UBA PPACA Advisor

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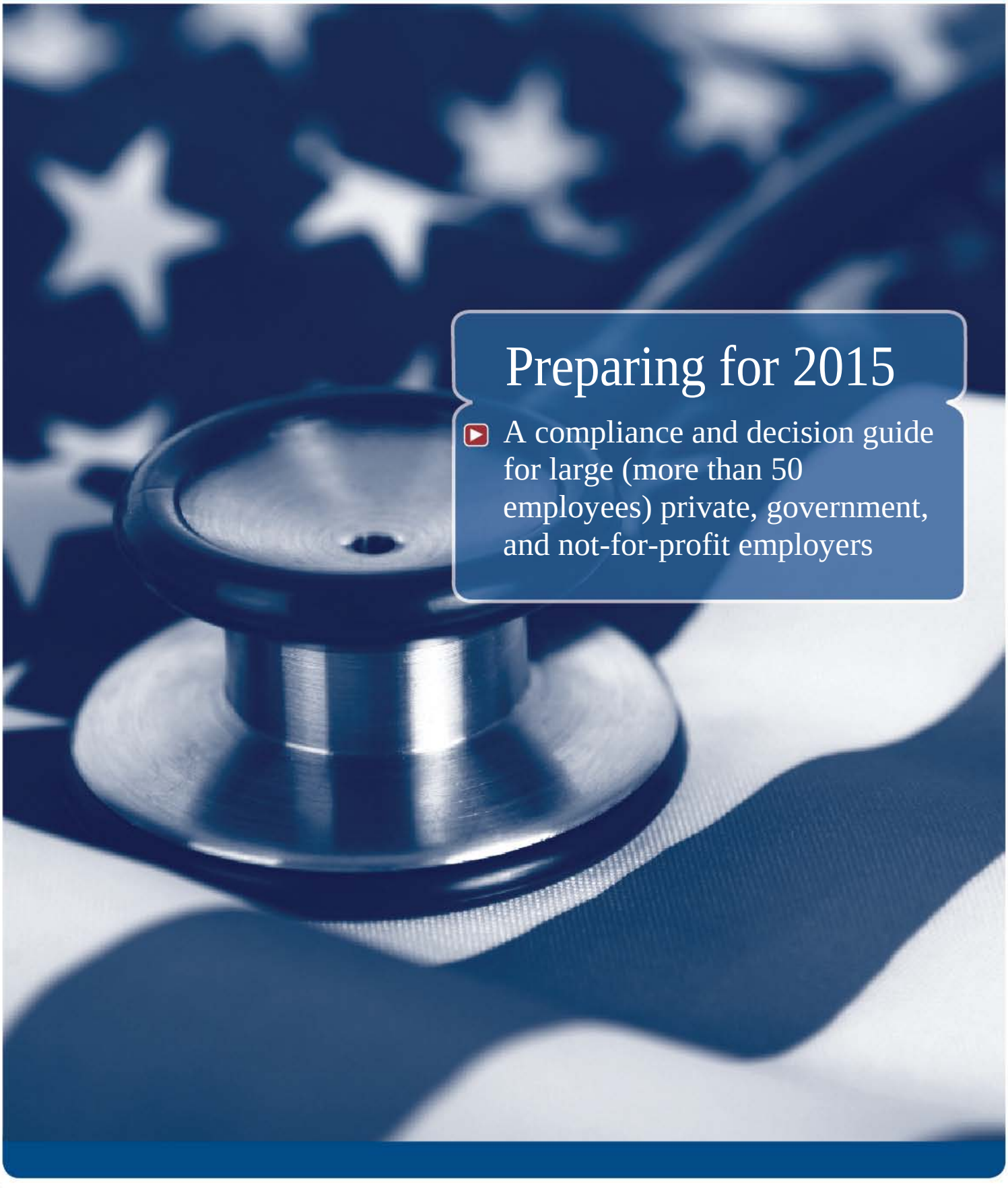

Preparing for 2015

A compliance and decision guide for large (more than 50 employees) private, government, and not-for-profit employers

This guide is intended to provide information to help employers understand their obligations and opportunities as the heart of the Patient Protection and Affordable Care Act of 2010 (PPACA) is implemented in 2014 and 2015. This law is complicated, and each employer will need to base its decisions on its particular situation.

