NECA-IBEW FAMILY MEDICAL CARE PLAN AFFORDABLE CARE ACT IMPACT BEGINNING 2014

NECA
NATIONAL ELECTRICAL CONTRACTORS ASSOCIATION

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OVERVIEW

The linchpin provisions of the Affordable Care Act (ACA) will go into effect in 2014. It is important for both union and employer Trustees to understand how the new rules will affect the Family Medical Care Plan (FMCP) and its current and retired participants.

This report addresses the portions of ACA that will most directly impact the FMCP, its Trustees and its participants and contractors, based on the guidance issued to date.

Although the agencies responsible for framing out the rules and procedures (HHS, DOL and the IRS) have issued several proposed regulations, notices and FAQs—especially since the November election—many details still require explanation and clarification. **Significantly, the agencies have yet to address how the ACA requirements will affect Taft-Hartley multiemployer plans.**

However, based on the guidance issued to date it appears that a large employer who contributes to the FMCP will NOT be subject to the pay-or-play penalties, which were delayed until January 2015, with respect to the employees for whom he makes those contributions. The employer is exempt from the pay-or-play penalties because the following requirements are satisfied:

- The employer is required to contribute to a multiemployer plan (the FMCP) pursuant to a collective bargaining agreement or participation agreement;
- The FMCP provides coverage to individuals who meet the eligibility requirements (and their dependent children);
- The FMCP coverage is affordable - the employee pays less than 9.5% of his household income (however, employers who charge an amount to employees will want to confirm those amounts are not more than 9.5% of household income); and
- The FMCP provides minimum value (at least 60% of actuarial value).

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Nothing in this document should be treated as legal advice. We suggest you contact your legal counsel for advice regarding any provisions of the Affordable Care Act.

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A. THE INDIVIDUAL MANDATE

Starting January 1, 2014 most Americans will be required to purchase health insurance coverage. Individuals who do not have qualifying health care coverage will incur a tax penalty that will be phased in as follows:

The greater of:

2014 - $95 or 1% of taxable income
2015 - $325 or 2% of taxable income
2016 - $695 or 2.5% of taxable income
2017 and after - penalty to be increased by the cost-of-living adjustment (COLA)

"Taxable income" does not include the amount under which the person does not pay income tax, currently around $10,000 for a single filer and $19,000 for a married couple filing jointly.

The penalty amounts are per person. The penalty for a child under age 18 is 50% of the normal rate. Family penalties are capped at 300% of the individual flat dollar penalty.

Exemptions apply to:

- Individuals with financial hardships,
- Individuals without coverage for less than three months,
- Those for whom the lowest cost plan option exceeds 8% of their income (the individual's income alone), and
- Those with incomes below the tax filing threshold (approximately $10,000).

Qualifying Health Care Coverage

Everyone will be responsible for demonstrating that they and their dependents maintain "minimum essential coverage." Minimum essential coverage includes:

- An employer-sponsored health plan, including a multiemployer plan,
- A government-sponsored plan like Medicare, Medicaid, SCHIP, TriCare and the VA, or
- An individual health plan, which may be purchased on the exchange.

Effect on Participants

Individuals will be required to demonstrate that they were covered under a qualifying health plan during the tax year on their annual income tax forms, and the IRS will check the individual's assertion about their health care coverage against a database based on employer-provided information (via W-2 forms).

Effect on Employers

At this time, employers that only contribute to multiemployer plans are not subject to the W-2 requirement. The IRS has requested comments on issues that would arise in applying the reporting requirements to employers contributing to multiemployer plans.

Exchanges

Individuals without qualifying employment-based health plans will be able to access insured plans through state exchanges. An employed individual can access the exchange in his state if: (1) his employer does not offer health coverage (i.e., "minimum essential coverage"); (2) his employer offers minimum essential coverage that does not provide "minimum value" (actuarial value greater than 60%); or (3) the employer offers minimum essential coverage that is unaffordable. Coverage is "unaffordable" if the employee's share of the premium exceeds 9.5% of his household income.

