Premium exchange subsidies apply to “State Exchanges” - ACA

“The Affordable Care Act contains more than a few examples of inartful drafting. (To cite just one, the Act creates three separate Section 1563s. See 124 Stat. 270, 911, 912.) Several features of the Act’s passage contributed to that unfortunate reality.”

Chief Justice Roberts: King vs. Burwell opinion of the Court (6-3 Decision); 6.25.2015

Supreme Court: “Tax Credits” apply to federal and state exchanges
What if The Supreme Court Ruled Differently?

**Federal Exchange States:** open separate state exchanges?

**Individual Mandate:** affordability issues (8% of family income)

**Employer Mandate:** penalties might be avoided

**Financial Peril to Insurers:** lost membership, lost subsidies

**Financing death spiral:** mandate might not be enforceable
<table>
<thead>
<tr>
<th>Provision</th>
<th>Perspective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definition of Full Time Employee</td>
<td>30 hour a week definition is not so simple after all</td>
</tr>
<tr>
<td>Automatic Enrollment</td>
<td>Continued delay in regulations. No date was set under the law.</td>
</tr>
<tr>
<td>Medical Device Tax</td>
<td>Delayed due to industry lobby with likely revision</td>
</tr>
<tr>
<td>Employee Benefits Tax Policy</td>
<td>Is the preferred tax status of employee benefits be at risk?</td>
</tr>
</tbody>
</table>
What Do We Know Today?

- Regulations have been substantially clarified
- Policy goals set by the government were met
- Employers are staying the course (for now)
- Health care “solutions” are being promoted
- Enforcement is around the corner
The Biggest Challenge of ACA: 2015 Survey

Administrative Issues: 57%
Cost Issues: 21%
Plan Design Issues: 11%
Communication Issues: 10%
Other: 1%

Sample of 598 benefit professionals and financial managers
Regulatory Milestones in Health Care

Government funding as a % of total health care spending

- 1965: 25.0%
- 1975: 37.5%
- 1985: 50%
- 1995: 50%
- 2005: 50%
- 2010: 50%
- 2015: 50%

Medicare and Medicaid

ERISA

COBRA

HIPAA

Medicare Part D

Affordable Care Act

King vs. Burwell 6.25.2015

Sources: Kaiser Family Foundation and CMS
Clinton Health Care (1993) 13.60%

Affordable Care Act (2010) 17.59%

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1990</td>
<td>13.60%</td>
<td>17.59%</td>
</tr>
<tr>
<td>1995</td>
<td>13.60%</td>
<td>17.59%</td>
</tr>
<tr>
<td>2000</td>
<td>13.60%</td>
<td>17.59%</td>
</tr>
<tr>
<td>2005</td>
<td>13.60%</td>
<td>17.59%</td>
</tr>
<tr>
<td>2010</td>
<td>13.60%</td>
<td>17.59%</td>
</tr>
<tr>
<td>2015</td>
<td>13.60%</td>
<td>17.59%</td>
</tr>
</tbody>
</table>

CMS Office of the Actuary Projection: 11/2013

Obesity rate*: 35.7%
Over age 65: 13.1%
Median age: 37.2

Obesity rate*: 15.0%
Over age 65: 12.6%
Median age: 32.9

* Based on data from Centers for Disease Control and U.S. Census Bureau
## ACA Milestones

### Coverage
- Coverage until age 26
- No lifetime limits
- Pre-existing conditions eliminated < age 19
- Preventive care covered in full
- 90 day waiting period
- All pre-existing conditions eliminated
- Deductible cap limits amended; small group/individual

### Reporting and Fees
- W-2 reporting (250 or more)
- Summary of Benefits and Coverage
- PCORI fee
- Reinsurance assessment
- Health insurer tax
- Forms 1094 and 1095

### Infrastructure
- Public health exchanges
- Underwriting rules
- Medicaid expansion

---

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ACA Coverage Mandates

Law Signed: March 23, 2010

- Individual
- Large Employer
- Small Employer
Option A

Offer a health plan with Minimum Value and Affordable coverage (95% of full time employees eligible to participate)\(^{(1)}\)\(^{(2)}\)

OR - Pay an Annual Tax

$3,126 per full time employee that receives a subsidy in a public health exchange