Your UBA advisor is well-prepared to assist you with your decision making.

CONTENTS

UNDERSTANDING PPACA

THE BASICS OF PPACA

What is PPACA intended to do?

One of the main purposes of PPACA is to reduce the number of Americans without health coverage. This is being done by:

- Requiring most Americans to have some type of health insurance or pay a penalty
- Making it easier for individuals to obtain coverage, by:
  - Creating insurance "exchanges" or "marketplaces"
  - Incenting employers to provide coverage to all full-time employees
  - Removing barriers for those who have medical problems[1]

When does PPACA begin?

Parts of the law are already in effect, and parts will take effect in 2013. But the main parts of the law will take effect in 2014 and 2015.

What happens in 2014?

- The individual mandate, which requires most people to have some type of medical coverage in effect or pay a tax, begins
- Exchanges are to be in effect in each state to make it simpler for individuals and small employers to purchase coverage

What happens in 2015?

- Employers who have 50 or more employees must provide health coverage that meets minimum requirements, or pay a tax. This requirement is often called "play or pay" or "employer-shared responsibility."

[1] This includes eliminating pre-existing condition limitations in all plans and requiring insured plans to follow rules regarding guaranteed issue.

INDIVIDUAL RESPONSIBILITIES

How do people avoid the individual mandate tax?

To avoid the tax, a person must have "minimum essential" coverage. This coverage can be obtained through the person's employer, Medicare, Medicaid, TRICARE, some VA programs, an individual policy, or an exchange.

What happens if a person doesn't have the required coverage?

The person will have to pay a tax, which will be collected with their federal income tax. The tax is being phased in. It is:

- 1 percent of income or $95, whichever is greater, in 2014
- 2 percent of income or $325, whichever is greater, in 2015
- 2.5 percent of income or $695 (indexed), whichever is greater, in 2016 and later years

If an entire family is without coverage, the tax applies to each adult. Fifty percent of the tax applies to each child under age 19. There is a family maximum of three times the individual adult tax.

What if the person can't afford coverage?

Premium tax credits (which may be claimed during the year, rather than waiting until the person files his or her federal income tax return) are available to help pay a person's premium if:

- They do not have access to adequate coverage through their employer, and
- They obtain coverage through a government exchange, and
- Their income is between 100 percent and 400 percent of the Federal Poverty Level (FPL). (The amount of the credit is graduated based on income, so that a person whose income is 100 percent of FPL will only pay 2 percent of his or her income for coverage and those at 400 percent of FPL will pay 9.5 percent.)

People below 133 percent of FPL will receive coverage through an expanded Medicaid program, unless their state opts out of expanded Medicaid.

Additionally, people with incomes of 100 percent to 250 percent of FPL will be eligible for reduced cost sharing (deductibles, coinsurance, and copayments) if they obtain coverage through the exchange. The amount of cost-sharing assistance is graduated based on income.

If an individual is without coverage for a short period (less than three straight months) no penalty will apply.

EXCHANGES

What's an exchange?

An exchange is an entity set up in each state to make it simpler for people to compare health insurance options. The exchanges will not provide insurance, but they will oversee the insurance options available through the exchanges and provide resources such as plan summaries to individuals to help them choose a plan.

How will exchanges work?

Each state will have one or more exchanges, which will be run, at the state's choice, by either a state agency or a not-for-profit organization.

The exchanges will be responsible for:

- Plan management functions – certifying and overseeing "qualified health plans" and assigning price and quality scores to plans in the exchange. (The exchange can either accept all insurers and plans that meet the guidelines or be an "active purchaser" of coverage and negotiate with insurers who wish to participate in an exchange.)
- Consumer assistance – operating the website and a toll-free call center, providing a cost of coverage calculator and creating a Navigator program to help people understand their choices
- Eligibility determinations and enrollment – determination of eligibility for premium and cost-sharing subsidies, and coordinating enrollment in the exchange, Medicaid, and CHIP

Each exchange must provide benefits that meet certain criteria, called "essential health benefits," at certain coverage levels, called "metal levels" and with certain cost-sharing limits.

