Health Care Reform

Moving Forward ➲➲➲

Presented by:

Dan McGill

Mid-Atlantic Regional Health Care Reform Specialist

Wells Fargo Insurance Services USA, Inc.

(919) 334-2630

dan.mcgill@wellsfargo.com

Prepared with:

Michael Schenk

Benefits Compliance Leader

Wells Fargo Insurance Services USA, Inc.

Virginia Network of Private Providers, Inc.

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Wells Fargo Insurance

Agenda

- PPACA impact 2014 and Beyond
  - ✓ What the employer “play or pay” delay does and doesn’t do
  - ✓ Exchange Overview and Subsidy access/eligibility
  - ✓ Medicaid Expansion Overview and Impact
  - ✓ Individual Mandate and Penalties
  - ✓ Upcoming employee disclosure issues
  - ✓ Supreme Court DOMA decision and benefits impact
  - ✓ New rules regarding wellness programs
- Employer “Play or Pay” for 2015
- ACA Impact on Small Employers **[≤ 50 FTE’s]**
- Down the Road

Acronym Glossary

- AV — Actuarial Value
- DOH — Date of Hire
- FTE — Full Time Equivalent Employee
- FPL — Federal Poverty Level
- HDHP — High Deductible Health Plan
- HHS — Department of Health and Human Services
- EHB — Essential Health Benefits
- HSA — Health Savings Account
- MAGHI — Modified Adjusted Gross Household Income
- MEC — Minimum Essential Coverage

Where are We Now?

Key Implications Effective 2013 - 2015

2013

- First payment of Patient Centered Research Outcomes Tax
- **Notify employees of Exchange availability**
- **Open enrollment of insurance exchanges**

2014

- ***Insurance exchanges***
- ***Potential federal subsidies for individual coverage***
- ***Medicaid expansion***
- ***Mandates on small group insurance***
- ***Individual mandate***
- 90-day maximum waiting period
- Out-of-pocket max limitation (with exceptions)
- No pre-existing conditions and annual dollar limits on EHB
- Reinsurance and insurer fees

2015

- ***Play-or-Pay mandate***
- Automatic enrollment (?)
- Non-discrimination tests for fully-insured plans (?)
- Payment of reinsurance fee
- Early 2016, new reporting and disclosure (for 2015 year)

Breaking News "Play or Pay" Mandate Delayed!

The "play or pay" provision of the Patient Protection Affordable Care Act (PPACA) requires employers with 50 or more employees to do the following to avoid penalties

Count employees' hours to determine whether they average 30 or more hours per week	Consider employees who average 30 or more hours per week eligible for employer sponsored health insurance	Offer minimum essential coverage to 95% of full-time employees.	Offer minimum value coverage to full-time employees (60% Actuarial Value)	Offer affordable coverage to full-time employees (Less than 9.5% of income)

Because of the delay, employers will **NOT** need to meet these requirements for 2014 calendar year

What's still required?

The delay in the "play or pay" mandate does not change insurance market reforms. The following requirements are still scheduled to go into effect as of the start of the 2014 plan year and will be subject to penalties of up to $100 per person per day for non-compliance:

Waiting periods cannot exceed 90 days from the date the employee becomes eligible*	All pre-existing condition limitations must be removed*	The "out-of-pocket" maximum cannot exceed $6,350 for individual and $12,700 for family coverage*	Essential health benefits may not have annual dollar limits*	All plans must cover dependent children to age 26 even if the child had access to his-her own employer provided coverage (regardless of grandfathered status)*	The new wellness program requirements*

Play or pay delay

- ONLY the potential penalties on employers for not offering compliant coverage are delayed to 2015
  - No need to ensure offer of coverage to all "full-time" employees
  - No need to ensure coverage offered meets 60% actuarial value
  - No need to ensure single-premium coverage is ≤9.5% of AGI

- What else isn't delayed?
  - W-2 reporting
  - Exchange notices to all employees (October 1, 2013)
  - Individual mandate penalty (still quite low in 2014)
  - Public exchange coverage availability
  - Possible federal assistance in buying exchange coverage
  - Possible eligibility for Medicaid in states that expand
  - New fees – patient-centered outcomes (perhaps 2013), reinsurance and "insurer" fees

Potential Implications

- More employees may enroll in exchange and/or be eligible for subsidies
  - Employers less likely to change current plans to meet new requirements
  - As a result, employees in certain industries hardest hit by PPACA will not be offered a plan or offered an affordable/acceptable plan

- Employee relations issues in 2015 when employers make necessary changes
  - Employees may be faced with less rich plan designs (60% Actuarial Value), higher payroll contributions (up to 9.5% of annual income), and the employees will not be eligible for subsidies

New Benefit & Coverage Rules

Employer Impact	Description	Individual	Small Group Fully Insured	Large Group Fully Insured	Self Funded
Essential Health Benefits (EHB)*	• Health plans must provide Essential Health Benefits (EHB) for individual and small group plans • 10 categories of EHB	Yes	Yes	No	No
Out of Pocket Maximums (OOP)*	• OOP limits must comply with OOP limits for HSA plans • All cost sharing (including copayments) for EHB services must count towards OOP	Yes	Yes	Yes	Yes
Deductible Limits*	• Beginning in 2014, plan deductibles may not exceed $2,000 (individual) or $4,000 (other than individual) annual limitation	No	Yes	No	No
Metal Plans	• Four EHB coverage packages: Bronze (60%), Silver (70%), Gold (80%) , Platinum (90%), catastrophic plan (under age 30 only) • Must meet actuarial value of one of these four plans • Requirement applies In and Out of Exchange	Yes	Yes	No	No

