The Affordable Care Act Update

Presented by:
The Union Labor Life Insurance Company
Overview

I. Key Provisions
II. Major Challenges
III. Healthcare Spending Growth
IV. ACA Challenges
   ➢ Keeping Grandfathered Status
   ➢ Premium Stabilization Rule
      ➢ Belly Button Tax (Temporary Reinsurance Fee)
      ➢ Transitional Risk Corridors Program
      ➢ Permanent Risk Adjustment Program
VI. Impact of Medicaid Expansion Under the ACA
VII. Minimum Essential Coverage (MEC) vs. Essential Health Benefits (EHB)
VIII. Public and Private Exchanges - What it means for Self Funded Plans
IX. Premium Subsidies
X. Employer Mandate
XI. Cadillac Tax
XII. What plan administrators & trustees should look for
Key ACA Health Plan Provisions Impacting Taft Hartley Plans

- Belly Button Tax per covered individual
- Coverage for approved clinical trials
- Employee notification of access to Exchanges
- FSA/HSA/HRA limits
- 90 Day Waiting Period
- Provide Minimum Essential Coverage (MEC)
- Removal of Lifetime + Annual Coverage Limits
Major challenges. Brought to you by the ACA.

- Health Insurance Marketplace
- Self Funded Plan
- Belly Button Tax in 2014
- Cadillac Tax in 2018
- Unfunded Mandates
- Unlimited Coverage Maximums
- Fluctuations in budgeting
- Eligibility Waiting Period Requirements
- Part/Full Time staffing
- Employer Mandate Penalty in 2015

Added complexity with Collective Bargaining Agreement

- Medicaid eligible? (Expanded program)
- Premium subsidy eligible?
- Changes in plan and benefits

Plan Member

September 2015
Healthcare Spending Growth -- Slowing Down?

- In 2013 U.S. health care spending increased 3.6 percent to reach $2.9 trillion, or $9,255 per person, the fifth consecutive year of slow growth in the range of 3.6 percent and 4.1 percent. The share of the economy devoted to health spending has remained at 17.4 percent since 2009 as health spending and the Gross Domestic Product increased at similar rates for 2010 to 2013.

- There is no fundamental shift yet in how health care is paid for or delivered. **We still have a healthcare spending problem?!**

- **Physician payment rate reduction for Medicaid.**
- **Coverage expansion to previously uninsured individuals increases competition among carriers.**
- **Slower growth in the use of healthcare services.**
- **Cost sensitivity related to low income growth.**
- **Employers efforts to control costs**

Source:
ACA Challenges: Keeping Grandfathered Status

- Decision to maintain or eliminate Grandfathered Status
  - Grandfathered plans are exempt from offering certain requirements:
    - New patient protection provisions
    - Limits on out-of-pocket maximums
    - Certain preventive services on a first-dollar coverage basis
    - Elimination of deductibles
- All plans, regardless of whether Grandfathered, must offer unlimited lifetime and annual benefits on medical coverage.

Source: www.sibson.com/publications
ACA Challenges: Keeping Grandfathered Status

What is the advantage of keeping this status? Plans can avoid many of the ACA’s requirements that may result in an increase in plan costs.

Yet, it’s very easy for Taft Hartley plans to lose this status if deductions or changes are made to premiums, benefits, co-pays and annual limits:

- Eliminating benefits for certain conditions.
- Increase in cost sharing by more than 15% (plus medical inflation).
- Increase in co-payments by more than $5 per member (adjusted for medical inflation) or 15% (plus medical inflation) – whichever is greater.

Source: www.sibson.com/publications
The ACA’s Premium Stabilization Rule

- Standards to addressing problematic risk distribution due to adverse selection and other health care market variations.

