The Affordable Care Act: Where Are We Now and What Comes Next?

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LeClairRyan

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Overview of the Large Employer “Shared Responsibility” Under the Affordable Care Act

(Patient Protection and Affordable Care Act, Public Law 111-148, and the Healthcare and Education Reconciliation Act of 2010, Public Law 111-152, Collectively, the Affordable Care Act)
ACA Universe of Coverage

Individuals and Small Employers

- Individuals Purchasing Private Insurance
- Employees Not Covered by Large Employers
  - Employees of Small Employers
  - Small Employers
  - Individuals
  - Individuals B/T 133% and 400% of FPL
- Medicare, over 65
- Medicaid 133% or less of FPL (State expansion)
- CHIP, other federal programs

Large Employers (Over “50 FTE”)

- Commercial Group Health Plans from Insurance Carriers
- Self-Insurance Using TPAs or Health Insurance Plans and Stop Loss Insurance
- Employer Sponsored Insurance
Penalty Rules in 2014-2015

LARGE EMPLOYER = “50 FT EMPLOYEES”
AN EMPLOYER WHO EMPLOYEES AN AVERAGE OF 50 FT EMPLOYEES ON BUSINESS DAYS DURING THE PROCEEDING CALENDAR YEAR, USING BOTH FULL-TIME EMPLOYEES AND FTEs (PART-TIME EMPLOYEES).

EMPLOYER DOES NOT OFFER MINIMUM ESSENTIAL COVERAGE

MINIMUM ESSENTIAL

EMPLOYER OFFERS MINIMUM ESSENTIAL COVERAGE

AFFORDABLE

EMPLOYER OFFERS MINIMUM ESSENTIAL COVERAGE

BUT

EMPLOYER OFFERS MINIMUM ESSENTIAL COVERAGE

AND

EMPLOYER OFFERS MINIMUM ESSENTIAL COVERAGE

PROVIDES MINIMUM VALUE (MORE THAN 60% OF COVERED EXPENSES) AND EMPLOYEE DOES NOT HAVE TO PAY MORE THAN 9.5% OF HOUSEHOLD INCOME (EMPLOYEE W-2 WAGES)

NO PENALTY: AFFORDABLE COVERAGE IS PROVIDED

NO PENALTY: AFFORDABLE COVERAGE IS PROVIDED

NO PENALTY: AFFORDABLE COVERAGE IS PROVIDED

ANNUAL PENALTY IS $2,000 X NUMBER OF FULL-TIME EMPLOYEES (30 HR WEEK) MINUS 30. PENALTY INCREASES YEARLY BY GROWTH OF INSURANCE PREMIUMS

ANNUAL PENALTY IS $3,000 X EACH FULL-TIME EMPLOYEE RECEIVING A TAX CREDIT (UP TO A MAX OF $2,000 X NUMBER OF FULL-TIME EMPLOYEES MINUS 30). PENALTY INCREASES EACH YEAR BY GROWTH OF INSURANCE PREMIUMS

AT LEAST ONE FULL-TIME (≥ 30 HRS PER WEEK) EMPLOYEE RECEIVES A PREMIUM TAX CREDIT OR COST SHARING SUBSIDY IN AN EXCHANGE

EMPLOYEE CHOOSES TO BUY COVERAGE IN AN EXCHANGE AND GETS A PREMIUM TAX CREDIT

EMPLOYEE RECEIVES A PREMIUM TAX CREDIT OR COST SHARING SUBSIDY IN AN EXCHANGE

PREMIUM TAX CREDIT
Starting point for the ACA is...

Section 4980H of the Internal Revenue Code


Employers must offer affordable and “minimum value” health care coverage for full time employees if they have more than 50 full time employees or their equivalent (FTE’s)
Employees and aggregation

- Who is an employee? An employee means an individual that is an employee under the IRS’s “common law” test, such that many independent contractors could be employees entitled to coverage if the employer has the requisite number of employees, when including such common law employees in the total amount of FTE’s.