*** Not required for Grandfathered plans**

PPACA Fees and Taxes

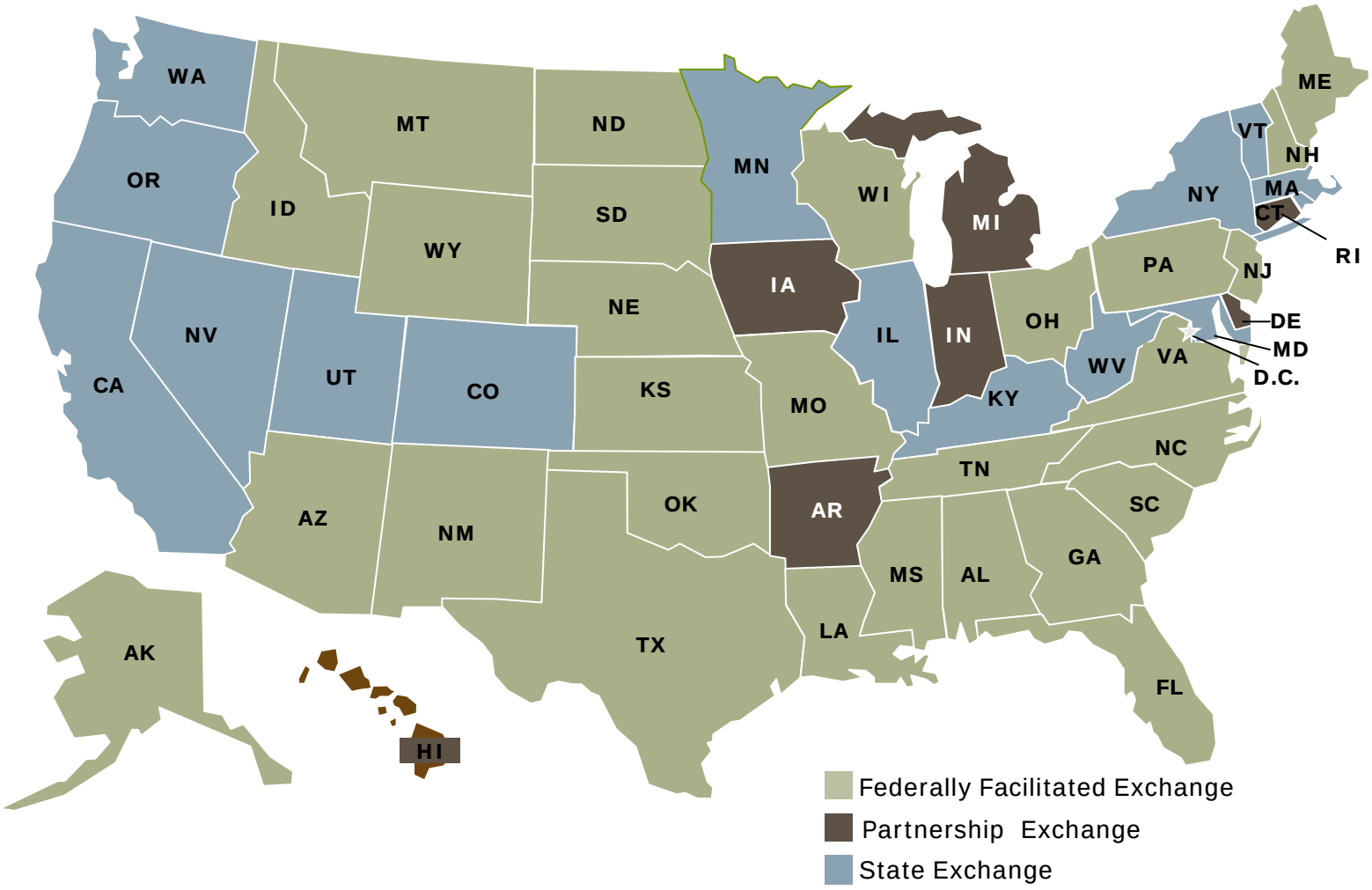
Fee	Effective Dates	Plans/responsible party	Annual tax/fee amount
PCOR Fee – funds research on the effectiveness, risks and benefits of medical treatments through the Patient-Centered Outcomes Research Institute	• 7 Years Only • Plan/policy years that end after 9/30/2012 through 9/30/2019	• Fully-insured – carriers • Self-insured – plan sponsors – file Form 720	• $1 per participant per year for first applicable plan year • $2 per participant per year in plan year 2 • $2 per participant, increased by the medical inflation rate, for next 5 plan years • Tax deductible for employers
Reinsurance Fee - this will support the transitional reinsurance program to provide subsidies to carriers offering coverage on the Exchanges. This fee aims to stabilize premiums for coverage in the individual market and lower the effects of adverse selection.	• 3 Years Only • Calendar years beginning 1/1/2014. • Collection of fee expected to begin January 2015.	• Fully-insured – carriers • Self-insured - Sponsors/ administrators	• Total amount to be collected is $12 billion in 2014, $8 billion in 2015 and $5 billion in 2016, totaling $25 billion. Some states may also assess their own fees in addition to the federal tax, but applicable only to insured plans. • $5.25 PMPM or $63 PMPY, reducing 40% by 2016. • Tax deductible for employers
Health Insurer Fee - an annual, permanent fee on health insurance providers to fund premium tax subsidies for individuals and families with household incomes between 100 percent and 400 percent of the federal poverty level who purchase health insurance through the Health Benefit Exchange.	• Ongoing • Tax years beginning 1/1/2014 and later. • Unclear of when first payable • by carriers though carriers are building into 2013 renewals that carry over into 2014	• Fully-insured only – carriers • Generally includes medical, dental & vision	• Expected to range approximately 2%-2.5% of premium, increasing to 3%-4% in later years. • Based on the insurer's market share of net premiums written based on the previous year (e.g., 2014 fee will be based on 2013 premiums). • Total fee amount to be collected across all insurers starts at $8 billion in 2014 and increases to $14.3 billion in 2018. After 2018 the fee increases annually based on premium growth. • Tax deductibility questionable

Health Exchange Overview

- "Easy" way to buy health insurance, usually through Web-based information and enrollment
- Two types: Individual and Small Employer ("SHOP")
- Different in each state and sometimes set up by the state, but many set up by the federal government
- Carrier participation might be limited, at least to start
- Federal assistance/Subsidy to pay for coverage?
  - Only for individual public exchange coverage, not SHOP
  - Many employees will not qualify, so need good communication

