Connecting the Dots for Nonprofits on Healthcare Reform:
The Exchanges, the Premium Subsidies, and the Employer Mandate

Thursday, September 12, 2013, 8:30 a.m. – 10:00 a.m. ET
Venable LLP, Washington, DC

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Upcoming Venable Nonprofit Legal Events

September 18, 2013 – Keeping Up with Technology and the Law: What Your Nonprofit Should Know about Apps, the Cloud, Information Security, and Electronic Contracting

October 24, 2013 – The IRS Final Report on Nonprofit Colleges and Universities: Lessons for All Tax-Exempt Organizations

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Agenda

- Introduction
- The Exchanges and The Subsidies
- Preparing for the Employer Mandate
- Employer Strategies
- Other Fees and Market Reform Provisions

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The Exchanges and The Subsidies

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The Drivers of Health Care Reform?

- Reform Insurance Laws
  - Mandate certain insurance standards
    - For example, “Essential Health Benefits,” “Actuarial Value,” Cost-Sharing Limitations, “Grandfather” Rules
- Coverage - Priority #1
  - Expand Medicaid
  - Provide premium subsidies to help low- to middle-income people purchase health insurance
    - The new health insurance Exchanges created under PPACA became the mechanism through which these subsidies could be accessed

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The Exchange – The "Concept"

- The original intent of the Exchange created under ACA was not to deliver the subsidies, but rather to serve as a marketplace
  - It was believed that the Exchange would reduce administrative costs
  - In addition, it was believed that the Exchange would attract multiple insurance carriers, which would promote competition
  - Achieving these two goals could translate into lower premiums
- Early on in the drafting process, it was "private" exchanges that served as the model, not the Massachusetts Connector

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What Should You Know about the ACA Exchanges?

- Initially, the Exchanges will service (1) individuals and families in the individual market and (2) employees of small employer
  - In 2017, a State may elect to permit the sale of fully-insured large group plans through the Exchange, but a State is not required to do so
    - Upon an election, the adjusted community rating rules would apply and it is likely that many of the other minimum standards (e.g., the requirement to provide the "essential health benefits" and the single risk pool rules) will apply
- An Exchange may be structured as (1) a governmental agency or (2) an independent non-profit entity

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What Should You Know about the ACA Exchanges?

- The Exchange is directed to perform specific functions
  - For example, determine eligibility for an advance-refundable tax credit for health insurance and cost-sharing subsidy (i.e., premium subsidies), establish and maintain a web site, and set up a call-center to field questions from consumers
- The statute also gives States the authority to permit their Exchanges to prohibit carriers from offering a plan through the Exchange
  - To date, 7 States have an “active purchaser” Exchange

The ACA Exchanges – The "Reality"

- October 1st will be a "soft" launch for most ACA Exchanges
  - Many State-based Exchanges – and even HHS with the Federally-facilitated Exchange – have been forced to de-scope the capabilities they planned to have available to consumers during the initial weeks of operation
  - This includes on-line capabilities, real-time enrollment, decision support and education tools, which won't be fully functional until some future date

The ACA Exchanges – The "Reality"

- What are some of the other challenges?
  - IT, IT, IT – establishing an Exchange is one of the most complex IT projects ever initiated by Federal and State governments in the area of health care
  - Verification of data
    - It is likely that not all State-based Exchanges will have completed the necessary rounds of testing with the Federal Data Services Hub by Oct. 1st
    - The debate over whether the Federal government will be able to accurately verify income for purposes of determining subsidy eligibility persist, who to believe?
  - Privacy and security
    - HHS Inspector General raised concerns of unauthorized use of personal information
    - Concerns over mishandling of personal information by the "assisters"

The Subsidies Offered through the "Public" Exchange

- GENERAL RULE – An individual is NOT eligible for subsidies offered through the Exchange if he or she is "eligible" for employer-sponsored coverage
  - So, even if your employees are subsidy-eligible, they CANNOT go to the Exchange and access the subsidies
- EXCEPTION – The employer-sponsored coverage
  1. Is "unaffordable" (i.e., the employee's contribution for the lowest cost for self-only plan exceeds 9.5% of the employee's household income) or
  2. Does NOT provide "minimum value" (i.e., the employer coverage does not pay for at least 60% of the benefits provided under the plan)
     - In this case, depending upon an employee's income, an employee may opt out of employer coverage, go to the Exchange, and access the subsidies

