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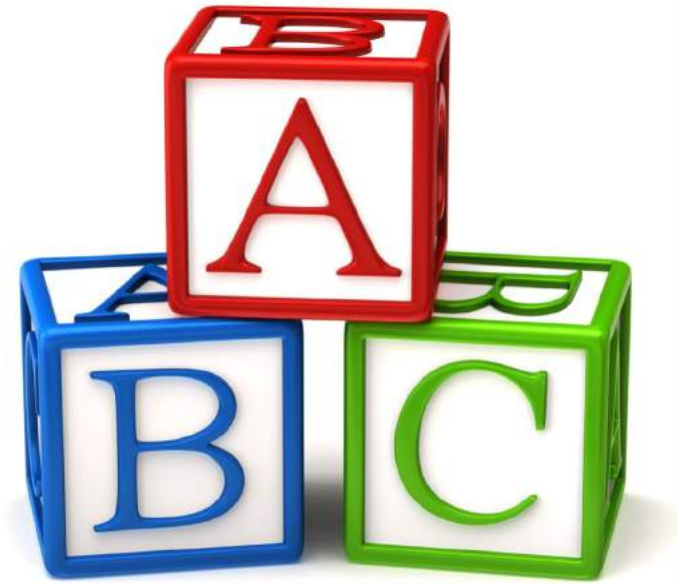

The ABC's of Group Insurance:

Affordability
Benefits
Compliance

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Employee Benefits Exam

Least Accurate 1 ..... 2 ..... 3 ..... 4 ..... 5 **Most Accurate**

_____ My company or church believes that offering health insurance and other employee benefits helps attract and keep qualified employees.

_____I am very knowledgeable about selecting medical insurance programs for my company or church.

_____I understand the Affordable Care Act and other components of medical insurance compliance.

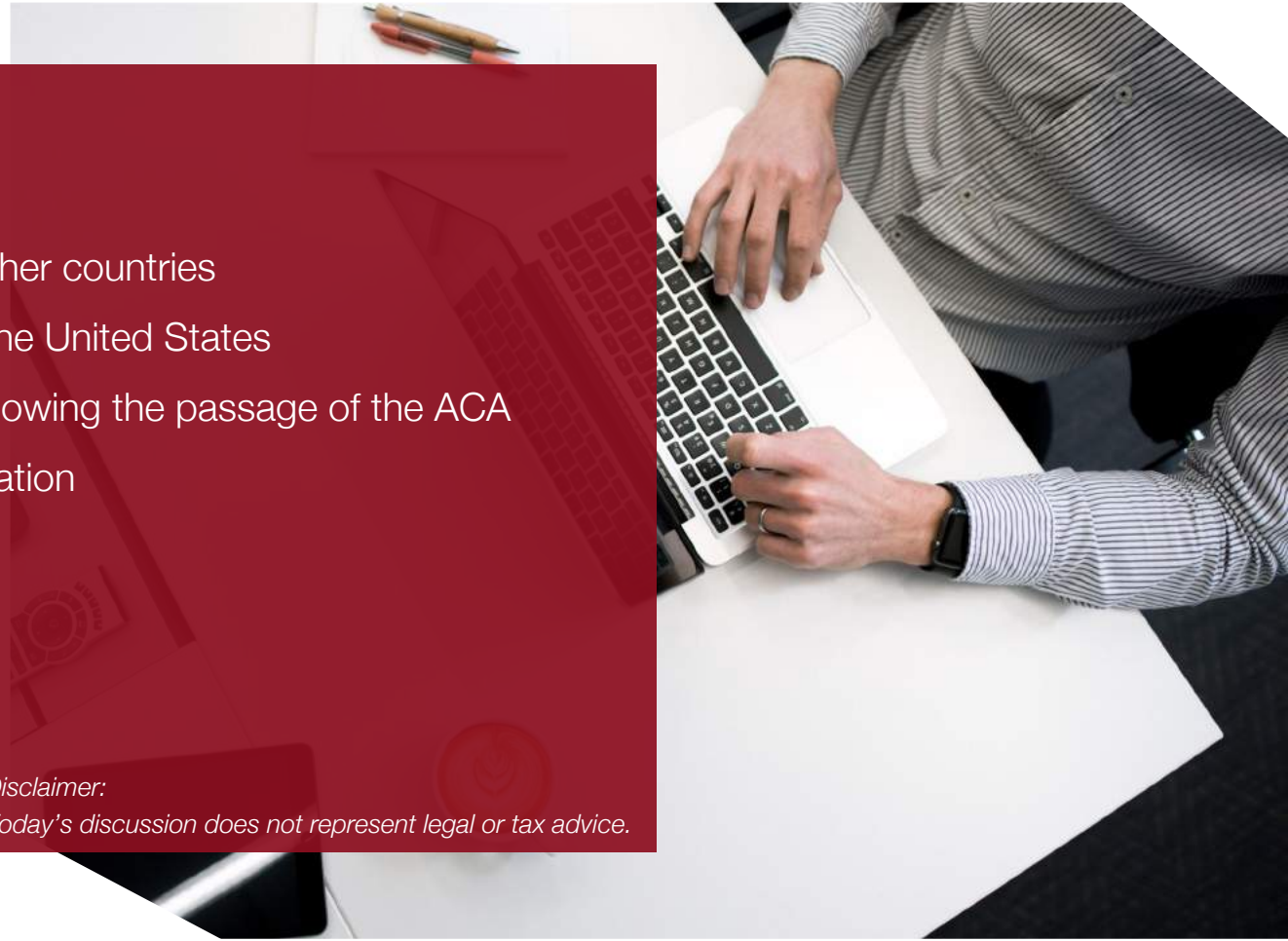
_____My church or company conducts an audit regularly to insure compliance with Federal and State insurance mandates.

