The Affordable Care Act Update

Presented by:
The Union Labor Life Insurance Company
Overview

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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

V. Impact of Medicaid Expansion Under the ACA

VI. Minimum Essential Coverage (MEC) vs. Essential Health Benefits (EHB)

VII. Public and Private Exchanges - What it means for Self Funded Plans

VIII. Premium Subsidies

IX. Employer Mandate

X. Cadillac Tax

XI. What plan administrators & trustees should look for

March 2016
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
- Belly Button Tax in 2014
- Cadillac Tax in 2020
- Self Funded Plan
- Unlimited Coverage Maximums
- Unfunded Mandates

Added complexity with Collective Bargaining Agreement

- Fluctuations in budgeting
- Eligibility Waiting Period Requirements
- Employer Mandate Penalty in 2015
- Part/Full Time staffing
- Employer

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

March 2016
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

March 2016
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

March 2016
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>What?</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>Why?</td>
<td>Helps QHPs compete on price, not on plans’ risk pools.</td>
</tr>
<tr>
<td>When?</td>
<td>2014-2016</td>
</tr>
<tr>
<td>How?</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

March 2016
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.


March 2016
Current Status of State Medicaid Expansion Decisions

NOTES: Current status for each state is based on KCMU tracking and analysis of state executive activity. *AR, IA, IN, MI, MT, NH and PA have approved Section 1115 waivers. Coverage under the PA waiver went into effect 1/1/15, but it has transitioned coverage to a state plan amendment. Coverage under the MT waiver went into effect 1/1/2016. LA’s Governor Edwards signed an Executive Order to adopt the Medicaid expansion on 1/12/2016, but coverage under the expansion is not yet in effect. WI covers adults up to 100% FPL in Medicaid, but did not adopt the ACA expansion. See source for more information on the states listed as “adoption under discussion.”
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
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

March 2016
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


March 2016
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.

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

State Based
Federally Based

Private Exchanges
Affordable Health Care
Public Exchanges

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 2016 (excluding Premium)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Platinum</td>
<td>90%</td>
<td>10%</td>
<td></td>
</tr>
<tr>
<td>Gold</td>
<td>80%</td>
<td>20%</td>
<td>$6,600 - <em>individual</em></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$13,200 - <em>family</em></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>

Source: [http://healthcare.gov](http://healthcare.gov)

March 2016
State Health Insurance Marketplace Types, 2016

Source: http://kff.org/health-reform/state-indicator/state-health-insurance-marketplace-types

March 2016
# Health Insurance Marketplace: Basics of the Public Exchange - Premium Subsidy

<table>
<thead>
<tr>
<th>Modified Annual Adjusted Gross Income (MAGI)</th>
<th>Maximum Annual Premium Contribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>% FPL (2015)</td>
<td>Individual</td>
</tr>
<tr>
<td>100%</td>
<td>$11,770</td>
</tr>
<tr>
<td>200%</td>
<td>$23,540</td>
</tr>
<tr>
<td>300%</td>
<td>$35,310</td>
</tr>
<tr>
<td>400%</td>
<td>$47,080</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></td>
<td></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)

March 2016
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><strong>What does this mean for enrollees?</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What?</strong></td>
</tr>
<tr>
<td>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.</td>
</tr>
<tr>
<td>Makes it <strong>easier</strong> for enrollees who are looking to purchase coverage to compare plans in the Health Insurance Marketplace.</td>
</tr>
<tr>
<td><strong>How?</strong></td>
</tr>
<tr>
<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><strong>Who is eligible?</strong></td>
</tr>
<tr>
<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><strong>Why?</strong></td>
</tr>
<tr>
<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).

Health plans that provide cost sharing reductions to enrollees will be eligible for full reimbursement for the reduction amounts from HHS.

Thank You!

March 2016
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.
Coverage is considered “affordable” if the cost to the employee of self-only coverage does not exceed 9.66% 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 9.66% 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.**
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.

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

- **YES**
- **NO**

**Coverage is at least 60% of covered health care expenses**

- **YES**
- **NO**

**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**

March 2016
The Employer Mandate: How it’s determined for 2016

- **Employer drops coverage completely:**
  - Employee is eligible to purchase health insurance on the exchanges and receiving a subsidy to cover
  - Employer is required to pay penalty \((\text{Total # of full time employees minus 30}) \times \$2,160\).

- **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 9.66% of that employee’s individual income.

- **Penalty is lesser of:**
  - \((\text{Total # of full time employees minus 30}) \times \$2,160\)
  - \([\text{Total # of employees who receive tax subsidies}] \times \$3,240\)

### Employer Penalty (Per Employee)

<table>
<thead>
<tr>
<th>Year</th>
<th>No Coverage</th>
<th>Not Affordable</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015</td>
<td>$2,080</td>
<td>$3,120</td>
</tr>
<tr>
<td>2016</td>
<td>$2,160</td>
<td>$3,240</td>
</tr>
<tr>
<td>2017</td>
<td>$2,260</td>
<td>$3,390</td>
</tr>
</tbody>
</table>

March 2016
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** that 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.


March 2016
## 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 HSA, 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 2020 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 HSA 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

**How much?**

**Thresholds will be based on:**
- Medical inflation between 2010 and 2020 and will increase if the actual growth in healthcare costs exceeds the projected growth.
- In 2021, will go by CPI-U plus 1% point.
- Cost threshold indexed after 2018 would have been $10,200 for Individual and $27,500 for a Family of 4. Delaying the Cadillac Tax until 2020 will result in a higher threshold, to be determined.
- Thresholds can be adjusted for age and gender, “qualified retiree” and/or “high risk profession” status.

The Cadillac tax will be fully deductible for any entity to which it applies (e.g., employers and insurers). As initially written, it would not have been deductible.

Source: www.uhc.com; www.aon.com

March 2016
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)

Source: www.uhc.com; www.aon.com
The Cadillac Tax

The cost excludes premiums paid by employers and employees for:

| Excluded Benefits: Critical illness, hospital indemnity, accident, disability, long term care, etc. |
| Vision and dental under separate policies from medical (considered excepted benefits) |

Source: www.uhc.com; www.aon.com

March 2016
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 2016.

- Is the plan in compliance?

- Preparing for Cadillac Tax in 2020.

- Added complexity to Collective Bargained Agreements.

Ullico

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