The Affordable Care Act and other Welfare-Related Updates

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WHERE IS THE ACA HEADED?

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- "Repeal and Replace" likely now on hold
  - Repeal versus reconciliation
  - The next significant legislative effort may not occur before January 2019 and is also dependent on the 2018 mid-term elections
- For now, the ACA and its provisions remain in effect
  - Recent Trump Administration action will likely put pressure on the public insurance marketplace and expand HRAs
  - The exemptions from providing coverage for women's contraceptives have been expanded

RECENT EXECUTIVE ACTION

- Cost sharing reduction subsidies (CSRs)
  - ACA provides CSRs for individuals between 100% and 250% of the FPL who enroll in a “Silver Plan” through the marketplace
    - ACA requires insurers required to provide reduced cost sharing, and they are reimbursed by federal government
    - Ongoing legal dispute whether CSR reimbursement requires direct appropriation from Congress
  - Trump Administration ending CSR reimbursement from discretionary budget
    - Without reimbursement, insurers will increase premiums enrollees to offset cost of CSRs (coincidentally affecting premium subsidies) or exit
    - Whether Congress fixes this or not, a number of states permitted insurers to increase premiums for 2018 on the assumption CSR reimbursements will end

RECENT EXECUTIVE ACTION

- DOL asked to consider ways to make it easier to form an Association Health Plan (AHP) by expanding existing membership rules
  - Intent is to allow smaller employers to participate in a self-insured ERISA plan or large group insurance coverage subject to fewer ACA mandates
- The ability to offer either type of AHP coverage across state lines appears limited
  - Self-insured AHPs are MEWAs subject to state regulation unless DOL circumvents this (e.g. Recognition as single employer plan)
  - States might be required to recognize AHP situs state or encouraged to enter into reciprocity arrangements
- It does not appear AHPs could permit non-employee individuals to participate and comply with ERISA
- Expanded AHPs will siphon healthy enrollees from the public insurance marketplace

RECENT EXECUTIVE ACTION

- The agencies have been directed to consider expanding the flexibility of health reimbursement arrangements (HRAs)
  - Intent is to allow employers to offer HRAs to current employees that can be used to purchase insurance coverage in the individual market

- This requires a reversal of current ACA guidance by either:
  - allowing HRA integration with individual coverage for ACA compliance; or
  - exempting HRAs from having to comply with the ACA's plan design mandates (e.g. Annual/OOPM limits)
- Employers will likely be given the flexibility to offer HRAs that exclude premium reimbursement entirely as well as offer HRAs that may solely be used for premium reimbursement

RECENT EXECUTIVE ACTION

- It is not clear if an employer will be able to meet the employer mandate by solely offering an HRA that may be used to purchase individual coverage or, if it can, how an offer of affordable coverage might be determined
- It is not clear if the agencies will revise existing guidance addressing the interaction of HRAs and eligibility for premium subsidies
- Expanded HRAs are likely to differ from the recently enabled and similar Qualified Small Employer Health Reimbursement Arrangements (QSEHRAs) in several ways:
  - Expanded HRAs will not be limited to small employers
  - Expanded HRAs will likely not be subject to annual reimbursement limitations (QSEHRAs have annual reimbursement limits based on the purchase of individual or family coverage)
  - Employers are unlikely to be prevented from offering other group health coverage
  - Expanded HRAs will still be considered group health plans (QSEHRAs are not)

WOMEN'S CONTRACEPTION

- As of October 6, 2017, significant expansion of entities that may avoid complying with the ACA's preventive services mandate to provide women's contraception
  - Exemption – Entity objects to any coverage for some or all women's contraceptive services
  - Accommodation – Entity willing to allow coverage for some or all women's contraceptive services through a third party but objects to providing directly through plan or paying for services
  - Grandfathered plans remain exempt but may now have a reason to drop grandfathered status
- Both religious and moral objections available
  - The moral objection regulations appear more vulnerable to challenge

WOMEN'S CONTRACEPTION

- An entity may object in whole or in part to the women's contraceptive requirements
  - Mandate generally requires coverage for at least one form of all eighteen FDA-approved methods
    - Cost alone will not sustain a religious or moral objection
    - Fertilization versus abortifacent contraceptives
- There is no filing requirement for claiming an exemption
  - Entities claiming exemption should consider developing a basis for the exemption in the event of a challenge

WOMEN'S CONTRACEPTION

- An accommodation can be requested on EBSA Form 700 or through other notice to HHS
  - Accommodations can be revoked and are effective:
    - The first day of the first plan year 30 days after revocation, or
    - Upon 60 days' prior notice to participants
- ERISA's disclosure rules are also in effect
  - A revocation of an accommodation is likely a material reduction in benefits unless the revocation results in the benefits being provided directly by the plan

WOMEN'S CONTRACEPTION

Entity	Religious Exemption or Accommodation Available	Moral Exemption or Accommodation Available
Church plan	✓	X
Other nonprofit	✓	✓
Closely held for profit	✓	✓
Other for profit	✓	✓/X[1]
Other non-government	✓	X
Government	X	X
Higher education	✓	✓
Insurance carrier[2]	✓	✓

[1] A moral objection is not available to publicly traded entities.
[2] An insurance carrier is also sheltered by a plan sponsor's objection (no guidance if plan sponsor's objection is unlawful).

THE ACA'S EXCISE TAX ON HIGH COST COVERAGE

EXCISE TAX – WHAT IS IT?

