



Health Care Reform: What Employers need to know NOW (and what you will have to learn later)

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Health Care Reform

- Patient Protection and Affordable Care Act (“PPACA”) signed March 23, 2010
 - 906 single-spaced pages
- Health Care and Education Reconciliation Act (“Reconciliation”) signed March 30, 2010
 - About 50 pages of which relate to health reform (rest to student loan changes)
- Last 150 pages of PPACA amend first 765 pages, and then Reconciliation further amends.

Health Care Reform

- Numerous regulations have now been issued to provide guidance on some of the early rules
 - Coverage to age 26: Regs issued 5/10/10
 - Grandfathered plans: Regs issued 6/17/10
 - Lifetime and annual limits, rescissions: Regs issued 6/28/10
 - Coverage of preventative services: Regs issued 7/17/10
 - Claims appeal process rules: Regs issued 7/23/10

What We Will Cover

- Taxes and Tax Reporting
- Required design changes for Health Plans
 - Some sooner, some later
- Grandfathered Plans
- How Medicare/Medicaid and Insurance Reforms affect Employers
- Exchanges
- “Pay or Play” Rules in 2014

Taxes and Tax Reporting

Small employer tax credit, if provide health coverage, effective 2010

- Amount: 35% of costs paid in Phase I [between 2010 and 2013]; 50% in Phase II [2014 and 2015]
- Affects only *very* small employers
 - Full credit only available if have 10 or fewer employees and ave. wages of \$25,000 or less—sliding scale reductions between there and 25 employees or with higher average wages up to \$50,000
 - Coverage must be qualifying coverage on which employer pays at least 50% of premium
 - Employee count determined based on 2080 hour FTE standard
- Credit to for-profit employers only to extent of profits
- Can be claimed by a nonprofit too (as offset to payroll taxes) but at 25% in Phase I and 35% Phase II

Taxes and Tax Reporting

New W-2 Reporting Requirement

- Beginning in 2011, employers will have to reflect on W-2 the “total value” of health benefits (other than those funded through HSAs or salary-deduction portion of FSAs)
 - Will need guidance on how to determine “value” for self-insured plan
 - W-2s reporting value will be first due January 31, 2012
 - This does not make health benefits taxable to employees (existing taxation rules continue)

Taxes and Tax Reporting

Changes Specific to Consumer Driven Health Plans

- In 2011, individuals who use an HSA for expenses that are not qualified medical expenses will see excise tax increase from 10-20%
- In 2011, reimbursements for over-the-counter medicines no longer permitted without a prescription, and if a health plan does so reimburse, the payment is not excluded from income
 - Applies to Medical Flex accounts, HSAs and HRAs
- FSA contributions will be capped at \$2,500 [indexed] in taxable years starting in 2013 and later

Taxes and Tax Reporting

Fees for Group Health Plans

- Effective for policy/plan years ending after 9/23/2012, a premium tax is assessed on each covered life under either a self-insured or fully-insured health plan
 - Amount is \$2 per covered life, except for Plan/Policy Years ending in “Fiscal 2013” (presumably the government’s fiscal year of 10/1/2012 – 9/30/2013), when it will be \$1.00
 - Intended to finance a comparative effectiveness research study

Taxes and Tax Reporting

Increased Hospital Insurance Tax

- In 2013, there is a new level of Medicare tax on higher earners = 0.9% on all wages over \$200,000 (single) or \$250,000 (joint return), *to be collected by employers*
- Employers do not match this tax payment as they do other Medicare taxes
- These same individuals will be taxed 3.8% (total then-Medicare rate) on other types of non-wage income like interest, dividends, pass-through business income, etc.

Taxes and Tax Reporting

Medicare Part D

- Employers who now get a Medicare Part D subsidy will no longer be able to both exclude it from income and deduct the drug costs to those retirees under its health plan, effective 2013
 - Tax deduction eliminated; subsidy still exists
- Donut hole is phased out

Early Design Requirements

- The following design changes are required
 - Effective for Plan Years beginning after Sept 23, 2010, for
 - All self-insured and fully-insured plans, including governmental and church plans
 - As long as the plans cover at least one active employee
 - Plans covering retirees only are not subject to the new rules
 - Retiree coverage can be separated into a separate plan before the effective date (1/1/11 for calendar year plans) and new requirements will not apply to the retiree plan
 - Plan year is often insurance contract year, but not if Form 5500s have been filed reflecting a different year