- 3 programs were implemented starting in 2014:
  1. Belly Button Tax (Temporary Reinsurance Program)
  2. Transitional Risk Corridors Program
  3. Permanent Risk Adjustment Program
1. The Belly Button Tax (Temporary Reinsurance Program)

<table>
<thead>
<tr>
<th>What?</th>
<th>Provides payment to plans covering an unhealthier population in the individual exchanges.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Why?</td>
<td>To stabilize individual market premiums during the early years of new market reforms (Guaranteed Issue Provision).</td>
</tr>
<tr>
<td>Who contributes?</td>
<td>All individual &amp; group issuers and Third Party Administrators (fully-insured &amp; self funded plans). Fee applies to each plan member, spouse and covered dependent <em>(i.e. each belly button)</em>.</td>
</tr>
<tr>
<td>Who is eligible?</td>
<td>Individual issuers that cover an unhealthier population (inside and outside exchanges) that are subject to ACA market rules are eligible for contributions.</td>
</tr>
<tr>
<td>How?</td>
<td>When plan’s cost of a covered individual exceeds a certain threshold, that plan is eligible for payments.</td>
</tr>
<tr>
<td>When?</td>
<td>2014 - 2016</td>
</tr>
</tbody>
</table>

Source: [http://kff.org/health-reform](http://kff.org/health-reform)
# 1. The Belly Button Tax (Temporary Reinsurance Fee)

<table>
<thead>
<tr>
<th>Year</th>
<th>Reinsurance Pool</th>
<th>U.S. Treasury</th>
<th>Insurance Issuers and TPAs (Individual &amp; Group Market)</th>
<th>Status for self-funded/self administered group plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>$10B</td>
<td>$2B</td>
<td>$5.25/month ($63/year) per member</td>
<td>Requires Payment</td>
</tr>
<tr>
<td>2015</td>
<td>$6B</td>
<td>$2B</td>
<td>$3.67/month ($44/year) per member</td>
<td>Temporarily Exempt*</td>
</tr>
<tr>
<td>2016</td>
<td>$4B</td>
<td>$1B</td>
<td>$2.25/month ($27/year) per member</td>
<td>Temporarily Exempt*</td>
</tr>
</tbody>
</table>

*Final rule has narrow definition:*

Plans must maintain and manage claims processing and adjudication in order to be recognized as self funded/self administered.

**Additional exemptions for self funded/self administered plans to use TPAs:**
- Uses an unrelated third party to obtain a discount provider network or claim re-pricing services.
- Outsources core administrative functions for pharmacy or other excluded benefits (limited scope dental/vision)
- Outsources no more than 5% of core administrative services on non-excluded benefits (major medical).

## 2. Transitional Risk Corridors Program

<table>
<thead>
<tr>
<th><strong>What?</strong></th>
<th>Sharing gains and losses on allowable costs between HHS and Qualified Health Plans (QHP) to help ensure stable health insurance premium settings in the health insurance marketplace (exchanges).</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Why?</strong></td>
<td>Helps QHPs compete on price, not on plans’ risk pools.</td>
</tr>
<tr>
<td><strong>When?</strong></td>
<td>2014-2016</td>
</tr>
<tr>
<td><strong>How?</strong></td>
<td>Works in conjunction with the ACA’s Medical Loss Ratio (MLR) provision to distribute risk across health plans (80% MLR in individual market &amp; 85% MLR in large group market).</td>
</tr>
</tbody>
</table>
2. Transitional Risk Corridors Program

*Plans with lower than expected claims experience.*

< 97% of targeted amount set by HHS.

✓ Charges and payments are on percentage basis, not first dollar basis.

✓ If issuer's allowable costs are less than 97 percent of its target amount, it pays HHS a percentage of the difference.