Option B

Offer a health plan to 95% of full-time employees + dependents \(^{(2)}\)

OR - Pay an Annual Tax

$2,084 per full time employee (less first 30) if only one employee receives a subsidy in a public health exchange \(^{(3)}\)\(^{(4)}\)

Regulation 138006-12

1. 95% coverage rules have been delayed until 1/1/2016. Coverage rules are 70% until that time.
2) Spousal coverage offer is not required. Dependents include son, daughter, adopted children
3) Penalty applies to all employees, including those with coverage
4) Penalties for 2015.
Individual Mandate

Exempted from penalty: can’t afford coverage, taxpayers below filing threshold, membership of Indian tribes, hardship, religious conscience, health care sharing ministry, incarcerated individuals, citizens living abroad, residents in U.S. territories

Maintain a “Bronze Level” Plan

OR – Pay an Annual Tax (greater of)

2014: $95 per uninsured person or 1.0% of household income above filing threshold

2015: $325 per uninsured person or 2.0% of household income above filing threshold

2016: $695 per uninsured person or 2.5% of household income above filing threshold
Forms 1094 and 1095: Verifying Coverage and Premium Credits

Can I just forget about the law?

Health Insurance Marketplace

Premium Credit? (Subsidy)

Employer

Tax to fund Premium Credit?

Form 1094

Form 1095

© The Fedeli Group
# IRS Tax Reporting

<table>
<thead>
<tr>
<th>Funding Approach</th>
<th>Responsibility</th>
<th>IRS Transmittal</th>
<th>IRS Employee Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fully Insured: ALE*</td>
<td>Medical Plan Insurer</td>
<td>1094-B</td>
<td>1095-B</td>
</tr>
<tr>
<td></td>
<td>Employer</td>
<td>1095-C</td>
<td>1095-C</td>
</tr>
<tr>
<td>Self Funded: ALE*</td>
<td>Employer</td>
<td>1094-C</td>
<td>1095-C</td>
</tr>
<tr>
<td>(includes non-employees)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self Funded: ALE* **</td>
<td>Employer</td>
<td>1094-B (non-EEs)</td>
<td>1095-B (non-EEs)</td>
</tr>
<tr>
<td>(includes non-employees)</td>
<td></td>
<td>1095-C (EE)</td>
<td></td>
</tr>
<tr>
<td>Small Employer</td>
<td>Medical Plan Insurer</td>
<td>1094-B</td>
<td>1095-B</td>
</tr>
<tr>
<td>Small Employer (Self Funded)</td>
<td>Employer</td>
<td>1094-B</td>
<td>1095-B</td>
</tr>
</tbody>
</table>

*ALE: Applicable Large Employer has 50 or more full time employees.
** Retirees and COBRA participants

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Social Security Number Required for Each Covered Individual


Three Attempts Required - Including Open Enrollment
For tax year 2015, penalties will not be levied if an employer shows a reasonable good faith effort to file the forms correctly.

The fine can also be mitigated if the employer corrects the forms in a timely manner.

No cap on penalty if “intentional disregard”

$250 penalty per form per day for incorrect filing

* Maximum Penalty

Trade Preference Extension Act (June 29, 2015) essentially doubles penalties
# Filings and Forms - Summary

<table>
<thead>
<tr>
<th>Filing and Form</th>
<th>Submission Format</th>
<th>Due Date</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCORI</td>
<td>IRS Form 720</td>
<td>7/31 (through 9/30/2019)</td>
<td>Fee based on average lives</td>
</tr>
<tr>
<td>Reinsurance Assessment Fee</td>
<td>Pay.gov</td>
<td>11/15/2014 (three years)</td>
<td>Fee based on average lives</td>
</tr>
<tr>
<td>Summary of Benefits Coverage (SBC)</td>
<td>Electronic or paper</td>
<td>Open enrollment</td>
<td>Includes new hires</td>
</tr>
<tr>
<td>Exchange Notice</td>
<td>Electronic or paper</td>
<td>10/1/2013</td>
<td>New hires only</td>
</tr>
<tr>
<td>Health Plan Identification Number (HPID) [Delayed until further notice]</td>
<td>HPOES Website</td>
<td>11/05/2015 (large plans)</td>
<td>Standardize electronic transactions</td>
</tr>
<tr>
<td></td>
<td></td>
<td>11/05/2016 (small plans)</td>
<td></td>
</tr>
<tr>
<td>IRS Reporting for Applicable Large Employers</td>
<td>Forms 1094 and 1095</td>
<td>1094 - 3/31/2016</td>
<td>Links employer plan information with exchange information</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1095 - 1/31/2016</td>
<td></td>
</tr>
</tbody>
</table>
40% excise tax on premiums above $10,200 single coverage and $27,500 family coverage (adjusted annually) note 1