- A 40% deductible excise tax on the cost of employer-provided group health coverage that exceeds certain statutory thresholds
- Currently set to go into effect in 2020, the tax is intended to:
  - Raise revenue to help pay for ACA expenditures;
  - Act as a sort of cap on the unlimited tax deduction for employer-provided coverage; and
  - Reduce the availability of high cost coverage

EXCISE TAX – FLIPPING THE SCRIPT

- The GOP has explored switching the excise tax to a tax paid by covered individuals
  - An example appeared in an early draft of the House version of the American Health Care Act with different thresholds and indexing
  - HSAs were excluded from the calculation
- This version of the tax is intended to:
  - Raise revenue to help pay for reform expenditures;
  - Act as a cap on the unlimited income tax exclusion for employer-provided coverage; and
  - Reduce the demand for high cost coverage

EXCISE TAX – NO PRISONERS

- This tax's reach is very broad and employer-sponsored group health coverage also includes:
  - Retiree plans*
  - Multiemployer plans
  - Federal/state/local government plans
  - Plans of other tax-exempt organizations (e.g. ch other nonprofit entities)

Note: The excise tax's deductibility does not benefit tax-exempt organizations.

* Retiree-only plans are exempt from many other provisions of the ACA, but they are not exempt from the excise tax on high cost coverage.

EXCISE TAX – WHAT IS INCLUDED?

Benefit	Included	Excluded
Medical	✓	
Prescription drug	✓	
Dental (if excepted benefit)		X
Vision (if excepted benefit)		X
Health reimbursement arrangement[1]	✓	
Health care flexible spending account[1]	✓	
Health savings account (pre-tax contributions by employer *and* employee)[2]	✓	

[1] HRAs/FSAs that can only reimburse for dental and/or vision expenses may be excluded.
[2] After-tax contributions by the employee to his/her HSA are excluded.

EXCISE TAX – WHAT IS INCLUDED?

Benefit	Included	Excluded
Onsite health clinic[3]	✓	
EAP (if excepted benefit)		X
Long-term care		X
Executive physical[4]	✓	
Other supplemental/secondary coverage[5]		X

[3] Onsite health clinics providing only first aid for workplace accidents or *de minimis* care (currently undefined) are excluded.

[4] Existing guidance indicates executive physical programs will likely be included which also presumably means executive medical coverage will be included.

[5] Illness/indemnity coverage is included if the cost of the coverage is excluded or deducted from taxes.

EXCISE TAX – HOW IS IT CALCULATED?

- The excess cost of coverage over statutory thresholds which were initially:
  - $10,200 self-only coverage; $27,500 family coverage
    - There are no geographical adjustments
    - Multiemployer plans use the family threshold for all calculations
    - Plans where the majority of covered employees are engaged in a high risk profession* use $11,850 self-only; $30,950 family

* High risk professions are limited to law enforcement, fire, medical first responders, longshoremen, construction, mining, agriculture, forestry, commercial fishing, and electrical/telecommunications installation or repair technicians

EXCISE TAX – HOW IS IT CALCULATED?

- Other adjustments to the thresholds apply
  - Indexed to Consumer Price Index (CPI)
    - CPI+1% in 2019 (which sets 2020 threshold), CPI thereafter
    - Medical inflation historically > CPI
    - Indexing issue means all plans will eventually be subject to tax unless thresholds or indexing is revised
  - Plans may be able to make age/gender adjustments using the Federal Employees Health Benefits Plan as a benchmark
    - Guidance for this is pending

EXCISE TAX – HOW IS IT CALCULATED?

- The thresholds for qualified retirees are $11,850 self-only; $30,950 family (same as high risk)
  - Qualified retirees are those with retiree coverage who are at least 55 but not Medicare eligible (i.e. pre-65)
  - Qualified retirees do not have to participate in a retiree-only plan for this increased threshold to apply
  - There is no adjustment for Medicare eligible retirees (i.e. post-65, pre-65 and disabled or ESRD)

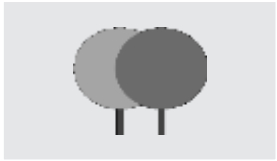
EXCISE TAX – HOW IS IT CALCULATED?

- The cost of coverage will be determined similar to COBRA premiums (less 2% surcharge)
  - Generally actuarial basis or past cost methods but IRS exploring additional methods (e.g. actual cost)
  - Eventual guidance may affect how COBRA rates are determined
- The calculation is pro-rated monthly per employee including retirees and other primary insured individuals
  - IRS exploring testing approaches for similarly situated individuals
    - Self-only versus family (mandatory)
    - Individuals who elect the same benefits package
    - Other bona fide employment criteria being considered

FACTORS THAT AFFECT PLAN COST
NOT JUST PLAN DESIGN–DEMOGRAPHICS MATTER

Characteristics of employers with plans that **will reach** versus **won't reach** the Cadillac tax threshold in 2020:

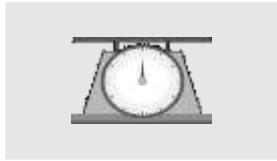
Older employees	
Average age: 42	Average age: 39



