Sterling Benefits, LLC

PREMIER PROVIDER OF EMPLOYEE & EXECUTIVE BENEFITS

Health Care Reform ~ Hot Topic

Issued: 10/1/2013

For Groups with Less than 50 Full-Time Employees or Equivalents

Small Group Benefits Options

As you know, 2013 is a transitional year with many changes in healthcare that go into effect January 1st, 2014. Our job at Sterling Benefits, LLC is to make sure:

1. you understand how the law affects you and your employees,
2. assist you in making informed decisions regarding your benefits, and
3. to assist you with compliance with the new regulations.

As an employer with less than 50 full time employees, you are not subject to penalties with regard to the affordability or minimum value test. However, the way you structure your health insurance benefits – plans offered, who the plans are offered to and what your employees are required to pay - can have a major impact on your employees and their families' ability to obtain coverage outside of your group.

Items to consider:

1. Are your plans "affordable"? Is the employee's cost for employee only coverage less than 9.5% of their net income (can be determined by box 1 of the W-2 or by taking the employees rate of pay x 130 hours).
2. Do your plans provide "minimum value"? (Does the plan pay for at least 60% of expenses?)
3. Would your employees qualify for a subsidy if your group plans were unaffordable, didn't meet the Minimum Value required, or you decide to disband coverage?
4. Do you own more than one company or do you have common ownership in more than one company? If so, IRC Section 414 Controlled Group Rules may apply and you may be classified as a large employer.
5. Have you amended your cafeteria plan for 2013 to allow exchange eligible employees and dependents to access the Marketplace?
6. Have you changed the waiting period on your plan to meet the 90 day provision for 2014? Failure to comply with the maximum waiting period will result in a $100 a day penalty.
7. How do variable or seasonal employees impact your business?

As you can see there are a multitude of issues to discuss as we plan for 2014.

Employee Benefits Options

I. **Renew As Is** – A normal renewal at the group's effective date. As has been customary at the group's renewal, all options will be explored, including new options such as SHOP and SIMPLE Cafeteria Plans. Simply stated, treating groups renewing for the remainder of 2013 the same as previous years and allowing sufficient time for all information regarding the ACA to come forward. If needed, make adjustments to the group's benefit plans, either at the group's renewal date or January 2014 if that proves beneficial.

II. **Renew Early -** Group makes the decision to renew on December 1, 2013 for the purpose of delaying the effects of the Affordable Care Act for an additional period of time. **Note**: This strategy is most effective for groups that have a younger overall population and are predominantly male. Early renewals options vary by carrier.

III. **Marketplace/SHOP**

- SHOP – Small Employer Health Insurance Options Program is a new benefit option available on the Exchange. For 2014, this option will be limited to one carrier and one plan of coverage from that carrier. In the future, the SHOP may include multiple carriers. With a SHOP program, an employer should be able to pick insurance products from various carriers that meet the needs of the employer's employees and receive a combined bill from the Exchange.
- SHOP will also be the vehicle that an employer would use to access tax credits that are available for small employers with fewer than 25 full-time employees, with average earnings of less than $50,000.

IV. **Split Decision -** The goal of a "split decision" strategy is to allow employers to maintain group coverage for their employees who would benefit from employer-sponsored coverage, while allowing other employees who would otherwise be subsidy-eligible to access the Exchange and related subsidies. This can be accomplished for small groups (under 50 full- time employees) through various techniques. For larger employers (50 or more full-time employees), all the same techniques are available for 2014; these employers must be aware this strategy will most likely result in penalties if continued into 2015. **Note**: The Employer Mandate has been delayed until 2015 and as a result of the delay, no penalties will be assessed until it is reinstated.