Exchanges by State

Federal exchanges will be dominant at first



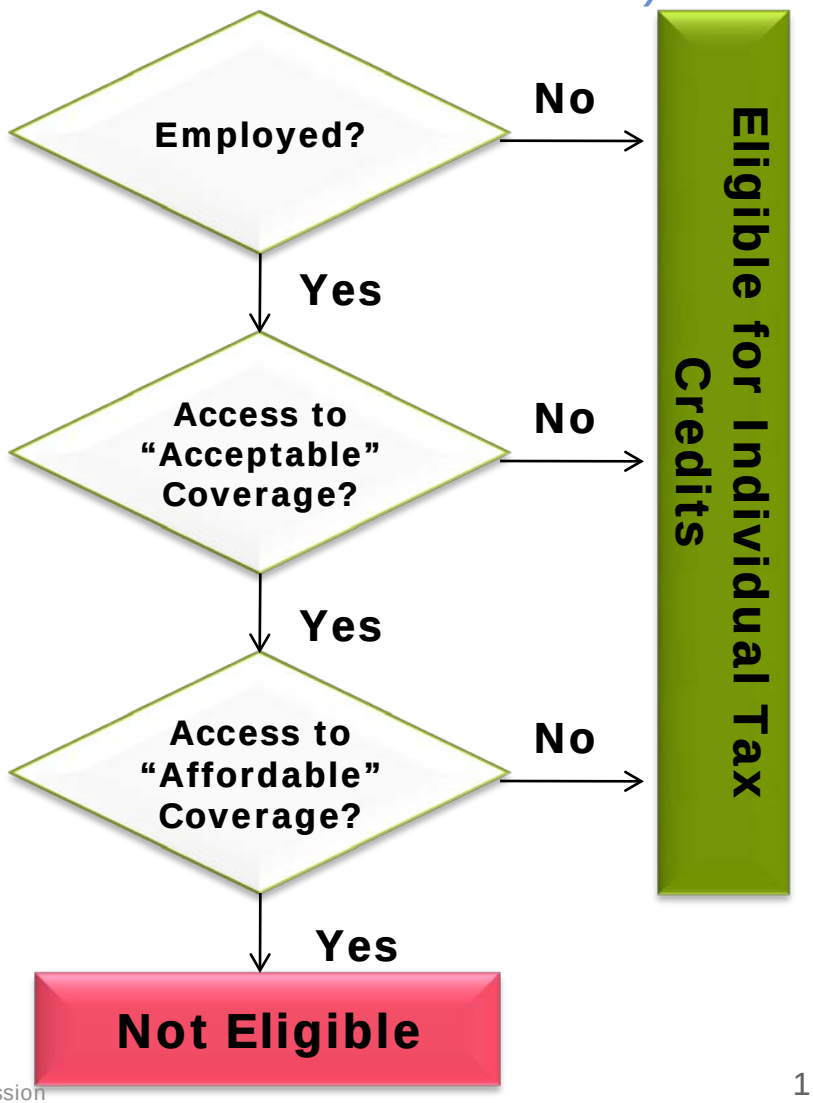
Source: HHS, Kaiser Family Foundation and Advisory Board Company (as of 2/12/13)

Local Marketplace

State	Medicaid Expansion	Exchange
North Carolina	NOT Expanding	• Federal Exchange • Pending (BCBS of NC and FCC) • CIGNA, UHC, Aetna declined to participant
Virginia	Undecided? **(potential expansion for 2015)**	• Partnership • Pending (unofficially - BCBS, Aetna, and UHC) • CIGNA declined to participate
South Carolina	NOT Expanding	• Federal Exchange • BCBS of SC, Blue Choice, and Consumer Choice (Gov. funded start-up)

Eligibility for Federal Subsidy

- Numerous conditions, including:
  - Must buy public exchange coverage
  - No employer coverage enrollment
  - No access to Medicare, Medicaid
- In particular, employees **offered** coverage from their employer **cannot** receive federally subsidized exchange coverage (even if their adjusted gross household income <400% of FPL) if:
  - Employer coverage has 60% actuarial value), **and**
  - Employee contributions for self-only coverage < 9.5% of household MAGHI)
- **2015** – Only full-time employees who obtain subsidized exchange coverage trigger any employer penalties



Subsidized Exchange Accessibility

Tax Credit Guidelines

Federal Poverty Level	Max Premium as % of AGHI	Estimated Plan Actuarial Value
100% - 133%	2%	100%
134% - 150%	3.0% - 4.0%	94%
151% – 200%	4.0% - 6.3%	87%
201% – 250%	6.3% - 8.05%	73%
251% - 300%	8.05% - 9.5%	70%
301% - 400%	9.5%	70%
>400%	Unlimited *	60%

***** Not eligible for subsidized exchange coverage

Federal Poverty Levels (2013)

Family Size	Medicaid Eligibility 100% FPL*	Medicaid Eligibility 138% FPL	Exchange Subsidy up to 400% FPL
1	$11,490	$15,856	$45,960
2	$15,510	$21,404	$62,040
3	$19,530	$26,951	$78,120
4	$23,550	$32,499	$94,200
5	$27,570	$38,046	$110,280
6	$31,590	$43,594	$126,360
7	$35,610	$49,142	$142,440
8	$39,630	$54,689	$158,520