More female employees	
54% female	44% female

Higher rate of dependent coverage election	
48% avg rate	40% avg rate

More likely to offer coverage to part-time employees	
38% offer	27% offer



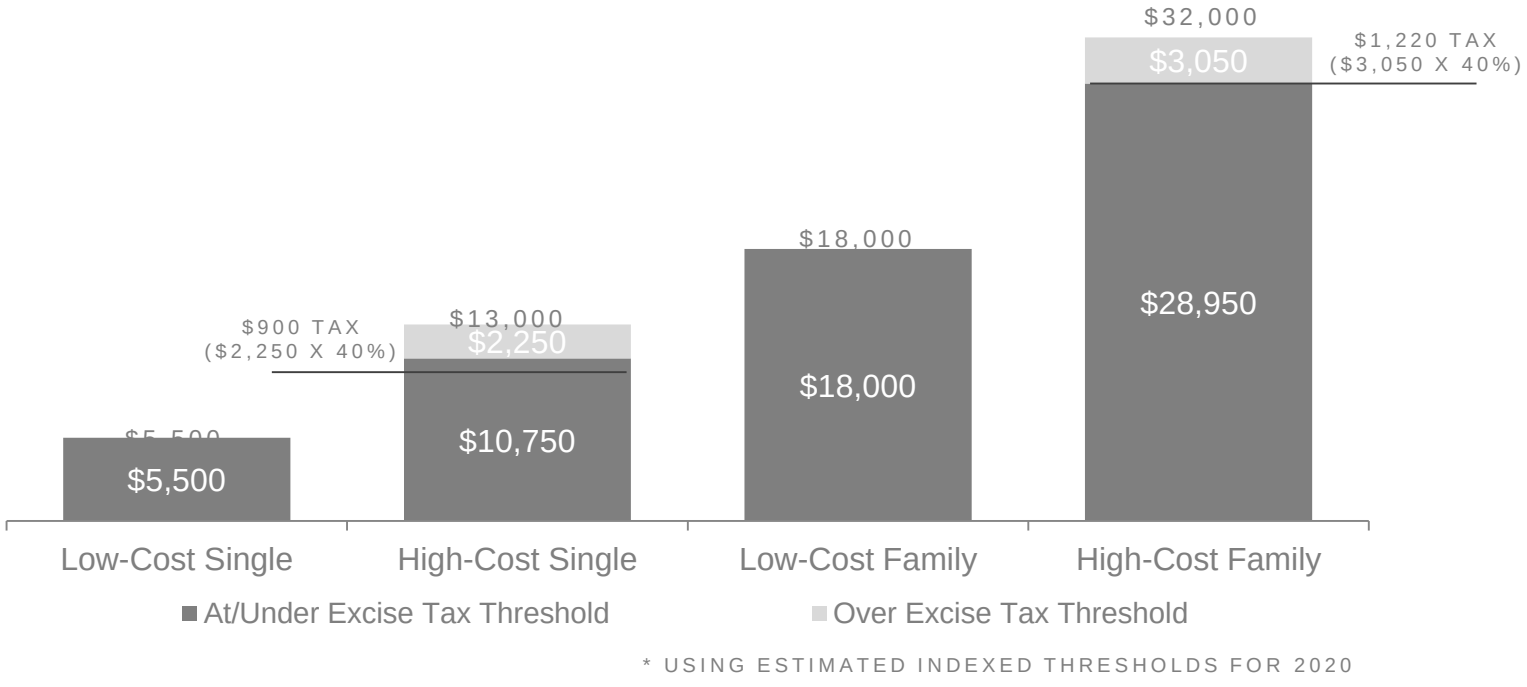
Plan values only *slightly* richer	
AV: 87%	AV: 84%

The Cadillac tax is more likely to penalize older workers, women, people with families, and employers who provide health benefits to part-time employees…

…And there is relatively little difference between the plan designs of those employers that will reach the threshold and those who won't.

Estimates based on data from Mercer National Survey of Employer-Sponsored Health Plans 2016; premium trended at 6%, tax threshold trended at 3% in 2021 and 2% in future years