Early Design Requirements

(eff. Plan Years beginning on or after 09/23/2010)

Children Retain Coverage to age 26

- Must allow children of employees **up to age 26** to remain on, or be added back to, the plan as a dependent
- This includes married children, but does not require that dependents (a spouse or child) of the employee's child, be allowed to enroll
- Gets rid of frequently-seen full time student and tax dependent criteria; No proof of financial dependency or residency may be required as a condition to coverage
- If the plan is "grandfathered," can exclude a child that is eligible to enroll in an employer-sponsored health plan through own job (until 2014)
- Plans cannot charge more for coverage for families with older children added, than for ones with younger ones

Early Design Requirements

(eff. Plan Years beginning on or after 09/23/2010)

Children Retain Coverage to age 26 (continued)

- Coverage will not be taxable to the employee (nor to the dependent), as long as the child does not reach age 27 by the end of the tax year (effective immediately, in case employers adopt the age 26 coverage provision early)
- Plans will have to have a special at-least-30-day open enrollment to add-back these children when rules are effective (even if plan does not otherwise have an open enrollment)
- Notice of rights can be sent to parents but if included with other open enrollment materials, the statement regarding new "dependents" who are eligible **MUST BE PROMINENT**
- DOL has issued a model notice

Early Design Requirements

(eff. Plan Years beginning on or after 09/23/2010)

Must eliminate *preexisting condition* exclusions for children under the age of 19

- PPACA prohibits *any* exclusion from a plan or coverage, if that exclusion is based on a preexisting condition
- HIPAA already prohibited exclusions of coverage for specific conditions or treatments associated with a preexisting condition in the case of an enrollee who has not had a 63 day break in coverage, and limits the period for any exclusion
- HIPAA continues to allow an exclusion of benefits for a condition under a plan or policy if the exclusion applies regardless of when the condition arose relative to the effective date of coverage
- Pre-existing condition exclusions must be eliminated for all enrollees with respect to plan years beginning on or after January 1, 2014.

Early Design Requirements

(eff. Plan Years beginning on or after 09/23/2010)

Lifetime and Annual Limits

- Plans are prohibited from imposing any *lifetime limits* on the dollar value of “essential health benefits”

- New notice and special enrollment right for individuals who reached a plan's lifetime limit before it has to be eliminated:
 - Individuals who reached a lifetime limit prior to the effective date must be given (a) a written notice that the lifetime limit no longer applies, and (b) an opportunity to enroll in any of the benefit packages currently offered to similarly situated individuals who did not lose coverage by reaching a lifetime limit
 - The Department of Labor has issued a model notice

Early Design Requirements

(eff. Plan Years beginning on or after 09/23/2010)

Lifetime and Annual Limits (cont.)

- The following "*reasonable annual limits*" may be placed on "essential health benefits" until 2014:
 - \$750,000 for plan years beginning on or after 09/23/2010 but before 09/23/2011
 - \$1,250,000 for plan years beginning on or after 09/23/2011 but before 09/23/2012
 - \$2,000,000 for plan years beginning on or after 09/23/2012 but before 01/01/2014

- Beginning in 2014, no annual limits may be placed on essential health benefits.

Early Design Requirements

(eff. Plan Years beginning on or after 09/23/2010)

Lifetime and Annual Limits (cont.)

- The annual limit rules do not apply to health FSAs or HSAs
- When HRAs are integrated with other coverage as part of a group health plan and the other coverage alone complies with the annual limits requirements, the fact that there is an overall limit on benefits under the HRA does not violate the requirements
- “Per-day” limits on benefits don’t seem to be prohibited ; While the law may be going in the direction of eliminating per-day limits, thus far the Departments have not expressed per-day limits as a prohibition

Early Design Requirements

(eff. Plan Years beginning on or after 09/23/2010)

Lifetime and Annual Limits (cont.)

- Essential health benefits will include items and services covered within the following general categories:
 - ambulatory patient services
 - emergency services
 - hospitalization
 - maternity and newborn care
 - mental health and substance use disorder services, including behavioral health treatment
 - prescription drugs
 - rehabilitative and habilitative services and devices
 - laboratory services
 - preventive and wellness services and chronic disease management
 - pediatric services, including oral and vision care

Early Design Requirements

(eff. Plan Years beginning on or after 09/23/2010)

Nondiscrimination

- Insured plans must not disproportionately favor highly compensated individuals (HCIs) (self insured were subject to these rules earlier)
- HCIs include: 5 highest paid officers, 10% or more shareholder, and those among the highest paid 25% of all employees (other than certain excludable employees)
- Must pass the "eligibility test" and the "benefits test"

Early Design Requirements

(eff. Plan Years beginning on or after 09/23/2010)

Nondiscrimination (cont.)