_____I am comfortable with the amount of time I devote to insurance issues during the work week.

Discussion

1. Health care models in other countries
2. Health care systems in the United States
3. American health care following the passage of the ACA
4. Pending insurance legislation
   - → State
   - → Federal
5. Plan designs for 2020
6. Q&A

Disclaimer:
Today's discussion does not represent legal or tax advice.




BEL
SCOTT


NIGERIA
CHAD
LIBYA
SUDAN
ETHIOPIA
KENYA
SOMALIA
ARABIA
YEMEN
OMAN
TANZANIA
ZAMBIA
SEYCHELLES

Healthcare in other countries

Breakfast Model

Started in England, the government owns the hospitals, doctors and staff nurses.

Bismarck Model

Started in Germany, employers and employees fund the cost of insurance for all citizens.

National Model

National taxes fund medical care for all citizens. Canada has this system.

No Insurance Model

Citizens either pay cash or barter for health care, or go without.

Healthcare in the United States

1

Breakfast Model

Veterans Administration

2

Bismarck Model

More than half of all Americans under age 65 get their health insurance through an employer.

3

National Model

Example: Medicare

~15% of Americans have Medicare

4

Uninsured

Despite efforts of the Affordable Care Act, almost 10% of Americans remain uninsured

ACA Compliance: The Basics

Patient Protection and Affordable Care Act

- **“ACA” or “Affordable Care Act”**
  - Collectively referred to as “Health Care Reform” or “Obamacare”
- **Signed into law on March 23, 2010**
- **Congress’ stated intent of the legislation:**
  - Provide affordable, quality health care for Americans
  - Reduce the growth of healthcare spending

Individual Coverage Subsidies

1. PPACA's premium tax credit (subsidies) only are available to qualified individuals purchasing coverage through health insurance exchanges after January 1, 2014.
2. Individuals with family incomes between 138-400% of the federal poverty level are eligible for a premium tax credit. Individuals with family incomes at or below 250% of the FPL also qualify for reduced cost-sharing. Medi-Cal has been expanded to 138% of Federal Poverty Level
3. Individuals and their dependents who have been offered coverage through an employer that meets an affordability and minimum value test ***are not eligible to get a subsidy in the exchange.***
4. The premium subsidy will come in the form of a refundable and advanceable tax credit paid directly to the individual's insurer.
5. The amount of the refundable premium tax credit received is based on the premium for the second lowest cost qualified health plan in the exchange (the silver plan) and in the rating area where the individual is eligible to purchase coverage.

VISION

- Improve the health of all Californians
- Access affordable care
- Provide high quality care

MISSION

- Increase insurance Californians
- Improve healthcare quality
- Lower costs
- Innovative, competitive marketplace
- Choice and value

PROGRAM ELIGIBILITY BY FEDERAL POVERTY LEVEL FOR 2019

Medi-Cal and Covered California have various programs with overlapping income limits.

