An Employer's Guide to Health Care Reform

Important details to navigate employer-provided benefits amidst a changing health care landscape.

Navigating a new health care landscape

Health care reform, also known as the Affordable Care Act (ACA), affects employers of all sizes. Even employers who are not intending to provide health benefits to their employees need to pay attention to some of the new provisions, and all employers with a health care plan have compliance requirements to address in the years ahead.

Several provisions in the new law pose strategic issues for employers, and this means businesses must make key decisions regarding health care benefits for their employees, followed by both appropriate implementation actions and adequate communications.

With nearly 1,000 pages of health care reform legislation and hundreds of thousands of pages of new regulations, it can be difficult to know where to begin. The following booklet will help your business to address important compliance issues and potential benefits strategies to help you navigate employer-provided benefits amidst health care reform.

1 **Basic Benefits Design Requirements**

2 **Implementation Timeline**

3 **Fundamental "Play or Pay" Considerations**

4 **Employer-Sponsored Benefits Strategies**

As details of the new health care reform legislation are established, you can rely on Aflac to provide you with ongoing updates at aflac.com/insights.

Disclaimer: This material is intended to provide general information about an evolving topic and does not constitute legal, tax or accounting advice regarding any specific situation. Aflac cannot anticipate all the facts that a particular employer or individual will have to consider in their benefits decision-making process. We strongly encourage readers to discuss their HCR situations with their advisors to determine the actions they need to take or to visit healthcare.gov (which may also be contacted at 1-800-318-2596) for additional information.

1

Basic Benefits Design Requirements

Benefit design requirements set forth in the Affordable Care Act (ACA) differ for employers by size. Understanding just a few basic key terms can help businesses to navigate important implementation dates, compliance requirements and strategy decisions.

Minimal Essential Coverage

Essential Health Benefits (EHB)

Actuarial Value Standards (Metal Levels)

Affordable Minimum Value Coverage

Health Insurance Portability and Accountability Act (HIPAA) Excepted Benefits

Grandfathering

Minimal Essential Coverage

Starting in 2014, most individuals are required to be covered by and employers with 50 or more full-time employees are required to offer minimum essential coverage or face a penalty. Minimum essential coverage is a broad definition that includes major medical health coverage under the following:

1. A government-sponsored program
2. An eligible employer-sponsored plan
3. A health plan offered in the individual market
4. A grandfathered health plan
5. Other health benefits coverage as HHS recognizes

Most employer-provided group coverage will qualify as "minimum essential coverage". Any "eligible employer-sponsored plan" means a group health plan that is either a government a plan offered in a state's small or large group market. Self-insured employer coverage qualifies. Additionally, benefits offered to a former employee such as COBRA or retiree health coverage qualifies. It does not, however, include certain HIPAA excepted benefits, and is separate and distinct from the Essential Health Benefits.

Essential Health Benefits (EHB)

These benefits are required to include at least the following 10 broad categories:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance abuse disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

Applies to: Insurance carriers offering insurance coverage to small businesses, and optional for self-insured and large businesses. Does not apply to grandfathered plans.

Actuarial Value Standards (Metal Levels)

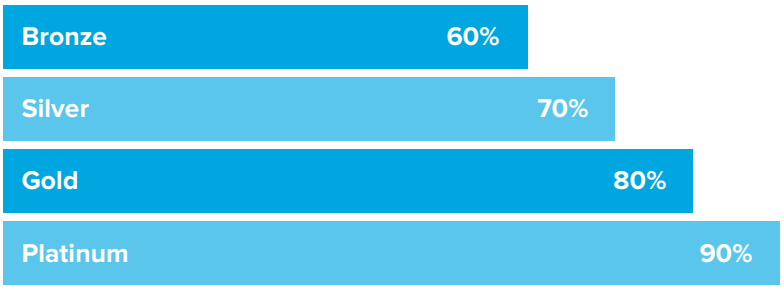
Beginning in 2014, health plans will be required to offer health insurance that meets certain levels of coverage. The coverage levels are based upon the actuarial value of the plan and are represented by metal levels: Bronze, Silver, Gold or Platinum. These values indicate the percentage of total average costs for covered benefits that a plan will cover. For example,

if a plan has a "Silver" actuarial value of 70 percent, on average, the covered individual is responsible for 30 percent of the costs of all covered benefits. The covered individual could be responsible for a higher or lower percentage of the total costs of covered services for the year, depending on the actual health care needs and the terms of the insurance policy.