Coverage provider is liable for any excise tax*  **

✓ Fully insured: insurer
✓ Multiemployer: plan sponsor
✓ All other: “person that administers the benefits”

[IRS Section 4980I (c) (1); not used in any other statutory context.]

A complex calculation awaits employers, regardless of funding

* Taxable Period: Treasury anticipates calendar year tax cycle; submitted through Form 720.

Note 1: Multiemployer Plans: $27,500 (single coverage not broken out)
Access Options Expand Under the Affordable Care Act

Public Exchange  Individual  Medicaid  Medicare  Other*

EMPLOYER

*Military, Indian Services, Spouse Plan, etc...
Access to Health Insurance – Circa - 2010

- **Employer Based**: 48.0%
- **Medicare**: 14.0%
- **Medicaid**: 16.0%
- **Uninsured**: 16%
- **Individual**: 5.2%
- **Other Public**: 1%


- Employer Based: 46.5%
- Medicaid: 21.0%
- Medicare: 16.5%
- Public Exchange: 3.8%
- Uninsured: 7.0%
- Unsubsidized Individual: 4.2%
- Other Public: 1%

Five Percentage Point Increase Since 2010

Sourced from: Depart of Health and Human Services ASPE Briefs: 2015; Centers for Disease Control; U.S. Census Bureau.
Access to Health Insurance – Estimate - 2018

- Employer Based: 45.5%
- Medicare: 19.0%
- Medicaid: 21.0%
- Other Public: 1%
- Individual (non-subsidized): 5.5%
- Public Exchange: 4.0%
- Uninsured: 4.0%

# Public Program Enrollment Change - May 1, 2015

<table>
<thead>
<tr>
<th>State</th>
<th>Type of Exchange</th>
<th>Public Exchange Enrollment</th>
<th>% of population</th>
<th>Increased Medicaid Enrollment</th>
<th>% of population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ohio</td>
<td>Federal</td>
<td>234,341</td>
<td>2.0</td>
<td>647,210</td>
<td>5.5</td>
</tr>
<tr>
<td>Indiana</td>
<td>Federal</td>
<td>219,185</td>
<td>3.3</td>
<td>194,732</td>
<td>3.0</td>
</tr>
<tr>
<td>Michigan</td>
<td>Federal</td>
<td>341,183</td>
<td>3.5</td>
<td>396,249</td>
<td>4.0</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>Federal</td>
<td>472,697</td>
<td>3.7</td>
<td>236,445</td>
<td>1.9</td>
</tr>
<tr>
<td>Texas</td>
<td>Federal</td>
<td>1,205,174</td>
<td>4.4</td>
<td>184,589</td>
<td>0.7</td>
</tr>
<tr>
<td>New York</td>
<td>State</td>
<td>408,841</td>
<td>2.0</td>
<td>763,485</td>
<td>3.7</td>
</tr>
<tr>
<td>California</td>
<td>State</td>
<td>1,412,200</td>
<td>3.6</td>
<td>3,470,234</td>
<td>8.9</td>
</tr>
<tr>
<td>Kentucky</td>
<td>State</td>
<td>106,330</td>
<td>2.4</td>
<td>510,402</td>
<td>11.6</td>
</tr>
<tr>
<td><strong>U.S. - TOTAL</strong></td>
<td><strong>17 State / 34 Federal</strong></td>
<td><strong>11,688,074</strong></td>
<td><strong>3.65</strong></td>
<td><strong>12,200,000</strong></td>
<td><strong>3.81</strong></td>
</tr>
</tbody>
</table>


