The Employee Medical Benefits Board held a Special Meeting Monday, September 23, 2013 in Meeting Room #1 at the Municipal Center, 3 Primrose Street, Newtown, CT.

THESE MINUTES ARE SUBJECT TO APPROVAL BY EMPLOYEE MEDICAL BENEFITS BOARD

Chairman Mark Mattioli called the meeting to order at 6:07 pm.

PRESENT: James Loring, Mark Mattioli (Chair), Dan McAloon, Paul Smith and Donna Van Waalwijk; **ALSO PRESENT**: Finance Director Robert Tait and Joseph Spurgeon, Consultant with Lindberg and Ripple.

ACCEPTANCE OF THE MINUTES: Mr. McAloon moved to accept the minutes of June 3, 2013. Ms. Van Waalwijk seconded the motion. The changes to the minutes are as follow: Under "Review Status of Fund", second sentence, change "$1.25 million" to "$1.025 million." Under "Review Aggregate Claims Experience for March/April 2013," second sentence, change "April was the worst month" to "May was the worst month." Then in the third paragraph, first sentence, change "forgave co-pays" to "forgave mental health visit co-pays". Then under "Communications", change the last sentence from "Mr. Tait confirmed that they are through the Town charter." To "It was noted that the Town Ordinance created the Employee Medical Benefits Board and determines how it will operate." The minutes were approved as amended.

REVIEW MOST RECENT CLAIM TREND / REVIEW RESERVE FUND STATUS

Mr. Tait distributed and reviewed his report titled "2012-2013 Medical Claims" (Attachment A). He noted that the estimate total cost for this fiscal year was $12.617 million and that the actual was $12.354 million. The fund balance on 07/01/12 was $2.339 million with an ending balance of $2.481 million on 06/30/13. Mr. Tait said the OPEB Trust Fund is smaller than most other towns.

Mr. Mattioli summarized by saying the plan year 2012/2013 ended well. The reserve fund has increased but is tempered a little by the first few months of the new fiscal year. Mr. Tait will keep an eye on this. Mr. Mattioli said this year's estimate is $13.3 million, which is $1 million more than what this past year ended with. Mr. Tait expects the employee numbers to remain steady with no massive changes on the benefits side. Mr. Spurgeon discussed the fluctuations within months and between fiscal years. Mr. Spurgeon said the early budget projections will be done in November, early December.

INSURANCE CONSULTANT

ACA Impacts as we Approach 2014 – Mr. Mattioli asked Mr. Spurgeon what to expect with the new Affordable Care Act . Mr. Spurgeon said Connecticut is on track to open the exchange in 2014. Enrollment is scheduled to open October 1, 2013. There are people who are hired or volunteered to be navigators to help residents. He discussed the employer Play or Pay penalties (Attachment B) which has been delayed until January 2015. The exposure for municipalities would be employees such as substitute teachers that work 30 hours or more but are not considered full time. Mr. Spurgeon distributed a presentation entitled "PPACA/ObamaCare/National Health Reform, Employer Considerations, High-Level Summary" (Attachment C) prepared by Lindbert & Ripple, Inc.
He noted that he is in direct communication with Ron Bienkowski and Carole Ross regarding potential impacts of ACA to the Town/BOE and employees.

Outcome of the Performance Guarantees (and discuss future use of PGs) – Item is tabled.

Outcome of the Wellness Initiative in the 2012-2013 Plan Year (dollars spent, number of members impacted) – Mr. Spurgeon said that Anthem provided $10,000 for a wellness initiative that was organized by the Health District and a representative of BOE. Mr. Mattioli asked if anyone has heard feedback on this. Mr. Tait said it was a well-organized event and will provide more information on its results to the group.

NEW BUSINESS

The next meeting is scheduled for December 2, 2013

NEW COMMUNICATIONS

ADJOURNMENT: Mr. McAloon motioned to adjourn the meeting. Mr. Loring seconded the motion which was unanimously approved. The Board adjourned at 6:55 pm.

Respectfully Submitted by Tammy Hazen, Clerk.