Exchanges are required to offer at least four plan choices, all of which provide "minimum value" coverage or better. The four levels of coverage are based on "actuarial value," meaning the percentage of health costs that, on average, would be paid the plan. The four levels are:

- Platinum - 90%
- Gold - 80%
- Silver - 70%
- Bronze - 60%

Estimated Actuarial Value Calculation (AV):			
A.	Allowed Plan Costs =	$1,000,000	
B.	Member cost * =	-$100,000	
C.	Net Plan Paid =	$900,000	
D.	AV =	90%	C / A

* Deductibles, coinsurance, co-pays, etc.

Government Subsidies

Premium tax credits and subsidies to purchase qualified health plans will be available to individuals with incomes up to 400% of the Federal Poverty Level (FPL).

Based on 2013 Federal Poverty Level (FPL) figures, families with the following annual salaries would qualify for premium support:

$45,960 for a single individual
$62,040 for a family of two
$78,120 for a family of three
$94,200 for a family of four

Tax credits will be based on the premium for a silver-level plan (70% AV) in the person's exchange and geographical area.

Exchange premium support is based on a sliding scale—the higher the person's income, the smaller the subsidy and the more the individual pays. For example:

2013 Family Income	Poverty Level (family of four)	Maximum Cost of Coverage	Estimated Annual Premium
$31,322	133%	3% of household income	$940
$58,875	250%	8% of household income	$4,710
$94,200	400%	9% of household income	$8,478

SHOP Exchanges

The exchanges will also allow small employers to purchase group coverage for their employees. This program is known as the Small Business Health Options Program, or "SHOP." For the purpose of the SHOP exchange, a "small employer" is an employer that employed no more than 100 employees on average during the prior calendar year. In 2017, states can choose to allow even larger employers to buy insurance through their exchanges.

The start date for this program has been pushed back to 2015 due to operational challenges. However, the individual state exchanges can still voluntarily choose to roll it out in 2014.

Guaranteed Issue

Starting January 2014 health insurers will be required to issue coverage to every employer and individual who applies for coverage, without a pre-existing condition limitation.

Premiums may only vary by the insured's age, geographic location, tobacco use, and for single versus family coverage.

Effect on Participants

Employees who do not have sufficient hours to meet the eligibility requirements for the FMCP may be able to purchase health care coverage cheaper through their exchanges rather than making short-hour self-payments to the FMCP.

For unemployed participants, exchange-provided coverage will almost certainly be cheaper than COBRA, but will they want to go through the hassle of changing plans? It could mean benefit reductions, switching doctors and pharmacies, and adjusting to a different plan structure.

Medicaid Expansion

In most states, eligibility for Medicaid will be expanded to include all non-elderly Americans with income below 133% of the Federal Poverty Level (FPL). More significantly, the eligibility criteria will be expanded to include more adults, with and without children. Currently, non-disabled adults without dependent children are not eligible for Medicaid except in a few states with expanded eligibility. An estimated 11 million people will gain coverage by 2022 through this eligibility expansion.

ACA also mandates a new method for calculating income, which will make the effective minimum threshold 138% of FPL. The 133% (or 138%) FPL level is a floor, not a ceiling, and states can opt for even higher levels.

Effect on Participants

More unemployed employees and their dependents may be eligible for Medicaid.

B. EMPLOYER PAY OR PLAY REQUIREMENT

Free-Rider Penalty for Large Employers

Basic Rules

- Starting January 1, 2015 employers with the equivalent of at least **50 full-time employees (FTEs)** must offer at least minimum essential health coverage to their employees and children or pay a "free rider" penalty. Minimum essential health coverage is a plan that is greater than 60% actuarial value and complies with essential health benefit coverage requirements of ACA.
  - o An employer with fewer than 50 FTEs can still be subject to the pay-or-play rule if the employer is part of a controlled group that has at least 50 FTEs. A "controlled group" consists of more than one corporate entity under common control.
  - o An employer will not be subject to the pay-or-play rule if, in the prior year, the employer's workforce exceeded 50 FTEs for only 120 or fewer days, and the employees in excess of 50 during that maximum 120-day period were seasonal workers.
  - o Interestingly, coverage does not have to be offered to spouses.
- **The penalty amount for failing to provide minimum essential coverage is $2,000 per year** for each FTE in excess of 30. Example: An employer with 50 FTEs pays $2,000 x 20 = $40,000 in 2015. After 2015, the penalty amount will be indexed to an annual "premium adjustment percentage."
- A large employer must offer its full-time employees **minimum essential coverage**, but the requirement to cover everything in the list of "essential health benefits" does not apply to self-insured employer-sponsored plans or insured large group plans.
- The penalty is triggered **if even one of the employer's workers buys coverage through an exchange** and qualifies for a premium tax credit or subsidy.