- Importantly, groups and companies with common ownership will likely be aggregated together to determine if these common controlled companies, when combined, have the requisite number of FTE’s.

- The aggregation standards to be applied here will be governed by tax and employee benefit standards.
Full Time Equivalents

- In determining if a company has 50 or more FTE’s the IRS has provided several, complicated look back tests that generally use a 6 month test in 2013 2014 and then a 3-to-12 month test thereafter
- Special rules are being proposed for employees that do not track their time, but have not yet been finalized, but they appear to consider whether such employees are expected to work more than 30 hours per week
- All employers are impacted: for profit, not for profit and governmental
- Foreign-based employment does not count, unless employer does not consider income paid to be foreign-based
Full Time Equivalents

- New employers: the IRS is requesting guidance at this point, except it appears that IRS will include new employers if the expectation is that they will have 50 FTE’s during the year that they start business.

- Calculating FTE’s is extremely complex and will require consultants and tracking of information on a long-term basis.

- Employers must also count paid time off (PTO) towards the hourly levels in measuring an employee’s work hours to compute FTE’s and their equivalents and employers will be able to average their number of employees during a year to take into account seasonal employees and fluctuating numbers of employees.
Starting in 2013-2014...

- Tracking for employers must start this year and at least 6 consecutive months needed for safe harbor
- New proposed regulations and guidance statements are being released on a monthly basis
- Other issues concern seasonal employees or employees with variable work hours
- Bottom line: it may be better to assume coverage if close to 50 FTE mark
Problem Areas That Need To Be Addressed

- Have more than 50 FTEs and are not offering coverage
- Have employees working > 30 hours/week not currently covered by health plan
- Have large percentage of employees **opting out**
- Have significant number of **low income** employees relative to Federal Poverty Level (FPL)
- Offer different **contributions or waiting periods** to sub-groups of employees
- Provide **minimal essential contribution** to premium threatening affordable coverage
Not Offering Insurance in 2014 Could Create Administrative Headaches:

- Coverage renewal issues
- May make it harder to track employee hours for 2015
- Employee morale
What should employers do?

- Evaluate current health plans and implement reporting systems
- If no current plan, determine what coverage needs to be provided and cost of penalties
- Determine effect on workforce
- Communicate with employees
ACA Reporting and Disclosure Requirements for Employers

- Grandfather status statement
- Rescission, 30 day advance written notice
- Patient Protection notice (new plans)
- Lifetime Limits notice
- Annual Limits Waiver notice
- Claims and Appeals notice
- Summary of Benefits and Coverage (SBC)
- 60 day modification notice
- W-2 Reporting of Cost of Employer – Provided Coverage
- Explanation of Exchanges
- Automatic Enrollment notice
October 1\textsuperscript{st} Notices: No worries, too late, or better late than never?

Two Notices:

1. Notice for Employers that provide healthcare
2. Notice for Employers that do not provide healthcare
The Notices: No worries, too late, or better late than never?

1. The ACA required that all employers subject to the Fair Labor Standards Act (FLSA) to send out ACA Notices to their employees by October 1, 2013.

2. The Department of Labor has opined that there is no penalty for failing to send out this required notice.
We recommend that all employers send out this required notice (and send them out now if they have not yet done so):

• No Penalty but still required under the law
• Possibility of claims of breach of fiduciary duty
• Negligence suits against employers
• CBA obligations and violation issues for unionized employers
Insurance Rebates: Why did I get one and what do I do with it?

Under the ACA, insurance companies are required to spend at least 80% of insurance premiums on actual healthcare (as opposed to salaries and marketing).

If an insurance company fails to satisfy this requirement it is required to refund the difference.
Insurance Rebates: Why did I get one and what do I do with it?

Rebates are Considered *Plan Assets*:

• If employees pay for a portion of coverage, at least a portion of the rebate must be distributed back to employees.