*Plans with higher than expected claims experience.*

> 103% of targeted amount set by HHS.
# 3. Permanent Risk Adjustment Program

| What? | ✓ Shifts funding among insurers based on risk. Plans covering healthier populations in a given state will be assessed a charge.  
✓ The charges will then serve as a source of payment to plans covering unhealthier populations. |
|---|---|
| Why? | ✓ Reduces incentive for plans to avoid providing coverage to unhealthier enrollees.  
✓ Program helps to fund health plans that cover a disproportionately unhealthy population both inside and outside the Health Insurance Marketplace to protect against adverse selection. |
| Who participates? | ✓ All non-grandfathered plans in the individual and group market.  
✓ Multi-state plans.  
✓ Consumer Operated & Oriented Plans (COOPs). |
| How? | ✓ States operating their own exchanges (established state exchanges) have the option to operate their own state-based Risk Adjustment Program or to allow the federal government to run the program. |
| When? | 2014-on |

How do all 3 programs work together?

- **Permanent Risk Adjustment Program**
  Spreads the risk so insurers don’t just focus on covering the healthier population.

- **Temporary Reinsurance Program**
  Helps to reduce premiums by covering the cost for unhealthier enrollees in the individual market.

- **Transitional Risk Corridors Program**
  Limits the extent of health insurers losses and gains.

*Reinsurance contributions to reinsurance payouts*
Impact of Medicaid Expansion Under the ACA

- Expanded Medicaid to include individuals between the ages of 19 and 64 with incomes at or below 138% Federal Poverty Level (FPL) as of 2015.

  **Individual:** $16,243  
  **Family of 3:** $27,724

- Eligibility for Medicaid and CHIP is now based on new Modified Adjusted Gross Income (MAGI):
  
  Taxable wages + other income – applicable adjustments = MAGI
  
  - Standardizes the approach to determining financial eligibility across states and health insurance affordability programs.

- As part of this transition, states converted their existing Medicaid income limits to MAGI-equivalent limits.

- **Advanced** payments of premium subsidies for individuals who purchased coverage on the individual exchanges are also determined using MAGI.

Current Status of State Medicaid Expansion Decisions

- **Adopted (31 States including DC)**
- **Adoption Under Discussion (1 State)**
- **Not Adopting At This Time (19 States)**

NOTES: Current status for each state is based on KCMU tracking and analysis of state executive activity. **MT** has passed legislation adopting the expansion; it requires federal waiver approval. *AR, IA, IN, MI, PA and NH have approved Section 1115 waivers. Coverage under the PA waiver went into effect 1/1/15, but it is transitioning coverage to a state plan amendment. WI covers adults up to 100% FPL in Medicaid, but did not adopt the ACA expansion.

Cost and coverage implications of Medicaid Expansion

- There is no deadline for states to implement the expansion.
- States that already implemented the Medicaid Expansion in 2014 will receive 100% federal funding for the first 3 years (2014 to 2016).
- Beginning in 2017, the federal match rate is as follows:
  - 2017: 95%
  - 2018: 94%
  - 2019: 93%
  - 2020+: 90%

Source: [http://kff.org/medicaid/fact-sheet](http://kff.org/medicaid/fact-sheet)
Minimum Essential Coverage vs. Essential Health Benefits:

- **Minimum Essential Coverage (MEC):**
  - Coverage an individual must have to comply with the individual mandate and avoid the *individual mandate penalty* tax – and that large employers will be required to offer in 2015 to their employees to avoid the *employer mandate penalty*.
  - Employer's/Plan's share of the total allowed costs of benefits provided is 60% or more of costs. *The remaining 40% of costs are paid for by the covered individual (i.e. co-pays, deductibles, co-insurance)*.

Minimum Essential Coverage vs. Essential Health Benefits:

**Essential Health Benefits (EHB):**

- 10 core benefits that “qualified health plans” (QHPs) must cover on the public exchanges.
- Insured plans that are **not offered on public exchanges and self insured plan** (i.e. self funded and multiemployer plans) do not need to provide EHB, but they must meet MEC requirements.