TOWN OF NEWTOWN
MEDICAL CLAIMS
2012 - 13

	CLAIMS			2013-14 CLAIMS TO DATE COMPARISON			
	EDUCATION	MUNICIPAL	TOTAL	EDUCATION	MUNICIPAL	TOTAL	
JULY	722,320	246,910	969,230	957,699	275,360	1,233,058	
AUGUST	764,277	226,095	990,372	865,066	238,107	1,103,173	
SEPTEMBER	611,491	168,232	779,722	700,000	400,000	1,100,000	est.
OCTOBER	811,876	198,331	1,010,207				
NOVEMBER	694,186	190,178	884,364				
DECEMBER	738,695	265,581	1,004,276				
JANUARY	595,729	241,341	837,069				
FEBRUARY	754,263	245,675	999,939				
MARCH	676,901	278,790	955,691				
APRIL	762,657	261,457	1,024,114				
MAY	843,468	303,996	1,147,464				
JUNE	708,743	214,571	923,313				
	8,684,606	2,841,154	11,525,760				

one person over the stop loss limit

	ADMIN/STOP LOSS		
	EDUCATION	MUNICIPAL	TOTAL
2012 - 13	615,692	212,854	828,546
GRAND TOTAL	9,300,298	3,054,008	12,354,306

compare to next page (7/1/2012 renewal amount)

ATTACHMENT A
EEMBB 09-23-13

Report 1

Renewal Cost Summary

Newtown Town And Board Of Education

Renewal Effective Date: July 1, 2012 (2012-13)

Expected Paid Claims by Coverage Category*	
Medical	$9,994,944
Drug	$1,393,476
Dental	$138,600
Vision	$3,372
Total Expected Paid Claims:	$11,530,392
Network Access Fee:	$224,158
Estimated Retention and Stop Loss:*	
Retention Fees	$210,950
Stop Loss Fees	$651,989
Estimated Total Retention and Stop Loss Fees	$862,939
Estimated Total Cost:	$12,617,490

The Expected Paid Claims represents the actuarial projection of claims cost for the renewal period. These amounts are provided to assist you with estimating claim liability for your budgetary purposes. These projections are also used as the basis for determining the maximum liability for aggregate stop loss coverage.

*Capped at 100% Network Access Fee
*Claims, Retention, and Stop Loss costs were calculated based on contracts as of January, 2012
The Network Access Fee is capped at 100%, a maximum dollar amount of $224,158.

The health benefit plan(s) reflected in this quote is not considered to be grandfathered under the provisions of the Patient Protection and Affordable Care Act. Nongrandfathered plans are subject to additional provisions under the Patient Protection and Affordable Care Act that do not apply to grandfathered plans. For further information, please contact your account representative.

This renewal rate includes changes to the standard medical plan to ensure compliance with the requirements of the federal health care reform legislation for nongrandfathered plans, including 100 percent coverage of in-network preventive care services.

Report 1

Renewal Cost Summary

Newtown Town And Board Of Education

Renewal Effective Date: July 1, 2013 (2013-14)

Expected Paid Claims by Coverage Category*	
Medical	$10,517,160
Drug	$1,499,796
Dental	$141,540
Vision	$3,708
Total Expected Paid Claims:	$12,162,204
Network Access Fee:	$220,243
Estimated Retention and Stop Loss:*	
Retention Fees	$260,595
Stop Loss Fees	$668,336
Estimated Total Retention and Stop Loss Fees	$928,931
Estimated Total Cost:	$13,311,378

$700,000 more than prior year

The Expected Paid Claims represents the actuarial projection of claims cost for the renewal period. These amounts are provided to assist you with estimating claim liability for your budgetary purposes. These projections are also used as the basis for determining the maximum liability for aggregate stop loss coverage.

*Capped at 100% Network Access Fee
*Claims, Retention, and Stop Loss costs were calculated based on contracts as of January, 2013
The Network Access Fee is capped at 100%, a maximum dollar amount of $220,243.

The health benefit plan(s) reflected in this quote is not considered to be grandfathered under the provisions of the Patient Protection and Affordable Care Act. Nongrandfathered plans are subject to additional provisions under the Patient Protection and Affordable Care Act that do not apply to grandfathered plans. For further information, please contact your account representative.

This renewal rate includes changes to the standard medical plan to ensure compliance with the requirements of the federal health care reform legislation for nongrandfathered plans, including 100 percent coverage of in-network preventive care services.

Your health benefit plan includes new and newly expanded benefits for women's preventive care. Certain services, drugs and supplies will now be paid at 100% in-network. Coverage for these services is included in this renewal. Please see your Account Manager for details.

Anthem

UNAUDITED FINANCIAL STATEMENT

SCHEDULE 7

TOWN OF NEWTOWN, CONNECTICUT

COMBINING STATEMENT OF NET ASSETS
INTERNAL SERVICE FUNDS
JUNE 30, 2013

	BOARD OF EDUCATION DENTAL	MEDICAL INSURANCE	TOTALS
ASSETS			
Current assets:			
Cash	$ 225,001	$ 2,770,361	$ 2,995,362
Accounts Receivable		$ 503,992	$ 503,992
Due from other funds	17,746	249,421	267,167
TOTAL ASSETS	242,747	3,523,774	3,766,521
LIABILITIES:			
Current liabilities:			
Claims payable	49,889	1,042,272	1,092,161
NET ASSETS			
Unrestricted	$ 192,858	$ 2,481,502	$ 2,674,360