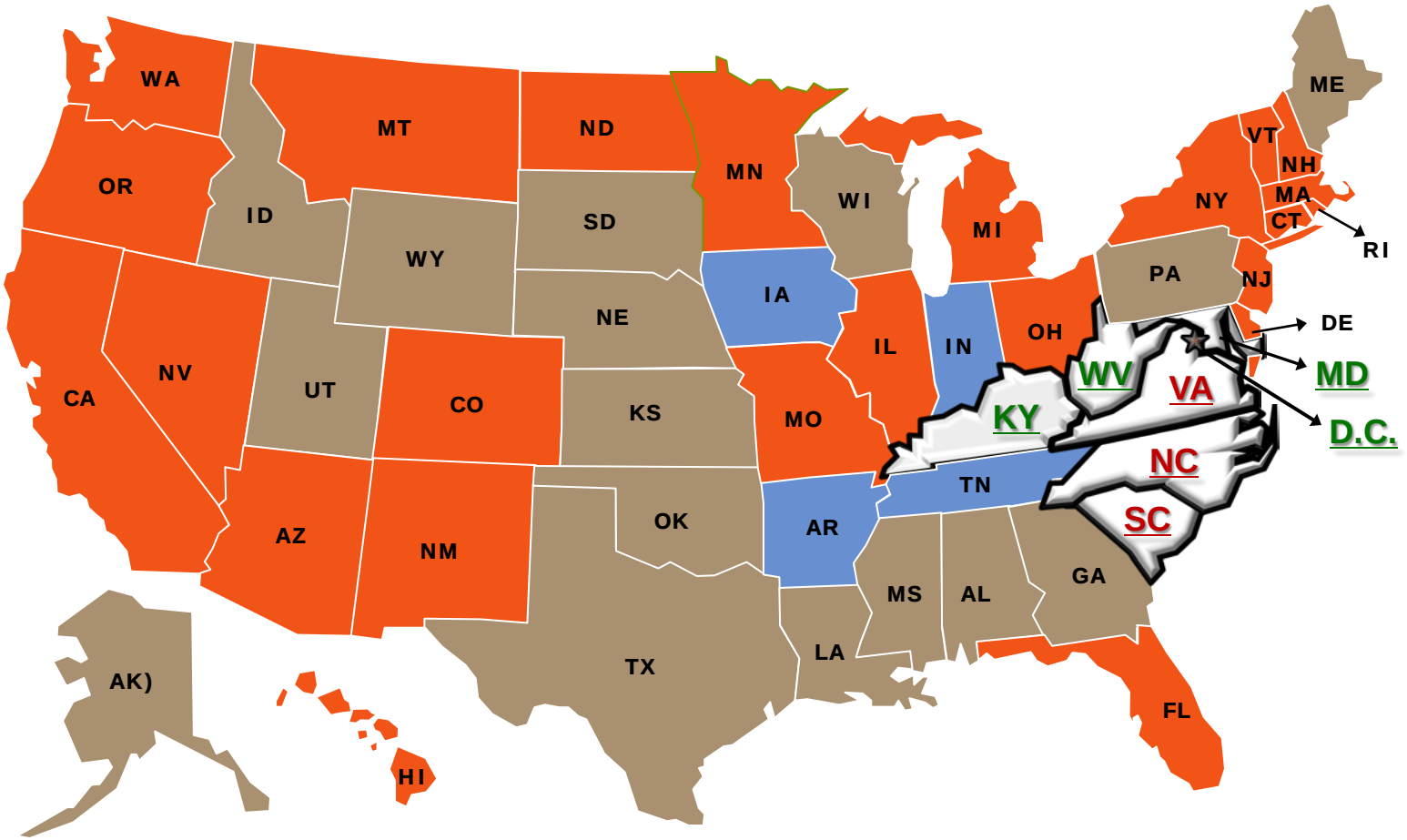
***** For family units of more than 8 members, add $4,020 per additional person

Medicaid Expansion

General Overview

- State by state decision to expand
- Expansion means Medicaid eligibility for all individuals in a household with MAGHI less than 138% of the FPL
- No expansion means keeping current state Medicaid criteria
  - Individuals with MAGHI between 100% FPL and 138% of FPL, however, will qualify for subsidized exchange coverage
  - **But only if** employer's benefits are unaffordable or do not provide minimum value (60% actuarial value)
- Employees (and their families) on Medicaid means NO cost to employers
  - Not on employer plan
  - Not receiving subsidized exchange coverage

Medicaid Expansion



- Medicaid expansion likely or leaning
- Medicaid expansion alternative pursued
- Medicaid expansion not likely or leaning

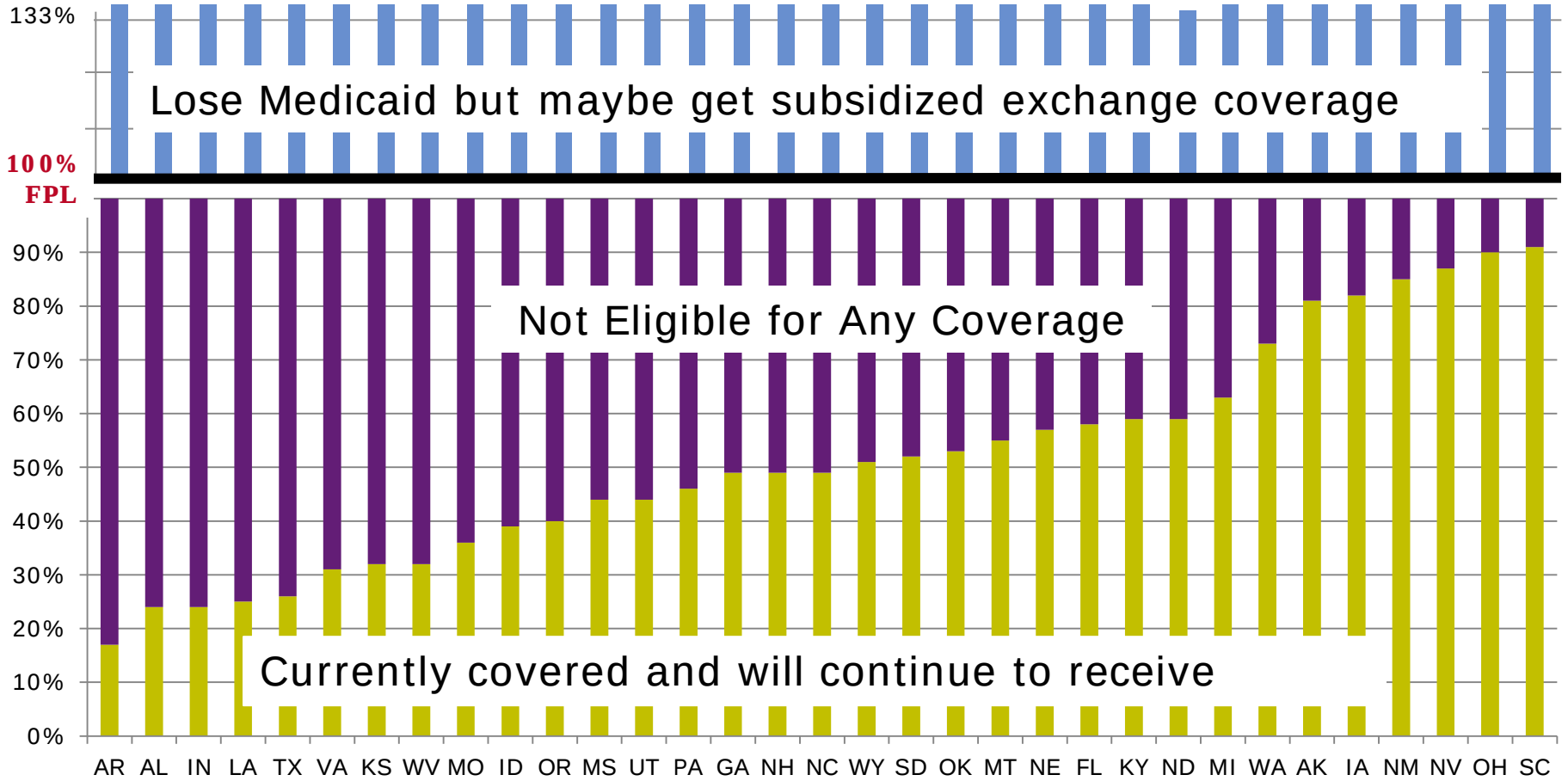
Mid-Atlantic States:
- Medicaid expansion - participating
- Medicaid expansion – Not participating

*__Note:__ VA is still undecided for possible 2015 participation

Source: Advisory Board Company (**as of 5/24/13**)

Medicaid eligibility if no expansion

as a Percent of the Federal Poverty Level (FPL)



Note 1: In 17 states and the District of Columbia, Medicaid is currently offered for families of three with incomes at 100 percent of the poverty level or higher. Income eligibility limits reflected are at time of application, which change after a certain amount of time in some states. Other eligibility requirements also may apply.