- **Make coverage unaffordable**. The ACA defines affordable coverage as coverage that costs employees, for employee-only coverage, less than 9.5% of their W2 (box 1) incomes. If an employer desires, they could choose coverage with a richer, more expensive set of benefits which could, in turn, make the cost of coverage exceed the 9.5% threshold for that employee's income. If the employee goes to the Exchange, they'll include all of their household income to determine subsidy eligibility. To use this strategy effectively, it is critical to know the employee's household income. Otherwise it is possible that the coverage may be "unaffordable" based upon an employee's W-2, but not when compared to household income.
- **39 hour solution.** ACA defines a full-time employee as an employee working 30 hours per week or 130 hours per month. This definition is contained within the Employer Mandate section of the ACA law. The Employer Mandate has been delayed until no sooner than 2015, and this section (and full-time definition) does not apply to groups of fewer than 50 employees. Technique – make eligibility for coverage 40 hours and reduce employees to fewer than 40 hours, making employees eligible to apply for Exchange subsidy.

V. **Disband Group Coverage –** With the advent of the Affordable Care Act and the subsidies that are potentially available to many employees, some groups will find it advantageous to no longer offer group health benefits. There are many issues that need to be considered prior to eliminating health benefits, such as 1) employee retention, 2) availability of subsidies for all or some employees and 3) cost of coverage if subsidies are not available (most likely your key employees will find qualifying for subsidies difficult). However, in some situations this will be the group's best option.

Employee Benefits Options– Continued

VI. **Spousal/Dependent Coverage –** By ACA rule, an employer is not required to offer health coverage to an employee's husband or wife. In 2015, ACA does require dependents under the age of 26 to be offered coverage (regardless of marital status). In addition, spousal coverage may be offered only to spouses without access to employer-sponsored coverage from their place of work.

The benefit of this strategy generally accrues to larger employers (over 50) that will continue to be medically underwritten. Spousal coverage is predominantly female. Female coverage on an actuarial basis is more expensive than male coverage. By eliminating spousal coverage, an employer's census is often a more attractive demographic, and as such, a lower premium results.

VIII. **SIMPLE Cafeteria Plan –** A SIMPLE Cafeteria plan is a new benefit program contained in the Affordable Care Act for businesses with less than 100 employees. In the past, Cafeteria plans were difficult to offer due to extensive discrimination testing. The testing purpose was to insure that a plan did not favor the "highly compensated" employees of a business. With a SIMPLE Cafeteria plan there is no discrimination testing required, so long as the plan uses one of three allowable contribution methods prescribed in the law. This allows employers to contribute on behalf of all employees without testing. The most common contribution method will be a percentage of earnings for all employees. The contribution percentage can range from 2% to 6% of earnings. The contribution will have the following characteristics:

- Deductible to the employer
- Non-taxable to the employee
- Limited in use to what the employer determines are eligible expenses
- Unused funds revert back to the employer at the end of the Cafeteria Plan Year