Visit: [www.healthcare.gov](http://www.healthcare.gov) for list of EHB
Public and Private Exchanges:
What it means for Self Funded Plans.
Health Insurance Marketplace

Continuum of Exchange Options

State-based Exchange
State operates all exchange activities

State-Federal Partnership Exchange
State operates plan management and/or consumer assistance activities; may determine Medicaid/CHIP eligibility

Federally-Facilitated Exchange
HHS operates all exchange activities; state may determine Medicaid/CHIP eligibility

Health Insurance Marketplace

PRIVATE EXCHANGE:
- “Defined Contribution” structure.
- Can control employer’s overall health costs.
- Enrollees can use HRA $$.
- Relies on carrier for plan choices.
- No premium or cost sharing subsidy available.

PRIVATE EXCHANGE:
- “Defined Contribution” structure.
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PUBLIC EXCHANGE:
- Covers Essential Health Benefits (EHB)
- Has out of pocket limits for In-Network EHB
- Provides Guaranteed Issue and Renewal
- Enrollees can use HRA $$
- State & federal government make plan choices
- Offers Premium & Cost Sharing subsidies for eligible enrollees.

2 variants:
- Marketplace
- State Partnership

PUBLIC EXCHANGE:
- Covers Essential Health Benefits (EHB)
- Has out of pocket limits for In-Network EHB
- Provides Guaranteed Issue and Renewal
- Enrollees can use HRA $$
- State & federal government make plan choices
- Offers Premium & Cost Sharing subsidies for eligible enrollees.

source: www.ncsl.org
Health Insurance Marketplace: Basics of the Public Exchange

**LEVELS OF COVERAGE**

<table>
<thead>
<tr>
<th>Metal</th>
<th>Actuarial Value</th>
<th>Out of Pocket</th>
<th>Maximum Out of Pocket for 2015 (excluding Premium)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Platinum</td>
<td>90%</td>
<td>10%</td>
<td>$6,600 - individual</td>
</tr>
<tr>
<td>Gold</td>
<td>80%</td>
<td>20%</td>
<td>$13,200 - family</td>
</tr>
<tr>
<td>Silver</td>
<td>70%</td>
<td>30%</td>
<td></td>
</tr>
<tr>
<td>Bronze</td>
<td>60%</td>
<td>40%</td>
<td></td>
</tr>
<tr>
<td>Young &amp; Invincible</td>
<td>For individuals under 30 yrs old.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

State Health Insurance Marketplace Types, 2015

### Health Insurance Marketplace: Basics of the Public Exchange - Premium Subsidy

<table>
<thead>
<tr>
<th>% FPL (2015)</th>
<th>Individual</th>
<th>Family of 4</th>
<th>% of income**</th>
<th>Individual</th>
<th>Family of 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>100%</td>
<td>$11,770</td>
<td>$24,250</td>
<td>2%</td>
<td>$235</td>
<td>$485</td>
</tr>
<tr>
<td>200%</td>
<td>$23,540</td>
<td>$48,500</td>
<td>6.3%</td>
<td>$1,483</td>
<td>$3,056</td>
</tr>
<tr>
<td>300%</td>
<td>$35,310</td>
<td>$72,750</td>
<td>9.5%</td>
<td>$3,354</td>
<td>$6,911</td>
</tr>
<tr>
<td>400%</td>
<td>$47,080</td>
<td>$97,000</td>
<td>9.5%</td>
<td>$4,473</td>
<td>$9,215</td>
</tr>
</tbody>
</table>

Based on premium costs for second lowest cost silver plan (70%)

* Based on a sliding scale of caps.

Premium subsidy amount is the same, even if enrollee selects a more expensive plan, such as platinum (90%) or gold (80%) or less expensive plan, such as bronze (60%). Young and Invincible level – (catastrophic coverage only) does not qualify for premium subsidy eligibility.

### Health Insurance Marketplace: Basics of the Public Exchange - Premium Subsidy

Subsidies will vary person to person within any plan and is based on family income and number of dependents.

