HEALTH CARE REFORM

December 2013

Presented by

BENEFIT ADMINISTRATORS

Topics of Discussion

- The Big Picture 3
- Taxes & Fees 6
- The Exchanges: Small Group & the Individual 16
- 2014 Market Reforms 31
- Compliance 34
- Over or Under 50 Employees? 63
- Pay or Play? 71
- Self-Funding 85
- Defined Contribution 89
- Safe Harbors 91

The Big Picture

How the Affordable Care Act (ACA) Became Law

- **March 11, 2010** -- In a letter to Senate Minority Leader Mitch McConnell, Majority Leader Harry Reid says Democrats will use 'reconciliation' to pass the health care bill, needing only 51 votes

- **March 21, 2010** -- The Senate passes its version of the bill, sending the legislation to President Obama's desk to be signed. A separate package of changes expanding the reach of the measure also passed the House over unanimous GOP opposition, and will be taken up by the Senate

- **March 23, 2010** – President Obama signs the health care bill into law

- **June 28, 2012** – Supreme Court upholds ACA, except for Medicaid funding

  - Individual Mandate not sustained as within the scope of Congress' Article 1, Section 8 power to regulate Commerce Clause, Congress cannot force commerce to justify regulatory action (5-4 Roberts, Kennedy , Scalia, Alito, Thomas)
  - Individual Mandate sustained as a constitutional exercise of Congress' Article 1, Section 8 taxing powers, aka a "Penalty Tax" (Roberts, Ginsberg, Breyer, Sotomayor, Kagan)

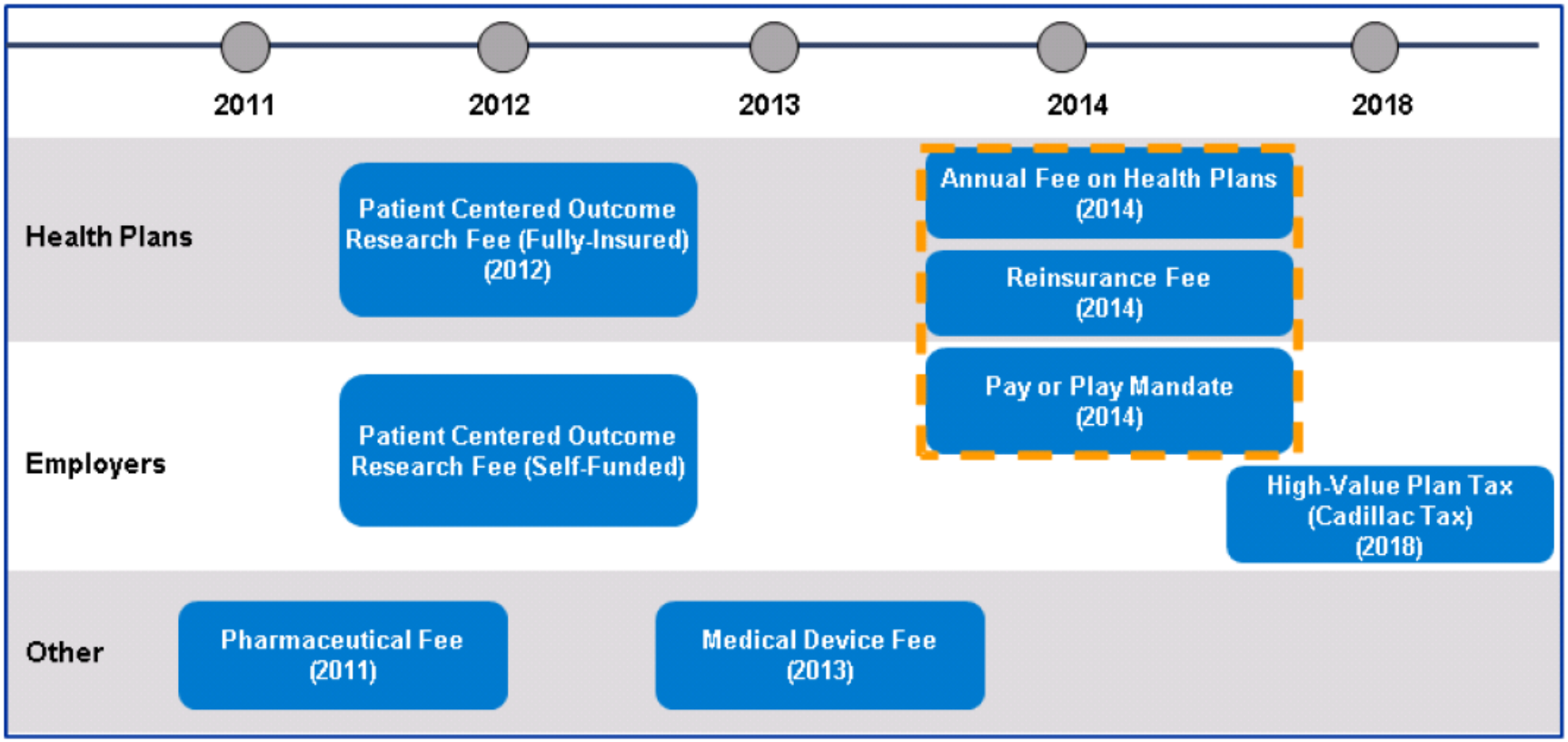
Fundamental Changes Impacting Americans

- Effective January 1, 2014, ***every American*** is required by law to have healthcare or pay a penalty.
- Insurance companies are required to cover all applicants regardless of health.
- Healthcare can be acquired through:
  - Employer
  - Exchange
  - Medicare
  - Medicaid

Taxes & Fees

Key 2014 Provisions: Taxes & Fees

The following taxes & fees will have a significant financial impact on health plans, employers and other groups.



Source: http://www.kff.org/healthreform/upload/8061.pdf, Kaiser Family Foundation, March 2010

Impact on Rates

- Medical Device Tax
- PCORI Fee
- Reinsurance Fee
- Insurer Fee

Annual Rate Impact

Fully Insured: 4-5%

Self Funded: 3%

Patient-Centered Outcomes Research Institute (PCORI)

- **The Affordable Care Act (ACA) established the Patient-Centered Outcomes Research Institute (PCORI) to fund and disseminate comparative effectiveness research that will assist patients, clinicians, purchasers, and policymakers in making informed health decisions.**

- **The fee applies to all plans with plan years ending on or after October 1, 2012 and before October 1, 2019.**

  - The amount of the fee depends on the policy year.

    - The fee is one dollar for policy years ending before October 1, 2013 and two dollars for policy years ending before October 1, 2014.

    - For policies ending on or after October 1, 2014, the fee is increased by projected per capita healthcare spending growth.

Reinsurance Fee

- **Under Section 1341 of ACA, health insurance issuers and third party administrators, on behalf of group health plans will pay an assessment to fund state non-profit reinsurance entities for the purpose of establishing a high-risk pool for the individual market.**
  - The recently issued proposed regulations still leave many procedural questions unanswered but we do know that the fee for 2014 will be $63 per covered life. Plans will receive a notice from HHS in November 2014 indicating the aggregate dollar amount of the assessment and the fee will be payable in December. This fee can be given to the TPA who will then remit to HHS on the plan's behalf.
  - The amount of the assessment is $25 billion and will be collected over the three-year period in the amounts of $12 billion in 2014, $8 billion in 2015 and $5 billion in 2016.
  - The assessment is imposed for a limited number of years, beginning in 2014 and ending in 2016.