• Failure to appropriately distribute rebates can result in a breach of fiduciary duty and even criminal liability!
New for 2014: 90-day limit of waiting time to begin coverage

- Employers qualified to receive healthcare insurance cannot be made to wait more than 90-days from eligibility to begin receiving coverage.

- Employers may still have qualifying events here otherwise permitted (such as working a minimum number of hours prior to eligibility) so long as the requirements are not intended to evade the law.

- It is unclear how this requirement will apply to California employers with the state’s new 60-day maximum waiting period.
Employer Mandate Delayed Until 1-1-2015

• It is unclear whether “transition relief” will still apply, or whether all large employers must start offering coverage on January 1, 2015.

• In some cases, non-calendar year (e.g. fiscal year) plans will need to begin tracking employee hours in 2013 if they wish to use a 12-month measurement period.

Bottom Line: Large employers should assume their obligations will begin on 1-1-2015.
Emerging Issue: Should my company consider self-insuring?

The idea of self insurance used to be the exclusive domain of mega-corporations. Many smaller and medium sized employees may now wish to give this option a second look.
Emerging Issue: Should my company consider self-insuring?

Self Insured Plans:

• Administration: Self insured plans are exempt from many aspects of the ACA.
• Economics: Self insured plans are exempt from certain ACA-related fees.

Unlike 10 years ago, TPA are able to assist smaller employers with administering plans and quantifying risk.
Emerging Issue: Contraceptive Coverage

Lawsuits remain ongoing concerning the extent that for profit businesses must include contraceptive care in plans over religious objections. The U.S. Sixth Circuit Court of Appeals recently weighed in on this issue:

• Private for profit corporations must comply with this ACA coverage mandate;
• Same rule may not apply to partnerships and sole proprietorships.
Who owns the process?

- CFO’s role
- Human Resources Dept. role
- Payroll Providers
- Outside CPA / Benefit Consultant
- Plan Administrators
- Legal Team
Implementation, the Private Exchanges and Hidden Issues
# Health Care Reform Overview

## A Trio of New Fees

<table>
<thead>
<tr>
<th></th>
<th>Patient-Centered Outcomes Research Fee</th>
<th>Transitional Reinsurance Fee</th>
<th>Health Insurance Industry Fee</th>
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</thead>
<tbody>
<tr>
<td><strong>What is it?</strong></td>
<td>▪ Annual plan year fee on insured and self insured plans beginning on/after 10/2/2011</td>
<td>▪ Annual calendar year fee on insured and self-insured plans, 2014-2016</td>
<td>▪ Annual fee on all insured plans beginning in 2014</td>
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<tr>
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<td><strong>How Much?</strong></td>
<td>▪ Annual fee of $1 PMPY, then $2 PMPY; indexed to medical inflation until 2019 ▪ First payable July 2013</td>
<td>Estimated costs: ▪ $63 PMPY in 2014 ▪ Projected to decrease, but still remains to be seen with Employer Mandate delay</td>
<td>Estimated costs: ▪ 2 to 2.5% for 2014 ▪ 3 to 4% for later years</td>
</tr>
<tr>
<td><strong>Who Pays?</strong></td>
<td>▪ FI: Carrier pays ▪ SF: Employer must calculate and pay own fee</td>
<td>▪ FI: Carrier pays ▪ SF: Employer must calculate and pay own fee</td>
<td>▪ Carrier pays ▪ Applies to all insured plans and will be based on each insurer’s share (among all U.S. insurers)</td>
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</tbody>
</table>
High Value ("Cadillac") Plan Excise Tax

Summary

- Includes medical/Rx, individual reimbursement accounts, EAP, and onsite medical clinics
- 2018 thresholds are $10,200 for single coverage and $27,500 for family coverage – will be indexed annually thereafter based on CPI
- 40% excise tax on the coverage value that exceeds these thresholds
- Threshold adjustments permitted for pre-65 retirees, high-risk professions, significant age/gender factors, and multi-employer plans