<table>
<thead>
<tr>
<th>Annual Family Income</th>
<th>Age</th>
<th>Single (S) or Family of 4 (F)</th>
<th>Premium</th>
<th>Amount paid by enrollee</th>
<th>Subsidy</th>
</tr>
</thead>
<tbody>
<tr>
<td>$30,000</td>
<td>35</td>
<td>S</td>
<td>$3,167</td>
<td>$2,492</td>
<td>$675</td>
</tr>
<tr>
<td>$30,000</td>
<td>35</td>
<td>F</td>
<td>Medicaid</td>
<td>$3,742</td>
<td>$0</td>
</tr>
<tr>
<td>$50,000</td>
<td>45</td>
<td>S</td>
<td>$3,742</td>
<td>$3,742</td>
<td>$0</td>
</tr>
<tr>
<td>$50,000</td>
<td>45</td>
<td>F</td>
<td>$10,776</td>
<td>$3,340</td>
<td>$7,436</td>
</tr>
<tr>
<td>$70,000</td>
<td>50</td>
<td>S</td>
<td>$4,629</td>
<td>$4,629</td>
<td>$0</td>
</tr>
<tr>
<td>$70,000</td>
<td>50</td>
<td>F</td>
<td>$12,548</td>
<td>$6,559</td>
<td>$5,989</td>
</tr>
<tr>
<td>$80,000</td>
<td>50</td>
<td>S</td>
<td>$4,629</td>
<td>$4,629</td>
<td>$0</td>
</tr>
<tr>
<td>$80,000</td>
<td>50</td>
<td>F</td>
<td>$12,548</td>
<td>$7,648</td>
<td>$4,900</td>
</tr>
<tr>
<td>$90,000</td>
<td>50</td>
<td>S</td>
<td>$4,629</td>
<td>$4,629</td>
<td>$0</td>
</tr>
<tr>
<td>$90,000</td>
<td>50</td>
<td>F</td>
<td>$12,548</td>
<td>$8,604</td>
<td>$3,944</td>
</tr>
</tbody>
</table>

Examples of estimated insurance premiums above are based on 2015 incomes and number of dependents. For family of 4, estimates based on 2 adults of same age, and 2 children under age of 21, all with no tobacco use.

Source: [http://kff.org/interactive/subsidy-calculator](http://kff.org/interactive/subsidy-calculator)
Health Insurance Marketplace: Basics of the Public Exchange- Premium Subsidy

To qualify for subsidies, Individual must NOT be:

- Eligible for coverage through an employer sponsored plan where the employer makes the required contribution toward that coverage.

- Covered by Medicaid, Medicare, military or veterans' coverage or other coverage recognized by HHS.

Subsidy eligibility in states that did not expand Medicaid

- Individuals with household incomes at or below 138% of FPL are NOT:
  - Eligible for a premium subsidy…AND
  - Responsible for paying the individual mandate fee.
### Health Insurance Marketplace: Basics of the Public Exchange-Cost Sharing Reductions

<table>
<thead>
<tr>
<th>What?</th>
<th>It <strong>protects</strong> enrollees in silver plans from high out-of-pocket costs by reducing the charges enrollees would have to pay to receive services. Make it <strong>easier</strong> for enrollees who are looking to purchase coverage to compare plans in the Health Insurance Marketplace.</th>
</tr>
</thead>
<tbody>
<tr>
<td>How?</td>
<td>Automatically reduces the charges for enrollee to receive services. It is not reimbursed to the enrollee and not reconciled at end of year.</td>
</tr>
<tr>
<td>Who is eligible?</td>
<td>Individuals enrolled in a silver plan ONLY to ensure that any cost sharing reduction is based on 70% actuarial value (AV).</td>
</tr>
<tr>
<td>Why?</td>
<td>Benefits all people enrolled in a silver plan on the exchanges (those who use very little services &amp; those who use a great deal of service).</td>
</tr>
</tbody>
</table>

Source: [http://khn.org](http://khn.org)
People who qualify for the premium subsidy will also be eligible for the cost sharing reduction if they enroll in a silver plan.

Cost sharing reductions based on FPL in a silver plan variations that corresponds with their household income.