Annual Fee on Health Plans

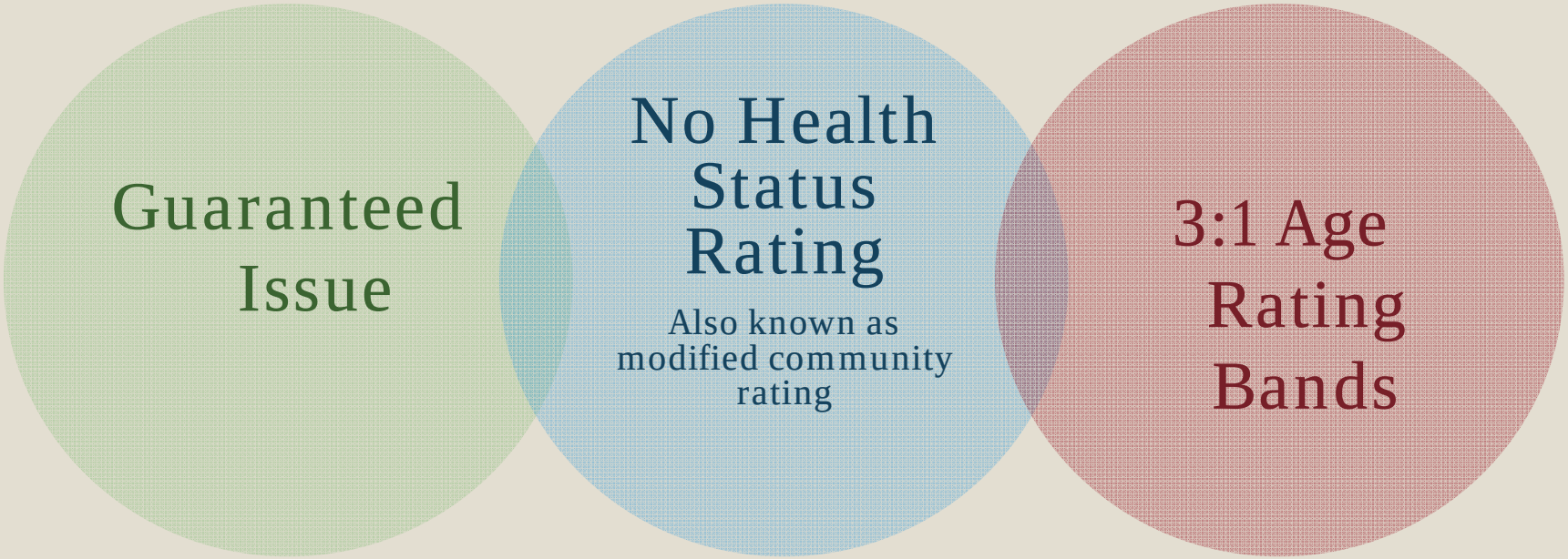
- Effective January 1, 2014, the ACA imposes a new annual fee on heath insurance providers based on their market share of net premiums written, or the sum of premiums earned from all policies, during the previous year.
- The fee is anticipated to raise $101.7 billion and is not tax deductible.
- Total fee to be collected across all health insurers is:
  - $8 billion in 2014
  - $11.3 billion in 2015 and 2016
  - $13.9 billion in 2017
  - $14.38 billion in 2018
  - After 2018, the fee increases annually based on premium growth

The Exchanges:
Small Group (2-50)
&
The Individual

Small Group (2-50) Options

- Discontinue offering employer sponsored coverage with no penalty
- Sponsor a SHOP (Small Business Health Options Program) Exchange plan
- Off Market Exchange
- December 1, 2013 Renewal
- Self-Funding
- Defined Contribution

Underwriting Changes: Small Group (2-50) & Individual Markets

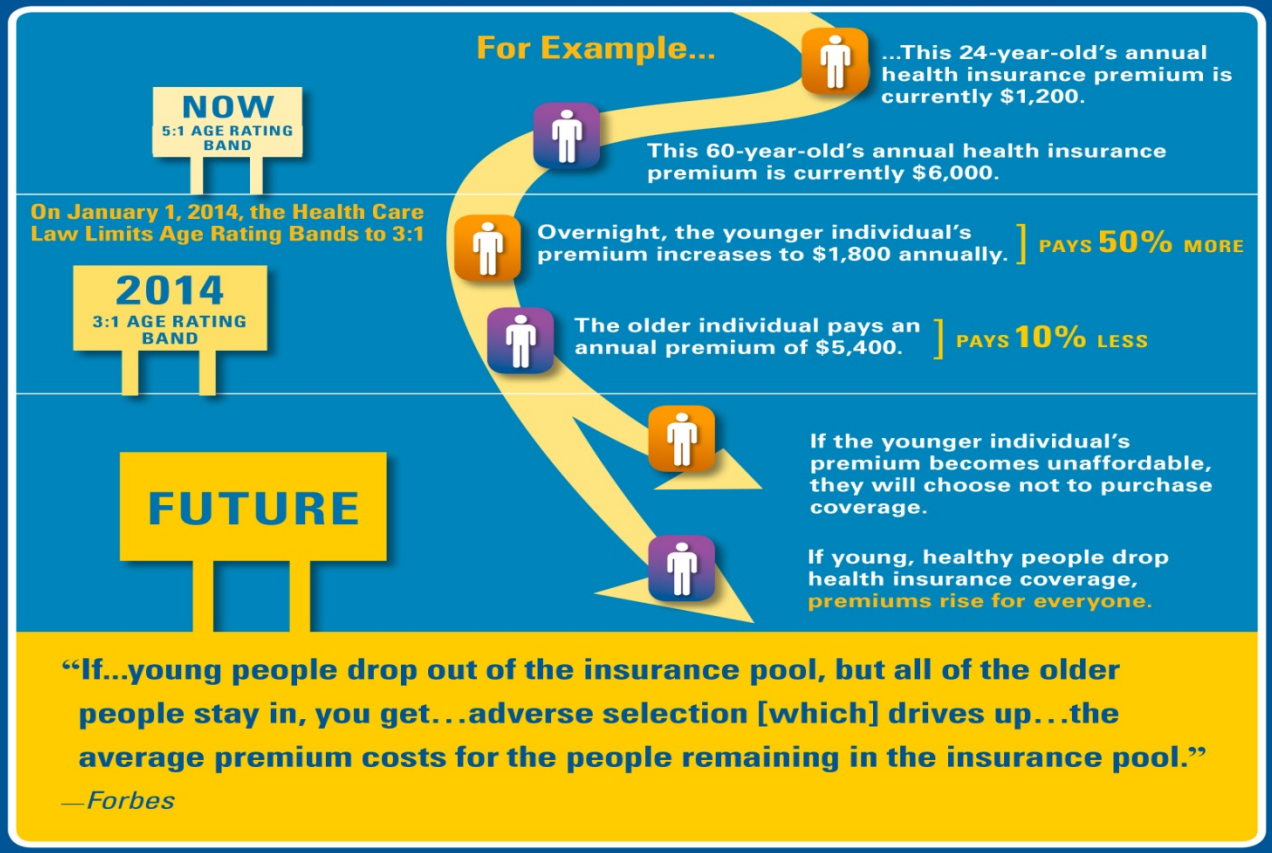


Age Rating

TIME FOR AFFORDABILITY.

Older patients typically utilize more, and higher cost health care services than younger patients. One way states can ensure that coverage remains affordable for everyone is to use age rating bands that spread premium costs over a range of age groups. Currently, in a state with a 5:1 age band, the ratio limits the amount an older individual will pay to no more than five times what a younger individual pays in premium dollars. Right now, 42 states have age rating bands that are 5:1 or more. On January 1, 2014, the health care law limits a state's age rating bands to 3:1.

EFFECTS OF AGE RATING BAND CHANGE FROM 5:1 TO 3:1*



"If...young people drop out of the insurance pool, but all of the older people stay in, you get...adverse selection [which] drives up...the average premium costs for the people remaining in the insurance pool."