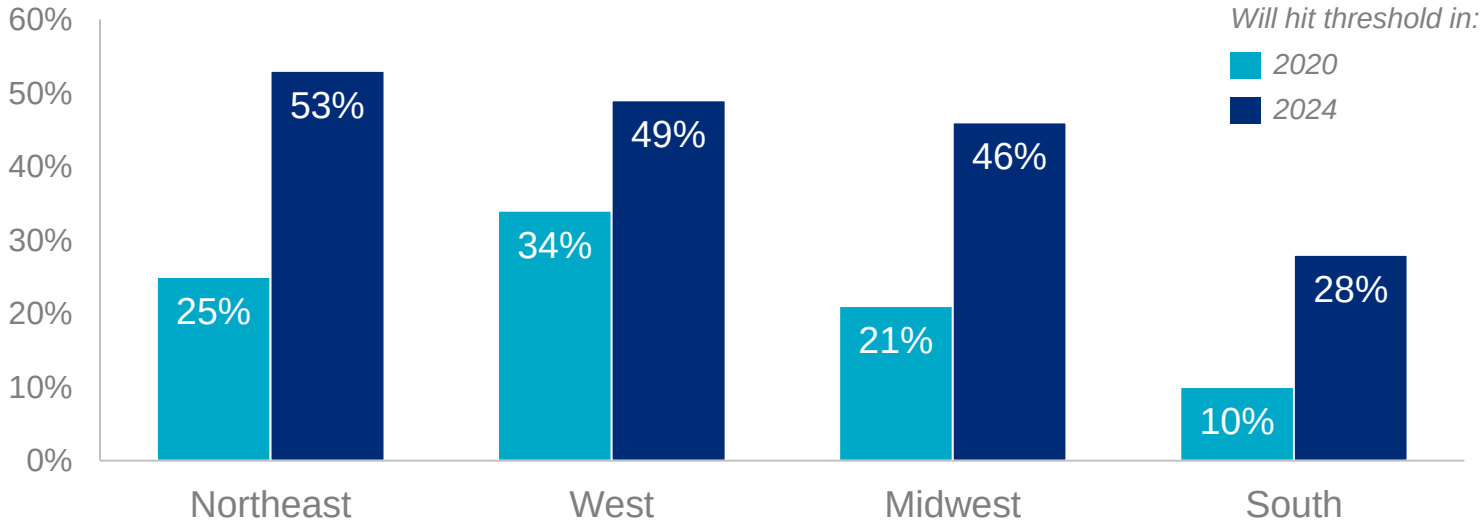
EXCISE TAX CALCULATION USING ESTIMATED 2020 TAX THRESHOLDS



* USING ESTIMATED INDEXED THRESHOLDS FOR 2020

EMPLOYER PLANS IN HIGH-COST REGIONS MUCH MORE LIKELY TO HIT CADILLAC TAX THRESHOLD

Percentage of employers (50+ employees) with plans that will be subject to excise tax by the specified year if they make no changes to their current plans. Regional cost variation would be a factor in all proposals based on premium.



Estimates based on data from Mercer National Survey of Employer-Sponsored Health Plans 2016; premium trended at 6%, tax threshold trended at 3% in 2021 and 2% in future years

EXCISE TAX – WHO PAYS?

- Single employer plan coverage
  - Insurance carrier for fully-insured coverage
  - IRS exploring either plan administrator and/or TPA for self-insured coverage
    - If TPA, likely coordination issues if self-insured plan uses multiple TPAs for benefits subject to excise tax
    - Employers have incentive to pay directly instead of through TPA
- No guidance available for multiemployer plans
  - Reporting by plan sponsor with apportioned payment by participating employers seems likely

EXCISE TAX – PAYMENT?

- Reported and paid on a lag basis
  - 2020 excise tax will be due in 2021, etc.
  - IRS will likely revise IRS Form 720 for this purpose
    - IRS Form 720 earlier revised to include ACA's PCORI filing
    - Reporting likely due at end of 2nd or 3rd quarter with payment made electronically sometime thereafter
  - Timing issues should prevent this from becoming a first quarter requirement
    - Data collection needs
    - Run-out for claims processing and grace periods for spending accounts

EXCISE TAX – SOME OPEN ISSUES

- The excise tax does not account for costs driven by geographical location which is largely outside an employer's control
- The excise tax is poorly indexed (or is it?)
- How do you calculate an individual's limit when the individual has self-only and family coverage for different benefits subject to the tax?
- How do you solve payment coordination when benefit packages include both self-insured and fully-insured coverage?

EXCISE TAX – SOME OPEN ISSUES

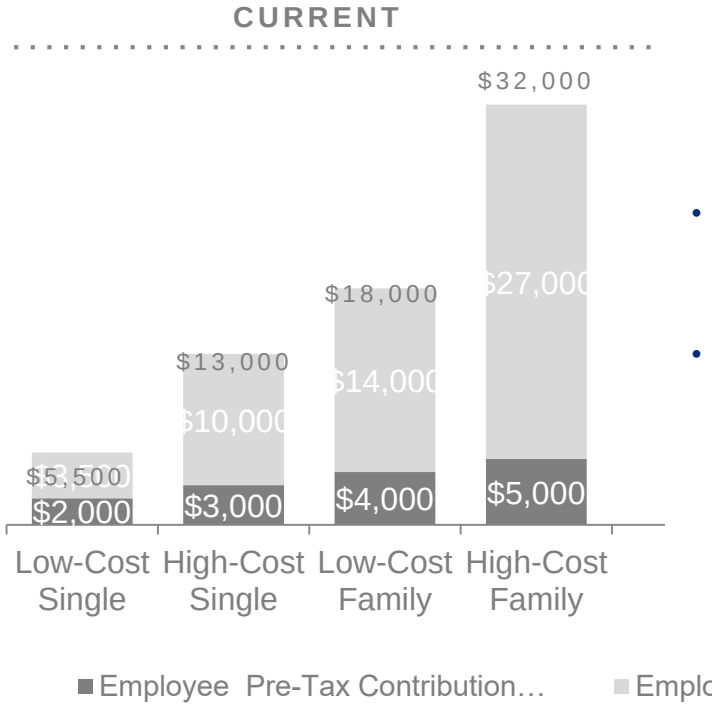
- Reporting and payment for multiemployer plans including apportionment adjustments for participating employers
- Collectively bargained plans and health care system plans will be disproportionately affected
- Will HSAs remain part of the calculation or be excluded entirely?
- Do I have to separate costs for plans covering both pre-65 and post-65 retirees?
- How difficult will it be to administer the permitted age/gender adjustments?

EXCISE TAX – TAKEAWAYS

- An excise tax is probably coming in some form or fashion so long as federal subsidies remain
- There are many uncertainties, but controlling cost will be key to avoiding/limiting the tax
  - The 60% MV issue and OOPM limit for non-GF'd plans will eventually act as brakes on cost shifting plan design changes
  - Controlling costs can also be achieved by reducing or eliminating benefits and services covered under a plan
  - Attempt to shift some of the delivery of certain services to lower cost alternatives (e.g. telemedicine, onsite clinics)
  - Dropping coverage?
- Will employers/unions focus more on compensation or other benefits?