UNAUDITED FINANCIAL STATEMENT

SCHEDULE 8

TOWN OF NEWTOWN, CONNECTICUT

COMBINING STATEMENT OF REVENUES, EXPENSES AND CHANGES IN FUND NET ASSETS
INTERNAL SERVICE FUNDS
YEAR ENDED JUNE 30, 2013

	BOARD OF EDUCATION DENTAL	MEDICAL INSURANCE	TOTALS
OPERATING REVENUES:			
Charges for services	$ 402,534	$ 11,707,200	$ 12,109,734
OPERATING EXPENSES:			
Claims incurred	473,794	10,676,978	11,150,772
Administration	1,438	896,581	898,019
TOTAL OPERATING EXPENSES	475,232	11,573,559	12,048,791
OPERATING INCOME (LOSS)	(72,698)	133,641	60,943
NONOPERATING REVENUES (EXPENSES):			
Investment income		8,239	8,239
NET CHANGE IN NET ASSETS	(72,698)	141,880	69,182
TOTAL NET ASSETS - JULY 1, 2012	265,556	2,339,622	2,605,178
TOTAL NET ASSETS - JUNE 30, 2013	$ 192,858	$ 2,481,502	$ 2,674,360

UNAUDITED FINANCIAL STATEMENT

EXHIBIT J

TOWN OF NEWTOWN, CONNECTICUT

STATEMENT OF FIDUCIARY NET ASSETS
FIDUCIARY FUNDS
JUNE 30, 2013

	PENSION TRUST FUND	OPEB TRUST FUND	SANDY HOOK TRUST FUND	AGENCY FUNDS
ASSETS				
Cash	$ 20,306	$ 20,714	$	$ 315,828
Due From Other funds			$ 19,183	
Investments at Fair Value:				
Certificates of Deposit				422,811
Mutual Funds:				
Equity	15,104,918	361,093		
U.S. Government Bonds				
Money market mutual funds	1,758,205	27,431		
U.S. Government Securities	588,271			
U.S. Government Agency Securities	1,018,056	13,915		
Corporate Bonds	11,707,716	249,201		
Total Investments	30,177,166	651,640	0	422,811
Due from other funds		313,919		-
TOTAL ASSETS	30,197,472	986,273	19,183	738,639
LIABILITIES				
LIABILITIES:				
Accounts payable		4,000	-	738,639
NET ASSETS				
NET ASSETS HELD IN TRUST				
FOR PENSION AND OPEB BENEFITS	$ 30,197,472	$ 982,273		$ -
FOR FAMILIES			$ 19,183	

The notes to the financial statements are an integral part of this statement.

UNAUDITED FINANCIAL STATEMENT

TOWN OF NEWTOWN, CONNECTICUT

STATEMENT OF CHANGES IN FIDUCIARY NET ASSETS
FIDUCIARY FUNDS
YEAR ENDED JUNE 30, 2013

	PENSION TRUST FUND	OPEB TRUST FUND
ADDITIONS:		
Contributions:		
Employer	$ 1,262,007	$ 775,470
Plan members	453,257	361,794
Others		
Total contributions	1,715,264	1,137,264
Investment income (loss):		
Net change in fair value of investments	796,263	12,577
Interest and dividends	1,128,389	26,127
Total investment income (loss)	1,924,652	38,704
Less investment expenses	157,162	8,752
Net investment income (loss)	1,767,490	29,952
TOTAL ADDITIONS	3,482,754	1,167,216
DEDUCTIONS:		
Benefits	1,417,321	795,441
Distributions		
CHANGE IN NET ASSETS	2,065,433	371,775
NET ASSETS - JULY 1, 2012	28,132,039	610,498
NET ASSETS - JUNE 30, 2013	$ 30,197,472	$ 982,273

The notes to the financial statements are an integral part of this statement.

PPACA "Pay or Play" Overview

Pay or Play Requirements Effective January 2015 (delayed from January 2014)

Initial highlights on Pay or Play (subject to ongoing guidance)

- There are two requirements to meet with "Pay or Play": one addresses access to coverage while the other addresses affordability and appropriate levels of coverage.

- Accessibility:
  - The access requirement states that employers must offer coverage to 95% of their full-time employee (those working 30 hours or more) and their child dependents (providing coverage for spouse is not required).
  - If an employer does not offer coverage to 95% of full-time employees and their child dependents **and** at least one full-time employee purchases coverage through the Health Care Exchange **and** receives a subsidy then the employer is subject to a fine.
  - The fine is $2,000 for every full-time employee. The employer can back out the first 30 full-time employees from the fine.