What benefits must be provided?

The available "essential health benefits" must be equal to the scope of benefits provided by a typical employer plan. Each state has determined the essential health benefits package to be offered in the exchange in its state, based on the benefits provided by a benchmark plan in the state.

Essential health benefits include services in each of these 10 categories:

- **Ambulatory (i.e., outpatient) patient services**
- **Emergency services**
- **Hospitalization**
- **Maternity and newborn care**
- **Mental health and substance use disorder services, including behavioral health treatment**
- **Prescription drugs**
- **Rehabilitative and habilitative services and devices (e.g., speech, physical and occupational therapy, for both those who had mastered the skill and lost it due to illness or injury, or for those who have not yet mastered the skill)**
- **Laboratory services**
- **Preventive and wellness services and chronic disease management**
- **Pediatric services, including oral (dental) and vision care**

What are the coverage or metal levels?

PPACA sets standard coverage levels, which are sometimes called the "metal plans." There will be four[2] levels of benefits available through the exchanges:

- **PLATINUM**
  - designed to pay 90 percent of covered claims costs
- **GOLD**
  - designed to pay 80 percent of covered claims costs
- **SILVER**
  - designed to pay 70 percent of covered claims costs
- **BRONZE**
  - designed to pay 60 percent of covered claims costs

What are the cost-sharing limits in an exchange?

The annual out-of-pocket maximum cannot be more than the limits for health savings account (HSA)-compatible high-deductible health plans. For 2014 those amounts will be $6,350 for self-only coverage and $12,700 for family coverage.

Who can enroll in an exchange?

Any eligible individual may enroll in an American Health Benefit Exchange (also called a Health Insurance Marketplace), even if they have access to coverage through their employer or Medicare. All U.S. citizens, nationals, and noncitizens who are lawfully present (e.g., in the U.S. with a work or study visa) may enroll.

Small employers (those with 50 or fewer employees[3]) also may enroll in a Small Business Health Options Program (SHOP) through an exchange. Beginning in 2017, states will have the option to open their exchanges to large employers.

Although the details of an exchange plan may vary from insurer to insurer (e.g., different deductibles, copays or managed care requirements), all plans at a given level must, on an actuarial basis, be equivalent.

[2] Individuals under age 30 and individuals with very low incomes may be offered catastrophic coverage.

[3] States may set the "small employer" limit at 50 employees for 2014 and 2015, and all states have chosen to do so. Beginning in 2016, states must define "small employer" as having 100 or fewer employees. This change will only affect insurance requirements, not the employer tax threshold.

Are there limits on stopping and starting coverage in an exchange?

People may only enroll in an exchange during open enrollment or if they have a special enrollment event.

The first open enrollment will be from Oct. 1, 2013 to March 31, 2014. Coverage will begin on Jan. 1, 2014, for those enrolling by mid-December 2013. Coverage will begin on the first of the following month for those enrolling between mid-December 2013 and the end of March 2014. For years after 2014, annual open enrollment for individuals will be from Oct. 15 to Dec. 7, with a Jan. 1 effective date.

People who have a special enrollment event (such as marriage, birth, adoption, loss of coverage under an employer plan, or loss of coverage that was affordable and met minimum value requirements) will have a special enrollment period in which they can elect coverage through an exchange, or change plans within the exchange.

What happens if my state decides not to set up an exchange, or isn't ready by January 2014?

If a state decides not to set up an exchange or if the exchange won't be ready by 2014, the federal government, through the Department of Health and Human Services (HHS), will perform the services on behalf of the state (a "federally facilitated exchange," or FFE). HHS is also willing to do some, but not all, of the exchange's services – this is called a state partnership FFE.