**Note:** Medicaid enrollment increase calculated from a baseline of September 2013.
<table>
<thead>
<tr>
<th>Federal Poverty Level</th>
<th>Family Income (4 Person) 2015</th>
<th>Maximum Family Premium</th>
<th>Maximum Out of Pocket*</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt;= 400%</td>
<td>$97,000</td>
<td>n/a</td>
<td>$12,900</td>
</tr>
<tr>
<td>300</td>
<td>72,750</td>
<td>6,955</td>
<td>10,900</td>
</tr>
<tr>
<td>250</td>
<td>60,625</td>
<td>5,796</td>
<td>6,450</td>
</tr>
<tr>
<td>200</td>
<td>48,500</td>
<td>3,929</td>
<td>6,450</td>
</tr>
<tr>
<td>150</td>
<td>36,375</td>
<td>2,306</td>
<td>4,500</td>
</tr>
<tr>
<td>133</td>
<td>32,253</td>
<td>1,296</td>
<td>4,500</td>
</tr>
<tr>
<td>100</td>
<td>24,250</td>
<td>no premium</td>
<td>0</td>
</tr>
</tbody>
</table>

* Based on 2015 HSA Maximums

Note 1: Subsidy begins at 100.01% of FPL but is not relevant if Medicaid coverage is expanded.

** Medicaid income levels may be up to 138% of FPL depending on the State.
### Premium Credits: Taxpayer Cost

<table>
<thead>
<tr>
<th>Platform</th>
<th>Enrollees (millions)</th>
<th>Premium credit eligible</th>
<th>Avg. monthly premium</th>
<th>Premium credit (avg.)</th>
<th>Net Premium</th>
<th>% Premium reduction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthcare.gov</td>
<td>8.84</td>
<td>87.0%</td>
<td>$364</td>
<td>$263</td>
<td>$101</td>
<td>72%</td>
</tr>
<tr>
<td>State Exchanges</td>
<td>2.84</td>
<td>80.8%</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
</tbody>
</table>

**Federal Exchange**

Premium Credit Cost: $24 billion

**State Exchanges**

Premium Credit Cost: $7 billion*

* Estimate assumes similar premium credit on the state exchanges; all costs are annual

Ohio Medicaid Expansion - January 1, 2015

Medicaid Expansion

<table>
<thead>
<tr>
<th>Participating</th>
<th>31 (Ohio, D.C., Pennsylvania, Arizona, Indiana)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not participating</td>
<td>19 (Texas, Maine, Florida, Mississippi)</td>
</tr>
<tr>
<td>Under Discussion</td>
<td>1 (Utah)</td>
</tr>
</tbody>
</table>

Ohio Medicaid Facts

- $23.6 Billion in FY 2015 – 64.6% federal / 35.4% state funded
- Adults 65+, Adults and Disabled Children - 18% of enrollment, 60% of cost

<table>
<thead>
<tr>
<th>Eligibility-Current</th>
<th>FPL%*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children up to 19</td>
<td>211</td>
</tr>
<tr>
<td>Pregnant women</td>
<td>200</td>
</tr>
<tr>
<td>Disabled workers</td>
<td>250</td>
</tr>
<tr>
<td>Parents of children</td>
<td>138</td>
</tr>
<tr>
<td>Seniors (65+)</td>
<td>75**</td>
</tr>
<tr>
<td>Single</td>
<td>138% FPL</td>
</tr>
</tbody>
</table>

Sources: Medicaid expansion from The Kaiser Foundation
Medicaid Facts and Guidelines from Health Policy Institute of Ohio
Ohio Office of Budget and Management

75% of enrollees are on one of five managed care options
(Insurers receive capitated payments)

* Federal Poverty Level
** 2016; up from 64%
The Medicare Challenge

Projected Medicare Enrollment

- 39.7% in 2000
- 47.7% in 2010
- 64.3% in 2020
- 81.5% in 2030
- 88.9% in 2030
- 92.4% in 2050

71% increase in 20 years

Source: 2013 Annual Report to the Boards of Trustees of the Federal Hospital Insurance and Supplemental Medical Insurance Trust Fund
Underwriting – Changed Fundamentals

Individual Market
Ease of access with guaranteed Issue

Small Group
Detailed health underwriting goes away

Large Group
Burden of fees and taxes makes fully insured programs less attractive
### Underwriting – Small Group and Individual

<table>
<thead>
<tr>
<th>Health Statements</th>
<th>Gender</th>
<th>Age*</th>
<th>Geography</th>
<th>Tobacco</th>
<th>Wide Range of Premium Tiers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-ACA</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>ACA</td>
<td>Not permitted</td>
<td>Not permitted</td>
<td>✔</td>
<td>✔</td>
<td>Limited</td>
</tr>
</tbody>
</table>

* Premium variations by age are capped at a 3:1 ratio.