HOUSEHOLD SIZE	% OF FPL	100%	138%	150%	200%	213%	250%	266%	300%	322%	400%
	1	$12,140	$17,237	$18,210	$24,280	$26,604	$30,350	$33,244	$36,420	$40,218	$48,560
	2	$16,460	$23,336	$24,690	$32,920	$36,019	$41,150	$44,981	$49,380	$54,451	$65,840
	3	$20,780	$29,436	$31,170	$41,560	$45,433	$51,950	$56,738	$62,340	$68,683	$83,120
	4	$25,100	$35,535	$37,650	$50,200	$54,848	$62,750	$68,495	$75,300	$82,915	$100,400
	5	$29,420	$41,635	$44,130	$58,840	$64,263	$73,550	$80,253	$88,260	$97,148	$117,680
	6	$33,740	$47,735	$50,610	$67,480	$73,677	$84,350	$92,090	$101,220	$111,380	$134,960
	7	$38,060	$53,834	$57,090	$76,120	$83,092	$95,150	$103,767	$114,180	$125,613	$152,240
	8	$42,380	$59,934	$63,570	$84,760	$92,506	$105,950	$115,524	$127,140	$139,845	$169,520
	each additional person, add	$4,320	$6,100	$6,480	$8,640	$9,415	$10,800	$11,758	$12,960	$14,233	$17,280

Medi-Cal uses FPL limits of the current year to determine eligibility for its programs. The column headings shaded in purple are associated with eligibility ranges for Medi-Cal programs:

- Medi-Cal for Adults — up to 138% FPL
- Medi-Cal for Children — up to 266% FPL
- Medi-Cal for Pregnant Women: — up to 213% FPL
- MCAP: — over 213% - 322% FPL
- CCHIP: — over 266% - 322% FPL

The shaded columns display 2019 FPL values according to the Department of Health Care Services (see annual values on page 4) which administers the Medi-Cal program.

Covered California uses FPL limits from the prior year to determine eligibility for its programs as required by regulation. The unshaded columns are associated with Covered California eligibility ranges:

Premium Assistance	**100% - 400% FPL**
Enhanced Silver Plans	*100% - 250% FPL*
• Silver 94	100% - 150% FPL
• Silver 87	over 150% - 200% FPL
• Silver 73	over 200% - 250% FPL
American Indian/ Alaska Native Plans	*100% - 300% FPL*

The unshaded columns display 2018 FPL values to determine eligibility for premium tax credits and cost sharing reductions for health plans effective in 2019. The unshaded columns, including the 100% column, display 2018 FPL values as published by the Department of Health and Human Services.

3/2019

Group Insurance

ACA Market Reform

Changes for all fully insured plans:

- All markets are guaranteed-issue with no preexisting condition limitations
- Benefits for small employers (2-100) and individuals will be tied to an essential benefits package
- Benefits for large employers will have a separate standard called a minimum value requirement
- Annual and lifetime limits on essential benefits will be fully prohibited for all plans
- State Exchanges will be developed as an additional venue for the purchase of health insurance coverage. Called Covered California in our state.

ACA Plan Designs

All plans must classify their actuarial value (percent of cost paid by the plan for covered benefits, in-network) by metal tier.

Bronze	Pays **60%** of the cost for covered benefits in-network Bronze level plans and above satisfy the “minimum value” portion of the employer mandate. (Lower premiums, higher OOP costs)
Silver	Pays **70%** of the cost for covered benefits in-network
Gold	Pays **80%** of the cost for covered benefits in-network
Platinum	Pays **90%** of the cost for covered benefits in-network (Higher premiums, lower OOP costs)

Out of Pocket (OOP) Maximum Limits

- ACA caps the allowable out-of-pocket maximum, which is the maximum financial exposure a participant may experience in a health plan year.