The Exchanges & The Premium Subsidies: Impact on Employers

- How will they impact employers?
  - *Behavioral Changes*
    - Small employees may drop coverage because (1) they can get out of the "health care game" and (2) a majority of their employees will likely get a better financial deal as long as the premium subsidies are available
    - Although large employers are NOT likely to drop coverage immediately, their employees may want the premium subsidies because (1) they may get a better financial deal as long as the premium subsidies are available and/or (2) the "family glitch" issue
  - *Verification Process*
    - If and when employees seek to access a premium subsidy, a verification process will be triggered which will require the employer to communicate with the Exchange in some way (e.g., establish an "electronic data source" that the Exchange may access or receive phone calls from the Exchange directly, attempting to verify plan information for purposes of determining subsidy eligibility)

The Exchanges & The Premium Subsidies: Impact on Employers

- Implications of one-year delay of "employer mandate" penalties
  - *Employer Response*
    - No incentive for employers to change their plan designs to satisfy the new requirements in 2014
    - This means more employees who would otherwise be considered "full-time" (i.e., working 30 hours a week) (1) will not be offered an employer plan or (2) will be offered an employer plan that is "unaffordable" or does not provide "minimum value" in 2014
  - *Employer/Employee Relations Issue*
    - If an employee accesses a premium subsidy in 2014, they may pay as little as 2% of income for health insurance (because the Federal government picks up the rest of cost)
    - But, in 2015, the employee may be required to pay 9.5% of income for an employer plan (because the employer offers an "affordable" plan); AND, the employee will NOT be eligible for a subsidy

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Preparing for the Employer Mandate

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Preparing for the Employer Mandate

DETERMINING IF THE MANDATE APPLIES

- The employer mandate applies to "applicable large employers"
  - Defined as "an employer that employed an average of at least 50 full-time employees (including full-time equivalent employees) on business days during the preceding calendar year."
  - Common law test used for identifying employees

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Preparing for the Employer Mandate

DECIDING TO PLAY OR PAY – AND AVOIDING DOING BOTH

- Was generally effective January 1, 2014
- Delayed until January 1, 2015
- Many questions on how it will be implemented in 2015

Preparing for the Employer Mandate

DECIDING TO PLAY OR PAY – AND AVOIDING DOING BOTH

- Penalty for Failure to Provide Coverage
  - If greater than 5% of "full-time" employees (or 5, if greater) are not offered coverage and even ONE "full-time" employees obtains a subsidy through an Exchange → the "no coverage" penalty is triggered
  - Penalty applies on an employer-by-employer basis

Preparing for the Employer Mandate

DECIDING TO PLAY OR PAY – AND AVOIDING DOING BOTH

- Penalty for Failure to Provide Coverage
  - Penalty = $2,000/year * TOTAL number of “full-time” employees
    - Assessed on a monthly basis ($166.67/employee/month)
    - First 30 “full-time” employees are disregarded

Preparing for the Employer Mandate

IDENTIFYING FULL-TIME EMPLOYEES

- Safe harbor for determining if an employee = "full-time"
  - If an employee averages 30 or more hours of service per week during a measuring period → he or she should be treated as "full-time" (i.e., offered coverage) during the subsequent stability period

Preparing for the Employer Mandate

IDENTIFYING FULL-TIME EMPLOYEES

- An “hour of service” is each hour for which an employee is paid, or entitled to payment:
  - For the performance of duties for the employer; and
  - On account of a period of time during which no duties are performed due to vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty or leave of absence.