- Eligibility Test:
 - 70% of all employees are eligible to benefit under the plan, and at least 80% or more of those eligible in fact benefit; or
 - The plan benefits a nondiscriminatory class of employees (the “nondiscriminatory classification test”)
 - For this test, can exclude employees who have not completed 3 years of service, part-time (using 35 hrs/week) or seasonal employees, employees subject to a collective bargaining agreement, employees < 25, and nonresident aliens
- Benefits Test:
 - All benefits provided for participants who are HCIs must be provided for all other participants
 - This test applies based on premium sharing and benefits subject to reimbursement, not to actual payments of claims

Early Design Requirements

(eff. Plan Years beginning on or after 09/23/2010)

Nondiscrimination (cont.)

- Different penalties apply to self-insured plans than to fully-insured plans for violating nondiscrimination rules
 - Self-insured plans: Gross income of HCIs will *include* “excess” reimbursement amounts
 - Fully-insured plans: \$100/day/individual up to the lesser of 10% of the cost of the group health plan or \$500,000
 - BIG EXCEPTION FOR SMALL EMPLOYERS-the \$100/day/penalty does not apply to small fully insured plans of employers who employ no more than 50 employees counted somewhat like COBRA counts employees for the small employer exception

Early Design Requirements

(eff. Plan Years beginning on or after 09/23/2010)

Rescissions

- Plans cannot *rescind* coverage once it has begun, except for fraud or intentional misrepresentation of a material fact.
- A "rescission" is a cancellation or discontinuance of coverage that has a retroactive effect
 - A cancellation is not a rescission if it has a prospective effect or if it is effective retroactively to the extent it is attributable to a failure to timely pay required premiums
- A plan seeking to rescind coverage for an individual who has committed fraud or made an intentional misrepresentation of material fact (assuming the plan allows such a rescission by its terms), must first provide 30 days advance written notice to the affected participant

Early Design Requirements

(eff. Plan Years beginning on or after 09/23/2010)

Rescissions (cont.)

- Example: Julia seeks to enroll in the company's health plan. The plan requires Julia to complete a questionnaire regarding Julia's prior medical history, which affects the group rate.
- The questionnaire includes the following question: "Is there anything else relevant to your health that we should know?"
- Julia inadvertently fails to list that she visited a psychologist on two occasions, six years previously. Julia is later diagnosed with breast cancer and seeks benefits under the plan. On or around the same time, the issuer receives information about Julia's visits to the psychologist, which was not disclosed in the questionnaire.
- The plan cannot rescind Julia's coverage because her failure to disclose the visits to the psychologist was inadvertent and thus not fraudulent or an intentional misrepresentation of material fact.

Early Design Requirements

(eff. Plan Years beginning on or after 09/23/2010)

Rescissions (cont.)

- Example 2: An employer sponsors a group health plan that provides coverage for employees who work at least 30 hours/week.
- Peter has coverage under the plan as a full time employee. Peter is then moved to a part-time position.
- If the plan mistakenly continues to provide health coverage and later discovers its mistake, the plan cannot rescind coverage because there was no fraud or an intentional misrepresentation of material fact.
- The plan may only cancel coverage prospectively (subject to other applicable Federal or State laws).

Early Design Requirements

(eff. Plan Years beginning on or after 09/23/2010)

Emergency Care

- If emergency services are covered, plans must provide coverage for all emergency services without regard to whether the provider is in- or out-of-network, without requiring preauthorization, without imposing administrative requirements more burdensome than those applicable to emergency care provided in-network, and without imposing higher cost-sharing burdens on patients
 - Copayment amounts or coinsurance rates for out-of-network emergency services cannot exceed the cost-sharing requirements that would apply if the services were provided in-network.
 - May impose different deductibles or out-of-pocket maximums on out-of-network emergency services than those that apply to in-network benefits

Early Design Requirements

(eff. Plan Years beginning on or after 09/23/2010)

Internal Appeals (six new requirements)

1. Clarification of meaning of adverse benefit determination (now clearly includes eligibility determinations)
2. Expedited notification of benefit determinations involving urgent care (now 24 hours/ was 72 hours)
3. Full and fair review
4. Avoiding conflicts of interest
5. Notice (model notices published by DOL at <http://www.dol.gov/ebsa> and <http://www.hhs.gov/ociio/>)
6. Allow for deemed exhaustion of internal claims and appeals processes

Early Design Requirements

(eff. Plan Years beginning on or after 09/23/2010)

Internal Appeals (cont.)