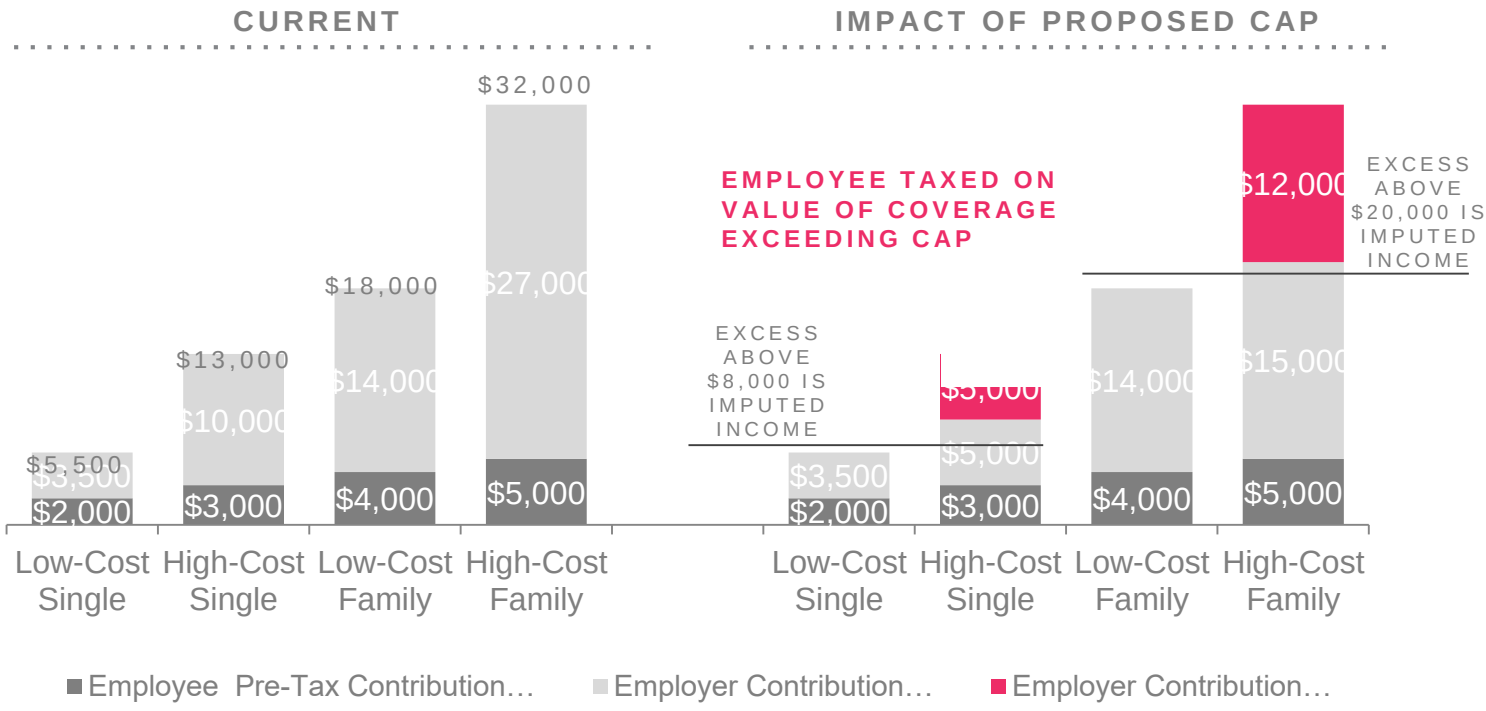
THE IMPACT OF CAPPING THE HEALTH COVERAGE TAX EXCLUSION

THE EMPLOYEE TAX EXCLUSION FOR EMPLOYER HEALTH COVERAGE



- The **LOW-COST PLANS** illustrate what we see among many of our clients who actively manage health plan cost
- The **HIGH-COST PLANS** displayed are not typical among our clients, but are displayed to illustrate the mechanics of the cap proposals