Most Likely Employer Actions Regarding Excise Tax

- Will do whatever is necessary to bring plan cost below threshold amounts (21%)
- Will attempt to bring cost below threshold amounts, but may not be possible (36%)
- Will take no special steps to reduce cost below threshold amounts (39%)
- Believe plan(s) are unlikely to ever trigger excise tax (4%)

Source: Mercer Survey of Employer-Sponsored Health Plans 2011
Advantages of Partial Self-Funding and the Affordable Care Act

- Creation of a smart long term health strategy
- Potential cost savings and increased cash flow
- Flexibility in benefit decisions/plan design
- Exemption for state mandates
- Reduction in premium tax and elimination of ACA taxes
- Benefit from good claim experience
- If set up properly, limited risk
- Receipt of quality claims data to understand the specific plan utilization issues and health concerns of the group
- Partnership with the carrier to understand and improve the health of the employees and their dependents

This is for informational purposes only, and is not intended to be used as legal advice.
Delivery Models
2014 and Beyond
Health Insurance Marketplace (formerly Exchanges)

Public Marketplaces

- Are intended to help individuals and small businesses shop for, select and enroll in high quality, affordable private health plans that fit their needs at competitive prices.

- The Act requires Marketplaces in each State by January 1, 2014. In 2014 – 2016, only individuals and employers in the small group market are eligible to participate in an Marketplace.

- States seeking to operate a State-based Marketplace had to submit a blueprint to HHS by December 14, 2012 (extended from November 16, 2012) to receive the required approval by January 1, 2013 for plan years beginning 2014.

- As of today:
  - 18 Approved State Based Marketplaces, including D.C.
  - 7 Partnership Models
  - 26 Federally-Facilitated Marketplaces
• Federal/State-based health insurance marketplaces
  • Law requires the creation of an American Health Benefit Exchange (AHBE) (for individuals) and Small Business Health Options Program (SHOP) Exchange for small employers up to 100 lives
  • States can combine their individual and small employer exchanges
  • Regional sub-exchanges optional
  • States can choose to expand their exchanges to serve employer groups of 100+ in 2017

• Carriers need final regulations by June 2013 and file plans by October 2013 to be ready to start open enrollment late 2013 for the proposed effective date of January 1, 2014.
• Offer choice of plans, carriers, networks (comparison shopping)
• Develop menu of choices based on quality, access, and premium costs
• Subsidies will be available for lower income individuals in the Government sponsored Individual Exchange Marketplace Only

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A new group insurance delivery option for employers of all sizes.

A private benefits exchange is designed to help employers more effectively manage their benefit costs providing employees and their dependents with superior choice, flexibility and service.

There will be a full suite of plans with all the benefits of group purchasing.

Each Private Marketplace is set up differently. Options include:

- Fully Insured Medical Plans
- Self Insured Medical Plans
- Voluntary Products
- Embracing a Defined Contribution Strategy
27 defaulting to the federal exchange program

17 creating state-run exchange program

7 planning partnership exchange

Exchanges are to be operational by Oct. 1, 2013

Source: Washington Post, Kaiser Family Foundation
Federal Agencies Responsible for Protecting the Integrity of Federal Healthcare Programs

**HHS:** The department Health and Human Services is the principle agency protecting the health of all Americans. It is comprised of the office of secretary with eighteen staff divisions and eleven operating divisions.

**CMS:** Centers for Medicare and Medicaid Services is a branch of the U.S. Department of Health and Human Services. CMS is the Federal agency that administers the Medicare program and monitors the Medicaid program offered by each state.

**OIG:** Department of HHS, Office of Inspector General, an independent oversight agency that protects the integrity of the Federal Healthcare programs. OIG is a department within the DOJ and its mission is to detect and deter fraud, waste and abuse in department programs.