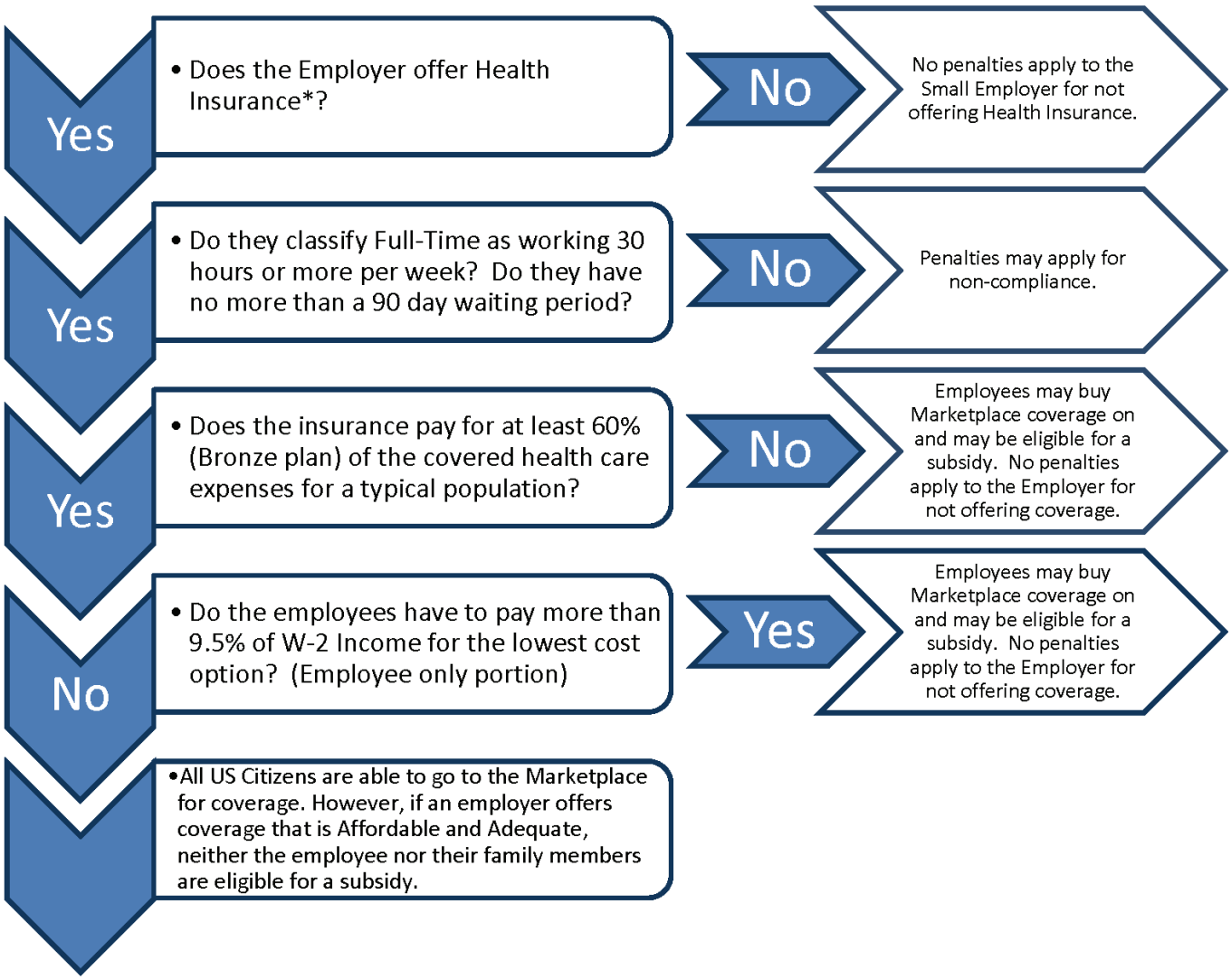
VIII. **Defined Contribution/Private Exchange –** In simplest terms, a defined contribution approach to funding employer- provided health benefits involves the employer offering a flat dollar subsidy to the employee. The employee then selects from a range of plans offered by the employer to its employees. Private Exchanges expand upon the defined contribution approach. Traditionally, for most companies under 1,000 employees, the choice of benefits has been limited to plans offered by one insurance company. Under the concept of a Private Exchange, which can be operated by insurers, third party administrators or brokers, the employees' choices are expanded through the availability of multiple companies and plan offerings. Administration, including billing and enrollment, is aggregated through the operating system of the Exchange.

IX. **Voluntary Plans –** In recent years, voluntary benefit plans have become an essential element of many employers' benefit programs. With the advent of the Affordable Care Act (ACA), and the likelihood of higher deductible plans under ACA, an increased emphasis will be placed on voluntary benefits to help employees with their coverage gaps. Voluntary plans can (at little or no cost to employers) help attract and retain employees by providing solutions to their needs. Benefits will be examined holistically to ensure the right combination of core and voluntary benefits is established to create benefit programs that complement each other.

X. **Employee Compliance Consent Form -** Employee acknowledgement of receipt of notices either in hard copy or via a website. All compliance forms may be distributed electronically. However, under the law, an employee has the right to receive all compliance materials in hard copy, unless the employee "consents" to receiving the information electronically. By signing the "consent/acknowledgment" form, the employee agrees to receive all information electronically.