- Plans must provide continued coverage pending the outcome of an internal appeal (i.e., may not reduce or terminate an ongoing course of treatment without providing advance notice and an opportunity for advance review)
- Individuals in urgent care situations and individuals receiving an ongoing course of treatment may proceed with expedited external review at the same time as the internal appeals process

Early Design Requirements

(eff. Plan Years beginning on or after 09/23/2010)

External Appeals

- External appeals to follow state regs if fully-insured or, if not or there are no regs (as in KY), must comply with the following safe harbor
 - Must complete a preliminary review within five business days after receiving an external review request to determine whether a claimant has provided all information necessary to process the request
 - Within one business day after completing a preliminary review, a group health plan must assign the external review to an independent review organization (IRO) accredited by URAC (a nonprofit group that audits health care organizations and accredits organizations' health care quality measures)
 - Plans must have contracts with at least three IROs and must rotate claims assignments among them or use random selection methods to prevent bias
 - After receiving notice of a final external review decision that reverses an adverse benefit determination or final internal adverse benefit determination, a plan must immediately provide coverage or payment for the claim

Early Design Requirements

(eff. Plan Years beginning on or after 09/23/2010)

External Appeals (cont.)

- Must allow requests for an expedited external review if
 - A final internal adverse benefit determination has been made AND the timeframe for completing an expedited internal review or a standard external review would jeopardize the life or health of the claimant or the claimant's ability to regain maximum function
 - The final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency care, and the claimant has not yet been discharged from the facility

Early Design Requirements

(eff. Plan Years beginning on or after 09/23/2010)

External Appeals (cont.)

- Now available:
 - 3 model documents to notify participants of adverse benefit determinations, final internal adverse benefit determinations, and final external review decisions
 - Model description of the internal claims and appeals and external review procedures for use in the summary plan description and for disclosure to participants and beneficiaries

Early Design Requirements

(eff. Plan Years beginning on or after 09/23/2010)

Preventative Services

- Health plans must cover certain preventive services, immunizations, and screenings, without any cost sharing
- Preventative services are published on the government website at <http://www.healthcare.gov/center/regulations/prevention/taskforce.html>
- When a new service is added to these lists, plans will have to add that service in the first plan year that begins 12 months after the addition
- When a preventative service and a non-preventative service are both performed in the same visit, if the primary purpose of the visit was not to seek preventative care and the preventative care is not billed separately, the co-pay can be charged
- If the preventative service is separately billed, co-pays can only be applied to the non-preventative service
- Plans do not have to provide no-cost preventative services when an out-of-network provider is used

Early Design Requirements

(with miscellaneous effective dates)

Miscellaneous

- All health plans will be required to have a no-more-than-4-page fact sheet no later than March 23, 2012 (standards/template to be issued by March 23, 2011)
- No health plan changes will be allowed before 60 days following written notice of change (\$1,000/enrollee penalty!)
 - Unclear *when* this 60-day advance notice is effective (at same time as 4-page summary requirement or next plan year after 9/23/10)
- Large employers (200+ full time employees) will be required to automatically enroll new full-time hires into health coverage, if they do not affirmatively opt out (effective date to be determined in regulations)
- Plus, effective immediately, the Act amends the Fair Labor Standards Act to require companies with more than 50 employees to provide a private, secure location (other than a bathroom) for new nursing mothers

Medicare/Medicaid and Insurance Reform--how it affects Employers

High Risk Pool

- Kentucky opted to have the Department of HHS run its high risk pool
- To qualify for coverage:
 - You must be a citizen or national of the United States or lawfully present in the United States
 - You must have been uninsured for at least the last six months before you apply
 - You must have had a problem getting insurance due to a pre-existing condition
- Employers face penalties equal to amount of claims paid, if they encourage employees or dependents to seek this Pool coverage rather than remaining in group coverage
- High risk pool will no longer be needed in 2014 when insurance exchanges (discussed later) go live