*Note: Underwriting rules will be phased in beginning in 2014 for employers with 50 or fewer full time employees. In 2016, the rules are expanding to include 100 or fewer full time employees.*
### The Claim Mix of a Health Plan is Changing

<table>
<thead>
<tr>
<th>Type</th>
<th>Situation</th>
<th>Cost Outlook</th>
</tr>
</thead>
<tbody>
<tr>
<td>High dollar claims</td>
<td>Cancers represent 25% of large claims. Kidney failure is next.</td>
<td>Negative: $1,000,000 plus claims on the rise. Cancer care advances will drive large claims higher.</td>
</tr>
<tr>
<td>Prescription drugs</td>
<td>“Patent cliff” expirations continue</td>
<td>Positive: “Core” drug trend is flat. More affordable maintenance drugs for plan members</td>
</tr>
<tr>
<td>Prescription drugs (biological)</td>
<td>Growing portfolio of specialty drugs for cancer, multiple sclerosis, and inflammatory conditions</td>
<td>Negative: Advances come with a high cost</td>
</tr>
<tr>
<td>Chronic disease</td>
<td>Aging population combined with a significant obese and sedentary population</td>
<td>Negative to Neutral: Is America “waking up” to wellness?</td>
</tr>
<tr>
<td>Preventive care</td>
<td>Preventive care is mandated by ACA</td>
<td>Positive: Direct financial cost is minor but potential long-term savings can be significant</td>
</tr>
</tbody>
</table>
$849 Billion of Exchange Subsidies
$847 Billion in Medicaid Expansion Costs*

# Taxes and Penalties: Individuals

## Ten Year Impact: 2013 - 2023

<table>
<thead>
<tr>
<th>Tax</th>
<th>Revenue (billions)</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare unearned Income</td>
<td>$317.7</td>
<td>Applies to couples with joint incomes greater than $250k. Tax of 3.8% on certain “net investment income.”</td>
</tr>
<tr>
<td>Medicare Payroll</td>
<td></td>
<td>Additional 0.9% tax from employees who earn more than $200,000 per year (only employee, no employer match)</td>
</tr>
<tr>
<td>Individual Mandate Penalties</td>
<td>55.0</td>
<td>Applies to individuals who do not obtain “minimum essential coverage” or are exempt.</td>
</tr>
<tr>
<td>“Cadillac” Tax</td>
<td>111.0</td>
<td>40% marginal tax on premiums above $10,200 single coverage and $27,500 family coverage (adjusted annually). Tax will be built into premiums.</td>
</tr>
</tbody>
</table>

*Source: Center for Health Care Research and Transformation (Issue Brief August 2013) with information sourced from the Joint Committee on Taxation (June 2012) and Congressional Budget Office (July 2013).*
### Ten Year Impact: 2013 - 2023

<table>
<thead>
<tr>
<th>Tax</th>
<th>Revenue (billions)</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCORI Fee</td>
<td>3.8</td>
<td>$2 per member per year. Adjusted for health care spending from 2015 to 2019. Funding for Patient Centered Outcomes Research Institute.</td>
</tr>
<tr>
<td>Reinsurance Assessment Fee</td>
<td>25.0</td>
<td>2014, 2015, 2016; $63 per member per year in 2014, $44 in 2015; $27 for 2016. Used to stabilize premiums in the individual market.</td>
</tr>
<tr>
<td>Health Insurer Provider Tax</td>
<td>101.7</td>
<td>General fee to offset costs associated with ACA.</td>
</tr>
<tr>
<td>Permanent Risk Adjustment</td>
<td>0.2</td>
<td>Fee to operate the Federal Risk Adjustment program. Insurers will pay $0.96 per member per year (2014). Adjustments thereafter.</td>
</tr>
</tbody>
</table>

Source: Center for Health Care Research and Transformation (Issue Brief August 2013) with information sourced from the Joint Committee on Taxation (June 2012) and Congressional Budget Office (July 2013).