There will not be a purely federal exchange. There is currently controversy about whether people in states that do not create a state exchange will be eligible for the premium tax credits, although it is the federal government's position that they will be.

What happens if a person lives in one state and works in another?

The law provides that a person who enrolls as an individual will use the exchange for the state in which they live.

PPACA also calls for the creation of multistate exchanges. The multistate exchanges will be overseen by the federal Office of Personnel Management (OPM) which manages the federal employee health program.

EMPLOYER RESPONSIBILITIES

What must I do to avoid the employer taxes?

Beginning in 2015, if you average 50 or more full-time employees or full-time employee equivalents during a calendar year, to avoid the shared-responsibility penalty you must provide medical coverage that:

- Provides "minimum essential coverage;" and
- Is "affordable" and provides "minimum value."

How do I know if I have 50 full-time or full-time equivalent employees?

An employee is counted as a full-time employee if the employee was employed an average of 30 hours per week during the prior calendar year.

An employee counts toward a full-time equivalent employee if the employee worked an average of less than 30 hours per week during the prior calendar year. To calculate the number of full-time equivalent employees for a month, the hours of all full-time equivalent employees are totaled and then divided by 120.

> **EXAMPLE:** Company A has 30 employees who average 40 hours per week, 10 employees who average 30 hours per week, 20 employees who average 25 hours per week and four employees who average 15 hours per week. (To account for a 30-day month, assume a month is 4.2 weeks.)
>
> Company A has 40 full-time employees [30 + 10] and 19.6 full-time equivalent employees [(20 x 25 x 4.2) + (4 x 15 x 4.2) ÷ 120 = 19.6]. Therefore, Company A has 59 employees for that month for purposes of the penalty.

There are special rules for employers with seasonal employees.

Who is an "employee"?

PPACA says that "common law" employees are the employees covered by the law.

Do I have to cover dependents?

Employers need to offer coverage to children up to age 26 to avoid penalties for not offering coverage. Employers do not have to offer coverage to spouses.

Note: Employers in a controlled group or affiliated service group are combined when deciding how many employees they have.

What happens if I, an employer, decide not to offer coverage?

If you do not offer minimum essential coverage to at least 95 percent of your full-time (30 hours per week) employees and dependent children and any full-time employee receives a premium or cost-sharing credit through an exchange, you must pay a fee of $2,000 per year for each full-time employee, excluding the first 30 employees. The fee is calculated on a monthly basis.

> **EXAMPLE:** In January, Company B has 115 full-time employees and 20 part-time employees. In February it has 120 full-time employees and 12 part-time employees. Company B does not offer minimum essential coverage. The fee for January is $14,166.95 [$166.67 x (115 – 30)]. In February the fee is $15,000.30 [166.67 x (120 – 30)].

There is no fee due for any part-time employee – "full-time equivalent" employees are considered when deciding if the employer meets the 50-percent threshold but do not count at all under the shared responsibility fee.

It is expected that no penalty will apply to new hires during their first three months of employment.

What is "minimum essential coverage?"

"Minimum essential coverage" appears to include most types of basic medical coverage. It is not clear yet whether a stand-alone health reimbursement arrangement (HRA) will qualify as minimum essential coverage.

What happens if I offer coverage but it doesn't meet government requirements?

If you do not offer coverage under at least one plan option that provides "minimum value" *and* is "affordable," you must pay a $3,000-per-year fee (calculated monthly) for each full-time employee who purchases coverage through an exchange and who receives a premium credit.

What is "minimum value coverage?"

Minimum value coverage is coverage that is expected to cover at least 60 percent of expected claims costs. *Large employer plans provided outside the exchanges do not have to provide the 10 "essential health benefits" listed previously, but they do have to provide minimum value coverage to avoid penalties.* The government has provided a few safe harbor plan designs. It has also provided a minimum value calculator for plans with standard features. Non-standard plans will be expected to obtain an actuarial certification.

HSA contributions and HRA contributions that may not be used to pay premiums will count toward the 60 percent minimum value calculation.