  - Note 1: the $2,000 fine is applicable to all full-time employees even if just one employee receives subsidized coverage via the exchange.

  - Note 2: to meet the access requirement, coverage need not meet the affordability or benefit coverage requirement (see below).

- Affordability and Benefit Coverage

  - The affordability and benefit coverage requirement requires that the plans offered to full-time employees must be affordable and meet a minimum value of benefit.
  - Affordability (based on an IRS safe-harbor) is based on the employee's cost for employee only coverage which cannot be greater the 9.5% of employee only wages; the actual test is based on 9.5% of Family Adjusted Gross Income (AGI).
  - Minimum value of benefit coverage states that the plan must pay at least 60% of the benefits covered by the plan (this should not be an issue for your benefit plans).
  - If the plan does not meet these requirements then the plan is subject to a fine.
  - The fine is $3,000 for **each** employee that purchases insurance **and** receives a subsidy via the exchange.

  - Note 1: the fine is $3,000, payable monthly, is levied only for the employee(s) that receives subsidized coverage via the exchange.

  - Note 2: Affordability is based on single only coverage. The employee cost for covering dependents may be greater than 9.5% of income.

- Again, to avoid the $2,000 penalty times all full-time equivalents, the Plan Sponsor must offer coverage to 95% qualifying FTEs, but that coverage need not be affordable. Employers will then decide (based on exposure) if they need to also create a plan that will be affordable or if they may opt to just pay the $3,000 penalty.

Several aspects of PPACA remain under review/development and are subject to change based on future guidance and revision

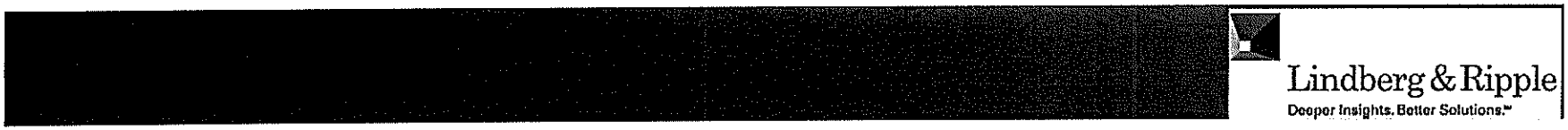
PPACA/ObamaCare/National Health Reform
Employer Considerations
High-Level Summary

Prepared by:
Lindberg & Ripple, Inc.

Updated August 27, 2013

100 Northfield Drive, Third Floor
Windsor, CT 06095
860.731.5566

ATTACHMENT C
EEMBB 09-23-13



PPACA Timeline

2010 and 2011 (Plans beginning/renewing after Sept. 23, 2010)

- Adult children eligible up to age 26 (grandfathered groups too-but can exclude if child is eligible for their own employer coverage).

***NOTE**: For fully insured groups, CT 11-58 extends coverage for children to the end of the policy year in which the child turns 26. Self-insured groups should consider past precedents in relation to accepting state mandates and specifically eligibility mandates. This will have employee tax implications (imputed income) for all non-January groups.*

- Elimination of plan lifetime dollar limits (applies to grandfathered groups)
- **Restrictions** on annual limits-full removal in 2014 (applies to grandfathered groups)
- Eliminate cost sharing on "Preventive Services"
  - Preventive service rated A or B by the U.S. Preventive Services Task Force
  - Expanded women's preventive care-including FDA approved contraceptives-in 2012
  - Grandfathered groups excluded
- Prescription required for drugs costs reimbursed through FSAs, HSAs, and HRAs

PPACA Timeline

2010 and 2011 (Plans beginning/renewing after Sept. 23, 2010)

- Establish an effective process for appeals-carriers have established these processes (grandfathered groups excluded)
- Non-qualified HSA distributions increases to 20% from 10%.
- Wellness grants for small business (no regs/rules supplied yet)
- Fully Insured Medical Loss Ratio (MLR) rebates
  - Calendar year 2011 reporting period
  - Rebates (if applicable) issued Aug 2012
  - Adds a rebate penalty to carriers if:
    - Large group plans MLR<85%
    - Small group plans MLR<80%
  - MLR calculation:
    - Numerator=Incurred Claims + Expenses for Activities Related to Health Improvement
    - Denominator=Earned Premium – Taxes – Licensing/Regulatory Fees – Risk Fees and Reinsurance (as allowed by PPACA)
  - ***Public Sector Groups who receive rebates must share proportionately with employees/retirees in the form of rate offset or cash.***