- **2019 Out-of-Pocket Maximum Limits**
  - $7,900 (Self-only)
  - $15,800 (Family)

- **2020 Out-of-Pocket Maximum Limits**
  - $8,150 (Self-only)
  - $16,300 (Family)

Essential Health Benefits (EHB)

The ACA mandates that all a and small group insurers offer plans that provide EHB in these ten categories:

1. Ambulatory services
2. Emergency services
3. Hospitalization
4. Maternity & newborn care
5. Mental Health & Substance Abuse Services
6. Prescription drugs
7. Rehabilitative and habilitative services and devices
8. Laboratory services
9. Preventive and wellness services
10. Pediatric dental and vision

California counties and rating regions

ACA Compliance: Rating Changes

Small Group Insurance Rating Structures

- **The ACA allows for rate variance by four factors only.**
  - Age, family composition, geographic location, tobacco use
    - California, however, prohibits tobacco use as a rating factor (CA AB 1083).
- **Other changes implemented:**
  - Member level rating: Each individual receiving coverage will be rated (cap of three on children under 21).
  - A 3:1 ratio limits rates charged to a 64 year old to be 3x the amount of those charged to 21 year olds.
  - Single-year age bands: rate increases happen on policy anniversaries only – not in the birthday month.
  - Risk adjustment factors (RAFs) are no longer used.

Summary of Benefits & Coverage (SBC)

The ACA requires individual and group health plans to provide a Summary of Benefits & Coverage (SBC) to all applicants and enrollees. Along with the SBC an employer must provide a Uniform Glossary to all applicants and enrollees.

- The aim is to make plan benefit displays uniform for all carriers, making it easy for consumers to compare benefits.
- The format was developed by the Department of Health & Human Services (HHS).
- A carrier's Summary of Benefits does not meet the criteria for the SBC
- Penalty for the failure to provide an SBC is up to $1,156 per enrollee.

90-Day Waiting Period Maximum

The ACA mandates that employers may not impose a waiting period that exceeds 90 calendar days. Health plans cannot impose a waiting period; only employers may do so with a maximum of 90 days.

- Many California groups elect “first of the month following 30 days of employment” or “first of the month following 60 days of employment” to comply with this waiting period mandate.
- Employers may delay eligibility up to an additional month to allow for a bona-fide orientation period during which the new employee goes through training and tests to determine whether the new employee and company are a mutually good fit.
- Ensure waiting periods are listed clearly and correctly in employee handbooks.

60-Day Notice of Modification

The ACA requires an employer offering group health coverage to provide a notice of plan modification to enrollees at least 60 days prior to the effective date of any modification.

- This requirement does not pertain to carrier-issued renewal modifications.
- Section 102 of ERISA law includes a modification to the coverage that would be considered by an average plan participant to be an important change

Is your group considered “large”?

Group Size Calculation: FT+ FTE

Group size is counted by FT + FTE

- FT = Full Time
- FTE = Full Time Equivalent
- Determines whether a group is in the Small or Large group market segment
- Determines ACA employer mandate and employer reporting responsibilities

Full Time

- Averages 30 hours/week or 130+ hours/month

Full Time Equivalents

- All PT employees' hours of service per month are totaled and divided by 120.
    - *If a PT employee averages 121-129 hours, round down to 120 for this calculation.*

Example: 40 FT employees + 20 PT employees all providing an average of 60 hours of service/month.

- 20 PT employees x 60 hours of service/month = 1,200 hours
- 1,200 hours total/120 hours = 10 FTEs
- 40 FT + 10 FTEs = Group size 50

Employer Mandate

50+ FTE employers are required to offer affordable insurance coverage (providing minimum value and minimum essential coverage) to “all” FT employees and their dependent children to age 26.

Groups with 50+ FTEs, called Applicable Large Employers, must comply.

- “All” employees = 95% of employees (all but the greater of: 5% or 5 FT employees)
- Minimum value = Plan must pay at least 60% cost of covered benefits.
- Minimum Essential Coverage = The type of coverage an individual needs to have to meet the individual responsibility requirement under the Affordable Care Act. This includes individual market policies, job-based coverage, Medicare, Medicaid, CHIP, TRICARE and certain other coverage.
- Employee cost share of the least-expensive plan offered for “employee-only” coverage must not exceed 9.86% of any of the following three safe harbors for the 2019 year:
  - Rate of pay (at the beginning of the calendar year)
  - W-2 Box 1 income for the corresponding tax year
  - Federal Poverty Level
- Group size determination is based on number of employees from the previous year.

**At the time this presentation was created, the 2020 affordability percentage has not been released by the IRS.*

IRS Section 6056 Employer Reporting

ACA regulations require information reporting to the IRS by ALEs with 50+ FTE employees relating to the health coverage the employer offers, or does not offer, to its FT employees and their dependent children up to age 26. Employers with less than 50 FTE employees sponsoring self-insured plans also are required to report to the IRS.