Definition of Full-Time Employee

- For the purpose of determining whether an employer is subject to the pay-or-play rules, an FTE is someone who works an average of at least 30 hours per week (or 130 hours per month).
- A complicated set of optional and transitional rules determine how newly hired, and variable hour and seasonal workers are treated for the purpose of the pay-or-play rules. Employers should consult with their legal advisors and accountants for advice about determining their FTEs.
- The definition of FTE is different, but also complicated, when it comes to determining an employer's actual penalty under the pay-or-play rules.

Effect on Employers

Employers should seek advice from their legal and accounting professionals to determine if they are subject to the pay-or-play requirements. This is especially prudent for employers who are close to the 50-FTE threshold.

Minimum Value and Unaffordable Coverage Penalty for Large Employers

Even if an employer offers minimal essential medical coverage, **an annual $3,000 per-person penalty** will be imposed on the employer for each full-time employee who obtains subsidized coverage through a state exchange because the employer's plan is not affordable.

If the large employer provides minimum essential coverage, its employees may still receive premium credits (subsidies) for coverage through the exchanges if: (1) the coverage does not meet the minimum value standard; or (2) the employee's share of the cost for employee-only coverage exceeds 9.5% of his household income. Since employers do not know the "household income" of their workers, for 2014 they can use the Box 1 wages on the employee's W-2 as "household income." There are other safe harbor methods available to employers who need to determine the employee's household income for this purpose.

The penalty does not apply to employees enrolled in their spouses' plans, or to part-time or seasonal workers.

Multiemployer Plans and the Employer Mandates

Most of the guidance issued to date has been remarkably silent about how the employer penalties will work if the employer's coverage is offered through a multiemployer plan.

However, recent guidance did indicate that, at least through 2014, a large employer is not subject to the pay-or-play penalties with respect to a full-time employee if:

- The employer is required to contribute to a multiemployer plan pursuant to a collective bargaining agreement or participation agreement;
- Coverage under the multiemployer plan is offered to the individuals who meet the plan's eligibility requirements (and their dependent children); and

- The coverage offered is affordable (the employee pays less than 9.5% of his household income) and provides minimum value (a bronze plan on the exchange, i.e., one that provides at least 60% of actuarial value).

Effect on Employers

Based on the guidance issued to date, it appears that the current FMCP Plans meet the requirements of the ACA (minimum essential coverage that is affordable and provides minimum value).

Also, since the FMCP Plans provides greater than 60% actuarial value, and because participants are typically not required to pay any part of their health care "premiums," large contributing employers in the FMCP will not face any pay-or-play penalties on account of their FMCP participation.

(Note that the only time an employee pays a "premium" for FMCP coverage (either as short-hours, retiree or COBRA self-pay) is when he is no longer a full-time employee. Some single employers charge employees an amount out of the employees' paycheck. These employers will want to ensure these amounts are deemed "affordable" under the ACA.)

However, large employers (those with at least 50 FTEs) will still be required to do the paperwork necessary to prove that they are in compliance. Additional guidance will be issued concerning this requirement.

Reporting Requirements

- **Disclosures to IRS -** Large employers subject to the pay-or-play rules will be required to file information to the IRS related to the health care coverage they provide. Details have yet to be released, but the information will, at a minimum, include the names of

covered individuals and the dates of coverage. The IRS notes that it may be feasible to allow employers to satisfy at least some of the new reporting requirements using a revised Form 5500.

- **Exchange Disclosure Notice to Workers -** Employers will be required to provide written notice to their workers advising them of the existence of exchanges, and informing them that if the employer does not provide minimum essential coverage that is affordable and provides minimum value, they may be eligible to purchase coverage through that exchange. The notice will also be required to state the employer's contribution for the coverage and must be distributed to all employees by October 1, 2013. The regulating agencies have provided a model notice for employers to use, which can be found at www.dol.gov/ebsa/healthreform. The FMCP is also providing a notice to participants about the exchanges.

Effect on Employers

The exchange disclosure notice requirement is **not just for large employers**. It applies to all employers covered under the Fair Labor Standards Act (FLSA), which generally means employers with annual sales of $500,000 or more or who are engaged in interstate commerce.