XI. **Self-Funding -** With self-funding an employer accepts an increased level of initial risk (funding) with the hopeful outcome of lower total cost for most plan years.

Small Group Coverage Options Flowchart



***If the employer has <25 employees and average wages of <$50,000, it may be eligible for a health insurance tax credit in the SHOP.**

Small Business Tax Credit

- 35% tax credit 2013 – 25% tax-exempt
- 50% tax credit 2014 – 35% tax-exempt
- Subsidy will be available for 2 years per employer
  - Program scheduled to last 6 years
  - Employer must pay 50% of the cost of the employee only premium
  - Owner's (& Family) income are not included in the calculation of wages except in C Corps
- Phase-Out
  - Wages between $25,000 and $50,000
  - Between 10 and 25 full-time workers or equivalents

Marketplace Plans ~ The Metal Levels

Plan Type	Plan Pays % of Total Covered Expenses (on avg.) = Actuarial Value	Consumer Pays For Deductibles, Co-Pays, & Coinsurance (on avg.)
Platinum	90%	10%
Gold	80%	20%
Silver	70%	30%
Bronze	60%	40%
Catastrophic	<60%	>40%

Higher Premiums & Lower Consumer Cost Sharing

Lower Premiums & Higher Consumer Cost Sharing

100% to 250% FPL are eligible for cost-sharing subsidies to reduce out-of-pocket costs – requires Silver Plan enrollment.

Actuarial Value

Actuarial Value (AV) is the average percentage paid by the insurance company for its membership as a whole as an average value spread across all of the plan's members. Consumers could be responsible for a higher or lower percentage of the total costs of covered services for the year, depending on actual health care needs and the terms of the insurance policy. Non-covered health care expenses aren't taken into account when determining a health plan's value.

Minimum Value Standard

A health plan meets this standard if it's designed to pay at least 60% of the total cost of medical services for a standard population. Starting in 2014, individuals offered employer-sponsored coverage that provides minimum value and that's affordable won't be eligible for a premium tax credit.

Minimum Essential Coverage

The type of coverage an individual needs to have to meet the individual responsibility requirement under the Affordable Care Act. This includes individual market policies, job-based coverage, Medicare, Medicaid, CHIP, TRICARE and certain other coverage.

Federal Poverty Level & Maximum Monthly Premium

Incomes as a Percentage of 2013 Federal Poverty Level (FPL)					
Household Size	Household Income (100%)	⟺	Household Income (250%)	⟺	Household Income (400%)
1	$11,490	Premium Tax Credits + Cost-Sharing Subsidies (Silver Plan)	$28,725	Premium Tax Credits	$45,960
2	$15,510		$38,775		$62,040
3	$19,530		$48,825		$78,120
4	$23,550		$58,875		$94,200
5	$27,570		$68,925		$110,280
For each additional person add	$4,020		$10,050		$16,080