- Investigates violations of Law for criminal prosecution, civil litigation, and administrative action.
- Conducts financial and performance audits
- Reports to the AG
- Coordinates with Federal and State agencies to prevent and detect fraud and abuse.

**DOJ:** Department of Justice.
ACA Section 1558 - Protection for Employees: A New Whistleblower Provision

- An employee who has been discharged or discriminated against can file a complaint under Section 2087(b) of Title 15 U.S.C.
- Retaliation must be related to the employee’s assistance in an investigation into the employer’s failure to comply with requirements of Title I or refuses to participate in any activity the employee reasonably believed to be in violation of Title I.
- After OSHA evaluation of initial complaint, the employee may file a civil action in federal court and obtain a jury trial and demand reinstatement, injunctive relief, back pay with interests, and other litigation costs.
- The employee has 180 days from the violation to submit the complaint to OSHA and within 90 days of OSHA’s determination or 210 days after filing the original complaint, the employee may file the civil action.
- Employer retaliation is broadly defined: job reassignment, failure to promote, pay reduction, etc.
Examples of Potential Benefit Plan Litigation

- Challenge anything not covered
- Seek coverage for “essential health benefits”
- Challenge grandfather status
- Use ERISA, PHSA or FLSA to challenge workforce restructuring
- Challenge internal \ external reviews
- Challenge employer use of state exchanges
What Does the Delay in Enforcement of the Employer Penalty Mean?

- Possible delay in implementation of other parts of the ACA, i.e., individual mandate
- Legal challenges to the delay
- Widespread confusion by employers who assume that the entire ACA is delayed
- Possible fraud at the exchanges as there will be no way to verify whether the individual has coverage
What We See Ahead

- Continuing Challenges to the ACA and possible revamping of certain issues
- Guidance Issues Continue to Mount
- Will Changes to ACA Cause Further Delays
- Notices slated for October 1 could be pushed back
- Exchanges *should be ready*, but that is far from certain at this time
Problem Areas

- Information Reporting
- Union Environment Implementation (numerous issues)
- Extensive Regulatory “Drift” simply too complex for federal agencies to implement
- Unclear that the ACA will be funded in terms of hiring workers and funding regulatory oversight mechanisms
- Continuing Litigation may overtake federal implementation
- Widespread Liability Claims Issues
The ACA: Where Are We Now?

- “Known Knowns”
  - The Health Insurance Marketplace is Open for Business
  - Employers Covered by the FLSA Must Provide Employees with A Notice of Coverage
  - “Employer Mandate” Delayed One Year
  - PPSA “Sunshine” Data Collection Underway
  - “Change is the Only Constant”
The ACA: Where Are We Now?

- “Known Unknowns”
  - Continuation of the Medical Device Excise Tax
  - Number of Enrollees in the Insurance Marketplace
  - Number of Individuals Ineligible for Medicaid & ACA Premium Subsidies
  - Impact of the ACA on Employer, Labor Union & Employee relationships
  - Real World Costs of ACA Implementation
The ACA: Where Are We Now?

- “Unknown Unknowns”

“We fear things in proportion to our ignorance of them.” Titus Livius
The ACA: What Comes Next?

- **2014**
  - Expanded Medicaid Coverage in Certain States
  - “Individual Mandate” – Maybe…
  - Persons Receive Health Insurance Coverage via the Exchanges—”Essential Health Benefits”
  - Eligible Persons Receive Premium Subsidies
  - IRS Reporting Requirements for Health Plan Sponsors
### Table 4: Weighted Average Premiums, 48 States