Preparing for the Employer Mandate

IDENTIFYING FULL-TIME EMPLOYEES

- Standard measuring period = 3-12 months
- Stability period = 6-12 months period immediately following the standard measuring period (and any applicable administrative period)
- Administrative period = up to 90 day period between a standard measuring period and a corresponding stability period

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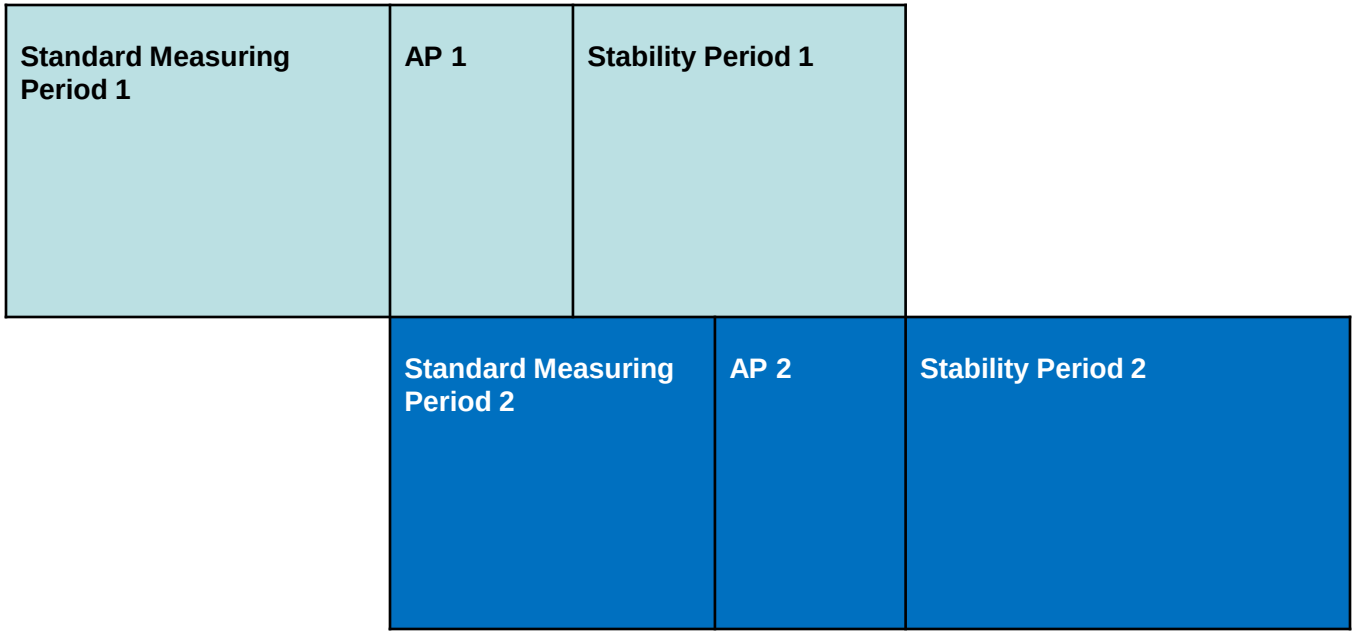
IDENTIFYING FULL-TIME EMPLOYEES

Ongoing Testing of Employees



Ongoing Testing of Employees

November 1, 2013 – October 31, 2014	**First Standard Measuring Period** The hours of all employees will be measured for this period to determine if they are "full-time" under the new rules (i.e., average 30+ hours per week).
November 1, 2014– December 31, 2014	**First Standard Administrative Period** During this period, the employer will review the hours during the first standard measuring period and will offer coverage to any employee identified as full-time based on hours from the first standard measuring period. This offer of coverage will extend through the entire first stability period. The employer should maintain documentation of the offer of coverage.
November 1, 2014 – October 31, 2015	**Second Standard Measuring Period**
January 1, 2015 – December 31, 2015	**First Standard Stability Period** Coverage will be maintained for all employees identified as "full-time" based on hours during the first standard measuring period (provided those employees elect coverage and pay applicable premiums).
November 1, 2015 – December 31, 2015	**Second Standard Administrative Period**
November 1, 2015 – October 31, 2016	**Third Standard Measuring Period**
January 1, 2016 – December 31, 2016	**Second Standard Stability Period**

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IDENTIFYING FULL-TIME EMPLOYEES