Until future guidance addresses multiemployer plan contributions, this relatively simple mandate **could be problematic for employers in multiemployer plans** who do not pay "premiums" and whose contributions vary based on hours worked and other collectively bargained-for factors.

Benefit Mandates

Mandates Already in Effect

The Plan has already been amended for the following ACA mandates on benefits coverage:

- Coverage of children to age 26
- No lifetime or annual dollar limits on essential health benefits
- Over-the-counter drugs can only be covered if there's a doctor's prescription
- Pre-existing condition limitations cannot apply to children
- Mandatory coverage of certain preventive services with no cost sharing in-network
- Coverage of out-of-network emergency room services at the in-network level
- External appeals allowed for claims involving a medical determination (non-grandfathered Plans)
- Distribution of Summary of Benefits and Coverage ("SBC") documents

Mandates Effective Starting in 2014

The following additional mandates will become effective in 2014:

- No waiting periods longer than 90 days for new employees who otherwise meet the employer's eligibility requirements for health coverage
- Pre-existing condition limitations cannot apply to adults
- Non-discrimination of providers, meaning that plans will most likely have to cover all licensed health care practitioners, including acupuncturists and chiropractors (non-grandfathered plans only)
- Coverage for "routine costs" while a patient is in an approved clinical trial, but not the actual drug or device being investigated (non-grandfathered plans only)
- Wellness programs cannot establish eligibility rules based on health status or medical condition
- A participant's annual cost-sharing (deductible, copays and coinsurance) cannot exceed $6,350 per person on $12,700 per family (non-grandfathered plans only)

Effect on Participants

The ACA coverage mandates are intended to, and do, benefit participants and their dependents. The age-26 limit for child coverage, the "free" preventive care, and the removal of dollar limits are reforms that many people appreciate.

Effect on Employers and Trustees

These benefit improvements along with future enhancements will continue to increase the cost pressures on the FMCP.

The increased costs for the benefit mandates, the fees and the administrative requirements may have to be offset with other benefit cuts, eligibility rule changes and self-pay increases at a later date.

Fees and Taxes

Health care plans, including self-funded multiemployer plans, will also be assessed the following direct fees:

- **PCORTF (Comparative Effectiveness Research Fees) -** For plan years ending after September 30, 2012, plans must pay $1 per member (employees and dependents) per year into a trust fund. The payment is due by July 31, 2013. The fee increases to $2 per member per year for subsequent years. The fees are temporary and will not apply to plan years ending after September 30, 2019.
- **Transitional Reinsurance Fees -** Insurers and TPAs will be required to pay into transitional reinsurance programs in each state from 2014 through 2016 on behalf of insured and self-funded plans. The fee for the first year is expected to be $63 per covered person.

- **Excise Tax on "Cadillac Plans" -** In 2018 plans that provide rich or generous benefits (so-called "Cadillac plans") will be subject to an excise tax of 40% of the value of the excess benefits. A Cadillac plan is one whose benefits are valued at $10,200 per year per individual or $27,500 per family. Multiemployer plans limits are tied to the family limit of $27,500.

Administrative Costs

In addition to the cost of implementing the mandates listed above, plans will have to bear the following administrative expenses in order to comply with ACA:

- **Certify Compliance with HIPAA Transaction Standards -** By December 31, 2013, health plans must certify to HHS that their data and information systems comply with, and have tested, current standards and operating rules for HIPAA transactions.
- **Reporting Requirement -** Like employers, plans will be required to file information to the IRS concerning the coverage the plan provides and who was eligible for that coverage. Additional guidance on how and what the Plan will have to report is overdue.

Effect on the FMCP

In addition to the expense of the mandated benefit improvements, and the additional administrative costs associated with ACA, the FMCP will have to bear the following additional ACA-related costs:

- $500,000 in PCORTF fees over seven years (2013-2019), and
- $5.25 million in transitional reinsurance fees ($2.5 million in 2014, $1.75 million in 2015, and $1.0 million in 2016.

The figures above are estimates only. The amounts are based on guidance regarding the per-participant costs and are based on the projected number of eligibles for 2013. If the covered population increases, so do the fees.

If current benefit costs are projected out to 2018 when the Cadillac tax begins, the FMCP Plans would not be subject to tax in 2018.