Self funded plans are exempt from the health insurer provider tax. Fully insured premiums increase by 2-3% a result of this tax. In addition, state taxes can add 1 to 2.5% to premiums.
### Ten Year Impact: 2013 - 2023

<table>
<thead>
<tr>
<th>Tax</th>
<th>Revenue (billions)</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tanning Excise Tax</td>
<td>1.5</td>
<td>10% of the amount paid for tanning services.</td>
</tr>
<tr>
<td>Branding Prescription Drug Tax</td>
<td>34.2</td>
<td>Percentage of sales to government programs.</td>
</tr>
<tr>
<td>Medical Device Tax</td>
<td>29.1</td>
<td>2.3% on the sales price of certain medical devices.</td>
</tr>
<tr>
<td>Employer Shared Responsibility</td>
<td>96.0</td>
<td>Paid by employers who do not offer health care coverage.</td>
</tr>
</tbody>
</table>

**Source:** Center for Health Care Research and Transformation (Issue Brief August 2013) with information sourced from the Joint Committee on Taxation (June 2012) and Congressional Budget Office (July 2013).

Significant uncertainty as to how many employers will no longer offer a qualified health care plan.
### Tax Advantages of Offering Health Care Coverage Continue

#### Example

<table>
<thead>
<tr>
<th></th>
<th>Continue Health Care</th>
<th>Exit Health Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health care premium – employer</td>
<td>$7,500</td>
<td>$0</td>
</tr>
<tr>
<td>Employee annual salary</td>
<td>100,000</td>
<td>107,500</td>
</tr>
<tr>
<td>Health care premium – employee (pre-tax)</td>
<td>(2,500)</td>
<td>n/a</td>
</tr>
<tr>
<td>Taxable wages before deductions</td>
<td>$97,500</td>
<td>$107,500</td>
</tr>
<tr>
<td>Federal Income Tax (16.5%; 17.5%)</td>
<td>(16,056)</td>
<td>(18,856)</td>
</tr>
<tr>
<td>FICA: employee (7.65%)</td>
<td>(7,458)</td>
<td>(8,414)</td>
</tr>
<tr>
<td>State Income Taxes – Ohio (2.98%; 3.2%)</td>
<td>(2,975)</td>
<td>(3,392)</td>
</tr>
<tr>
<td>Employee purchases health insurance (after tax)</td>
<td>n/a</td>
<td>(10,000)</td>
</tr>
<tr>
<td>Net wages (after taxes and health care premium)</td>
<td>$71,011</td>
<td>$66,838</td>
</tr>
</tbody>
</table>

#### Added Tax Burden – Employee and Employer

- Additional FICA: employer: 956
- Penalty (not deductible; $2,000 grossed up by 35%): 3,075

\[ (956 - 3,075) = (4,031) \]

\[ (4,031) + (8,204) = (12,235) \]

#### Notes:

1. The employer substitutes health care coverage for increased wages under the “Exit Health Care” scenario.
2. The employee needs coverage for himself and two child dependents. Spouse is covered elsewhere. Premiums are $10,000.
3. Employee contributes 25% towards health care coverage under the “Continue with Health Care Scenario”.
4. Employee files taxes as “married, filing separate” and realizes deductions of $17,800 for exemptions and standard deduction.
Employment Relationships – Unique Challenges

*Are independent contractors considered employees under ACA?*

“Common law employee” definition to determine employment status

*What about leased employees?*

Leased employees are considered employees of the leasing company - “shared responsibility” requirements fall on the leasing company.

*What about temporary staffing agencies?*

Requirements fall on the staffing agency

*What about control groups?*

Shuffling ownership structures does not work

*ERISA 510?*

Reducing hours to avoid benefits? [Class action lawsuit filed May 8, 2015 against Dave and Buster’s](https://www.doxinglawyer.com/dave-and-busters-case) [U.S. District Court for the Southern District of New York]
Requirements to Plan for the Future

Know Your Plan Data
Your pre-conceived assumptions may not be correct

Get Your HR Technology in Order
Regulatory requirements will consume your human resources department

Educate Your Team and Your Plan Members
A lack of understanding leads to dissent
Long Term Solutions?