- At Date of Hire
  - Any individual reasonably expected to complete at least 30 hours of service per week is automatically considered a “full-time” employee
  - All other employees = variable hour employees
  - “Seasonal employees” also = variable hour employees (even if they are initially expected to complete 30 or more hours of service per week)

Preparing for the Employer Mandate

IDENTIFYING FULL-TIME EMPLOYEES

- No penalties apply during the first three calendar months of employment
- Initial measuring period = 3-12 months
  - Overlaps with first full standard measuring period after employment begins
- Initial measuring period + administrative period cannot extend beyond the last day of the first calendar month beginning on or after the one year anniversary of the employee's start date ("13-month rule")

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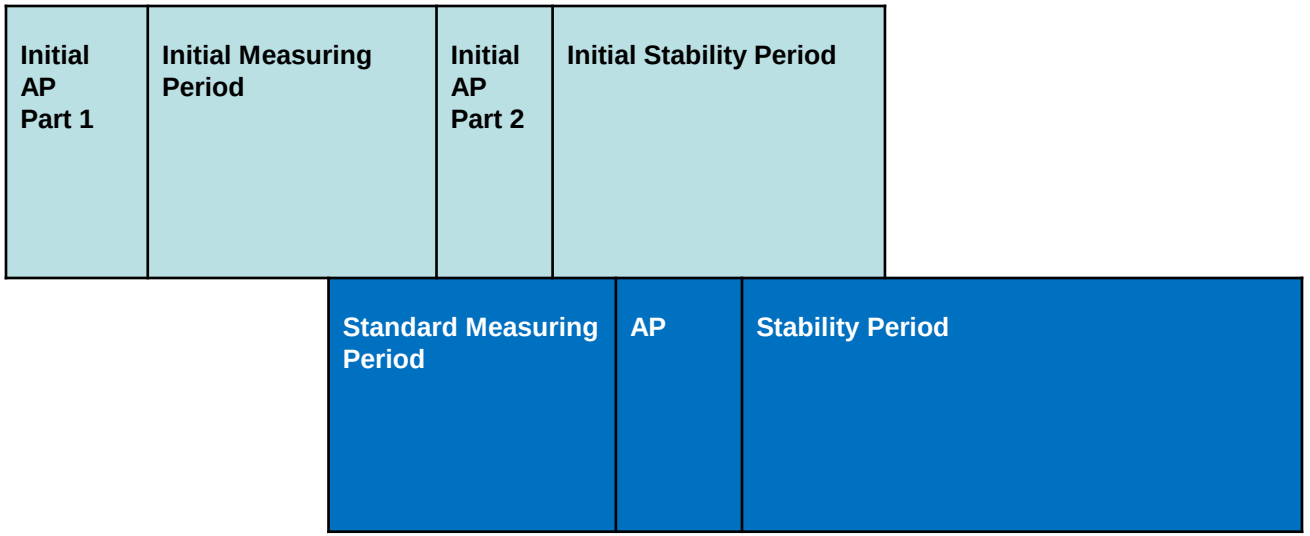
IDENTIFYING FULL-TIME EMPLOYEES

Testing for New Variable Hour Employees



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Testing for New Variable Hour Employees

August 15, 2015	Date of Hire
August 15, 2015 – August 31, 2015	**Initial Administrative Period, Part 1** The purpose of this initial administrative period, Part I, is to begin the initial measuring period on the first of the following month. Essentially, all variable hour employees hired in August will begin their initial measuring period on September 1st. This reduces the number of potential initial measuring periods from 365 to 12.
September 1, 2015 – August 31, 2016	**Initial Measuring Period**
November 1, 2015 – October 31, 2016	**Standard Measuring Period** This is the first full standard measuring period commencing after the employee is hired.
September 1, 2016–September 30, 2016	**Initial Administrative Period, Part 2**
October 1, 2016–September 30, 2017	**Initial Stability Period** Coverage will be maintained if the employee is identified as "full-time" based on hours during the initial measuring period (provided the employee elects coverage and pays the applicable premiums).
November 1, 2016–December 31, 2016	**Standard Administrative Period**
November 1, 2016 – October 31, 2017	**Next Standard Measuring Period**
January 1, 2017 – December 31, 2017	**Standard Stability Period** Coverage will be maintained if the employee is identified as "full-time" based on hours during the standard measuring period (provided the employee elects coverage and pays the applicable premiums).