—*Forbes*

*Illustrative Example

Follow AHIP on Twitter at @AHIPCoverage and @AHIPEducation | Follow America's Health Insurance Plans on LinkedIn | Follow the AHIP Coverage Blog at www.ahipcoverage.org

AHIP

Exchanges

Exchange plan product requirements

Plus catastrophic plan offering for individuals younger than 30 or facing financial hardship

Essential Health Benefits

These expanded benefits have:

- ✓ No lifetime limits
- ✓ No annual dollar limits

Individual Market Case

40-Year Old Family with 2 Children
Average Health Status in Columbus, Ohio

Product: Contract Type, Gender and Subscriber Age: Underwriting Class:	Lumenos $3000 ded, 100% Coins Family with 2 Children Age 40 20% Rate Up	
	Family Monthly Premium	% Increase
Current premium	$332	
Impact of guaranteed issue and no effective individual mandate, resulting in many waiting to purchase until services are needed	$499	50%
Limiting age discount to 3:1; eliminating gender rating	$588	18%
Eliminating health status discount	$633	8%
Requiring higher benefit level (70% actuarial value and required new benefits)	$708	12%
Health insurer $6.7B annual tax	$730	3%
Pharmaceutical tax and medical device tax	$737	1%
Total Impact	$332 to $737	122%

Subsidies for Individuals

For Exchange plans only

- **To be eligible, individuals must:**
  - Have income between 133% and 400% of federal poverty level (FPL)
  - Not have access to minimum essential coverage through their employer or have access to coverage, but it is not affordable
- **Premium credits** for any Exchange plan
- **Cost-sharing subsidies –** Silver plan only

Income ranges for 133% to 400% FPL

- **Individual:**
  - $15,857 to $45,960
- **Household of four:**
  - $35,500 to $94,200

Subsidy Impact

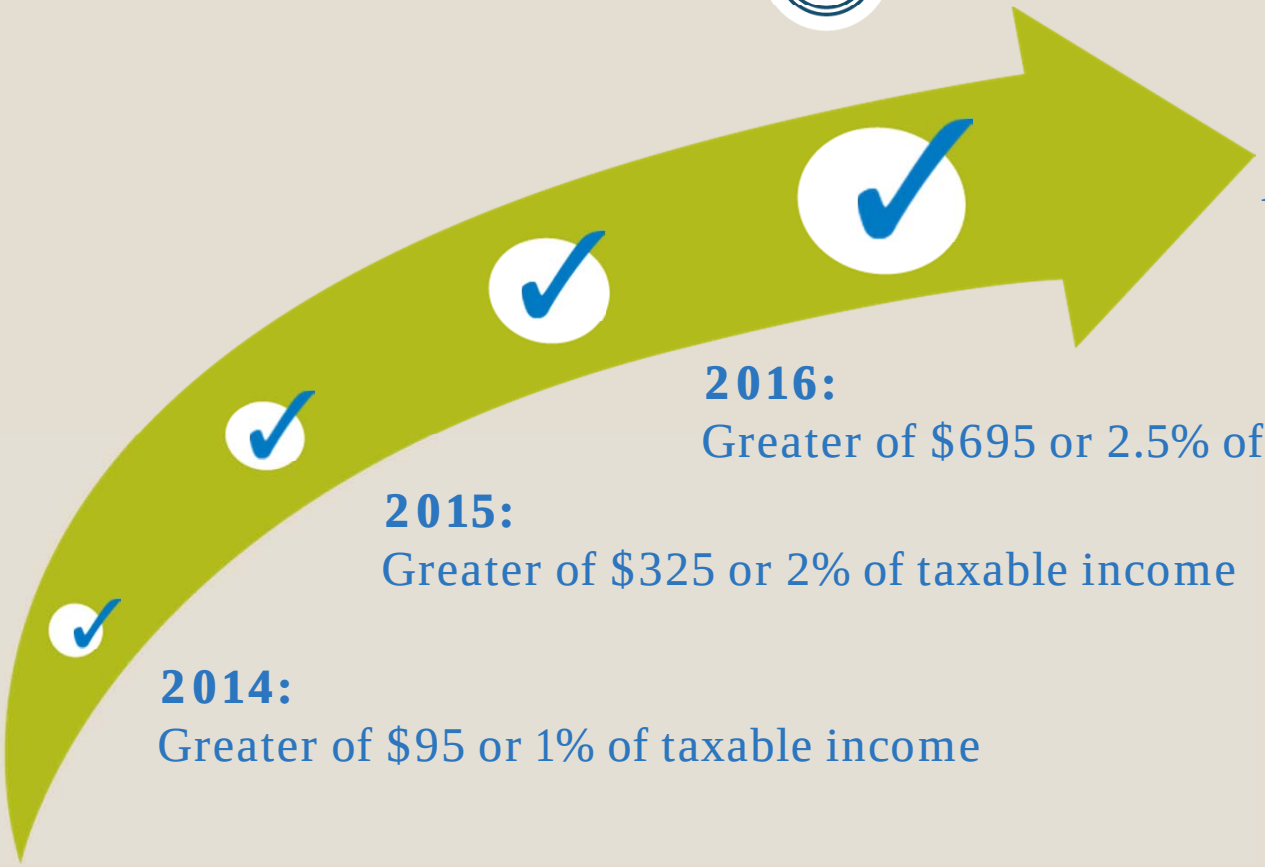
55 –Year Old Male with a Family of 4

HOUSEHOLD SALARY	TOTAL ANNUAL PREMIUM	INDIVIDUAL'S COST	GOVERNMENT SUBSIDY
$100,000	$19,069	$19,069	$0
$75,000	$19,069	$10,141	$8,928
$50,000	$19,069	$6,373	$12,696
$35,000	$19,069	$4,393	$14,676

30–Year Old Single Male

INDIVIDUAL SALARY	TOTAL ANNUAL PREMIUM	INDIVIDUAL'S COST	GOVERNMENT SUBSIDY
$47,000	$3,777	$3,777	$0
$32,000	$3,777	$3,441	$336
$22,000	$3,777	$1,893	$1,884
$16,000	$3,777	$1,137	$2,640

Penalties for Individuals



2014:
Greater of $95 or 1% of taxable income

2015:
Greater of $325 or 2% of taxable income

2016:
Greater of $695 or 2.5% of taxable income

2017 and beyond:
Annual adjustments

- Families will pay half the amount for children up to a cap of $2,250 for the entire family.

Sample Individual Marketplace Plans

2014 MARKETPLACE PRODUCT PORTFOLIO						
PLAN NAME	NETWORK DEDUCTIBLE Single/Family	NETWORK COINSURANCE	NETWORK OUT OF POCKET MAX* Single/Family	EMERGENCY USE OF ER COPAY	NETWORK OFFICE VISIT COPAY LIMIT	RX COVERAGE
Gold *Classic 1000*	$1,000/$2,000	20%	$5,000/$10,000	$250	$25 PCP/Urgent Care $50 Specialist Unlimited Visits	$15/$30/$50 copays Specialty Rx - 20% up to max of $150 Mail Order 3x
Gold *HSA 2000*	$2,000/$4,000 *aggregate deductible*	0%	$2,000/$4,000	Deductible	Deductible	Deductible
Silver *Classic 2000*	$2,000/$4,000	20%	$6,350/$12,700	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance
Bronze *Classic 5000*	$5,000/$10,000	40%	$6,350/$12,700	$300	$40 PCP/Urgent Care $80 Specialist Limit 3 then Ded/Coin	Deductible/Coinsurance
Bronze *HSA 4000*	$4,000/$8,000 *aggregate deductible*	30%	$6,350/$12,700	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance
Bronze *HSA 6000*	$6,000/$12,000 *aggregate deductible*	0%	$6,000/$12,000	Deductible	Deductible	Deductible
Essentials *Young Adult*	$6,350/$12,700 *aggregate deductible*	0%	$6,350/$12,700	Deductible	$40 PCP/Urgent Care Specialist - Ded/Coin Limit 3 then Ded/Coin	Deductible

** Includes deductibles, copays and out-of-pocket amounts.*

Anthem Individual Benefit Snapshot

- Network
  - Tier 1 – Lower cost share - Mount Carmel
  - Tier 2 – Higher cost share
- Office Visits
  - Depending on plan, cost of first 2-3 visits is the office visit copay
  - After 2-3 visits, cost of office visit applies to deductible/coinsurance
- Pharmacy
  - Allowed 2 courtesy fills at retail pharmacy
  - After 2 refills at pharmacy, mandatory mail order