Note 2: Only 6 states have open programs that provide full Medicaid coverage to nondisabled, low-income childless adults.

Source: Kaiser Family Foundation (statehealthfacts.org) Income Eligibility Limits for Working Adults at Application as a Percent of the Federal Poverty Level (FPL) by Scope of Benefit Package, January 2012 , http://www.statehealthfacts.org/comparereport.jsp?rep=54&cat=4

Individual Mandate

- Applies to all U.S. residents
- Pay a tax penalty for each month beginning on 1/1/2014, unless have "Minimum Essential Coverage," including:
  - Eligible employer-sponsored group health (generally, "major medical")
  - Individual market, including exchange, insurance policies, or
  - Certain governmental programs (e.g., Medicare, Medicaid, CHIP, TRICARE)
- Exceptions apply
  - Native Americans and some religious exemptions
  - Short (< 3 month) lapses
  - Expatriates
  - Individuals with household income before tax filing threshold
  - **KEY for employers** – Individuals unable to obtain coverage costing less than 8% of their household income
  - **NEW** – Individuals who work for employer with non-calendar year plan in 2013 get delay until plan year start date in 2014

Individual Mandate Tax Penalties

- 2014 – *Greater of:*
  - $95 per person ($47.50 for minors), with family cap
  - 1% of gross income in excess of filing threshold
- 2015 – *Greater of:*
  - $325 per person ($162.50 for minors), with family cap
  - 2% of gross income in excess of filing threshold
- 2016 – *Greater of:*
  - $695 per person ($347.50 for minors), with family cap
  - 2.5% of gross income in excess of filing threshold
- Filing thresholds (decent rule of thumb):
  - 2014: likely $10,000 for single, $20,000 for couple, add $5,000 per child
  - Some indexing up every year thereafter

Disclosure issues to deal with now

- Summary of Benefits and Coverage
  - 4 pages (both sides) and no less than 12 point font
  - Must go out at open enrollment and to eligible new hires
- Exchange availability notice
  - Must be provided starting October 1, 2013
  - Model notice available
  - Goes to all employees from all employers
  - Allows for inclusion of other employer plan information
    - May require identifying plans' "actuarial value" and affordability
- Items to consider
  - Broader information on Medicaid eligibility
  - Specific information on employees being ineligible for federal assistance since employer offers coverage that meets 60% AV and is "affordable"

Disclosures to deal with eventually

- Status of coverage – first due 1/31/2015 (DELAYED!!)
  - Report to IRS
  - Provide IRS information to employees as well

- Automatic enrollment
  - No guidance at all as of yet
  - Looks like implementation in 2015 at the earliest
  - Applies to new hire full-time employees only
  - Mainly must include in enrollment materials that coverage (which may include employee contributions) is automatic unless employee affirmatively opts out

The Supreme Court's DOMA Decision

- What did the decision do?
  - Removed part of DOMA that says, for all federal law purposes, marriage is between a man and a woman
  - Opens all federal laws involving spouses as treating same-sex spouses the same as opposite sex spouses – some laws implicated:
    - ✓ Federal income tax
    - ✓ COBRA
    - ✓ HIPAA
    - ✓ FMLA
    - ✓ Social Security
- What did the decision NOT do?
  - Keeps in place ability for a state to not recognize same-sex marriage from another state
  - No impact on domestic partnerships/civil unions
- Impact on health & welfare benefit plans
  - No imputing income for federal income tax purposes
- Questions answered:
  - Do not impute income in any states for federal taxes
  - Consider retroactive correction of imputed income
- Open question:
  - Do self-insured plans have to recognize all or some same-sex marriages?