PPACA Timeline

2012

- Uniform Coverage Summaries/Summary of Benefits and Coverage (SBC)-(1st Open Enrollment after 9/23/12)
  - Must contain general plan info: cost sharing, description of coverage, and common coverage examples (as identified by the Secretary), uniform glossary
  - Released: upon renewal, when there's a plan change, upon request
  - Issued to participants and potential participants
  - Can only be 4 double sided pages with font no less than 12pt
  - Expect that carriers will be providing to plan (fully and self)
  - Does not replace the plan document (SPD)
  - Timing SBCs must be provided:
    - 30 days prior to policy renewal
    - and 60 days prior to plan change within the policy year (off cycle plan changes)

SBC Timing Considerations:
+Prior to renewal-ideally at start of open enrollment but not later than 30 days prior to renewal

+Take note of ***60 days*** notice for off cycle plan changes in relation to the collective bargaining process

- Cost of employer provided health coverage reported on Box 12 W-2-Code DD (the 2012 W2 filed in 2013).

  NOTES:
  +Dental and vision need not be reported if a separate election
  +FSA/HSA/HRA contributions not reported

- Further elimination of cost shares for expanded women's preventive care (including FDA approved contraception) (plans renewing after 7/30/2012)

- Comparative Effectiveness Research Fee to be charged --$1 pmpy for plan years after 9/30/12 and $2 pmpy for plan years after 9/30/13 thru 2019. Fee due in July. Establishes a Not-for-Profit Patient-Centered Outcomes Research Institute. ***(Tax slated to end 2019)***

PPACA Timeline

2013

•Maximum FSA contribution capped at $2,500. Future increases linked to annual rise in Consumer Price Index.

•Employers required to issue notices regarding Health Exchanges in By October 1, 2013 (model notices provided) and within 14 days of employees start date thereafter

•Medicare tax increases 0.9% from 1.45% to 2.35% on individuals earning >$200 or married couples filing jointly earning >$250. Also implements a 3.8% assessment on unearned income for higher earning taxpayers.

•For non-calendar year plans see Exchange taxes effective January 2014

PPACA Timeline

2014

- Waiting period for new full-time employees not to exceed 90 days
- Exchanges and Essential Health Benefits established. Individuals and small groups (up to 100) may purchase approved plans from the exchange. Will have 4 levels of plans: Bronze, Silver, Gold, & Platinum.
- Report to IRS and participants on minimum essential benefits (rules still TBD). Likely reporting the following calendar year.
- Employer/Individual mandates (see Pay or Play pages at end of presentation)
- Annual dollar limits on health care expenses eliminated
- Coverage must be offered to employees' adult children up to age 26 even if other coverage is available (impacts grandfathered plans)
- Employers 200+ must auto enroll employees in health plan (employee may opt out)

PPACA Timeline

2014

- Insurer Fee/Premium Tax=2.5% for **Fully Insured Only**. Funds premium subsidizes offered to individuals seeking insurance through the exchange.
  - Includes premium for: Medical, RX, Dental & Vision premium
  - $8 Billion spread across insurance carriers in 2014
  - Increasing each year to $14.3 Billion in 2018
  - Indexing each year thereafter
  - Tax is ongoing (no targeted end date)

- Transitional Reinsurance Fee=Approx. $6.35 PMPM ($190 per employee per year) Fully & Self Insured. Redistributes funds from employer market to individual market to offset anticipated high medical risk in the individual market.
  - $12 Billion spread across insurance carriers in 2014
  - $8 Billion spread across insurance carriers in 2015
  - $5 Billion spread across insurance carriers in 2016
  - $25 Billion Total
  - Tax slated to end 2016

Non-Calendar Year 2013 plans: Taxes prorated on # of months the plan carries over to 2014

PPACA Timeline

Beyond 2014

- States may allow large employers to purchase from health exchanges (2017)

- Part D "Donut Hole" effectively closes. Decreases in employee cost share beginning in 2013 (from 100% in 2010 and 50% in 2011 and 2012) as Medicare implements payments and increases them annually.

- "Cadillac Tax" (2018)-***see following page***

PPACA Timeline

Cadillac Tax (2018)

- 40% excise tax imposed on "High-Cost" insurance Plans
- Cost includes Medical, RX, *Employer Contributions to HSA*, and *Reimbursements from HRA and FSA* (further guidance needed)—Standalone Vision and Dental excluded
- High-Cost defined as premiums exceeding:
  - $10,200 for single coverage
  - $27,500 for other than single coverage (i.e. 2 Person/Family)
  - Single plans with a monthly premium of **$535** today are likely to reach $10,200 in 2018 (using a low expected trend of 8%)
  - 2 Person/Family plans with a monthly premium of just under **$1,444** today are likely get to $27,500 in 2018 (using a low expected trend of 8%)
- Higher threshold for "High Risk" professions, including:
  - Public Safety (i.e. PD, FD, EMT)
  - Longshore work, construction, mining, agriculture, forestry & fishing
  - Telecommunication line work
- Higher threshold for non-Medicare eligibles age 55 or older in retiree plans
- Higher threshold:
  - $11,850 for single coverage
  - $30,950 for other than single coverage (i.e. 2 Person/Family)
- Thresholds increases:
  - 2019 match CPI increase plus one percentage point
  - 2020 and succeeding years, thresholds match percentage rises in the index.
- Tax is ongoing (no targeted end date)