Sponsoring a SHOP (Small Business Health Options Program) Exchange Plan

- Law allows employers to sponsor an Exchange plan
- You choose the level of coverage you'll offer, and define how much you'll contribute towards your employees' coverage.
- 25 or fewer employees + average wages less than $50,000 qualify for subsidy for **first two years coverage is offered** through an Exchange
- Credit up to 50% of employer cost
- Credits decrease on a sliding scale as group size and employee wages increase

Small Group Product Chart - Proposed

Plan #	Metal	Type	Deductible	Member Coins %	Max. OOP	Office Visit (OV/SP)	Member Rx Cost Share	
1	Platinum	Copay	$250	20%	$1750	20/40	10/20/40/20%	
2	Platinum	Copay	$500	20%	$1750	20/40	10/20/40/20%	
3	Platinum	Copay HRA	$2500 (ER $1250)	20%	$4500	20/40	10/20/40/20%	Removed
4	Platinum	Copay HRA	$5000 (ER $3000)	20%	$6350	20/40	10/20/40/20%	Removed
5	Gold	Copay	$1000	20%	$5000	25/50	15/30/50/20%	Public
6	Gold	HDHP	$2000 (Agg, ER $0)	0%	$2000	Deductible	Deductible	
7	Gold	Copay	$2000	20%	$4000	25/50	15/30/50/20%	
8	Gold	HDHP	$2500 (ER $650)	20%	$4000	Deductible	Deductible	Removed
9	Gold	HDHP/HRA	$2500 (Agg. ER $750)	20%	$4000	Deductible	Deductible	Removed
10	Silver	Ded/Coins	$1000	30%	$6350	Deductible	Deductible	
11	Silver	Copay	$2000	30%	$6350	35/70	20/40/60/20%	Public
12	Bronze	HDHP	$3000 (ER 0)	40%	$6350	Deductible	Deductible	
13	Bronze	HDHP	$5000 (ER 0)	20%	$6350	Deductible	Deductible	
14	Bronze	Copay	$5000	40%	$6350	40/80	Ded/Coins	

NOTES

- **Bronze exemption applied per draft regulations**
- **Single benefits only shown, all Family benefits 2x**
- **Max. OOP includes Deductible, Coinsurance, and Copayments for Medical and Rx benefits**
- **HDHP employer contribution compliance TBD**
- **Standalone Dental TBD**

December 1, 2013 Renewal

- Move renewal date to December 1, 2013
- Allows group to avoid community rate for 11 months in 2014

2014 Market Reforms

Auto Enrollment

- Employers with 200 or more full time employees will be required to automatically enroll all new employees and to continue the enrollment of current employees in group health coverage.
  - Plans must provide for an opt-out.
  - We are still awaiting regulations on how Auto-enrollment will work which are anticipated to be released sometime in 2014 with the effective date for Auto-enrollment beginning likely sometime in 2015.

What Reforms Do We Need to Be Concerned With?

- Pre-existing exclusion limitations will be prohibited, regardless of age.
- If offered, Dependent Coverage must be extended until age 26 regardless of the availability to the dependent child of other employer sponsored group health coverage.
- No annual dollar limits on essential health benefits.
  - Be aware that plans can put an annual dollar limit and a lifetime dollar limit on spending for health care services that are not considered “essential.”
- Limitation on waiting period may not exceed 90-days.
- Employer awards for wellness programs increased to 30% of the COBRA cost of coverage (Secretary has discretion to increase to 50%).

Compliance

Compliance

- Increased Audits
- Group Health Plans need plan documents and Summary Plan Descriptions (SPDs) just like retirement plans
- Employer “Notice of Exchange”
- Health Care Reform Annual Notices
- Summary of Benefits and Coverage (SBC)

Employer Notice of Exchange

- Under the ACA, employers ***should*** provide a "Notice of Exchange" to all current employees by October 1, 2013. After October 1, 2013, notices ***should*** be provided to new employees within 14 days of hiring. **There is no fine or penalty under the law for failing to provide the notice.**

- Requirements of the Notice include:
  - information about the existence of the Exchange and the services provided and the manner in which employees may contact the Exchange to request assistance;
  - explanation of how employees may be eligible for a premium tax credit or a cost-sharing reduction if the employer's plan does not meet certain requirements; and
  - informs employees that if they purchase coverage through the Exchange, they may lose any employer contribution toward the cost of employer-sponsored coverage, and that all or a portion of this employer contribution may be excludable for federal income tax purposes

- Model Notices available at:
  - http://www.dol.gov/ebsa/pdf/FLSAwithplans.pdf
  - http://www.dol.gov/ebsa/pdf/FLSAwithoutplans.pdf

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.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name		4. Employer Identification Number (EIN)
5. Employer address		6. Employer phone number
7. City	8. State	9. ZIP code
10. Who can we contact about employee health coverage at this job?		
11. Phone number (if different from above)	12. Email address	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
  - ☐ All employees.
  - ☐ Some employees. Eligible employees are:
- With respect to dependents:
  - ☐ We do offer coverage. Eligible dependents are:
  - ☐ We do not offer coverage.

☐ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☐ **Yes** (Continue)

13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? _____ (mm/dd/yyyy) (Continue)

☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?
☐ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* offered **only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
a. How much would the employee have to pay in premiums for this plan? $
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?
☐ Employer won't offer health coverage
☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)
a. How much will the employee have to pay in premiums for that plan? $
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

Date of change (mm/dd/yyyy):

HCR Annual Notices

Grandfathered Plans

- Grandfathered Model Notice
- WHCRA Notice (Women's Health and Cancer Right Act)
- CHIPRA Notice (Children's Health Insurance Program Reauthorization Act
- HIPAA Special Enrollment Rights Notice

Non-Grandfathered Plans

- Patient Protection Notice – Choice of Providers
- WHCRA Notice (Women's Health and Cancer Right Act)
- CHIPRA Notice (Children's Health Insurance Program Reauthorization Act
- HIPAA Special Enrollment Rights Notice

HCR Annual Model Notices

Grandfathered Model Notice

This [group health plan or health insurance issuer] believes this [plan or coverage] is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your [plan or policy] may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at [insert contact information]. [For ERISA plans, insert: You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.] [For individual market policies and nonfederal governmental plans, insert: You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.]

HCR Annual Model Notices

WHCRA Model Notice

Federal law requires that all plan participants be notified at enrollment and **annually** of their rights under the "Women's Health and Cancer Rights Act." This notice is being furnished to you in compliance with the requirements of the law.

The law requires that all group health plans that provide coverage for a surgically removed breast must also:

- Provide coverage for reconstruction of the surgically removed breast;
- Provide coverage for surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Provide coverage for prostheses and any physical complications that may occur in any stage of a mastectomy, including lymph edemas (swelling associated with the removal of lymph nodes).

Coverage for breast reconstruction and any related services will be subject to any Plan deductibles and covered percentage amounts that apply to other covered medical benefits of the Plan.

HCR Annual Model Notices

CHIPRA Model Notice

If you or your children are eligible for Medicaid or CHIP and you are eligible for health coverage from your employer, your State may have a premium assistance program that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for these programs, but also have access to health insurance through their employer. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must permit you to enroll in your employer plan if you are not already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, you can contact the Department of Labor electronically at www.askebsa.dol.gov or by calling toll-free 1-866-444-EBSA (3272).

HCR Annual Model Notices

HIPAA Special Enrollment Rights Model Notice

Individuals whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26 are eligible to enroll in [Insert name of group health plan or health insurance coverage]. Individuals may request enrollment for such children for 30 days from the date of notice. Enrollment will be effective retroactively to [insert date that is the first day of the first plan year beginning on or after September 23, 2010.] For more information contact the [insert plan administrator or issuer] at [insert contact information].

HCR Annual Model Notices

Patient Protection – Choice of Providers Model Notice

Designation of Primary Care Providers

You have the right to designate any primary care provider (PCP) who participates in the network and who is available to accept you or your family members. For children, you may designate a pediatrician as the PCP. For information on how to select a primary care provider, and for a list of the participating primary care providers, call the Customer Service number on the back of your insurance card.