<table>
<thead>
<tr>
<th>Household Income</th>
<th>New Actuarial Value %</th>
<th>Annual Out of Pocket Maximums</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of FPL</td>
<td>For cost sharing reduction</td>
<td>Self Only</td>
</tr>
<tr>
<td>100% – 150%</td>
<td>94%</td>
<td>$2,250</td>
</tr>
<tr>
<td>150% - 200%</td>
<td>87%</td>
<td>$2,250</td>
</tr>
<tr>
<td>200% – 250%</td>
<td>73%</td>
<td>$5,200</td>
</tr>
</tbody>
</table>
Health Insurance Marketplace: Basics of the Public Exchange-Cost Sharing Reductions

What does this mean for insurance providers offering silver plans on the exchanges?

Can use existing cost sharing limits that apply to high-deductible health plans (HDHPs) that are qualified to be paired with Health Savings Accounts (HSAs).

Thank You!

Health plans that provide cost sharing reductions to enrollees will be eligible for full reimbursement for the reduction amounts from HHS.
Health Insurance Marketplace: Basics of the Public Exchange

- Sets the standards for Qualified Health Plans QHPs
- Determines eligibility for Medicaid, CHIP & premium subsidies

Open enrollment period:

*No enrollment outside this period, except for special circumstances:*


Eligibility Requirements:
- Resident of the state where the exchange is established.
- Not incarcerated.
- US Citizen.
Defining Coverage Affordability

Coverage is considered “affordable” if the cost to the employee of self-only coverage does not exceed 9.5% of that individual employee’s “household income.”

The definition of “affordability” is an issue for multiemployer plan participants.

- **What if employer offers dependent coverage?**
  - The employee’s cost for coverage may exceed 9.5% of his or her household income. Employee and his/her dependents are NOT eligible for subsidies on the exchanges, even if coverage offered by employer is NOT affordable.

- **Is there a solution for self funded plans?**
The Employer Mandate

• Also known as the “Employer Shared Responsibility Penalty” or “Employer Penalty of 2014.”
• Requires businesses that do not provide affordable coverage to pay a penalty.
• Mandate was delayed until 2015 for large employers and 2016 for small to medium employers.
The Employer Mandate

- **Employer has more than 100 employees**
  - **YES**
  - **NO**

- **If more than 50 employees but fewer than 100 - has until 2016 to phase in health care coverage for their full time employees.**

- **Coverage is at least 60% of covered health care expenses**
  - **YES**
  - **NO**

- **Employer offers the opportunity to enroll in ‘minimum essential coverage’ MEC-under an eligible employer-sponsored plan.**

- **Did at least 1 employee receive a premium subsidy or cost sharing subsidy in the Health Insurance Marketplace?**
  - **YES**
  - **NO**

- **Employer pays penalty for not offering coverage at all OR not offering affordable coverage**
  - **YES**
  - **NO**

- **There is no penalty payment requirement of the employer**

September 2015
The Employer Mandate: How it’s determined

**Employer drops coverage completely:**
Employee is eligible to purchase health insurance on the exchanges and receiving a subsidy to cover.

**Employer offers coverage that is not considered “affordable” or of minimum value:**
Penalty would only apply if the coverage provided to the employee is more than 9.5% of that employee’s individual income.

**Employer is required to pay penalty**
(Total # of full time employees minus 80) X $2,000.

**Penalty is lesser of:**
(Total # of full time employees minus 80) X $2,000] or [Total # of employees who receive tax subsidies) X$3,000.]

Starting in 2016, the penalty will exempt the first 30 full-time employees, instead of the first 80.
The Employer Mandate: 90 Day Waiting Period

How will the Employer Mandate impact employers who participate in collectively bargained plans?