Employer Pay or Play

Employer Penalty

Note: The following slides are based on proposed rules issued by IRS and Dept. of Treasury. Comments on these rules are accepted thru March 18, 2013 and a public hearing is to be held on April 23, 2013. Final ruling expected sometime after April 23, 2013.

Pay or Play Delayed until January 2015

- Employers with 50 FTEs will be subject to penalties if:
  - First Requirement-They do not offer coverage to at least 95% of their full-time (30 hrs or more) employees
  - Second Requirment-They do not offer "affordable" coverage that meets a "minimum value" coverage
- Employer's will get to 50 FTEs based on number of employees times hours worked, so part-timers will count on a prorated basis
  - Example- 25 employee working 30+hours and 50 employees working 15 hours will meet the 50 FTE threshold
- Part-timers working less than 30 hours count towards the 50 FTE threshold but do not need to be offered coverage
- Once it is determined that an employer has 50 FTEs then the employer is subject to both requirements to determine if a penalty will apply

Employer Pay or Play

Employer Penalty-First Branch-Coverage Offered?

- First Requirement-Is Coverage Offered?
  - To satisfy this requirement employer must offer coverage to at least 95% of full-time (30 hours or more) employees and their child dependents (coverage of spouse is not required)
  - Coverage of part-time employees (under 30 hours) is not required
- Penalty Applies
  - If an employer does not offer coverage to at least 95% of full-time employee
  -and-
  - At least one employee receives subsidized coverage through the Exchange
  - The employer is subject to a $2,000 penalty for every full-time employee less the first 30 full-time employees
- Notes:
  - Penalty applies to all full-time employees (less the first 30) even if only 1 employee receives subsidized coverage through the Exchange
  - For this requirement the employer DOES NOT need to offer "affordable" coverage that meets "minimum value" coverage, just that they offer coverage.
  - "One-year-good-faith" period for employers currently not offering coverage to children

Employer Pay or Play

Employer Penalty-Second Branch-Affordable/Minimum Value?

- Second Requirement-Affordability & Minimum Coverage
  - To satisfy this requirement the employer must offer affordable coverage that meets a "minimum value" of coverage
- Affordability Requirement (based on safe harbor)
  - The employee's portion of employee only coverage can not be more the 9.5% of employee's wages (basis for employee only coverage and employee's wages is from IRS safe harbor)
  - To determine employee wages employer can use one of three safe harbors:
    - "W-2 Safe Harbor"-Wages from Box 1 of W-2
    - "Rate-of-Pay Safe Harbor"-Wages as calculated using salary or hourly rate times 130 hours. Note: if this safe harbor is used the employer cannot reduce the employee's wages during the year
    - "Design-Based Safe Harbor"-uses 100% of Federal Poverty Level (FPL). If cost for employee only coverage is 9.5% or less than 100% of FPL then plan meets the affordability requirement. For 2013 100% of FPL is $11,490. 9.5% of 100% FPL-employee only coverage would be $1,091.55.