Direct Access to OB/GYNs

You do not need prior authorization to obtain direct access to obstetrical or gynecological care from a health care professional in the network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, call the Customer Service number on the back of your insurance card.

The SBC – What is it?

- As of September 2012, ACA now requires group health plans and health plan issuers to compile and provide an SBC that "accurately describes the benefits and coverage under the applicable plan and coverage."

- The SBC requirement applies to insured and self-funded ERISA group health plans, including grandfathered plans*, as well as to non-ERISA group health plans and individual health insurance coverage.

*A grandfathered plan is a group health plan that was created on or before March 23, 2010. Grandfathered plans are exempted from many changes required under the Affordable Care Act. Plans or policies may lose their “grandfathered” status if they make certain significant changes that reduce benefits or increase costs to consumers.

The SBC – When do you deliver it?

- **General rules on when group health plans must deliver an SBC to plan participants and beneficiaries.**
  - At enrollment: The plan must provide an SBC for all options for which an individual is eligible to enroll with any written application materials distributed by the plan. If the plan does not distribute written application materials for enrollment, the SBC must be distributed no later than the first day the participant is eligible to enroll.
  - The plan also must provide an SBC to HIPAA special enrollees within 7 business days of a request for enrollment.
  - Upon Request. If a participant or beneficiary requests, the plan must provide an SBC as soon as practicable, but no later than 7 business days after request.

The SBC –Plan Changes

- **What if the plan is modified?**
  - If a plan makes a mid-year material modification to coverage that would affect the content of the SBC, the plan must provide notice of the modification to enrollees no later than 60 days ***prior*** to the date the modification becomes effective.
  - The requirement does not apply to modifications at renewal.
  - The modification notice can either be a separate notice describing just the material modification or an updated SBC.
  - If delivered electronically, the modification notice must follow the electronic delivery rules for SBCs.

The SBC – Penalties for Failure to Deliver

- **Is there a penalty for not providing an SBC?**
  - Yes, a health plan that willfully fails to provide an SBC will be subject to a fine of up to $1,000 for each failure.
  - A failure with respect to each participant and beneficiary constitutes a separate offense.
  - DOL has enforcement authority over ERISA plans and indicated it will issue separate penalty regulations. HHS has enforcement authority over insurers and non-federal governmental plans.
  - Failures also are subject to the excise tax reporting requirements for group health plans (other than governmental group health plans) under Internal Revenue Code 4980D.

Anthem BlueCross BlueShield
Lumenos® Health Savings Account Option E51 Rx 9

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 03/01/2013 - 02/28/2014

Coverage For: Individual/Family | Plan Type: CDHP

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.anthem.com or by calling 1-855-333-5735.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$2500** single / **$5000** family for In-Network Provider **$5000** single / **$10000** family for Non-Network Provider Does not apply to In-Network Preventive Care In-Network Provider and Non-Network Provider deductibles are separate and do not count towards each other.	You must pay all the costs up to the **deductible** amount before this health insurance plan begins to pay for covered services you use. Check your policy to see when the **deductible** starts over (usually, but not always, January 1st.) See the chart starting on page 3 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 3 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes; In-Network Provider Single: **$3500**, Family: **$7000** Non-Network Provider Single: **$7000**, Family: **$14000**	The **out-of-pocket limit** is the most you could pay during a policy period for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Balance-Billed Charges, Health Care This Plan Doesn't Cover, Premiums, Non-Network Human Organ and Tissue Transplant services.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the insurer pays?	No. This policy has no overall annual limit on the amount it will pay each year.	The chart starting on page 3 describes any limits on what the insurer will pay for specific covered services, such as office visits.

Questions: Call 1-855-333-5735 or visit us at www.anthem.com.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 1-855-333-5735 to request a copy.

Important Questions	Answers	Why this Matters:
Does this plan use a network of providers?	Yes. See **www.anthem.com** or call **1-855-333-5735** for a list of participating providers.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Plans use the terms in-network, preferred, or participating to refer to providers in their network.
Do I need a referral to see a specialist?	No, you do not need a referral to see a specialist.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 8. See your policy or plan document for additional information about excluded services.

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **In-Network Provider** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	0% coinsurance	30% coinsurance	————none————
	Specialist visit	0% coinsurance	30% coinsurance	————none————
	Other practitioner office visit	Manipulative Therapy 0% coinsurance Acupuncturist Not covered	Manipulative Therapy 30% coinsurance Acupuncturist Not covered	Manipulative Therapy Coverage is limited to a total of 12 visits, In-Network Provider and Non-Network Provider combined per year.
	Preventive care/screening/ immunizations	No cost share	30% coinsurance	————none————
If you have a test	Diagnostic test (x-ray, blood work)	Lab - Office 0% coinsurance X-Ray - Office 0% coinsurance	Lab - Office 30% coinsurance X-Ray - Office 30% coinsurance	————none————
	Imaging (CT/PET scans, MRIs)	0% coinsurance	30% coinsurance	————none————

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.anthem.com/pharmacyinformation/	Tier 1 – Typically Generic	$10 copay/ prescription (retail and mail order)	50% coinsurance (retail only) with $70 minimum per script	If the member selects a brand drug when a generic equivalent is available the member is responsible for the generic copay + the cost difference between the generic and brand equivalent. If the physician indicates no substitutions the member is only responsible for the brand copay. Covers up to a 30 day supply (retail pharmacy), Covers up to a 90 day supply (mail order program)
	Tier 2 – Typically Preferred/Formulary Brand	$35 copay/ prescription (retail only) and $88 copay/prescription (mail order only)	50% coinsurance (retail only) with $70 minimum per script	If the member selects a brand drug when a generic equivalent is available the member is responsible for the generic copay + the cost difference between the generic and brand equivalent. If the physician indicates no substitutions the member is only responsible for the brand copay. Covers up to a 30 day supply (retail pharmacy), Covers up to a 90 day supply (mail order program)
	Tier 3 – Typically Non-preferred/ non-Formulary Drugs	$70 copay/ prescription (retail only) and $175 copay/prescription (mail order only)	50% coinsurance (retail only) with $70 minimum per script	If the member selects a brand drug when a generic equivalent is available the member is responsible for the generic copay + the cost difference between the generic and brand equivalent. If the physician indicates no substitutions the member is only responsible for the brand copay. Covers up to a 30 day supply (retail pharmacy), Covers up to a 90 day supply (mail order program)
	Tier 4 – Typically Specialty Drugs	25% coinsurance (retail only) with $200 max and 25% coinsurance (mail order only) with $200 max	50% coinsurance (retail only) with $70 minimum per script	If the member selects a brand drug when a generic equivalent is available the member is responsible for the generic copay + the cost difference between the generic and brand equivalent. If the physician indicates no substitutions the member is only responsible for the brand copay. Covers up to a 30 day supply (retail pharmacy), Covers up to a 90 day supply (mail order program)

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you have outpatient Surgery	Facility Fee (e.g., ambulatory surgery center)	0% coinsurance	30% coinsurance	————none————
	Physician/Surgeon Fees	0% coinsurance	30% coinsurance	————none————
If you need immediate medical attention	Emergency Room Services	0% coinsurance	0% coinsurance	————none————
	Emergency Medical Transportation	0% coinsurance	0% coinsurance	————none————
	Urgent Care	0% coinsurance	30% coinsurance	————none————
If you have a hospital stay	Facility Fee (e.g., hospital room)	0% coinsurance	30% coinsurance	Physical Medicine and Rehabilitation (Network and Non-network combined) limited to 60 days, includes Day Rehabilitation programs.
	Physician/surgeon fee	0% coinsurance	30% coinsurance	————none————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Mental/Behavioral Health Office Visit 0% coinsurance Mental/Behavioral Health Facility Visit - Facility Charges 0% coinsurance	Mental/Behavioral Health Office Visit 30% coinsurance Mental/Behavioral Health Facility Visit - Facility Charges 30% coinsurance	Mental/Behavioral Health Office Visit Coverage is limited to 30 visits per yearIn-Network. Out of Network coverage is limited to 10 visits per year.. Behavioral health and substance abuse care both count towards your day or visit limit. Outpatient and office services count towards the limit. Limitations may vary by site of service. You should refer to your formal contract of coverage for details.
	Mental/Behavioral health inpatient services	0% coinsurance	30% coinsurance	Coverage is limited to a total of 30 days, In-Network Provider and Non-Network Provider combined per yearBehavioral health and substance abuse care both count towards your day or visit limit..