Self funding approaches

Consumer driven plans

Wellness programs

New approaches to buying services
Self funding - Be Aware of the Risk!

1. Assess your risk tolerance *(self funding is not a one year deal)*
2. Measure your risk *(statistical tools, not just rules of thumb)*
3. Mitigate future risk *(incorporate wellness strategies and culture)*
4. Purchase the proper risk protection *(don’t skimp on reinsurance)*
5. Know your contract – be wary of gimmicks
HSA Eligible Plans – Cost Shift or a Consumer Model?

Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) enabled Health Savings Accounts

HSA- enrolled on an eligible plan  
17 million

HSA- accounts with balances  
$24.2 billion in assets; $1,750 average account balance

13.8 Million

2004  2010  2014
## HSA Compatible Plans - Out of Pocket Maximums

<table>
<thead>
<tr>
<th></th>
<th>Minimum Deductible</th>
<th>HDHP* Maximum Out of Pocket</th>
<th>Maximum HSA Contribution</th>
<th>ACA Maximum Out of Pocket</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Single</strong></td>
<td>$1,300</td>
<td>$6,550</td>
<td>$3,350</td>
<td>$6,850</td>
</tr>
<tr>
<td><strong>Family</strong></td>
<td>$2,600</td>
<td>$13,100</td>
<td>$6,750</td>
<td>$13,700</td>
</tr>
</tbody>
</table>

For 2016: Embedded Deductible Rule: Individual with family coverage can not pay more than single out of pocket maximum.

* High Deductible Health Plan
## Private Exchanges - Part of a Long-Term Strategy

### Enrollment Approaches

<table>
<thead>
<tr>
<th>Feature</th>
<th>Paper Enrollment</th>
<th>Online Enrollment</th>
<th>Private Exchange</th>
</tr>
</thead>
<tbody>
<tr>
<td>Defined contribution funding</td>
<td>Sometimes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Regulatory compliance support</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Decision support tools</td>
<td>No</td>
<td>Sometimes</td>
<td>Yes</td>
</tr>
<tr>
<td>Multiple plans</td>
<td>Limited</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Multiple medical insurers</td>
<td>No</td>
<td>No</td>
<td>Sometimes</td>
</tr>
<tr>
<td>Administrative efficiency</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Wellness - The Great Hope

Participatory

Reward **not** based on attaining a health standard

Health Contingent

Reward **based** on attaining a health standard

*HIPAA wellness rules apply*

30% premium differentials allowed; up to 50% if tobacco use considered

**Health Standard:** BMI, Blood Pressure, Glucose, Cholesterol, Tobacco

Be mindful of “Reasonable Alternative” Standards
The Motivation to Change

Likelihood of Quitting Smoking

- **No Diagnosis**: 1.0
- **New Diagnosis**: 2.5
- **Multiple Diagnosis**: 6.0 times as likely

Relative Weight Loss

- **No Diagnosis**: 1.0
- **New Diagnosis**: 1.5
- **New Diabetes**: 2.5

National Institute of Health, “Smoking and Weight Change after New Health Diagnosis in Older Adults”
“Suffering” employees cost their employers 2.5 times as much in health care costs compared to thriving employees.

_Gallup and Healthways Research_

28% of employees are not thriving in any one of five well-being categories

- Purpose
- Social Relationships
- Financial Security
- Community Linkage
- Physical Health

Have your reviewed your Employee Assistance Plans (EAP)?
1. Cultural alignment and senior management support
   Is your wellness program a natural extension of your organization’s identity?

2. Proactive and ongoing education
   Is your message being reinforced – actions and words?

3. Financial Reward for measurable goal attainment
   Carrots and sticks?
The Affordable Care Act Affects Everyone!

- Insurers
- Health Care Providers
- Medical Device Companies
- Pharmaceutical Companies
- Medicare
- Medicaid
- Hospitals
- Employee
- Employer

December 2014 © The Fedeli Group
Predictions we made in 2010 stand

A ten year timeframe to sort out the Affordable Care Act

Certain industries will pay substantially more for health care
Exchange penetration will be gradual and vary by State
New partners, consolidation, new businesses, dying businesses
Self funding will continue to increase in popularity
Movement from risk selection to improving outcomes
New patient delivery models will have an impact on cost and waste
A disrupted model will create shortages and possible price controls