- Limits on waiting periods:
  - Full time, part time, seasonal, intermittent?
- Setting rules for becoming eligible:
  - Measurement or look-back period in determining eligibility.
The Employer Mandate: Possible Outcomes

**Employer:**
May try to avoid or reduce penalty for not providing MEC &/or offering unaffordable coverage.

**Employee:**
Will want to avoid the individual penalty for not purchasing MEC.

**Potential Result:**

1. **Rise in employers offering mini-med/skinny plans to employees.**
   These plans do not have annual dollar limits but do have **limited** categories of **coverage**.

   On November 5, 2014, HHS, Department of Treasury, including IRS released a guidance document advising that large employers offering health plans that DO NOT cover **inpatient hospital services** are **NOT** offering **minimum value health coverage**.

2. **Rise in Private Exchanges and in offering supplemental insurance products.**
   Critical illness, dental, vision, hospital confinement, short term disability.

The Cadillac Tax

| What? | 40% tax on benefits exceeding certain thresholds based on total cost of coverage for: 
|       | ✓ The average cost for the health insurance plan (whether insured or self-funded) 
|       | ✓ Employer contributions to an HAS, Archer medical spending account or HRA 
|       | ✓ Contributions (including employee-elected payroll deductions and non-elective employer contributions) to an FSA 
|       | ✓ The value of coverage in certain on-site medical clinics 
|       | ✓ The cost for certain limited-benefit plans if they are provided on a tax-preferred basis |

| When? | Scheduled to take effect in 2018 and is permanent. |

| Who Pays? | The entity that “shall pay” the excise tax is (1) the “health insurance issuer” in the case of applicable coverage provided under an insured plan, (2) “the employer” if the applicable coverage “consists of coverage under which the employer makes contributions to” an HAS or Archer MSA, and (3) “the person that administers the plan” in the case of any other applicable coverage. |

| Why? | To help finance component of the ACA, including the creation of low-cost health insurance products on the exchanges. |
## The Cadillac Tax

<table>
<thead>
<tr>
<th>How much?</th>
<th>Thresholds will be based on:</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ Medical inflation between 2010 and 2018 and will increase if the actual growth in healthcare costs exceeds the projected growth.</td>
<td></td>
</tr>
<tr>
<td>✓ In 2019, will go by CPI-U plus 1% point.</td>
<td></td>
</tr>
</tbody>
</table>

### Cost threshold indexed after 2018:

<table>
<thead>
<tr>
<th>Individual:</th>
<th>$10,200</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family:</td>
<td>$27,500</td>
</tr>
</tbody>
</table>

*Multiemployer Plans can use the family threshold.*

✓ Thresholds can be adjusted for age and gender, “qualified retiree” and/or “high risk profession” status.
The Cadillac Tax

**EXAMPLES:**

**Family Coverage**
*Cost of Plan per Family = $32,500*
$32,500 - $27,500 = $5,000 over threshold
500 Families x $5,000 = $2,500,000

*Excise Tax = $1,000,000 (40% of $2.5M)*

**Self-only Coverage**
*Cost of Plan per Individual = $12,000*
$12,000 - $10,200 = $1,800 over threshold
250 covered individuals x $1,800 = $450,000

*Excise Tax = $180,000 (40% of 450,000)*
The Cadillac Tax

The cost excludes premiums paid by employers and employees for:

<table>
<thead>
<tr>
<th>Excepted Benefits: Critical illness, hospital indemnity, accident, disability, long term care, etc.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vision and dental under separate policies from medical (considered excepted benefits)</td>
</tr>
</tbody>
</table>

Source: www.uhc.com; www.aon.com
What plan administrators & trustees should look for:

- **Minimum Essential Coverage (MEC) and affordability.**
  - Is the plan within the 60% minimum value standard and is the coverage intended to be affordable for plan members?

- **Maintaining or losing Grandfathered status.**

- **Employer Mandate.**
  - Future rules will be issued by the IRS detailing reporting requirements for the Employer Mandate in 2015 and 2016.

- **Is the plan in compliance?**

- **Preparing for Cadillac Tax in 2018.**

- **Added complexity to Collective Bargained Agreements.**