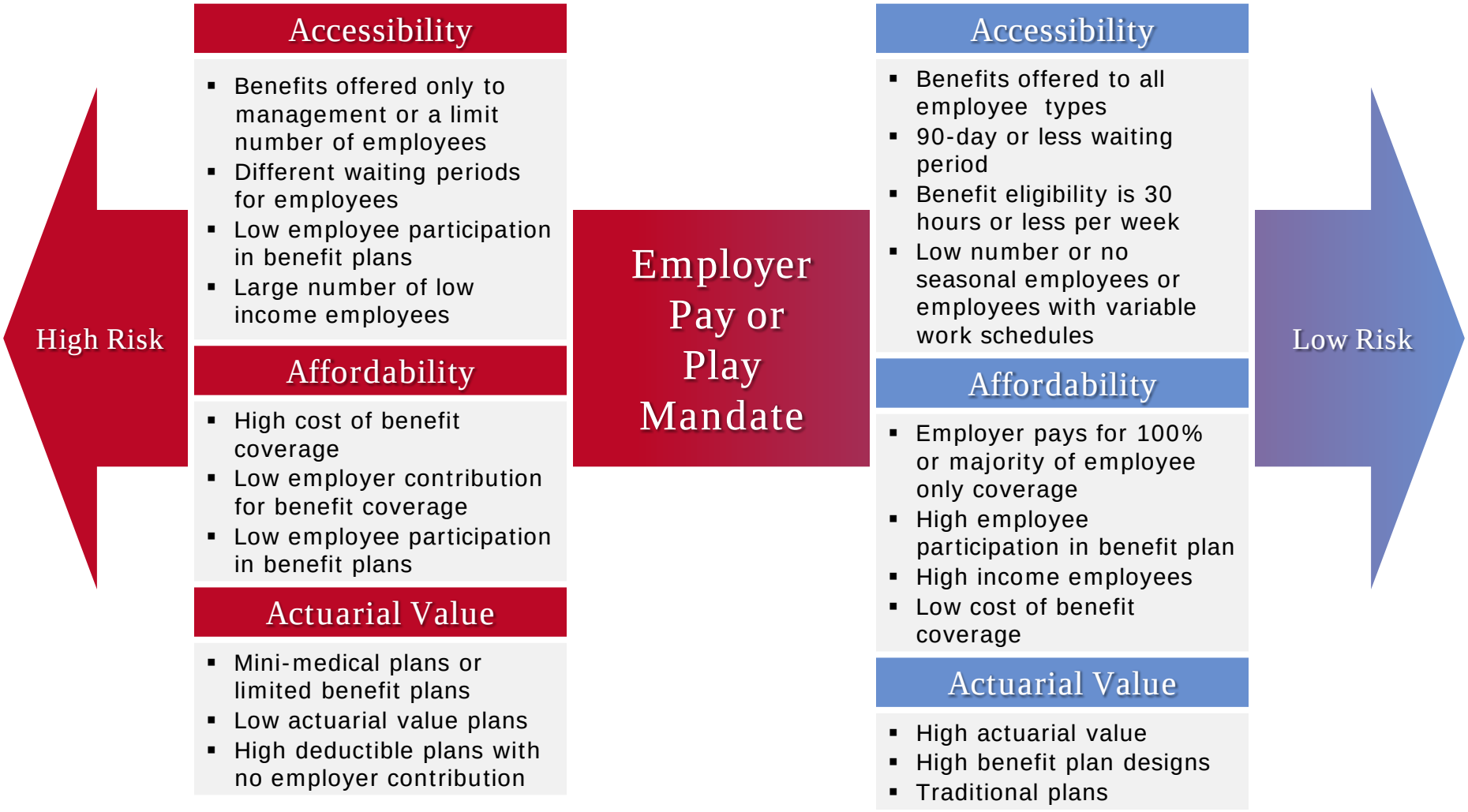
New regulations on wellness programs

Types of wellness programs

- "Old rules" through 2013 plan year – two types:
  - Participation-based – carte blanche
  - Standard-based – 20% max with other requirements
- "New rules" effective first plan year starting in 2014 – Three types:
  - Participatory – not related to a health factor - HRAs
  - Health-contingent
    - ✓ Activity-only – walking program
    - ✓ Outcome-based – nonsmoker, low BMI/cholesterol
  - Health-contingent subject to requirements
    - ✓ Move to 30% differentials (50% for tobacco-based)
    - ✓ Must provide reasonable alternatives when called for
    - ✓ Always provide reasonable alternative for outcome-based
    - ✓ Offer once per year

To “Pay or Play”?

Assessing Employer Play or Pay Risk



Employer "Play or Pay" Mandates

All Employees ≥ 30 hrs/week
(some regulatory relief available)

"Acceptable" Health Insurance

"Minimum Essential Coverage" **and** at least 60% Actuarial Value

"Fair" Employee Access

"Affordable" Employee Contributions

Federal Poverty Line
> 100% and < 400%
(income threshold only)

"Individual" Tax Credits

< 9.5% of Household Income
(some regulatory relief available)

Fundamental Paradigm Shift in 2015

- Employer-provided health care delivery system will be further restructured in 2015 primarily due to the following:
  - **Employee Drivers:**
    - ✓ Individual mandate
    - ✓ Other employer plans adjustments
    - ✓ Automatic enrollment (2015 or later)
  - **Employer Drivers:**
    - ✓ Two different variations of employer "play or pay" mandates; Covering more employees or Penalty exposure?
    - ✓ New fees and mandate costs (4% to 10% in addition to trend)
  - **New Potential Options for Individuals:**
    - ✓ Subsidized public exchange coverage
    - ✓ Medicaid eligibility expansion (if living in opt-in state)
- HR, finance, and senior management need to work together to balance cost issues and goals of the benefits programs

2015 Employer "Play or Pay" Mandates

Applicable large employer

- 50 or more full-time equivalent employees
- Determined on an IRC controlled group basis

No minimum essential coverage (MEC) for "substantially all" full-time employees (and "dependents") AND at least one employee obtains subsidized exchange coverage

$2,000 annually ($166.67 per month) per total number of full-time employees

- Exclude first 30 FT Employees

Offers MEC but it is either "unacceptable" or "unaffordable" AND employee still obtains subsidized exchange coverage

$3,000 annually ($250 per month) per each full-time employee that receives premium tax credit/cost-sharing reduction from an exchange

- Penalty capped at level as if no minimum essential coverage offered

“Fair” Employee Access

Offer MEC to full time employees

- ≥ 30 hrs/week (or 130 hrs/mo)
- Offer enrollment effective within 90 days of DOH

Action Items:

- Ensure coverage is MEC (excepted benefits are not MEC)
- Identify all full time employees
- Implement measurement periods for variable hour and seasonal employees, if any
- Monitor/manage hours below 30 hours/wk or 130 hours/month
- “Offer” (to accept or decline) enrollment within 90 days from DOH after meeting eligibility requirements

Definition of Full-Time Employee

- Common law test applies for purposes of defining “employer” and “employee”
  - Labels (e.g., “1099 worker”) are generally irrelevant
  - Particularly important to understand importance of proper worker classification implications

- Statutory definition = “full-time employee means, with respect to any month, an employee who is employed on average at least 30 hours of service per week”

Employer play or pay – Who is a "full-time" employee?

- Two schemes – per 12/28/2012 proposed regulations
- **#1 – Ongoing employees** - Allows 3 to 12 month look-back/stability period for some or all ongoing employees
  - Employer selects period, typically based on plan year start date
  - Typical election is 12-month look-back running October 15 to October 15, in order to determine FT employees for January 1 effective date
- **#2 – New hire variable hour and seasonal employees** – Allows 3 to 12 month look-back/stability period for new hire variable hour and seasonal employees
  - Based on anniversary date
  - Typical election is 11 or 12-month look-back with only one-time application
- Both allow for an administrative period of 60 to 90 days
- Stability period for both has to be the same – this generally results in all MPs and SPs being same length