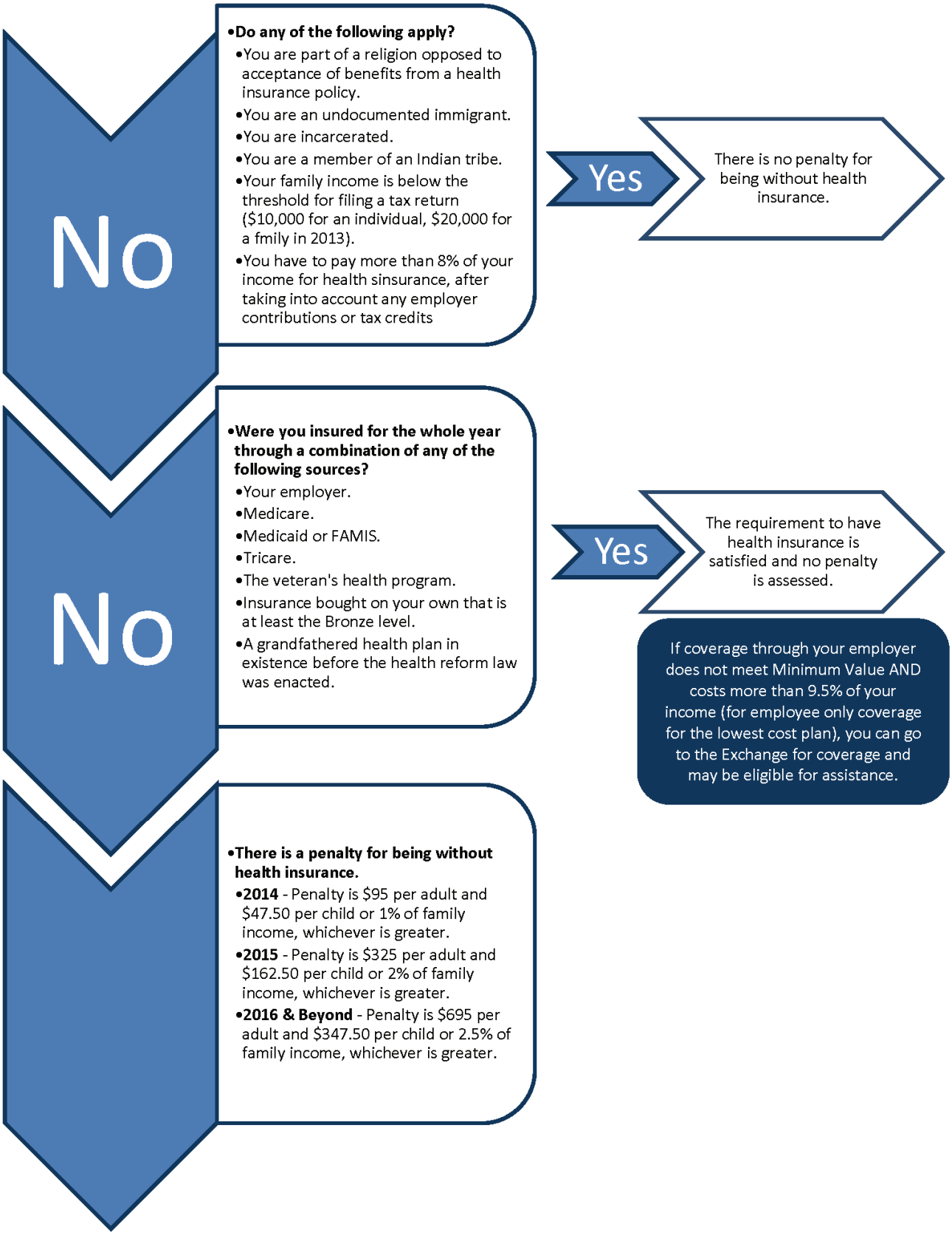
2013 Maximum Monthly Premium with Tax Credits for the Silver Plan					
Household Size	100% FPL *2.0% of Income*	⟺	250% FPL *8.05% of Income*	⟺	400% FPL *9.5% of Income*
1	$19.15	Premium Tax Credits + Cost-Sharing Subsidies (Silver Plan)	$192.70	Premium Tax Credits	$363.85
2	$25.85		$260.12		$491.15
3	$32.55		$327.53		$618.45
4	$39.25		$394.95		$745.75
5	$45.95		$462.37		$873.05
For each additional person add	$6.70		$67.42		$127.30

Amounts based on 2013 Incomes above. 2014 amounts may be higher.
Federal Government pays balance of premium directly to the Insurer.
Insurer can charge a tobacco surcharge up to 50% of the base premium (not subsidized).

Assistance

- **Premium Tax Credit**—Premium tax credits are available to individuals and families with incomes between 100% to 400% of FPL, who are not eligible for other minimum essential coverage, and who purchase coverage in the health insurance marketplace.
- **Cost Sharing Subsidy**—Cost-sharing subsidies are available to individuals and families with incomes up to 250% of FPL that lower deductibles and the total out-of-pocket costs under the plan, are only available to people who purchase a silver plan.