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IDENTIFYING FULL-TIME EMPLOYEES

- Change in Employment Status Rule
  - If a **new** variable hour or seasonal employee has a material change in employment status (and would have been considered full-time on their date of hire had they been hired into this new role)→ must be offered coverage by the earlier of:
    - The first day of the fourth month following the change, or
    - The first day of the employee's initial stability period (if full-time based on hours or service during initial measuring period)
  - Rule does not apply to ongoing employees

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Preparing for the Employer Mandate

IDENTIFYING FULL-TIME EMPLOYEES

- Special rules apply to “rehires”
- Rehires can only be classified as new employees if not credited with **any** hours of service for at least:
  - 26 consecutive weeks, or
  - A period of greater than 4 consecutive weeks that exceeds the number of weeks the employee previously worked for the employer
- If the “newness” standard is not met → prior status still applies

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AFFORDABLE COVERAGE AND MINIMUM VALUE

- Penalty for Providing "Unaffordable" Coverage
  - Applies if:
    - Employee's share of the premium for lowest-cost employee-only coverage would exceed 9.5% of the employee's income, or an "affordable" plan does not provide "minimum value"—pay at least 60% of the allowed costs under the plan, AND
    - The employee receives a subsidy from an Exchange

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AFFORDABLE COVERAGE AND MINIMUM VALUE

- Penalty for Providing "Unaffordable" Coverage
  - Penalty = $3,000/year/employee
  - Only applies to employees who actually receive subsidized coverage through an Exchange
  - Assessed on a monthly basis ($250/employee/month)

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AFFORDABLE COVERAGE AND MINIMUM VALUE

- Safe harbors for determining if the cost of coverage exceeds 9.5% of employee's income
  - Form W-2 Compensation
  - Rate of Pay
  - Federal Poverty Limit

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AFFORDABLE COVERAGE AND MINIMUM VALUE

- Minimum Value (60%) = plan's anticipated spending for benefits provided under any particular EHB-benchmark plan for any State
- Takes into account
  - All amounts paid towards essential health benefits
  - Current year employer HSA contributions
  - Current year employer HRA contributions (that may not be used to pay premiums
  - Reduced cost-sharing attributable to wellness programs designed to prevent or reduce tobacco use (but not other wellness programs)

Preparing for the Employer Mandate

AFFORDABLE COVERAGE AND MINIMUM VALUE

- Calculating Minimum Value
  - Must use MV Calculator (unless within a safe harbor)
  - Percentage can then be adjusted based on actuarial analysis of plan features that are outside the parameters of the calculator
- Proposed Safe Harbors
  - **OPTION 1:** $3,500 combined medical and Rx deductible, 80% cost-sharing, $6,000 out-of-pocket maximum
  - **OPTION 2:** $4,500 combined medical and Rx deductible, 70% cost-sharing, $6,400 out-of-pocket maximum, $500 HSA contribution
  - **OPTION 3:** $3,500 medical deductible, $0 Rx deductible, 60% medical cost-sharing, 75% Rx cost-sharing, $6,400 out-of-pocket maximum, Rx co-pays of $10/$20/$50, with 75% co-insurance for specialty drugs

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Preparing for the Employer Mandate

THE EMPLOYER EXCHANGE NOTICES

- "Notice of Coverage Options"
- Must be distributed to all employees by October 1, 2013 and to all new employees thereafter
- Includes
  - Basic information about the exchanges
  - Detailed information about coverage available through the employer

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Employer Strategies

Employer "play or pay" mandate- 2015

No minimum essential coverage: employer does not offer coverage for all full-time employees (working 30 hour per week) and at least one employee obtains subsidized exchange coverage