“Acceptable” Health Insurance

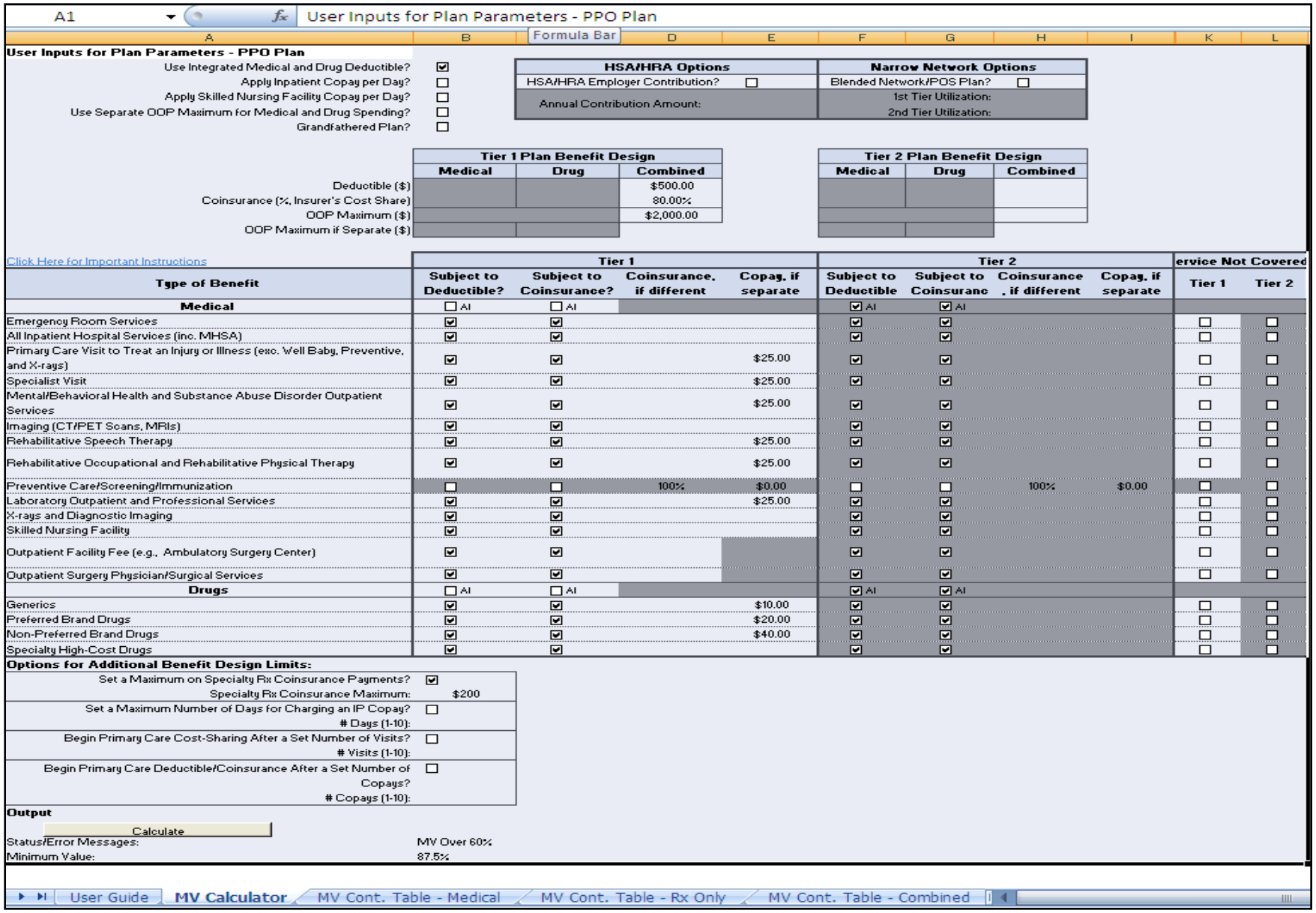
Must provide “minimum value” (≥ 60% actuarial value)

- HDHP/HSA compatible plan
- HMO with deductibles and coinsurance
- Low deductible high coinsurance plan

Action Items:

- Assess AV of benefit plan(s):
  - HHS minimum value calculator
  - Plan design checklists
  - Actuarial certification
  - Healthcare reform modeling tool
- Determine if plan consolidation is required
  - Cost of insuring more employees
  - Complexity of communicating plan options
  - Nondiscrimination rule exposure
- Consider offering a core 60% AV plan and buy up plans or gap coverage
- Consider offering MEC with an AV lower than 60%

Sample HHS MV Calculator Output



A1 — User Inputs for Plan Parameters - PPO Plan

User Inputs for Plan Parameters - PPO Plan

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Grandfathered Plan?	☐

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$500.00			
Coinsurance (%, Insurer's Cost Share)			80.00%			
OOP Maximum ($)			$2,000.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible	Tier 2 Subject to Coinsurance	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate	Service Not Covered Tier 1	Service Not Covered Tier 2
Medical	☐ AI	☐ AI			☑ AI	☑ AI				
Emergency Room Services	☑	☑			☑	☑			☐	☐
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑			☐	☐
Primary Care Visit to Treat an Injury or Illness (exc. Well Baby, Preventive, and X-rays)	☑	☑		$25.00	☑	☑			☐	☐
Specialist Visit	☑	☑		$25.00	☑	☑			☐	☐
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑		$25.00	☑	☑			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑			☐	☐
Rehabilitative Speech Therapy	☑	☑		$25.00	☑	☑			☐	☐
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑		$25.00	☑	☑			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00	☐	☐
Laboratory Outpatient and Professional Services	☑	☑		$25.00	☑	☑			☐	☐
X-rays and Diagnostic Imaging	☑	☑			☑	☑			☐	☐
Skilled Nursing Facility	☑	☑			☑	☑			☐	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑			☐	☐
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑			☐	☐
Drugs	☐ AI	☐ AI			☑ AI	☑ AI				
Generics	☑	☑		$10.00	☑	☑			☐	☐
Preferred Brand Drugs	☑	☑		$20.00	☑	☑			☐	☐
Non-Preferred Brand Drugs	☑	☑		$40.00	☑	☑			☐	☐
Specialty High-Cost Drugs	☑	☑			☑	☑			☐	☐

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	$200
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages: MV Over 60%

Minimum Value: 87.5%

User Guide | MV Calculator | MV Cont. Table - Medical | MV Cont. Table - Rx Only | MV Cont. Table - Combined

Definition of Actuarial Value

Sample Plan #1	Platinum Plan *(90% AV)*
Deductible	$250
Coins.	0%
OOP Max	$750
PCP/ Specialist	$30 / $60
Rx	$15/$30/$55/ 50% after ded. $200 max

Sample Plan #2	Gold Plan *(80% AV)*
Deductible	$500
Coins.	25%
OOP Max	$3,000
PCP/ Specialist	$25 / $65
Rx	$15/$40/$60/ 50% after ded. $200 max

Sample Plan #3	Silver Plan *(70% AV)*
Deductible	$2,000
Coins.	30%
OOP Max	$5,000
PCP/ Specialist	$40 / $65
Rx	$25/$35/$60/ 50% after ded. $200 max

Sample Plan #4	Bronze Plan *(60% AV)*
Deductible	$3,000
Coins.	50%
OOP Max	$6,500
PCP/ Specialist	50% after deductible
Rx	50% after medical ded.