- Employers subject to this mandate are required to complete the following forms:
  - ALEs with 50+ FTEs sponsoring fully-insured plans or self-insured plans: IRS Forms 1094-C and 1095-C
  - Non-ALEs with less than 50 FTEs sponsoring a self-insured plan: IRS Forms 1094-B and 1095-B
  - Non-ALES with less than 50 FTEs sponsoring a fully-insured plan: No reporting required
- The IRS uses these reports to determine whether or not the employer must pay any noncompliance penalties, and also to determine a Marketplace participant's eligibility for a Premium Tax Credit (PTC).

Reporting Timelines: IRS Section 6055 & 6056

Who reports?	Plan Type	Forms	Purpose	Copy to covered individual / employees	Paper submission to IRS	Electronic submission to IRS
Employers with < 50 FTEs sponsoring self-insured plans	Self insured	1094-B 1095-B	Enforce individual mandate	1095-B and 1095-C only: on or before last day of January	On or before last day of February	On or before last day of March*
Applicable Large Employees (ALEs): Plan sponsors with 50+ FTEs	Fully insured	1094-C 1095-C (Parts I & II)	Enforce *employer* mandate			
	Self-insured	1094-B 1095-B (Parts I, II, III)	Parts I & II: Enforce *employer* mandate Parts III: Enforce *individual* mandate			

Noncompliance: Employer Reporting

An ALE (or Non-ALE group with self-insured coverage) that does not comply with the ACA's employer reporting responsibilities faces hefty penalties.

- Most penalties have a maximum cap, although there is no cap for intentional disregard of the employer reporting responsibilities, which is $550 per filing (2019 tax year).
- Employer penalties have increased since the inception of the ACA and may continue to rise.
- Failure to furnish IRS reporting return (form 1094-B or 1094-C) or individual statements (form 1095-B or 1095-C) to employees is $270 per filing (2019 tax year), with a maximum penalty of $3,339,000 (2019 tax year).
- Penalties are lessened if the employer complies within a certain preset timeframe after the due date.

Noncompliance: Employer Mandate

If an ALE does not offer affordable minimum essential coverage, providing minimum value 60%, to full-time employees and their dependent children up to age 26, the employer could face one of two penalties under IRS Code Section 4980H (a) and (b). An employer will never be assessed both penalties. An employer will never be assessed both penalties for any month.

- **Penalty "A" – 4980H (a)**
  - Assessed when a 50+ FTE employer does not offer minimum essential coverage (MEC) to at least 95% of its FT employees (all but the greater of 5% or 5 FT) and their dependent children to age 26. The penalty triggers when one employee receives a Premium Tax Credit (PTC) for the coverage on Covered California or the Marketplace for out-of-state employees.
  - For the 2018 tax year, the annual penalty is $2,320 x all FT employees, minus the first 30. The penalty is calculated on a monthly basis at 1/12 of $2,320 or $193.33 per month.
  - Example: An employer with 80 FT employees does not offer MEC to its FT employees and their dependents and at least one of those 80 employees receives a PTC from Covered California or the Marketplace for out-of-state employees for a full year.
    - 80 FT employees – 30 = 50
    - 50 x $2,320 = $116,000 penalty

**At the time this presentation was created, the 2019 and 2020 Penalties have not been released by the IRS.*

Noncompliance: Employer Mandate

- **Penalty “B” – 4980H (b)**
  - Assessed when the 50+ FTE employer offers coverage that is not affordable by ACA standards and/or does not provide 60% minimum value. The penalty triggers when an employee receives a PTC for coverage on Covered California or the Marketplace for out-of-state employees.
  - For the 2018 tax year, the penalty is $3,480 per FT employee receiving a PTC. The penalty is calculated on a monthly basis at 1/12 of $3,480 or $290 per month.
  - Example: An employer with 65 FT employees does not offer coverage that is affordable, and 20 of those employees receive a PTC for coverage through Covered California or the Marketplace for out-of-state employees for a full year.
  - 20 x $3,480 = $69,600 penalty
  - An employer that does not incur Penalty “A” may incur Penalty “B” if any of the 5% or 5 FT employees who are not offered affordable coverage that meets MV gets a PTC from Covered California or the Marketplace for out-of-state employees.