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
	Substance use disorder outpatient services	Substance Abuse Office Visit 0% coinsurance Substance Abuse Facility Visit - Facility Charges 0% coinsurance	Substance Abuse Office Visit 30% coinsurance Substance Abuse Facility Visit - Facility Charges 30% coinsurance	Substance Abuse Office Visit Coverage is limited to 30 visits per yearIn-Network. Out of Network coverage is limited to 10 visits per year.. Behavioral health and substance abuse care both count towards your day or visit limit. Outpatient and office services count towards the limit. Limitations may vary by site of service. You should refer to your formal contract of coverage for details. Substance Abuse Facility Visit - Facility Charges Alcoholism Outpatient (non-network) limited to 10 visits.
	Substance use disorder inpatient services	0% coinsurance	30% coinsurance	Coverage is limited to a total of 30 days, In-Network Provider and Non-Network Provider combined per yearBehavioral health and substance abuse care both count towards your day or visit limit. Alcoholism Inpatient (non-network) limited to 1 day. Inpatient and outpatient substance abuse rehabilitation programs are limited to 1 episode per benefit period (Network and Non-Network)..
If you are pregnant	Prenatal and postnatal care	0% coinsurance	30% coinsurance	Your doctor's charges for delivery are part of prenatal and postnatal care.
	Delivery and all inpatient services	0% coinsurance	30% coinsurance	Applies to inpatient facility. Other cost shares may apply depending on services provided.
If you need help recovering or have other special health needs	Home Health Care	0% coinsurance	30% coinsurance	Coverage is limited to a total of 100 visits, In-Network Provider and Non-Network Provider combined per yearDoes not include I.V. therapy.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
	Rehabilitation Services	0% coinsurance	30% coinsurance	Coverage for physical therapy is limited to 20 visits per year, occupational therapy is limited to 20 visits per year, speech therapy is limited to 20 visits per year, cardiac rehabilitation is limited to 36 visits per year, and pulmonary rehabilitation is limited to 20 visits per year. Outpatient and office services count towards the limit. Limitations may vary by site of service. You should refer to your formal contract of coverage for details. Services from In-Network Provider and Non-Network Provider count towards your limit.
	Habilitation Services	0% coinsurance	30% coinsurance	Habilitation and Rehabilitation visits count towards your Rehabilitation limit.
	Skilled Nursing Care	0% coinsurance	30% coinsurance	Coverage is limited to a total of 100 days, In-Network Provider and Non-Network Provider combined per year.
	Durable medical equipment	0% coinsurance	30% coinsurance	----------none----------
	Hospice service	0% coinsurance	0% coinsurance	----------none----------
If your child needs dental or eye care	Eye exam	0% coinsurance	30% coinsurance	Coverage is for vision exam only. Consult your formal contract of coverage.
	Glasses	Not covered	Not covered	----------none----------
	Dental check-up	Not covered	Not covered	----------none----------

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (adult)
- Hearing aids
- Infertility treatment
- Long- term care
- Routine foot care unless you have been diagnosed with diabetes. Consult your formal contract of coverage.
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care
- Most coverage provided outside the United States. See www.bcbs.com/bluecardworldwide.
- Private-duty nursing Limited to $50,000 per benefit period with a lifetime max of $100,000. Consult your formal contract of coverage.
- Routine eye care (adult) for vision exam only. Consult your formal contract of coverage.

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-855-333-5735. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA(3272) or www.dol.gov/ebsa/healthreform

Suite 300
Columbus OH 43215, (800) 686-1526 http://insurance.ohio.gov

Ohio Department of Insurance
Consumer Services Division
50 West Town Street, Third Floor,

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

如果您是非會員並需要中文協助，請聯絡您的銷售代表或小組管理員。如果您已參保，則請使用您 ID 卡上的號碼聯絡客戶服務人員。

Doo bee a'tah ni'liigoo eí dooda'í, shikáa adoołwoł íníżinigo t'áá diné k'éjíigo, t'áá shoodí ba na'ałníhí ya sidáhí bich'į naabídíiłkiid. Eí doo biigha daago ni ba'nija'go ho'aałagíí bich'į hodiilní. Hai'dąą iini'taago eíya, t'áá shoodí diné ya atáh halne'ígíí ní béésh bee hane'í wólta' bi'ki si'niilígíí bi'kéhgo bich'į hodiilní.

Si no es miembro todavía y necesita ayuda en idioma español, le suplicamos que se ponga en contacto con su agente de ventas o con el administrador de su grupo. Si ya está inscrito, le rogamos que llame al número de servicio de atención al cliente que aparece en su tarjeta de identificación.

Kung hindi ka pa miyembro at kailangan ng tulong sa wikang Tagalog, mangyaring makipag-ugnayan sa iyong sales representative o administrator ng iyong pangkat. Kung naka-enroll ka na, mangyaring makipag-ugnayan sa serbisyo para sa customer gamit ang numero sa iyong ID card.

About These Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $4,870
- **Patient pays:** $2,670

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Total Deductibles	$2,500
Co-pays	$20
Co-insurance	$0
Limits or exclusions	$150
Total	**$2,670**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $2,580
- **Patient pays:** $2,820

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Total Deductibles	$2,500
Co-pays	$240
Co-insurance	$0
Limits or exclusions	$80
Total	**$2,820**

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: www.anthem.com or 1-855-333-5735.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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W-2 Reporting - Updated Guidance

- **The requirement for 2014**

  –Employers must report value of aggregate cost of employer-sponsored health benefits on W-2s for 2013 (issued in January 2014)

  - This does not mean the value of health coverage will become taxable income.

    - *"The reporting is intended to inform employees of the cost of their health care coverage and does not cause excludable employer-provided coverage to become taxable."*

W-2 Reporting - Updated Guidance

- **Certain costs and types of coverage are not reportable on the Form W-2.**
  - Does not apply to Health Care FSAs if contributions only occur through IRC 125 employee salary deferrals
  - Does not include Dental and/or Vision coverage that is considered limited scope or unbundled from Medical/Rx benefits
  - Does not include any amounts contributed to a Health Savings Account (but continue reporting on HSAs in box 12 using code W); and
  - Does not include costs under an EAP, wellness program, or on-site medical clinic if the employer does not charge a premium for that coverage under COBRA

Over or Under 50 Employees?

Are you an Applicable Large Employer (ALE)?

- **Did you average at least 50 FTE (full time equivalents) in the preceding calendar year?**
  - For 2014 transition year you may use a 6 month average (rather than a full year) during 2013 to make the determination.
  - For new employers in 2014 if you anticipate hiring 50 or more FTE in 2014 you will be considered an ALE.
  - ALE status is determined on a controlled group basis, however any penalty fees owed will be assessed against the individual members of the control group.

What is a Controlled Group?

- Control Group Concept
  - Multiple Employers may be treated as a single employer for ACA issues
  - Parent – Subsidiary
  - Brother – Sister
  - Must know ownership percentages
    - Effective Control
    - Controlling Interest

Are you an Applicable Large Employer (ALE)?

- **In order to determine if you are an ALE you must add the following:**
  - Anyone who works on average 30 or more hours per week or 130 hours per month is considered full time.
  - Anyone who works less than 30 hours per week is considered part time but you must calculate their full time equivalency. This is done by adding the total hours worked and dividing by 120. Add this number to the number of full time employees and round **down** to determine if you have 50.
  - Regarding seasonal employees; if they work no more than 4 calendar months or 120 days, you can back these out of ALE calculation.