Medicare/Medicaid and Insurance Reform--How It Affects Employers

Premium Controls

- Insurers will be accountable to HHS to justify premiums based on actual claims experience, effective 2011
- Beginning in 2014 plan year premiums are controlled and community rating takes effect:
 - No more than 3:1 ratio from highest to lowest age-band premium; can charge 1.5:1 ratio for tobacco use; some risk adjustments based on regional differences, etc.
 - Guarantee issue and renewal
 - All insured plans must cover “essential benefits package”
 - Annual reports/review by government of premiums

Medicare/Medicaid and Insurance Reform--How it Affects Employers

Early Retiree Reinsurance Program:

- Will pay employer 80% of the claims of enrollees to the extent they exceed \$15,000 (up to \$90,000).
 - Early retirees = those ages 55 and older who do not yet qualify for Medicare
- Employers can apply the money to reduce their own health care costs or offer premium assistance to their employees
- Eligibility:
 - Must apply to HHS for certification
 - Must implement procedures to generate cost-savings for chronic/high-cost participants
- Program ends in 2014 or when \$5B spent
 - The Employee Benefit Research Institute released a report in June that said the \$5 billion for the program would run out in two years, leaving no subsidies in 2012 and 2013

Medicare/Medicaid and Insurance Reform--How It Affects Employers

Loss Ratio Controls

- Beginning in 2011, rebates to "enrollees" from carriers are required if medical loss ratios (percentage of premium spent on clinical services and "activities that improve health") are lower than 85% in the large group market (80% in small groups)
 - This essentially caps administrative costs and insurers' profit at 15%.
 - Is unclear who gets the rebate, where both employer and employee pay the premiums.

Medicaid Expansion

- Medicaid is expanding to cover a broader group—will cover even childless adults who earn up to 133% of Federal poverty level, beginning in 2014
 - For perspective: poverty level in 2009 for a family of 3 was \$18,310

Medicare/Medicaid and Insurance Reform--How It Affects Employers

- Employers may elect to auto-enroll employees in a new Federal long term care program (unless employee opts out) in 2011
 - Late enrollees pay higher premium
 - Cost expected to be about \$65/mo. for a \$50/day benefit to cover “non-medical” costs, that applies after 5 years of participation

2014 Requirements

- All pre-existing condition exclusions will be banned beginning in 2014
- Annual dollar limits on essential health benefits will be banned beginning 2014.
- Waiting periods before coverage is effective can be a max. of 90 days for full-time employees beginning in 2014
 - Full time = average of 30 hours per week

2014 Requirements

- HIPAAs nondiscrimination prohibition based on health status etc. is expanded
 - Wellness incentives—which are allowed as a specific exception to this nondiscrimination requirement—and which are now limited to 20% of total plan cost, will be allowed for 30% of plan cost in 2014
- Health plans must provide coverage to individuals who participate in ***clinical trials***.
 - May not drop from coverage individuals (who require treatment for cancer or another life-threatening condition) who choose to participate in a clinical trial
 - May not deny coverage for routine care that they would otherwise provide because an individual is enrolled in a clinical trial
 - Don't have to cover the investigational item or service itself, but types of items and services typically covered for individuals not in a clinical trial must be covered.

Grandfathering

Which Plans are Grandfathered, and What Does Being Grandfathered Mean?

- Generally, a self-insured plan or insurance contract is "grandfathered" if it was in effect on March 23, 2010 and not changed since in certain ways
- Grandfather rules apply separately to each benefit package/option under a grandfathered health plan
 - Grandfather status of insured benefit considered separately from grandfather status of self-funded benefit
 - One plan can have grandfathered package and non-grandfathered package
- *Some* of the new design rules may not affect your plan, for so long as it is "grandfathered"

Grandfathering

Grandfathering does not exempt a plan from:

- The lifetime and annual benefit limit restrictions (2010)
- The up-to-age-26 coverage mandate [but does allow you to deny coverage if older child has access at own job] (2010)
- The ban on rescissions (2010)
- The max. waiting period of 90 days (2014)
- The elimination of < age 19 pre-existing condition limits this year, and on all pre-ex in 2014
- The 4-page uniform explanation of coverage (2012)
 - and 60 day advance notice before design changes are effective
- The rebates for excessive loss ratios from insurers (see Insurance Reform)
- The FSA contribution cap and restriction on use of health accounts to pay for over-the-counter drugs

Grandfathering

What does this leave?