SAMPLE TAX EFFECTS WITH A PROPOSED CAP ON HEALTH COVERAGE TAX EXCLUSION

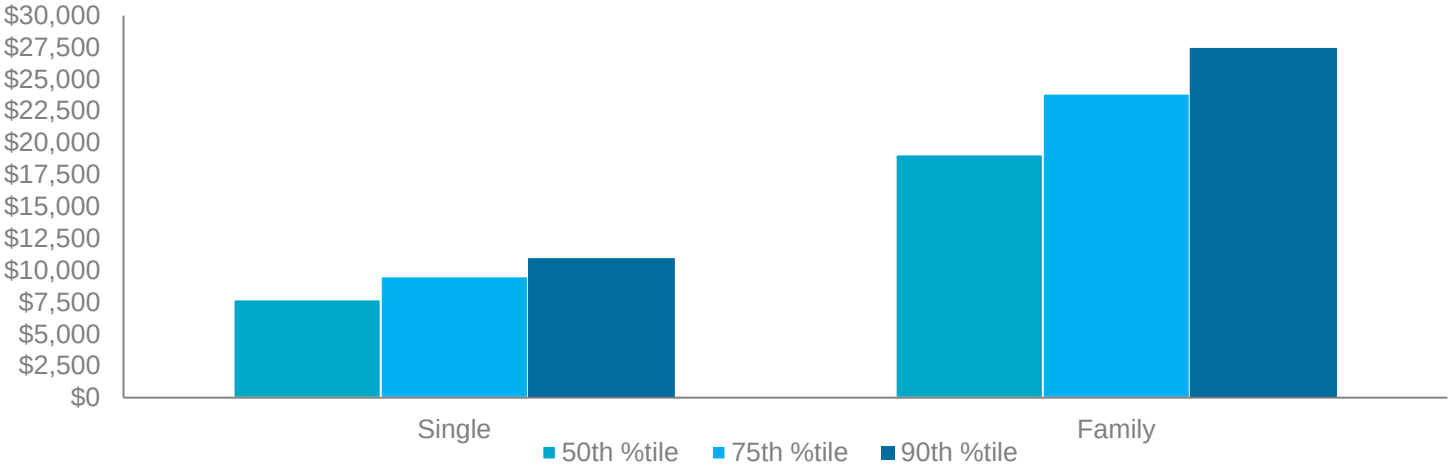


IMPACT FROM EMPLOYER PLAN PERSPECTIVE

CBO SCENARIOS

Cost Thresholds by scenario in 2020 are shown below

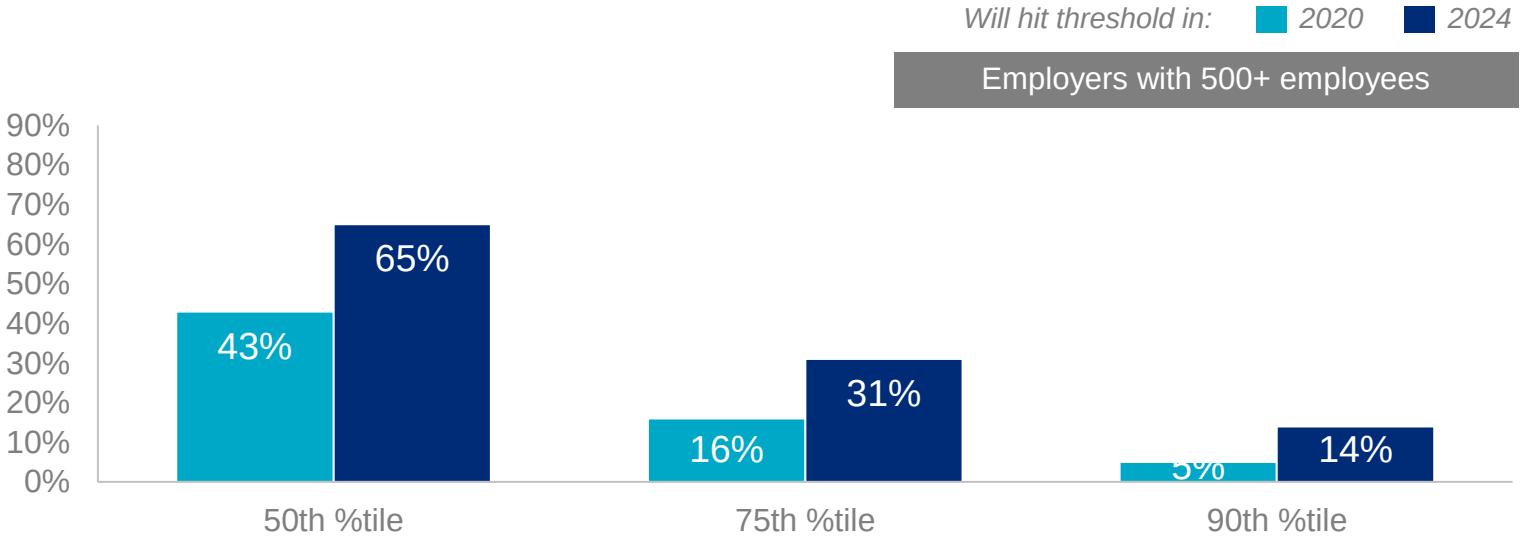
The higher the threshold, the lower the impact of any proposal



CBO proposal thresholds for 50th and 75th percentiles are taken from CBO report; 90th percentile was extrapolated from these figures

CBO SCENARIOS

Percentage of employers with plans that will be subject to taxation by the specified year if they make no changes to their current plans.

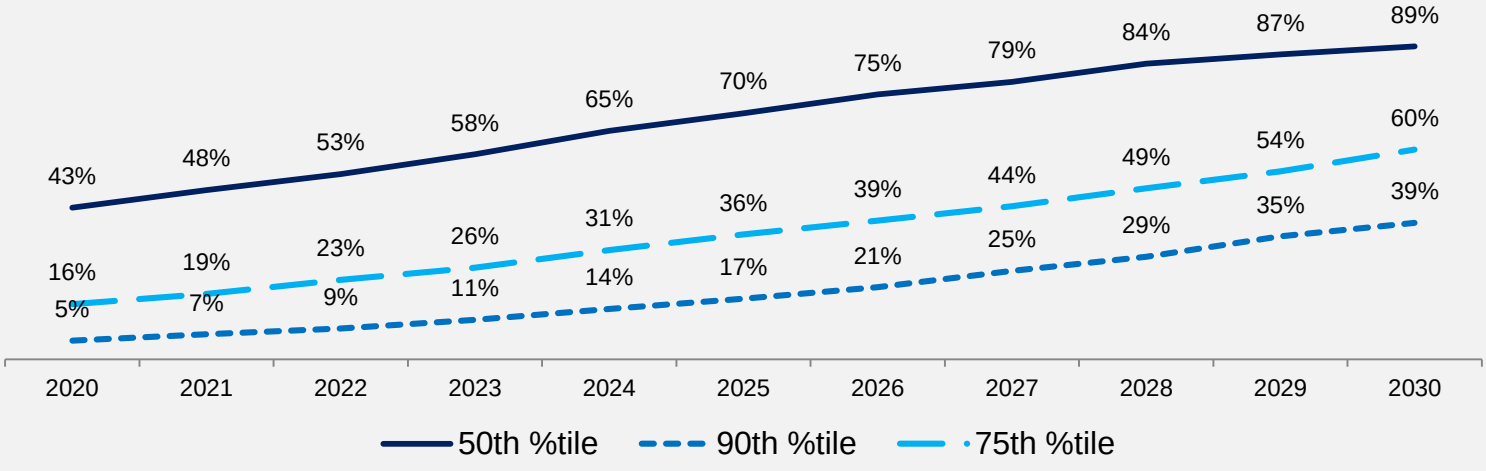


Estimates based on data from Mercer National Survey of Employer-Sponsored Health Plans 2016; premium trended at 6%, excise tax threshold trended at 3% in 2021 and 2% in future years. CBO proposal threshold trended at 2% beginning in 2020, and Patients First Act proposal threshold trended at 2% beginning in 2016.