**At the time this presentation was created, the 2019 and 2020 Penalties have not been released by the IRS.*

Pending State Legislation

- Drug Cost Transparency – Multiple Bills
- SB 65 (Pan-D) – would increase subsidies for insurance premiums to California residents below 600% of the federal poverty level. This would potentially benefit an additional 650,000 Californians, thereby placing a strain on the small group market. Currently, individuals up to $48,500 and a family of four up to $100,400 are eligible for subsidies (400% fpl).
- Medicare for All – nothing will pass in time for 2020 implementation.
- Surprise billing legislation.
- Governor Newson wants to reinstate individual mandates and extent Medi-Cal to undocumented adults under age 26 with low incomes.

Pending Federal Legislation

- Repeal of Cadillac Tax – Affordable Care Act's high-cost plan tax (HCPT) – a 40% excise tax on employer plans exceeding $10,200 in annual premiums for individuals and $27,500 for families.
- Prescription Drug Transparency – multiple bills.
- Health Reimbursement Arrangements -- if passes, employers could offer an HRA to be used for the purpose of purchasing individual health coverage in lieu of a traditional group health plan.
- Surprise billing legislation.
- Medicare-for-All -- multiple bills but nothing will be in place in 2020. The price tag is $32 trillion, an average tax increase of $24,000 per household.
- Texas versus US Federal Lawsuit – if passes, the Affordable Care Act would be struck down. Spring of 2021 is the earliest it would take effect.

What to Expect in 2020

Available Medical Products include:

- Fully Insured Plans
- HMO
- PPO
- EPO (Closed PPO Plan)
- *Health Savings Account (HSA)
- *Health Reimbursement Account (HRA)

  *Note: High Deductible Health Plans comprise 40% of all group coverage.
- Partially Self Insured
  - Employers work with a TPA to set up funding arrangement for paying difference between costs of a MEC (Minimum Essential Coverage) plan and a richer plan design, to maximize premium savings.
  - There is an extra layer of administration for both the employer and employee, and inherent risk that incurred claims will exceed projected savings.
- Self Funding
  - In California, groups under 100 lives cannot have specific deductibles below $40,000, following passage of SB 161. There are multiple self-funding plan designs, usually involving a specific and aggregate deductible level, to guard against abnormally large individual or group claims. Groups implementing a self-funded plan have substantial reporting requirements.

2020 HSA Contribution Limits

Max Contributions	2019	2020
Individual	$3,500.00	$3,550.00
Family	$7,000.00	$7,100.00
Catch-up (55 years and older)	$1,000.00	$1,000.00
Max Individual with Catch-up	**$4,500.00**	**$4,550.00**
Max Family with Catch-up	**$8,000.00**	**$8,100.00**
Deductible Cannot be Less Than (Defined by IRS)		
Individual	$1,350.00	$1,400.00
Family	$2,700.00	$2,800.00
Out of Pocket Max Cannot be More Than (defined by the IRS)		
Individual	$6,750.00	$6,900.00
Family	$13,500.00	$13,800.00

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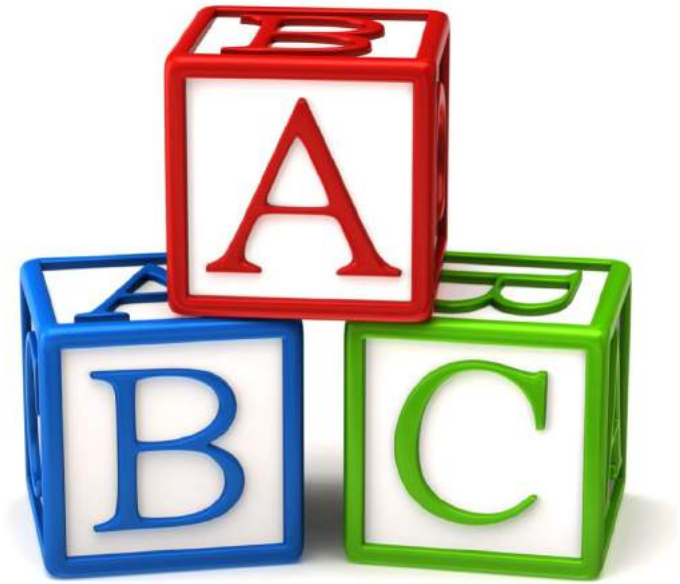

Thank you!

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