- Actuarial value measures the percentage of covered medical expenditures that a plan will pay in the aggregate with respect to a standardized population
  - Measures the relative "richness" of a plan with focus on cost-sharing provisions
  - Premium cost of coverage between employer and employee is **not** taken into account
- Table above shows some sample plan designs that correspond to various proposed actuarial value standards
  - However, by using these cost-sharing levers, there are many different ways to design a plan with a given actuarial value

“Affordable” Employee Contributions

< 9.5% of household income

Safe harbors:

- W-2, Box 1
- Rate of pay
- 100% of FPL

Wellness incentives in 2014(?) then tobacco only

Action Items:

- Identify method to assess affordability of employee-only coverage
- Identify plan to make affordable (lowest cost plan); ***only one*** plan must be affordable and meet 60% AV
- Consider contribution structure to encourage desired migration and potentially account for differences in state Medicaid programs
  - Defined contribution model
  - Reverse discriminatory contribution models (e.g., salaried-based)
  - Spousal surcharges

Employee Affordability Safe Harbors

- Pursuant to proposed regulations, federal regulators have provide some relief for employer's inability to ascertain their employees' household incomes
  - Form W-2 Safe Harbor: Use Box 1 of employee's Form W-2 wages to determine if employee contribution for self-only coverage for employer's lowest cost "acceptable" plan is "affordable" (but employee contribution rate cannot be increased during plan year)
  - Rate of Pay Safe Harbor: Determines affordability of an employee's monthly contribution for self-only coverage relative to their rate of pay times 130 hours worked per month (but rate of pay cannot be decreased during plan year)
  - Federal Poverty Line Safe Harbor: Coverage will be affordable if employee's cost for self-only coverage does not exceed 9.5% of 100% of the Federal Poverty Line for a single individual ($11,490 in 2013, so effectively $90.96 per month or less)
- Note that employer just needs to subsidize coverage to keep the employee share for self-only coverage under 9.5% of household income (or applicable safe harbor)
  - There is no requirement for employers to make any tier of dependent coverage "affordable"

Employer “Play or Pay” Delay Unknowns

- Delays for non-calendar year plans?
- Delays in rules for determining “full time” employees” such as transition rule?
- First year “pass” on all wellness program incentives in determining “affordability”?

ACA Impact on Small Employers $\leq$ **50** FTE's

2014 Facts for Small employers under ACA: The Good news.....

- Access to SHOP Exchange coverage *(Single product choose 1st year)*
  - Questionable whether any access to coverage outside of an Exchange
  - Guaranteed issue coverage, with no medical underwriting, thus potential for advantageous rates, particularly for groups with older populations
  - Some employees better off with individual exchange to get subsidies
- Tax advantages still remain
  - Deductibility of contributions towards employee coverage
  - Employees exclude employer premium subsidies
  - Employees can pay their share of premiums pre-tax through a cafeteria plan (not allowed if purchased through individual insurance exchange)
  - Owners may get to deduct costs of their own coverage
- Other new advantages under PPACA
  - Tax credits (not for everyone, and must use SHOP)
  - SIMPLE cafeteria plans

2014 Facts for Small employers under ACA: The other news.....

- Coverage subject to modified community rating – guaranteed issue with no individual medical underwriting
  - Rates can **vary only** based on (1) individual or family coverage; (2) geographic area; (3) *tobacco use* (up to *1.5:1 ratio* band); and (4) *age* (but only within *3:1 ratio* band for adults)
  - No gender rating
  - Must provide all 10 categories of essential health benefits
  - Cost of unsubsidized individual coverage will increase significantly in most states
- Rates will not vary between Group Policies outside the State Exchange and inside the State Exchange (SHOP Exchange coverage)
  - Questionable in some States whether any access to Small Commercial Group coverage outside of an Exchange
  - Potential for wide variations in rates, particularly for groups with younger or older populations. (Average increase for same coverage could be 20 to 50% more expensive)
  - Some employees better off with individual exchange to get subsidies

Sample Premium Age Band Chart

Age Band	Male Employee	Female Employee
0-24	$173.42	$406.93
25-29	$202.74	$491.92
30-34	$249.13	$553.49
35-39	$307.76	$562.77
40-44	$376.16	$607.71
45-49	$488.51	$659.49
50-54	$657.04	$757.20
55-59	$854.89	$854.89
60-64	$1,074.72	$1,050.30
65+	$1,416.69	$1,362.95

Down the Road.....

Dynamic Employer Benefit Marketplace

Health Insurance Carriers

- Limitations on profit/administrative costs (Medical Loss Ratio regulations)
- Shift from claim payers to health management service providers
- Harnessing technology to increase member engagement & outcomes
- Evaluating distribution channels and approach to quote requests

Ancillary Benefit Insurance Carriers / Plans

- More carriers developing and selling voluntary products
- Healthcare insurers offering all lines of coverage and offering purchasing discounts
- New/enhanced products being introduced to fill in gaps of consumer driven, high deductible plans
- More self-funding in the healthcare market

Delivery System

- Accountable Care Organizations (ACO's)
- Insurance carriers purchasing local health systems
- Increasing focus on quality and pay for performance

Participant Engagement

- Personal accountability through consumerism
- Technology-on line enrollment systems, e-portals, call centers
- Increasing range of voluntary benefits, potentially replacing some employer paid benefits
- Increased discussion around Defined Contribution for benefits

Regulatory Environment

- Filing requirements
- Plan design mandates
- Employee communications

What Are We Seeing Down the Road?

- Growth of CDHPs will accelerate, especially those that condition employer-funded contributions to funding sidecars (HSAs or HRAs) on employee engagement/wellness activities
- "Defined contribution"?
  - Some interest in transitioning employer funding of health coverage toward more of a defined contribution model (a/k/a private exchanges)
  - Not clear how fast if and actually how it may occur
- Health insurance market highly dynamic for at least next 5 years
  - All stakeholders (employers, individuals, carriers, providers, governments) adjust and re-adjust

Questions and answers

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