IMPACT ON INDIVIDUALS ENROLLED IN EMPLOYER PLANS

CBO SCENARIOS
% OF HOUSEHOLDS EXCEEDING CAP

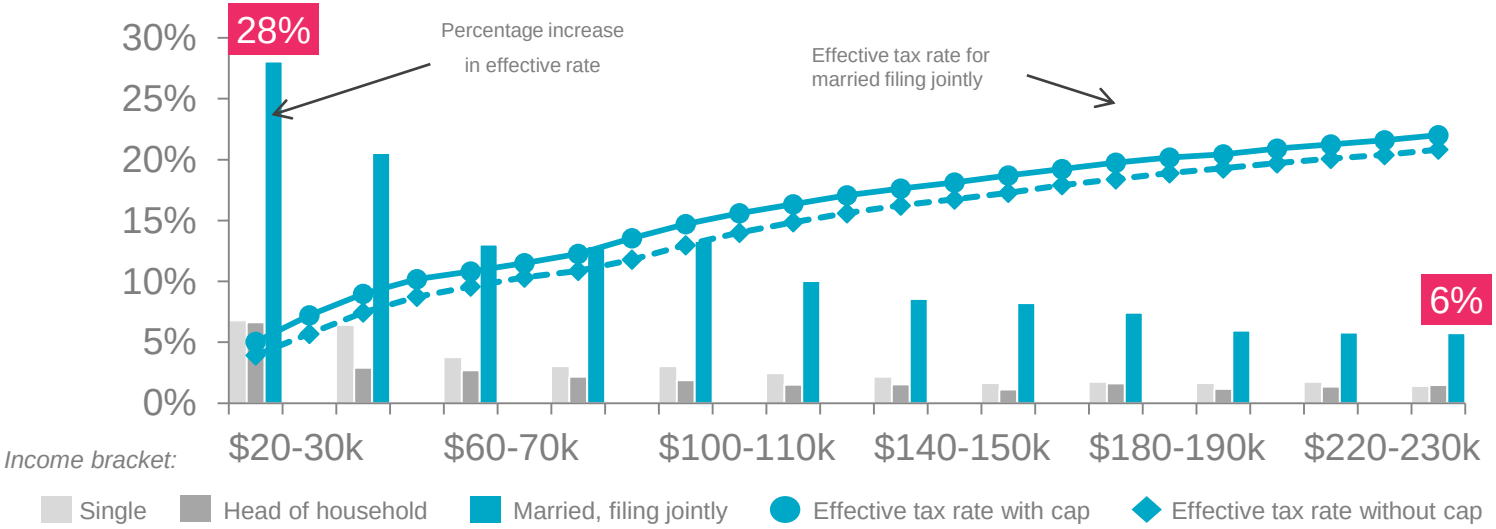
Percent of households exceeding cap is expected to increase significantly over time:



- Medical plan trend (assumed to be 5.5%) has historically outpaced CPI and is anticipated to continue
- Based on a Mercer proprietary database of 600,000 members' salary and benefits. Salary information used as proxy for household income.
- Includes FSAs, HRAs, HSAs

CBO 50TH %TILE
LOW INCOME FAMILIES HIT HARDEST

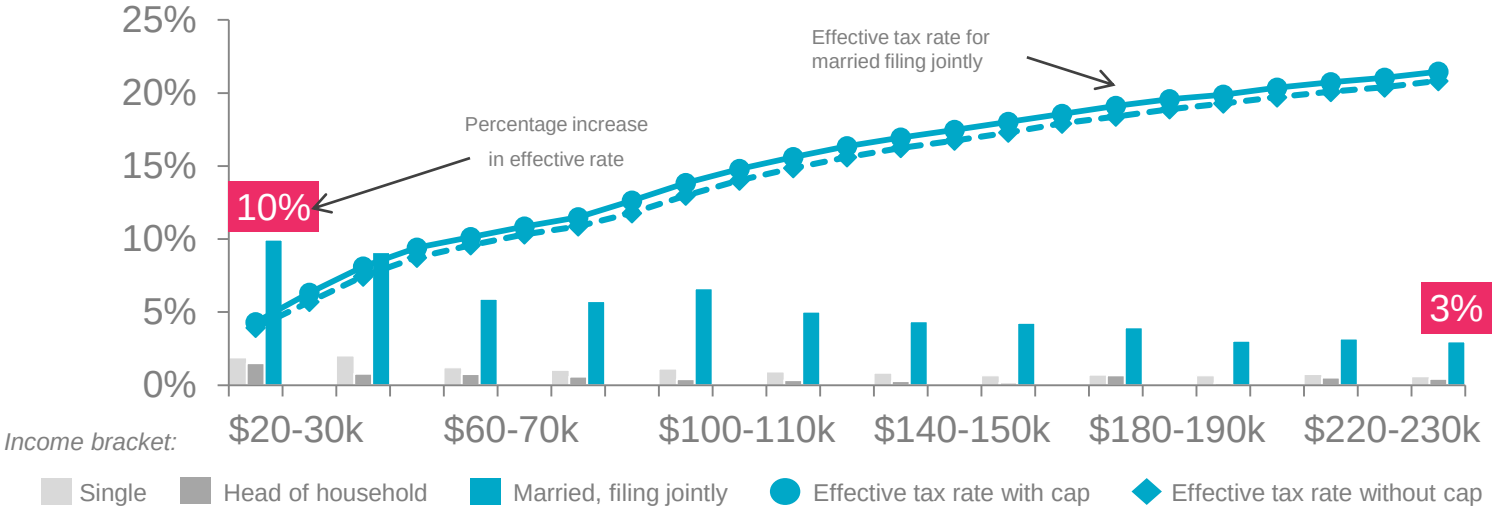
Cap will result in **increased income tax liability** for middle-income Americans