ALE FTE Calculation: Seasonal Employees

- IRS says employers may use reasonable good faith interpretation of the term "seasonal employee" in 2014 to include retail employees employed during the holiday season, or agricultural workers
  - The preamble to the Proposed Rule indicates the IRS may issue a future rule that defines a seasonal EE that works less than a specified period of time within a calendar year

The ALE FTE Calculation - An Example

- ABC Company has 47 employees that work at least 30 hours per week. They also employ 3 part time workers who work varying hours. In the month of December 2013 the following are the total number of hours worked:
  - Mary – 100 hours
  - Ted – 100 hours
  - Liz – 40 hours

The ALE FTE Calculation

- In order to determine if ABC has 50 FTE's add the total hours worked by Mary, Ted and Liz (100 + 100 + 40 = 240 and divide by 120 = 2) .
- ABC must add 2 FTE to their total count bringing the headcount to 49 FTE.
- This sample calculation must be done each month and if ABC continues to average less than 50 FTE for each month, they will not be considered an ALE and will not be subject to 4980H.

Are you an ALE? The Results…

- If you have less than 50 FTE …YOU ARE NOT AN ALE AND YOU ARE NOT SUBJECT TO 4980H
  - No potential penalties apply, but you still need to pay PICORI and Reinsurance Tax, as well as comply with other 2014 benefit mandates.
- If you do have 50 FTE, you are subject to 4980H
  - This doesn't mean you have to provide coverage it just means you need to factor in the cost of no coverage/coverage too expensive to your plan design considerations.


Pay or Play?
50+ Employees
Delayed until 2015

The Employer Mandate – IRC 4980H

- **Overview**
  - IRC 4980H prescribes one of two excise taxes on an Applicable Large Employer if a full time employee enrolls in the Exchange and receives an IRC 36B premium tax subsidy for any month.
  - These are:

    - **4980H(a) – "Sledgehammer":** The Applicable Large Employer failed to offer full time employees minimum essential coverage during such month.

    - **4980H(b) – "Pickaxe":** The Applicable Large Employer failed to offer full time employees with Minimum Essential Coverage that is affordable and provides Minimum Value during such month.

Before we Begin…Let's Step Back

- It is easy to get caught up in the frenzy … To offer coverage or not to offer coverage…that is the question….
- BUT, it is important to remember that there is nothing in the ACA that requires you to make this decision.
- The real question is NOT how many hoops do I have to jump through and days/weeks of time must my team spend to avoid these penalties.
- RATHER the ACA does not change our most fundamental questions about employer sponsored coverage which are:
  - WHAT COVERAGE do I want to offer?
  - TO WHOM do I want to offer it to?
  - HOW MUCH do I want to share the cost with my employees?

Before we Begin…Let's Step Back

- As we start to formulate our answers to these questions, the ACA potential penalties must now be factored in.

- These potential penalties now compel us to add a few new questions:
  - BASED on what I want to offer, MIGHT I have to pay the government for:
    - FAILURE to offer coverage to everyone?
    - FAILURE to meet minimum standards of coverage; or
    - FAILURE to make it affordable to all my employees.

Before we Begin…Let's Step Back

- Remember that in either penalty scenario an employee must go to the Exchange and qualify for a subsidy and use it to buy a policy.
  - Will employees do it?
    - Some employees will jump on spouse's plan and not go to the Exchange.
    - Some employees will make too much money to get a subsidy.
    - Some household incomes will be low enough to qualify for Medicaid.
    - Some may not get any coverage at all and pay individual mandate.

No Coverage – "Sledgehammer" Penalty

- This penalty is applicable in the instance where an ALE does not offer Minimum Essential Coverage (MEC).
  - Coverage for spouses is NOT required to avoid this penalty.
  - This penalty does not factor in the cost of coverage to the employee, avoiding this penalty is as simple as providing access to a plan that can be 100% employee paid.
  - Employees must have an effective opportunity to enroll no less than 1 time per plan year.
  - There is currently NO guidance on what constitutes MEC.

No Coverage – "Sledgehammer" Penalty

- In the event that coverage is not offered and any full time employee goes to the Exchange, grabs a federal government subsidy and purchases coverage, **the employer will be required to pay a penalty on all full time employees, not just the employee who went to the Exchange.**
  - The amount of the penalty has initially been set at **$2000/year**.
  - The penalty is assessed monthly for any month in which an employee utilizes a subsidy to purchase an Exchange policy.
  - When calculating the penalty, you subtract 30 from your full time employee count.

“Sledgehammer” Penalty- An Example

- ABC Company in Columbus, OH has 200 employees that work more than 30 hours per week.
- ABC Company, decides to discontinue offering coverage to employees.
- Mary Jones, a full time employee enrolls in the Marketplace. Because her family household income is below $88,000, Mary qualifies for a premium subsidy to help offset the cost of a family policy through the Marketplace.
- Mary purchases a one year family policy through the Marketplace using her subsidy plus some money she has in savings.
- No other employees of ABC Company get coverage through the Marketplace.
- ABC Company will be assessed the No Coverage Penalty, calculated as follows:
  - (200-30) x 2000 = $340,000 will be owed by ABC merely because one of their 200 full time employees utilized a subsidy to purchase a policy.

Insufficient or Unaffordable Coverage – "Pickaxe" Penalty

- In the event that you offer coverage to all of your full time employees and their dependent children, you may be subject to a smaller penalty of $3000/ year in the event of one of 2 instances:
  - COVERAGE IS TOO EXPENSIVE – If the cost of a single only policy on your plan is more than 9.5% of an employee's household income and an employee goes to the Marketplace and uses a subsidy, your coverage would be determined to be unaffordable.
    - Safe harbor determination allows you to use W-2 wages (you cannot add back pre-tax salary reductions for things like 401(K); hourly rate of pay x 130 hours (hourly employees or monthly rate of pay (salary employees); or published FPL for a single individual.

Insufficient Coverage – "Pickaxe" Penalty

- COVERAGE DOES NOT MEET MINIMUM VALUE- If the plan's share of the total allowed costs of benefits provided under the plan is LESS than 60% and an employee goes to the Marketplace and buys a policy using a subsidy the $3,000 penalty will apply to that employee.
  - There is no guidance yet on how to calculate Minimum Value but HHS/IRS plan to develop a calculator, they will also publish design based safe harbors that will meet the minimum value.

Insufficient Coverage – "Pickaxe" Penalty – An Example

- ABC Company has 200 employees that work more than 30 hours per week.
- ABC Company, rather than risk the Sledgehammer Penalty, offers healthcare coverage to all of their employees **BUT** in order to defray the cost of doing so, they increase premiums to their employees to much higher rates. The employee share of the premium for single only coverage on ABC's plan is $5000/year.
- Mary Jones, a title clerk, makes approximately $25,000 per year. The premium charged by ABC of $5000, is equal to 20% of Mary's W-2 reported income. ABC coverage is "too expensive" for Mary because it is more than $2,375 or 9.5% of Mary's annual income.

Unaffordable Coverage – "Pickaxe" Penalty – An Example

- Mary decides to explore the Marketplace and finds that she qualifies for a subsidy based on her household income.
- Mary enrolls in the Marketplace and purchases a family policy using her subsidy plus some money she has in savings.
- No other ABC employees utilize subsidies to buy coverage through the Marketplace.
- ABC Company will pay a penalty equal to $3000. Since coverage is offered to all full time employees, ABC's total cost in this example for offering "expensive" coverage is $3000, NO OTHER PENALTIES APPLY.