- If grandfathered, a plan doesn't have to
 - Provide no-cost *preventive* services,
 - Cover *emergency care* at non-network facilities, or pay for *clinical trial* costs
 - Implement the *appeals process* changes
 - Comply with the *salary-based nondiscrimination* rules (unless already subject because the plan is self-insured)
 - Report on quality and wellness initiatives
 - Place caps on deductibles and out-of-pocket max., and meet other requirements to have “minimum essential benefits” in 2014

Grandfathering

Plan Changes That Revoke Grandfathered Status:

- Obtain an entirely new policy of insurance to fund benefits
- Change the insurance carrier, even if the new carrier's policy is very similar to that offered by the prior carrier
- Eliminate coverage for a specific condition (i.e., organ transplants) or eliminate benefits necessary to diagnose or treat a condition
- Increase dollar co-pays for prescriptions or doctor visits by the greater of \$5 or medical inflation plus 15%
- Increase fixed dollar cost-sharing by more than medical inflation plus 15%
- Change the sharing arrangement between the employer and employees by more than 5 percentage points
- Impose new annual or lifetime dollar limits or lower annual limits

Grandfathering

Grandfathered plans must comply with the following requirements:

- Must include a statement of grandfathered status in all plan materials provided to a participant or beneficiary that describes covered benefits
 - The Grandfather Regulations contain model language that may be used
- Must retain records documenting the terms of the plan in effect on March 23, 2010, and for each subsequent year showing how changes comply with the restrictions in the Grandfather Regulations and any subsequent guidance
 - Records must be made available for examination upon request

Grandfathering

Changes that do NOT revoke grandfathered status

- Renew coverage for existing enrollees and add dependents
- Enroll new employees (and their families) in the plan
- Insurer's change in premiums
- Make changes to comply with federal or state legal requirements or voluntarily comply with the PPACA
- Change third-party administrators (self-insured benefit options)
- Insured union-bargained plans in effect March 23, 2010 are grandfathered until the bargaining agreement expires

Grandfathering

Transition Rules for Changes Made before Regs

- For employers who entered into a legally binding contract before March 23, 2010 to make plan design changes after March 23rd, the changes are considered part of the plan as of March 23rd
 - For example, if an employer had, before March 23, 2010, signed a contract or adopted plan amendments to switch insurance carriers, change co-pays or deductibles, effective for a date after enactment (e.g., for an April 1 open enrollment), that change will not revoke grandfathered status
- Grace period for employers who made plan design changes pursuant to a contract change or plan amendment adopted after March 23rd but before June 14th (the date clarifying regulations were issued)—if the plan is modified to remove the changes that would otherwise revoke grandfathered status (i.e., the plan is restored to its March 23, 2010 plan design) before the first plan year beginning after September 23, 2010, the plan will still be treated as grandfathered after that date

The Insurance Exchanges

- Government to set up a virtual marketplace on internet for shopping for coverage
- State-based exchanges to buy coverage; multiple states can join together for this
- Open in 2014 for individuals and employees working for a company with 50 or fewer full time employees (expanded to 100 in 2016)
- State may allow larger employers to use in 2017 or later
- Federal Office of Personnel Management to approve at least 2 multi-state plans to be offered (one must be by a non-profit)

The Insurance Exchanges

- Individual and small employer group markets can be separate or combined for risk-pooling purposes and for purchase Exchanges (decided by State)
 - Smaller employers should benefit from geographic risk-pooling
- Designs of plans to fall in 4 design tiers—bronze (60% of health costs paid by plan), silver (70%), gold (80%), platinum (90%), each subject to out of pocket limits
- Plus a "young invincible" plan for certain qualified persons under age 30
- All state-licensed insurers must participate, but can have outside plans too
- Each must cover "essential benefits"
 - This will include some basic oral and vision care for kids

Individual Mandate

- In 2014 individuals are mandated to have health coverage with minimum essential benefits via individual policy or through employer, for themselves and all dependents under age 18
 - or will pay a penalty of 1% (increases to 2% in 2015 and 2.5% in 2016) of gross income, with a minimum dollar level of \$395 (indexed upward to \$695 for individual or 3x that for family by 2016) and capped at the then-average cost of a "bronze" level Exchange Plan.
 - No criminal penalties or tax liens allowed to enforce this
 - Exceptions for incarcerated, religious objectors, those without coverage for short periods