- The bars represent the percentage increase in income tax liability in 2026. Payroll taxes not included
- Proposed caps indexed at CPI% (CPI assumed to be 2%); medical plan trend assumed to be 5.5%
- Projects the impact of including account contributions – FSAs, HRAs and HSAs – in value of coverage
- Based on a Mercer proprietary database of 600,000 members' salary and benefits. Salary information used as proxy for household income.

CBO 75TH %TILE
LOW INCOME FAMILIES HIT HARDEST

Cap will result in **increased income tax liability** for middle-income Americans



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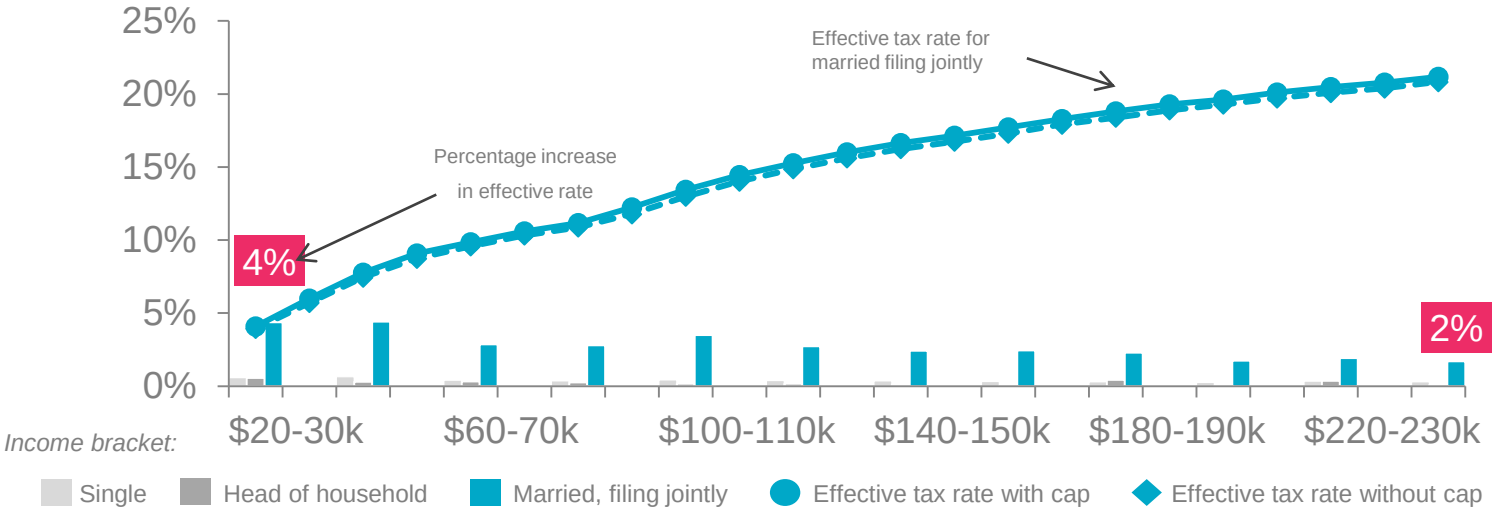
CBO 90TH %TILE
LOW INCOME FAMILIES HIT HARDEST

Cap will result in **increased income tax liability** for middle-income Americans



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CBO SCENARIOS

RESULTS DIFFER BY PLAN TYPE AND FAMILY STATUS

% Exceeding Cap	2020			2030		
Plan Type	**50th %tile**	**75th %tile**	**90th %tile**	**50th %tile**	**75th %tile**	**90th %tile**
PPO	53%	19%	7%	95%	74%	50%
HMO	36%	11%	2%	86%	62%	33%
CDHP	35%	11%	4%	83%	47%	29%
ALL	**43%**	**16%**	**6%**	**88%**	**60%**	**39%**

% Exceeding Cap	2020			2030		
Family Status	**50th %tile**	**75th %tile**	**90th %tile**	**50th %tile**	**75th %tile**	**90th %tile**
Single (no dependents)	39%	10%	2%	93%	60%	35%
Head of Household (children – no spouse)	13%	3%	1%	58%	21%	10%
Married Filing Jointly (spouse with or without children)	57%	27%	11%	92%	71%	52%
ALL	**43%**	**16%**	**6%**	**88%**	**60%**	**39%**

- Based on a Mercer proprietary database of 600,000 members' salary and benefits. Salary information used as proxy for household income.
- Includes FSAs, HRAs, HSAs

QUESTIONS?