Employer Pay or Play

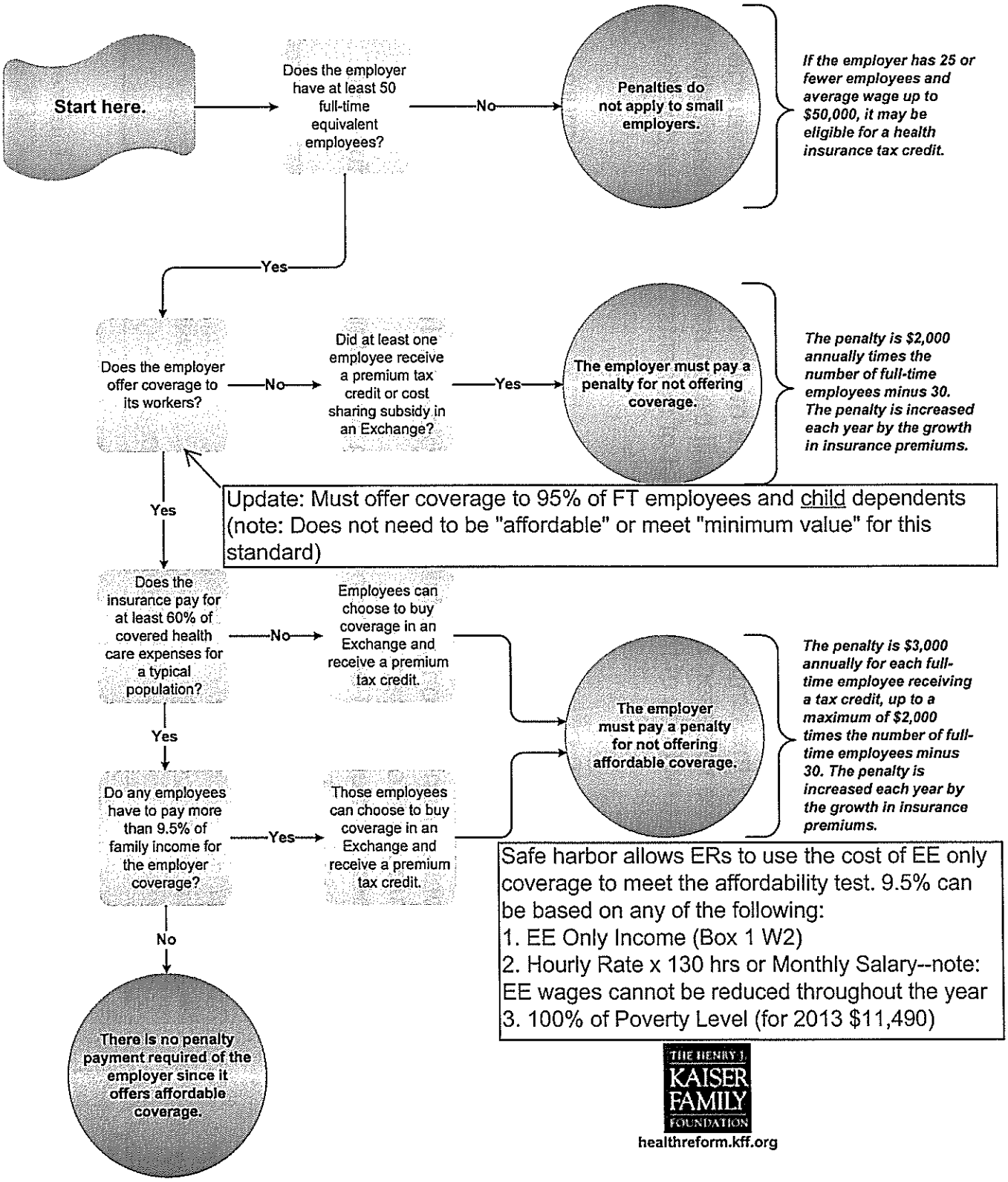
Employer Penalty-Second Requirement-Affordable/Minimum Value Continued

- Minimum Value of Coverage
  - The plan offered by the employer must meet a minimum value of coverage
  - Guidance still to be released but the basis will be an actuarial determination that the plan pays at least 60% of the overall cost of benefits provided under the plan
- Penalty Applies
  - If an employer fails to offer an "Affordable" plan that covers the "Minimum Value" of benefits under the plan
  - The employer is subject to a $3,000 penalty for each full-time employee that receives subsidized coverage through the Exchange
  - Note: the penalty applies only to full-time employees that receive subsidized coverage through the exchange
  - Note: the penalty here will be no greater than $2,000 times every full-time employee less the first 30

Key Take Away

To avoid the $2,000 penalty times all full-time employees, the Employer must offer coverage to 95% qualifying FTEs, but that coverage need not be affordable. Employers will then decide (based on exposure) if they need to also create a plan that will be affordable or if they may opt to just pay the $3,000 penalty.

Penalties for Employers Not Offering Affordable Coverage Under the Affordable Care Act Beginning in 2014