What makes coverage affordable?

Coverage is considered affordable if it costs less than 9.5 percent of the employee's household income. Because employers typically do not know their employees' household income, under the proposed rules coverage will be considered affordable for purposes of the employer-shared responsibility penalty if the cost of single coverage is less than 9.5 percent of one of the safe harbors:

- The employee's W-2 (Box 1) income for the year
- The employee's rate of pay at the start of the year
- Federal Poverty Level for a household of one at the start of the year

There will be no requirement that employers contribute to dependent coverage. Employer contributions to HSAs will not count toward affordability. HRA contributions will only count if they may be used toward premium costs.

How do I decide if an employee who has fluctuating hours is a "full-time employee" when applying the minimum value and affordability tests?

Final rules have not been released yet, but it is expected that you will be able to average hours over a specified "measurement" period of three to 12 months and then project that the person's hours will remain at that level over the next specified "stability" period, which must be at least as long as the measurement period.

What happens if I offer coverage that meets government requirements and an employee purchases coverage through an exchange?

If you *offer* even one plan option that provides the required 60 percent minimum value and costs less than 9.5 percent of the employee's safe harbor wages, no penalty will apply to the employer even if an employee purchases coverage through an exchange.

Note that the employee's purchase will be with after-tax dollars – premiums for coverage through an exchange cannot be paid on a pre-tax basis through a Section 125 plan.

Will these penalties apply to tax-exempt employers? Will they apply to grandfathered plans?

YES. The penalties will apply to all employers – private, government, and not-for-profit. They will apply to grandfathered plans and they will apply whether the plan is fully insured or self-funded.

DECISIONS

What decisions do I need to make as an employer?

The most basic decision is whether to continue to offer health benefits, and if so, in what manner.

What should I consider when making this decision?

Employers should look at:

- Why do I currently offer coverage, when there is no requirement to do this?
- Do I believe that my current reasons for offering coverage will still apply in 2015?
- The full cost of dropping coverage
- The viability of reducing coverage to the "minimum value" level

The "Planning for the Future" chart at the end of this brochure may help you with this process. Details on some things to consider are discussed below.

If I decide to continue to offer coverage, will I need to revisit my contribution strategy to avoid penalties?

Coverage will be considered "affordable" only if the cost for single coverage for at least one plan option is less than 9.5 percent of the employee's safe harbor wages.

There will be no affordability requirement for employer contributions for dependent coverage.

Do I currently offer coverage to all employees who work 30 or more hours per week?

If you do, continuing benefits should not be significantly more costly. If you do not, you need to consider:

- The cost of covering these additional employees
  - Under your current benefits
  - Under reduced "minimum value, affordable" coverage
- The viability of dropping those working 30-plus hours per week who are not currently eligible for coverage to less than 30 hours per week

It is permissible under federal law to charge higher earners a larger dollar amount or percentage of the premium than others.

It may make sense to base contributions on salary levels.

You may want to assess whether employees currently pay more or less than 9.5 percent of their safe harbor wages for their share of the premium.

What are the tax advantages of offering group health benefits?

Employer-provided health benefits have a very favored status under the Internal Revenue Code. While wages are deductible by the employer as a business expense, they are taxable income to employees. In contrast, the employer contribution for health insurance is tax-free to employees regardless of whether a Section 125 plan is used, and employee premiums for health insurance can be payroll-deducted on a pre-tax basis through a Section 125 plan. In addition, neither the employer nor the employee pays FICA or FUTA on premiums pre-taxed through a Section 125 plan.

What are the reporting implications of continuing, modifying, or discontinuing coverage?

Some reporting to the federal government will be required regardless of whether coverage is offered or not. Details on the reporting requirements, which will begin with 2015, are not available yet.

Employers will be asked to verify whether an employee who applies for a premium tax credit is eligible for affordable, minimum value coverage. Employers that do not offer health benefits can expect a higher volume of inquiries than those who maintain group coverage. The exchanges will advise employers when an employee has been determined to be eligible for a premium tax credit. Employers will have the right to appeal those determinations.