50+ Penalty Exhibit I

ABC DEALERSHIP

50+ EMPLOYER PENALTY EXHIBIT I

BENEFIT ADMINISTRATORS

PENALTY FOR DISCONTINUING EMPLOYER SPONSORED HEALTHCARE IN 2014

TOTAL # OF FULL TIME EMPLOYEES	LESS 30	# OF EMPLOYEES CONSIDERED	PENALTY PER EE	TOTAL PENALTY COST	
80	30	50	$2,000	$100,000	(not tax deductible)

Assuming 45% tax rate, the total penalty cost is equivalent to $181,819 in benefit cost

EXHIBIT BASED ON 80 ELIGIBLE EMPLOYEES WITH 55 EMPLOYEES ENROLLING

FOR ILLUSTRATIVE PURPOSES ONLY

HEALTH SAVINGS ACCOUNT ELIGIBLE PLAN - $2500 SINGLE DEDUCTIBLE/$5000 FAMILY DEDUCTIBLE/100% COINSURANCE

CATEGORY	RATE	COMPANY CONTRIBUTION	EMPLOYEE CONTRIBUTION	EMPLOYEE ANNUAL CONTRIBUTION	% PAID BY EMPLOYER	# EMPLOYEES	MONTHLY EMPLOYER RATE	ANNUAL EMPLOYER RATE	MONTHLY EMPLOYEE RATE	ANNUAL EMPLOYEE RATE
EE	295.89	147.95	147.95	1,775.34	50%	40	5,917.80	71,013.60	5,917.80	71,013.60
Family	740.93	147.95	592.99	7,115.82	20%	15	2,219.18	26,630.10	8,894.78	106,737.30
							$8,136.98	**$97,643.70**	**$14,812.58**	**$177,750.90**
					Annual Employer Rate after 45% tax:			**$53,704.00**		

Additional savings due to FICA = $13,598

If an employee were to purchase insurance through the exchange and $1,775.34 is more than 9.5% of their AGI ($18,684), ABC Dealership would be subject to a $3,000 fine per employee who receives a subsidy for exchange coverage.

50+ Penalty Exhibit II

ABC DEALERSHIP

50+ EMPLOYER PENALTY EXHIBIT II

BENEFIT ADMINISTRATORS

PENALTY FOR DISCONTINUING EMPLOYER SPONSORED HEALTHCARE IN 2014

TOTAL # OF FULL TIME EMPLOYEES	LESS 30	# OF EMPLOYEES CONSIDERED	PENALTY PER EE	TOTAL PENALTY COST	
150	30	120	$2,000	$240,000	(not tax deductible)

Assuming 45% tax rate, the total penalty cost is equivalent to $436,364 in benefit cost

EXHIBIT BASED ON 150 ELIGIBLE EMPLOYEES WITH 110 EMPLOYEES ENROLLING

FOR ILLUSTRATIVE PURPOSES ONLY

HEALTH SAVINGS ACCOUNT ELIGIBLE PLAN - $2500 SINGLE DEDUCTIBLE/$5000 FAMILY DEDUCTIBLE/100% COINSURANCE

CATEGORY	RATE	COMPANY CONTRIBUTION	EMPLOYEE CONTRIBUTION	EMPLOYEE ANNUAL CONTRIBUTION	% PAID BY EMPLOYER	# EMPLOYEES	MONTHLY EMPLOYER RATE	ANNUAL EMPLOYER RATE	MONTHLY EMPLOYEE RATE	ANNUAL EMPLOYEE RATE
EE	350.00	175.00	175.00	2,100.00	50%	70	12,250.00	147,000.00	12,250.00	147,000.00
Family	1,000.00	500.00	500.00	6,000.00	50%	40	20,000.00	240,000.00	20,000.00	240,000.00
							$32,250.00	$387,000.00	$32,250.00	$387,000.00
					Annual Employer Rate after 45% tax:			$212,850.00		

Additional Savings due to FICA = $29,025

If an employee were to purchase insurance through the exchange and $2,100.00 is more than 9.5% of their AGI ($22,105), ABC Dealership would be subject to a $3,000 fine per employee who receives a subsidy for exchange coverage.

Self-Funding

Self-Funding Advantages

- Carriers are beginning to offer self-funding for groups with as few as 15 employees
  - Allows groups size 15-50 to avoid community rating
  - Risk of self-funding may be more cost effective then Exchange premiums
- Allows all groups the ability to design own benefit plan
  - Must comply with employer mandate and minimum essential benefits
- Control of Reserves
  - Employer can hold onto reserves and has ability to invest them where they see fit
  - Employer only pays reserves when claims occur
- Claims experience
  - All groups will receive claims experience regardless of size
- Avoid premium tax
- Only paying renewal increase on fixed costs

Self-Funding Overview

- Employer will pay a low fixed cost to an insurance carrier or Third-Party Administrator (TPA), every month, regardless of claims.
- The fixed costs include but are not limited to:
  - Specific Deductible: The stop loss deductible is the amount for which the client is responsible for each individual employee or dependent claim in the policy year.
  - Aggregate Stop-Loss: Provides protection for an excessive amount of claim expenditures for the entire group for the policy year.
  - Medical Administrative Fee
  - Network Access Fee
  - Utilization Management Fee
  - Prescription Fee
  - COBRA and HIPAA
- Fixed Costs are approximately a third of the fully insured equivalent premium.
- Employer then pays the cost of eligible claims up to each individual's specific deductible.

ABC Company Self-Funded Financial Analysis

Census:	Medical:
Employee	13
Family	41
Total	54

	Stop Loss Carrier
Specific Deductible (Per Individual)	$30,000

Specific Premium	Employee	Annual
Employee	$ 95	$ 14,820
Family	$ 240	$ 118,080
Total Specific Premium		$ 132,900
Aggregate Premium	$ 9	$ 5,832
Total Stop Loss Premium		$ 138,732
Administrative Fees--2 Year	$ 44	$ 28,512
Total Annual Fixed Cost		**$ 167,244**
Total Expected Claims		**$ 316,080**
Total Expected Cost		**$ 483,324**
Total Maximum Claims		**$ 395,100**
Total Maximum Cost		**$ 562,344**

Defined Contribution

Defined Contribution

- Fixed budget: control cost
- Less administrative burden
- More plan options for employees
- Solutions for full, part-time, retired employees
- Attract and retain employees

Safe Harbors

Full Time Employees – Available Safe Harbors

- Safe harbor rules are available if you want to examine your employee population to determine more precisely who should be deemed full time under the proposed regulations.
- You do not have to use these safe harbors but they are available.
- The basic concept of the safe harbor is to utilize both a look back or measurement period and a look forward or stability period.

Full Time Employees – Available Safe Harbors

- NEW EMPLOYEES
  - Utilization of the safe harbor may be a good idea if you are uncertain on average how many hours per week a new employee will work.
  - For these employees you will set up an Initial Measurement Period (generally 3-12 months) and if during that period the employee works on average more than 30 hours per week, you will be required to offer that new employee coverage during the subsequent stabilization period (cannot be less than the IMP). You may have a short (up to 90 day, Administrative Period after the IMP to allow for plan enrollment), however coverage must begin no later than the end of the 1st month that begins on or after the anniversary of the employee's hire date.
  - For new employees where hours worked is more certain, the safe harbor should not be used, rather coverage must be offered to such new employee within 90 days of date of hire.
  - If the new employee changes status (drops to part time) during the stability period, this does not affect their classification as full time, coverage must be continued.

Full Time Employees – Available Safe Harbors

- ONGOING EMPLOYEES
  - Utilization of the safe harbor may be a good idea for your ongoing employees if you are uncertain on average how many hours per week your non-exempt employees actually work.
  - For these employees you will set up a Standard Measurement Period (generally 3-12 months) and if during that period the employee works on average more than 30 hours per week, you will be required to offer that ongoing employee coverage during the subsequent stabilization period (cannot be less than the SMP). You may have a short, up to 90 day, Administrative Period after the SMP to allow for plan enrollment.
  - For exempt employees who are considered full time employees and are expected to work at least 30 hours or more per week, the safe harbor should not be used, rather coverage must be offered to such employees.
  - If the employee changes status (drops to part time) during the stability period, this does not affect their classification as full time, coverage must be continued.

Questions?

Contact Information

Benefit Administrators
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