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

- Exclude first 30 FT Employees

Applicable large employer

- 50 or more full-time equivalent employees

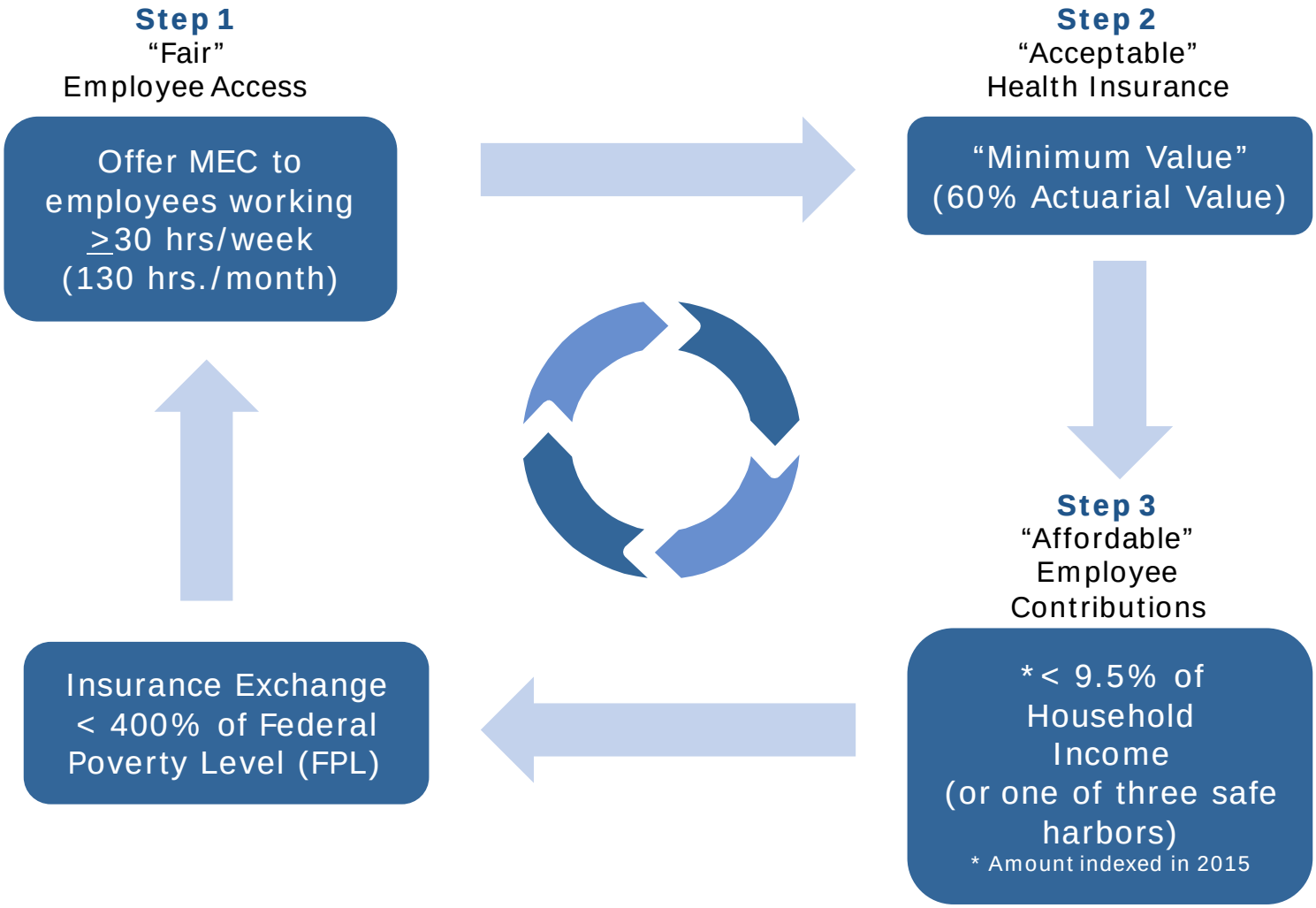
★ $3,000 annually ($250 per month) per each full-time employee that receives premium tax credit /cost-sharing reduction from an exchange

- Penalty is capped at penalty assessed for not offering minimum essential coverage
- No penalty applies to employees enrolling in Medicaid

Offers unaffordable coverage or coverage that does not meet minimum AV (60% AV): employee obtains subsidized exchange coverage

★ Amounts will be indexed in 2015

What is the employer Play or Pay mandate?