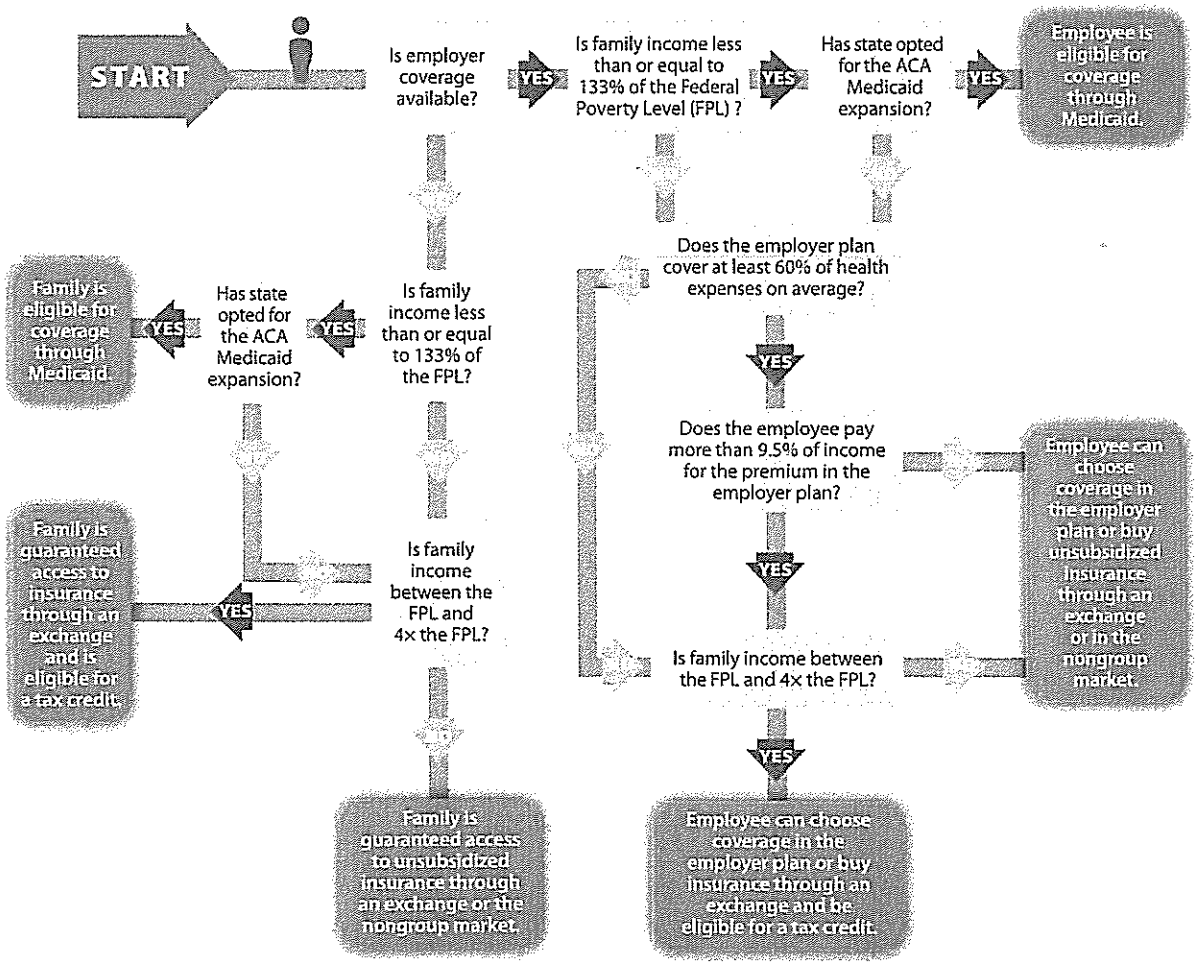


THE HENRY J. KAISER FAMILY FOUNDATION

healthreform.kff.org

HEALTH COVERAGE UNDER THE AFFORDABLE CARE ACT (ACA)

How to Get Coverage Beginning in 2014



KEY FACTS

- The FPL in 2012 is $11 170 for a single individual and $23 050 for a family of 4.
- In 2012 employees paid $951 on average towards the cost of single coverage in an employer plan and $4316 for a family of 4.

NOTES

- Some states may have higher income eligibility levels for Medicaid.
- In general, individuals who are currently eligible for Medicaid in their state of residence (who are mostly parents and children today) will continue to be eligible for Medicaid after ACA implementation. Those below 133% of the FPL who will be newly eligible for Medicaid after implementation are mostly adults without dependent children.
- For a discussion of the tax credit that may be available for insurance purchased through an exchange, please see Levitt L. "The Middle Class Tax Break Hardly Anyone Is Talking About." The *JAMA* Forum. http://tinyurl.com/chogalp. August 2, 2012.
- In some cases, children may be eligible for public coverage through Medicaid or the Children's Health Insurance Program (CHIP) while their parents are covered through an employer or an exchange.
- Undocumented immigrants are ineligible for Medicaid and may not purchase coverage in an exchange or receive a tax credit.
- In general, people are required to obtain coverage or pay a penalty, but those whose health insurance premiums exceed 8% of family income (after tax credits or employer contributions are taken into account) will not be penalized if they choose not to purchase coverage.
- Final regulations specifying how dependents of workers with employer coverage available are treated have not yet been issued. Draft rules indicate that the affordability of employer coverage (ie, whether it costs more than 9.5% of income) will be based on the required premium for a single worker rather than family coverage.
- Small businesses may choose to buy insurance through newly created Small Business Health Options Program (SHOP) exchanges or directly from insurers.

Source: Kaiser Family Foundation (http://www.kff.org) analysis.

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