<table>
<thead>
<tr>
<th>State</th>
<th>Lowest Cost Silver</th>
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<th>Lowest Cost Bronze</th>
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**NOTE:** Premiums shown above are a weighted average of the lowest cost silver plan, the second lowest cost silver plan, and the lowest cost bronze plan in each rating area within the 36 Supported State-based Marketplaces, State Partnership Marketplaces, and Federally-Facilitated Marketplaces as of September 13, 2013, as well as 12 State-based Marketplaces. The rating area weights are constructed based on county-level population under the age of 65. For State-based Marketplaces, premiums are the weighted average across all rating areas for California and New York, and are for the entire state in DC, Rhode Island, and Vermont. For the remaining states, premiums are for the following rating areas: Denver, Colorado; Bridgeport, Hartford, and New Haven, Connecticut; Baltimore, Maryland; Minneapolis and St. Paul, Minnesota; Las Vegas, Nevada; Portland, Oregon; Seattle, Washington. Age weighting for all states is based on expected age distribution in the Marketplaces, estimated by the RAND Corporation.

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<td>$365</td>
<td>$211</td>
</tr>
<tr>
<td>Utah</td>
<td>$239</td>
<td>$266</td>
<td>$201</td>
</tr>
<tr>
<td>Vermont</td>
<td>$395</td>
<td>$413</td>
<td>$336</td>
</tr>
<tr>
<td>Virginia</td>
<td>$323</td>
<td>$355</td>
<td>$237</td>
</tr>
<tr>
<td>Washington</td>
<td>$350</td>
<td>$357</td>
<td>$264</td>
</tr>
<tr>
<td>West Virginia</td>
<td>$331</td>
<td>$331</td>
<td>$280</td>
</tr>
<tr>
<td>Wisconsin</td>
<td>$344</td>
<td>$361</td>
<td>$287</td>
</tr>
<tr>
<td>Wyoming</td>
<td>$489</td>
<td>$516</td>
<td>$425</td>
</tr>
</tbody>
</table>

**Weighted Average, 48 States**

<table>
<thead>
<tr>
<th>State</th>
<th>Lowest Cost Silver</th>
<th>Second Lowest Cost Silver</th>
<th>Lowest Cost Bronze</th>
</tr>
</thead>
<tbody>
<tr>
<td>South Dakota</td>
<td>$341</td>
<td>$357</td>
<td>$298</td>
</tr>
<tr>
<td>Tennessee</td>
<td>$235</td>
<td>$345</td>
<td>$181</td>
</tr>
<tr>
<td>Texas</td>
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</tbody>
</table>

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*New York premiums are the same for all ages.

*Vermont premiums are the same for all ages.*

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**ASPE Office of Health Policy**  
**September 25, 2013**
The ACA: What Comes Next?

Medicaid

Projected Growth in Enrollment, Total and State Medicaid Spending As Appropriated in State Budgets for FY 2014

<table>
<thead>
<tr>
<th>Enrollment Growth</th>
<th>Total Spending Growth</th>
</tr>
</thead>
<tbody>
<tr>
<td>All States</td>
<td>States Moving Forward (25)</td>
</tr>
<tr>
<td>8.8%</td>
<td>10.3%</td>
</tr>
</tbody>
</table>


SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, October 2013.
The Requirement to Buy Coverage Under the Affordable Care Act Beginning in 2014

Do any of the following apply?
- You are part of a religion opposed to acceptance of benefits from a health insurance policy.
- You are an undocumented immigrant.
- You are incarcerated.
- You are a member of an Indian tribe.
- Your family income is below the threshold for filing a tax return ($10,000 for an individual; $20,000 for a family in 2013).
- You have to pay more than 8% of your income for health insurance, after taking into account any employer contributions or tax credits.

No

Were you insured for the whole year through a combination of any of the following sources?
- Medicare.
- Medicaid or the Children's Health Insurance Program (CHIP).
- TRICARE (for service members, retirees, and their families).
- The veteran’s health program.
- A plan offered by an employer.
- Insurance bought on your own that is at least the Bronze level.
- A grandfathered health plan in existence before the health reform law was enacted.

No

2014
Penalty is $95 per adult and $47.50 per child (up to $285 for a family) or 1.0% of family income, whichever is greater.