If you decide to not offer group health benefits, leaving employees to purchase coverage through an exchange, your ultimate cost may be more than the $2,000 penalty. This would occur if employees demanded increased wages to cover the cost of insurance through the exchange (which will not be available on a pre-tax basis). Wages likely would need to be “grossed up” to cover the employee’s additional tax liability, and FICA/FUTA would be payable on the full wage increase.

Why would I want to continue coverage, but at reduced levels?

If you discontinue coverage, the $2,000 penalty will be due on all full-time employees, if even one employee receives a premium tax credit. If your lowest cost plan that provides minimum value coverage is affordable (less than 9.5 percent of the employee's safe harbor wages) and provides minimum value (pays at least 60 percent of expected costs), there is no penalty, even if the employee purchases coverage through the exchange. It may be less expensive to provide fairly basic, tax-advantaged coverage than to pay the non-deductible penalty and any additional compensatory wages.

Employers with lower-paid employees should remember that no premium tax credit is available if employer coverage that is both affordable and minimum value is offered. For some employees, the premium tax credit will be significant. It may be that the best total solution for some employers is a contribution design that is not affordable to those below a certain income level. That would put those employees in the exchange with a tax credit, with the employer responsible for a penalty of $3,000 for each employee who is in the exchange with a tax credit. The penalty is not tax deductible but may be less than the employer's current contribution for health coverage. Meanwhile, higher-income employees likely would remain in the group health plan.

How confident am I that the exchanges will be fully operational on Jan. 1, 2014?

If you plan to move employees to the exchange, you may want to have a plan to address the possibility that the exchange in your state may miss the deadline, or may be operating but not well, with attendant disruption to employees' focus on their jobs.

Have I coordinated my strategy for 2014 and 2015?

Employers who plan to offer affordable, minimum value coverage in 2015 should carefully consider the implications of encouraging employees to obtain subsidized coverage through the exchange in 2014. Employees who enjoy premium tax credits in 2014 may be unhappy if larger, unsubsidized contributions are needed to purchase employer-provided coverage in subsequent years.

Will I be able to exclude a small number of employees without causing the $2,000 per employee penalty to apply?

Employers can exclude up to 5 percent of their full-time employees.

EMPLOYER OBLIGATIONS

What do I need to do between now and January 2014?

Employers must do these things:

- Reduce the maximum employee contribution to $2,500, if the employer sponsors a health flexible spending account (FSA), as of the beginning of the plan year that starts on or after Jan. 1, 2013
- Provide a notice about the upcoming exchanges to all employees by Oct. 1, 2013
  - Model notices are available

What do I need to do in 2014?

These requirements are effective in 2014 for *non-grandfathered* plans:

- Work with exchanges to identify those employees eligible for premium tax credits
- Amend the plan to:
  - Remove all annual dollar limits on essential health benefits
  - Provide coverage for those in clinical trials for services outside the trial
  - Limit cost sharing (out-of-pocket maximums)
  - Remove pre-existing condition limitations for adults
- Limit eligibility waiting periods to 90 days
- Calculate and pay the transitional reinsurance fee if the plan is self-funded
  - The fee will probably be due in January 2015
  - Insurers are responsible for calculating and paying the fee for fully insured plans but will likely pass the cost on

These requirements are effective in 2014 for *grandfathered* plans:

- Work with exchanges to identify those employees eligible for premium tax credits
- Amend the plan to:
  - Remove all annual dollar limits on essential health benefits
  - Remove pre-existing condition limitations for adults
  - Cover dependent children to age 26 even if they are eligible for coverage through their own employer's plan
- Limit eligibility waiting periods to 90 days
- Calculate and pay the transitional reinsurance fee if the plan is self-funded
  - The fee will probably be due in January 2015
  - Insurers are responsible for calculating and paying the fee for fully insured plans but will likely pass the cost on

What do I need to do in 2015?