What are the main risks faced by employers under the Play or Pay mandate?

For employers with 50 or more FTEs:

- Identify all FT employees as defined by the ACA
- Offer MEC to all FT employees – at least 95% of FT employees
- MEC must be affordable and meet minimum value requirements
- Educate employee population on Exchanges and employer options as well as the individual mandate penalty

Play or Pay – Accessibility to MEC

Step 1
"Fair"
employee access

Offer MEC to full-time employees

- ≥30 hrs/week (130 hrs/mo)
- 90 days from Date of hire (DOH)

Required Actions

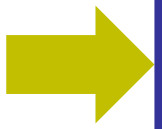
- Offer MEC to all full-time employees
  - Review plan designs to ensure plan meets MEC requirements
    - Beware of excepted benefit plans- not MEC
    - For 2014, consider offering MEC plans ("skinny MEC" or similar plans); assist employees to avoid imposition of individual mandate penalty/be uninsured if not currently eligible for subsidized marketplace coverage
- Modify waiting periods to 90 calendar days from date of hire
- Monitor/manage work hours below 30 hours per week

Play or Pay – Accessibility to MEC (continued)

Step 1
"Fair"
employee access

Offer MEC to full-time employees

- ≥30 hrs/week (130 hrs/mo)
- 90 days from Date of hire (DOH)



Required Action

- Identify all full-time employees
  - Measurement periods for variable hour and seasonal employees
    - Standard measurement period (SMP) for ongoing/IMP for new hires
      - Different SMP and IMP for salaried vs. hourly
    - Document measurement periods
    - Confirm systems support administration (work with payroll vendor)
    - Implement a "test" or official measurement period based on plan renewal date

Play or Pay – Minimum Value

Step 2
"Acceptable" health insurance

"Minimum Value" (60% actuarial value)

Required Action

- Assess Actuarial Value of benefit plan(s):
  - HHS calculator
  - Actuary
  - Healthcare reform modeling tool such as Wells Fargo Insurance Health Care Reform Analyzer tool
  - Contributions to HSA and HRA included in AV
- Consider plan choices and how contribution structure should be based on lowest AV plan
- Determine viability of a buy-down or buy-up option
  - Buy-down plan – more affordable plan that allows employees to enroll family in employer plan and pay for premiums pre-tax

Play or Pay – Affordable Coverage

Step 3
"Affordable" contributions for employee only coverage

★ < 9.5% of household income or safe harbor

Required Action

- Box 1 of W-2 Form
- Rate of pay (times 130 times 9.5%); rate of pay may not decrease
- 100% of Federal Poverty Level
- For affordability purposes employer can use non-smoker rate to establish plan's affordability
  - No other wellness incentives considered for affordability other than in 2014 if wellness program was in effect prior to 5/3/13 and reward was available on 5/3/13

★ Amount will be indexed in 2015

Play or Pay – Affordable Coverage (continued)

Step 3

"Affordable" contributions for employee only coverage

★ **< 9.5% of household income or safe harbor**

Required Action

- Unsure if other wellness incentives may be considered for 2015
- Consider contribution structure to encourage desired migration and account for state differences (Medicaid, Medicare, other)
  - Cafeteria plan model
  - Salary-based contributions
  - Spousal surcharges – UPS approach
- Develop communication strategies

★ Amount will be indexed in 2015

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What should employers do?

- Determine if they are subject to the Play or Pay mandate
  - Uncertain if six-month rule will be extended to 2014
- Identify and quantify financial risks under the ACA
  - Implement and manage measurement periods- for calendar year plans measurement period must commence no later than 10/15/13.
    - SMP – 10/15/13-10/14/14; AP – 10/15/14-12/31/14; SP – 1/1/15-12/31/15
  - Review systems to confirm management of hours and measurement periods
  - Assess financial impact of Play or Pay mandate on business operations

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What should employers do?

