

- ☑ Determine if the plan meets the 60% minimum value test
- ☑ Review dependent eligibility rules and contribution strategies
- ☑ If there are employee contributions for self-only coverage, determine whether affordable
- ☑ Review application of the 90-day waiting period rules and other applicable group health plan mandates
- ☑ Determine when plan would hit the excise tax threshold, effective in 2018
- ☑ Consider impact of individual mandate, premium assistance subsidies, and the Exchanges on the plan
- ☑ Segal can assist with these tasks, including modeling the impact of the coming changes

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Health Care Reform Guide
After discussing, debating and analyzing for over a year, Congress passed health care reform legislation in March 2010. Throughout the process, Segal has provided timely updates on the latest developments and guidance on how health care reform will affect your health plan.
Below, we have gathered the resources that we are producing to help you as you move forward in making your plan compliant with the new law.
Learn more about our health care reform services for Multiemployer and Public Sector plans.
Health Care Reform Timeline for Calendar-Year Group Health Plans
Segal Publications
February 8, 2013 Capital Checkup, "Affordable Care Act's Employer Notice of Exchange Coverage Delayed" (for Public Sector plans)
February 8, 2013 Capital Checkup, "Affordable Care Act's Employer Notice of Exchange Coverage Delayed" (for Multiemployer staff plans subject to the rules of single-employer plans)
January 25, 2013 Capital Checkup, "Proposed Rule on the Affordable Care Act's Employer Penalty Addresses Application to Multiemployer Plans" (for Multiemployer plans)
January 25, 2013 Capital Checkup, "IRS Proposes Rule on Employer Penalty Under the Affordable Care Act" (for Public Sector plans)
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