- Provide affordable, minimum value coverage to full-time (30-plus hours per week) employees or pay a penalty
- Begin reporting to the IRS on coverage offered and available (the first reports are actually due in 2016)

What are the limits on waiting periods?

In most instances, you will not be able to have an eligibility waiting period of more than 90 days. (An entry date of the first of the month after 90 days of employment will not be allowed. You may have a shorter waiting period – or no waiting period – if you prefer.)

What else will I need to do?

Employers with more than 200 full-time employees will need to automatically enroll employees who do not either enroll or specifically decline coverage. An effective date has not been set.

Nondiscrimination rules will apply to insured plans at some point (an effective date has not been set). This requirement will not apply to grandfathered plans. Nondiscrimination rules already apply to self-funded plans.

Beginning in 2018, a 40 percent, nondeductible, excise tax will apply to high-cost health coverage. This is also called the tax on "Cadillac" plans. For 2018 the tax will apply to amounts above $10,200 for single coverage and $27,500 for family coverage. Employee and employer contributions will be combined when deciding if the threshold has been exceeded. The cost of medical coverage (including dental and vision if inseparable from medical), health reimbursement account (HRA) contributions, health flexible spending account (FSA) contributions, employer contributions to an HSA, and the cost of onsite clinic coverage all count toward the high-cost trigger. Higher limits apply to certain retirees and those in high-risk occupations. The trigger amount will be increased annually.

Although not a requirement, beginning in 2014 employers may provide a wellness incentive/penalty of up to 30 percent of the premium. An incentive/penalty of up to 50 percent may be used in connection with tobacco use. (Currently, the limit is 20 percent.)

What should I already be doing to comply with PPACA?

If your plan *is not grandfathered*, it:

- May not have a lifetime dollar maximum on any "essential health benefit"
- May not have an annual dollar limit on an "essential health benefit" that is over $2 million for plan years beginning on or after Sept. 23, 2012, unless you have obtained a waiver from HHS
- Must cover the employee's dependent children until the dependent reaches age 26 – even if the child is married or employed
- May not exclude pre-existing conditions for children under age 19
- May not retroactively rescind coverage, except for fraud or material misrepresentation or for nonpayment of premium by certain terminated employees
- Must provide first-dollar coverage for specific preventive services, including contraception
  - The contraception requirement does not apply to religious employers
  - Not-for-profit religious-affiliated organizations that object to contraception may decline to cover these costs, but their insurer or administrator will be required to offer this coverage to participants
- Must cover emergency department services at in-network level regardless of provider
- If a primary care physician (PCP) must be chosen, allow each person to choose their own PCP and allow a pediatrician to be the designated PCP
- Must allow women to see an OB-GYN without a referral
- Must have a specific and comprehensive process for handling claims appeals
- May not reimburse over-the-counter drugs under a health FSA, an HRA, or an HSA unless the drug is prescribed by a doctor

You should also:

- Include the total value of group health benefits on each employee's W-2 if you issued more than 250 W-2s in the prior calendar year
- Promptly distribute medical loss ratio rebates if any are received from the insurer
- Provide summaries of benefits and coverage (SBCs) to all enrollees (beginning with the plan year that starts on or after Sept. 23, 2012)
- Withhold an extra 0.9 percent FICA/Medicare tax on employees who earn more than $200,000, once the employee reaches $200,000 in paid wages for the year (beginning in 2013)
- Calculate and pay the Patient Centered Outcomes Fee (PCORI) by July 31 if the plan is self-funded (the first fee was due in July 2013 for plan years ending between Oct. 1, 2012 and Dec. 31, 2012; plans with later plan years must begin paying the fee in July 2014)
  - Insurers are responsible for calculating and paying the fee for insured plans but will likely pass the cost on

If your plan *is grandfathered*, it:

- May not have a lifetime dollar maximum on any "essential health benefit"
- May not have an annual dollar limit on an "essential health benefit" that is more than $2 million for plan years beginning on or after Sept. 23, 2012, unless you have obtained a waiver from HHS
- Must cover the employee's dependent children until the dependent reaches age 26 – even if the child is married – however, an employed child who is eligible for coverage through the child's employer may be excluded until 2014
- May not exclude pre-existing conditions for children under age 19
- May not retroactively rescind coverage, except for fraud or material misrepresentation or for non-payment of premium by certain terminated employees
- May not reimburse over-the-counter drugs under a health FSA, an HRA, or an HSA unless the drug is prescribed by a doctor

You should also:

- Include the total value of group health benefits on each employee's W-2 if you issued more than 250 W-2s in the prior calendar year
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- Provide summaries of benefits and coverage (SBCs) to all enrollees (beginning with the plan year that starts on or after Sept. 23, 2012)
- Withhold an extra 0.9 percent FICA/Medicare tax on employees who earn more than $200,000, once the employee reaches $200,000 in paid wages for the year (beginning in 2013)
- Calculate and pay the Patient Centered Outcomes Fee (PCORI) by July 31 if the plan is self-funded (the insurer will pay the fee if the plan is insured, but will likely pass the cost on)

What is a grandfathered plan?

A grandfathered plan is a plan that has only made permitted changes to its benefits design and cost structure since March 23, 2010. The permitted changes are described in detail by the regulatory agencies and severely limit changes in cost sharing.

Compared with their coverage in effect on March 23, 2010, grandfathered plans:

- **cannot significantly cut or reduce benefits**
- **cannot raise coinsurance percentages**
- **cannot raise copayments by more than the greater of $5 (adjusted annually for medical inflation) or a percentage equal to medical inflation plus 15 percentage points**
- **cannot raise deductibles by more than medical inflation plus 15 percentage points**
- **cannot lower employer contribution percentage by more than 5 percentage points**
- **cannot add or tighten an annual limit on an essential health benefit**

PLANNING FOR THE FUTURE

Employers will need to decide if they want to offer coverage going forward. Things to think about include:

Why do I offer group health coverage now, when I don't have to? (e.g., recruiting, retention, productivity, paternalism)	
Do I think those reasons will still apply in 2015?	
Do I think my competitors will discontinue group health coverage?	
Would I benefit from doing something different from my competitors?	
If I drop group health coverage, do I think my employees will demand additional compensation?	
Do I fully understand the tax break I get from offering group health benefits?	
Do I think the exchanges will be ready in 2014?	
If not, is continuing the status quo until 2015 something to consider?	
Do I have a significant number of part-time employees?	
How many more people will I need to cover who work 30 to 40 hours per week than I do now?	
Can I restructure my workforce so that more employees regularly work less than 30 hours/week?	
If yes, am I equipped to monitor hours worked to be sure they stay below 30 hours/week?	
If yes, are there busy seasons where staying below 30 hours will be difficult?	
Would my employees be better off with the premium tax credit?	
Are health benefits an important part of my total compensation package?	

Employers who decide to offer coverage going forward should think about:

Will I need to budget for additional covered lives and fees?	
How will I budget for additional claim costs resulting from higher costs and more covered lives?	
Do I need to staff for additional reporting?	
Have I staffed to handle inquiries from and about the exchange?	
Should I redesign my plan (perhaps to stay just above the 60 percent minimum value threshold)?	
Do I need to redesign my contribution strategy to meet affordability requirements (to avoid the employer penalty, the employee's share may not exceed 9.5 percent of safe harbor wages)?	
Do I need to coordinate my 2014 and 2015 strategy?	

Employers who decide not to offer coverage going forward should think about:

Have I considered how to handle requests for additional compensation?	
Have I fully considered the tax breaks group health plans get?	
Have I budgeted for the (non-deductible) penalty?	
Have I considered if my position would be the same if the penalty increased to $5,000 or $7,500?	
Have I considered a plan design change instead (perhaps to stay just above the 60 percent minimum value threshold)?	
How will I communicate this decision to employees?	
Do I need to staff for additional reporting?	
Have I staffed to handle inquiries from and about the exchange?	

Penalties for Employers Not Offering Adequate Coverage under the Affordable Care Act Beginning in 2015

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