- Assess changes to be implemented to plan designs, contributions and eligibility criteria
  - Determine actuarial value of plans
  - Determine affordability of plans
  - Identify newly eligible employees
  - Determine if reclassification of employees is required
- Educate key staff and employees
  - Educate key staff on Play or Pay mandate and ACA strategy
  - Educate employees on individual mandate, exchanges and Medicaid expansion (when applicable)
- Monitor developments

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Communication Strategies

Topic	Description
Basic PPACA Questions & Answers	▪ Short list of questions to address key elements of the legislation
Medicaid Expansion	▪ Based on states that have elected to expand Medicaid
Individual Mandate	▪ Description of the requirement and what they need to do to be compliant for January 1, 2014
Employer Mandate	▪ Employer requirements and impact on current and future plan offerings
Insurance Exchanges	▪ Mandatory notice required by October 1, 2013 ▪ Employees will need additional information to understand their options ▪ Additional burden for multi-site employers

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Questions?

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Appendix

Planning for New Assessments

PCORI Fees

- For calendar year plans applies from 2012 through 2018
- Annual fee based on average number of covered lives
  - $1 for first year
  - $2 for subsequent years (as adjusted for inflation)
- Reported on IRS Form 720 (Quarterly Federal Excise Tax Return) and paid annually
- Generally due by July 31

Planning for New Assessments

TRANSITIONAL REINSURANCE PROGRAM FEES

- Three year fee to fund transitional reinsurance pool (2014-2016)
- Uniform contribution rate of $63/year/covered life for 2014
- Collected annually

Planning for New Assessments

"CADILLAC" TAX

- First applies in 2018
- 40% non-deductible tax on "excess benefits"
- Excess benefit = benefits provided in excess of annual limit ($10,200/$27,500 for 2018)

Evaluating Your Plan Design

LIMITATION ON WAITING PERIODS

- Effective for plan years beginning on or after January 1, 2014
- Plans may not apply a waiting period that exceeds 90 days
  - "Waiting Period" = the period of time that must pass before coverage becomes effective for an employee or dependent who is **otherwise eligible** to enroll in the plan
- Rule is not violate if an employee fails to elect coverage within 90 days

Evaluating Your Plan Design

LIMITATION ON WAITING PERIODS

- One day = One day
  - The 90-day period is calculated based on calendar days
  - Weekends and holidays are counted
  - If the 91st day falls on a weekend or holiday → plan may provide coverage sooner
- Waiting periods that will no longer work
  - Three months
  - 1st of the month or 1st payroll period following 90 days of employment

Evaluating Your Plan Design

LIMITATION ON WAITING PERIODS

- Rule is still in proposed form—no more restrictive provision in the final rules will apply to plans before January 1, 2015
- For participants who are mid-waiting period when rule becomes effective (January 1, 2014 for calendar year plans), the restriction will apply.
  - So, if January 1, 2014 is the 92nd day of a 120 day waiting period for an employee, the employee must become eligible for coverage as of January 1, 2014

Evaluating Your Plan Design

SATISFYING BENEFIT MANDATES

- Prohibitions on:
  - Pre-existing condition exclusions
    - Requirement to issue notices of creditable coverage is anticipated to be eliminated as of December 31, 2014
  - Lifetime and annual dollar limits on essential health benefits
  - Rescission

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Evaluating Your Plan Design

SATISFYING BENEFIT MANDATES

- Limit on Out-of-Pocket Maximum
  - Applies beginning in 2014 to non-grandfathered employer-sponsored plans
  - 2014 Maximum = the 2014 out-of-pocket limit for high deductible health plans (then indexed for inflation)
    - $6,350 for self-only coverage and $12,700 for coverage for more than one person
- Limit on Deductibles
  - Only apply to individual and small group market

Evaluating Your Plan Design

SATISFYING BENEFIT MANDATES

- Required coverage for:
  - Children through age 26
  - If not grandfathered:
    - Preventive care (on a first-dollar basis)
    - Direct access to OB/GYN
    - Certain emergency care
    - Clinical trials for cancer and other life-threatening diseases

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Evaluating Your Plan Design

ADDING AUTOMATIC ENROLLMENT

- Applies to employers with over 200 employees
- Plans will be required to automatically enroll new full-time employees and continue the enrollment of current participants
- Notice and opportunity to opt-out is required
- Effective date is unclear—waiting on guidance