2015
Penalty is $325 per adult and $162.50 per child (up to $975 for a family) or 2.0% of family income, whichever is greater.

2016 and Beyond
Penalty is $695 per adult and $347.50 per child (up to $2,085 for a family) or 2.5% of family income, whichever is greater.

Income is defined as total income in excess of the filing threshold ($10,000 for an individual and $20,000 for a family in 2013). The penalty is prorated for the number of months without coverage, though there is no penalty for a single gap in coverage of less than 3 months in a year. The penalty cannot be greater than the national average premium for Bronze coverage in an Exchange. After 2016 penalty amounts are increased annually by the cost of living.

Key Facts:
- Premiums for health insurance bought through Exchanges would vary by age. The Congressional Budget Office estimates that the national average annual premium in an Exchange in 2016 would be $4,500-5,000 for an individual and $12,000-12,500 for a family for Bronze coverage (the lowest of the four tiers of coverage that will be available).
- In 2012 employees paid $951 on average towards the cost of individual coverage in an employer plan and $4,316 for a family of four.
Exchanges are to be operational by Oct. 1, 2013

Source: Washington Post, Kaiser Family Foundation
## The ACA: What Comes Next

### Figure 6: Premium and Cost-Sharing Subsidies, by Income in 2014

<table>
<thead>
<tr>
<th>Income (% Poverty)</th>
<th>Premium Cap (% of income on 2nd lowest silver)</th>
<th>Cost-Sharing Subsidies? (OOP Limit Indiv./Family)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 100%</td>
<td>No Cap</td>
<td>No ($6,350 / $12,700)</td>
</tr>
<tr>
<td>100% - 133%</td>
<td>2.0%</td>
<td>Yes ($2,250 / $4,500)</td>
</tr>
<tr>
<td>133% - 150%</td>
<td>3% - 4%</td>
<td>Yes ($2,250 / $4,500)</td>
</tr>
<tr>
<td>150% - 200%</td>
<td>4% - 6.3%</td>
<td>Yes ($2,250 / $4,500)</td>
</tr>
<tr>
<td>200% - 250%</td>
<td>6.3% - 8.05%</td>
<td>Yes ($5,200 / $10,400)</td>
</tr>
<tr>
<td>250% - 300%</td>
<td>8.05% - 9.5%</td>
<td>No ($6,350 / $12,700)</td>
</tr>
<tr>
<td>300% - 400%</td>
<td>9.5%</td>
<td>No ($6,350 / $12,700)</td>
</tr>
<tr>
<td>Over 400%</td>
<td>No Cap</td>
<td>No ($6,350 / $12,700)</td>
</tr>
</tbody>
</table>

Source: Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2014 Final Rule
The ACA: What Comes Next?

Average ACA Premium Subsidy for People Now Buying Insurance in the Individual Market

Average Premium Per Family for Silver Plan = $8,250

Average Premium Subsidy = $2,672 (32%)

Source: Kaiser Family Foundation analysis.
The ACA: What Comes Next?
The ACA: What Comes Next?

- IRS Reporting Requirements for Plan Sponsors
  - Section 6055 Reporting
    - Employer Self-Insured Plans Must Report
    - Multi-Employer Plans Create reporting Issues
    - Written Report to Responsible Individuals
  - Section 6056 Reporting
    - Applicable Large Employers – “Mandate Employers”
    - Bifurcated Reporting for Multiemployer Plans
    - “Employee Report” to Full-time EEs
The ACA: What Comes Next?

- Key Issues for Healthcare Providers
  - Effects of Physician Payment Sunshine Act
  - Role of APRNs, NPs & PAs in Collaborative Care
  - Impact of the Independent Payment Advisory Board
  - ACA Fraud and Abuse Enforcement
  - Trends in ACOs, Hospital “Economic” Credentialing,” Health Plan Provider Restrictions
Questions?
Thank you.

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