Individuals--Premium Tax Credits and Cost-Sharing Assistance

- A new Section 36B is added to the Code to grant certain lower income persons a tax credit for getting coverage
 - Applies to persons/families with income between 100% and 400% of Federal poverty level
 - Only applies if the individual cannot get “affordable” self-only coverage through employer
 - Affordable is Employee share premium that is less than 9.5% of household income
- May also get cost-sharing assistance on their coverage
 - Reduction in out of pocket limits under policies on Exchange by 1/3 to 2/3rds, depending upon % of poverty level

Pay or Play in 2014 for Employers

- Applies ONLY to employers with 50+ employees (based on a 120 hour/mo. Full-time equivalency (FTE) count)
- Must have 50 EEs for at least 120 days in prior year if reason for falling below is because of employment of “seasonal workers”
- New companies determine size based on “reasonably expected” no. of workers
- Successor/predecessor rules to apply

Pay or Play in 2014 for Employers

- “Min. essential coverage” (new Section 5000A of Code)
 - A grandfathered plan, or
 - A non-grandfathered plan with at least the "essential benefits package," to be defined by HHS. Generally must
 - Be actuarially designed to pay at least 60% of health costs,
 - Enroll full timers beginning no later than 90 days following hire,
 - limit out-of-pocket expenses to \$5,959 (ind.)/\$11,900 (family)[indexed]

What are the Large Employer’s options?

- Option 1—provide min. essential coverage to all full-time employees
- Option 2—provide min. essential coverage to some, but not all full time employees
- Option 3—do not provide health coverage

Pay or Play in 2014 for Employers

- Option 1—no tax penalty, but possible voucher requirement
- Option 2—if have even one full-time employee who selects an Exchange plan and claims a tax subsidy instead, will have to pay a penalty of
 - \$3,000 per year (prorated by month) per full time employee claiming a tax credit (unless they take a voucher—see below),
 - But in no event more than \$2,000/yr. for ALL full time employees in excess of the first 30
- Option 3—if even 1 employee selects Exchange plan and takes tax credit or cost-sharing, same result as Option 2, except penalty is \$2000/yr. x No. of Full time employees, minus 30
- All penalties will adjust after 2014 based on health premium adjustments; penalties are not tax deductible
- All large employers will have to give HHS extensive reports as to their coverage design, who is enrolled, etc. and furnish similar statement to employees

Pay or Play in 2014 for Employers

Example: 40 full time employees, and 20 employees who work 100 hours per month, on average

- This is a large employer, because $40 \text{ full timers} + 20 \text{ PT's} \times 100 \text{ hours} = 2000/120 = 16.7 \text{ FTEs} = 56.7 \text{ FTEs}$
- If employer provides minimum essential coverage to full time employees that costs employees no more than 8% of income, and no one opts out—no penalties
- If any full time employee opts out and buys Exchange plan, and claims tax credit, employer pays \$3000 per such person (even if single) (but never more than $40 - 30 = 10 \times 2000 = \$20,000$)
- If employer's cost for coverage is more than \$250 per month, covering person in a health plan costs more than penalty (except note coverage cost is tax deductible, and penalty is not!)
- If employer does not provide coverage to any employee, penalty will be \$20,000

Pay or Play in 2014 for Employers-Vouchers

- If employee's share of cost of self-only coverage under the employer plan would be between 8-9.8% of his “household income,” and the workers' household income is less than 400% of Federal poverty level (\$73,240 for family of 3 now), then
 - Employer must give employee a voucher (tax free) for plan with largest employer cost share, in an amount equal to employer's cost for ind. or family level, as the employee elects
- “Cost” will be determined in fashion similar to COBRA rules, but HHS may require age-band adjustments
- Voucher then requires Employer send monthly amounts to Exchange; if plan selected costs less than voucher, Exchange pays difference to employee
- Employer does get tax deduction for voucher amount

Pay or Play in 2014 for Employers--Vouchers

- To avoid most vouchers—make sure no full time employee's share of health cost exceeds 8% of income
 - But beware that “income” is not readily determinable
- Employee foregoes tax credit if uses voucher, and employer avoids any penalties related to that person

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Questions?