Individual Coverage Flowchart



Premium Subsidy Scenarios

Sample 1: Family of 4 - Two 40 year old, non-smoking parents with two children under 21.								
Household Size	Annual Income	Monthly Income	FPL %	Premium Cap %	Total Premium	Tobacco Surcharge	Potential Tax Credit	Monthly Premium
4	$53,000	$4,417	225%	7.18%	$962	$0	$645	$317
Sample 2: Family of 2 - Two 60 year old, non-smoking adults.								
Household Size	Annual Income	Monthly Income	FPL %	Premium Cap %	Total Premium	Tobacco Surcharge	Potential Tax Credit	Monthly Premium
2	$25,000	$2,083	161%	4.51%	$1,365	$0	$1,271	$94
Sample 3: Single - One 30 year old, smoker. (Tobacco Surcharge Applies.)								
Household Size	Annual Income	Monthly Income	FPL %	Premium Cap %	Total Premium	Tobacco Surcharge	Potential Tax Credit	Monthly Premium
1	$30,000	$2,500	261%	8.37%	$428	$143	$76	$352

Working Examples								
Household Size	Annual Income	Monthly Income	FPL %	Premium Cap %	Total Premium	Tobacco Surcharge	Potential Tax Credit	Monthly Premium

Tobacco Surcharge

Insurers can charge smokers and other tobacco users as much as 50 percent more on their premiums due to the higher health risks they face compared to non-tobacco users. **Tobacco use is defined as using tobacco an average of four or more times per week in the past six months, excluding religious or ceremonial use.** Some services to help people quit smoking are covered under the Affordable Care Act.

An insurance policy may be terminated if one commits fraud and does not share accurate medical information (i.e. Smoking Status.)

Essential Health Benefits Explanation

Essential Health Benefits are a set of health care service categories that must be covered by certain plans, starting in 2014.

The Affordable Care Act ensures health plans offered in the individual and small group markets, both inside and outside of the Health Insurance Marketplace, offer a comprehensive package of items and services, known as essential health benefits.

Essential health benefits must include items and services within at least the following 10 categories:

- ambulatory patient services;
- emergency services;
- hospitalization;
- maternity and newborn care;
- mental health and substance use disorder services, including behavioral health treatment;
- prescription drugs;
- rehabilitative and habilitative services and devices;
- laboratory services;
- preventive and wellness services and chronic disease management;
- and pediatric services, including oral and vision care.

Insurance policies must cover these benefits in order to be certified and offered in the Health Insurance Marketplace. States expanding their Medicaid programs must provide these benefits to people newly eligible for Medicaid.

CMS 2014 Rate Chart

AGE	PREMIUM RATIO	AGE	PREMIUM RATIO	AGE	PREMIUM RATIO
0-20	0.635	35	1.222	50	1.786
21	1.000	36	1.230	51	1.865
22	1.000	37	1.238	52	1.952
23	1.000	38	1.246	53	2.040
24	1.000	39	1.262	54	2.135
25	1.004	40	1.278	55	2.230
26	1.024	41	1.302	56	2.333
27	1.048	42	1.325	57	2.437
28	1.087	43	1.357	58	2.548
29	1.119	44	1.397	59	2.603
30	1.135	45	1.444	60	2.714
31	1.159	46	1.500	61	2.810
32	1.183	47	1.563	62	2.873
33	1.198	48	1.635	63	2.952
34	1.214	49	1.706	64 and Older	3.000

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IMPORTANT: This document has been compiled from numerous sources and is designed to provide a general overview of the new health reform law. It does NOT attempt to cover all of the law's provisions and should NOT be used as legal advice for implementation activities.

We encourage you to seek any professional advice, including legal counsel, regarding how the new requirements will affect your specific plan.

Links - Further Reading

HR 3590 – Patient Protection and Affordable Care Act.

HR 4872 – Health Care and Education Reconciliation Act.

HealthCare.gov

HHS – The U.S. Department of Health and Human Services.

IRS – The Federal Internal Revenue Service.

White House Fact Sheets

Healthcare Reform Website

HealthCare.gov

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