Applies to: Insurance carriers offering insurance coverage to small usinesses. Does not apply to grandfathered plans.

Figure 1: Actuarial Value Standards

Small Employers (≤ 50 employees or ≤ 100 employees, depending on the state)



Note: The definition of actuarial value may vary by 2 percent.

Affordable Minimum Value Coverage

Affordable, minimum value coverage means that health plans must generally cover at least 60 percent of the total allowed cost of benefits using the actuarial value definitions. Additionally, a plan is considered affordable if the employee portion of the premium for self-only coverage is less than 9.5 percent of the employee's W-2 income. Large employers must meet affordable minimum essential coverage requirements, or may be subject to a penalty.

Applies to: Large businesses (with 50 or more full-time employees or their equivalencies).

Figure 2: Affordable Minimum Value Coverage

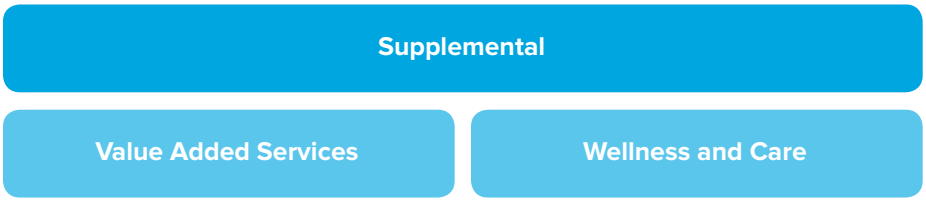
Large Employers (with at least 50 employees)

Health plans cover at least 60% of the total allowed cost of benefits using the minimum value definitions.	**Employee contribution does not exceed 9.5% of the employee's W-2 income.**	**Self-funded plans and fully insured plans not required to cover Essential Health Benefits (EHB).**	**If EHB are included, no dollar limits on lifetime or annual benefits are allowed.**

Health Insurance Portability and Accountability Act (HIPAA) Excepted Benefits

HIPAA excepted benefits are not subject to market reform changes of the ACA, and are available to employers of all sizes, as well as individuals. These include: supplemental indemnity coverage, hospital indemnity coverage, critical illness coverage, accident insurance, vision and dental insurance, as well as wellness programs and value-added services.

Figure 3: HIPAA-excepted products will be available for all segments and will not be subject to ACA market reforms.



Grandfathering

An employer-sponsored health plan can be grandfathered if it: (1) covered employees when the ACA was enacted (March 23, 2010), (2) if the plan does not make certain changes that lower benefits or employer contributions, (3) if the plan does not increase employee paid coinsurance or copayment costs, and (4) if notice of the plan's grandfathered status is provided to employees. Many employers make changes to their benefits design and contribution levels annually to keep the cost under control. While grandfathered plans may have lower premiums than some of the non-grandfathered plans, other factors such as medical trends, benefits design (e.g. variations in deductibles) may have an impact on renewal rates. The number of employers with grandfathered plans and employees in grandfathered plans has steadily decreased each year because of these changes.

Grandfathered plans:

- Cannot significantly cut or reduce benefits
- Cannot raise employee co-insurance charges
- Cannot significantly raise co-payment charges (15 percent more than medical trend since 2010)
- Cannot significantly raise deductibles (15 percent more than medical trend since 2010)
- Cannot significantly lower employer contributions (more than 5 percent of proportional cost share for any coverage category)
- Cannot add or tighten an annual limit on what the plan pays
- May change insurance companies, provided no change in coverage as described above

Grandfathered plans are exempt from a number of health care reform provisions, such as:

- Certain benefit mandates, such as essential health benefits or requirements to cover certain preventive benefits at no cost sharing
- Clinical trial coverage
- External appeals process
- Non-discrimination testing for fully insured plans
- Maximum out-of-pocket and deductible limits
- Some of the additional reporting and disclosures
- Guaranteed availability and renewability

Grandfathered plans are subject to certain health care reform provisions, such as:

- Prohibition on annual and lifetime dollar limits
- Prohibition on pre-existing condition exclusions
- Coverage of adult children
- 90-day limit on waiting periods
- Certain reporting and disclosure requirements

2

Implementation Timeline

While many health care reform provisions are already in place, several significant requirements are phased in over the next several years. The following timeline will help businesses identify important milestones that impact employer-sponsored benefits, compliance and reporting.

2013: Preparing for Reform

Delayed or Still to be Determined Provisions

2014: Putting the Law into Practice

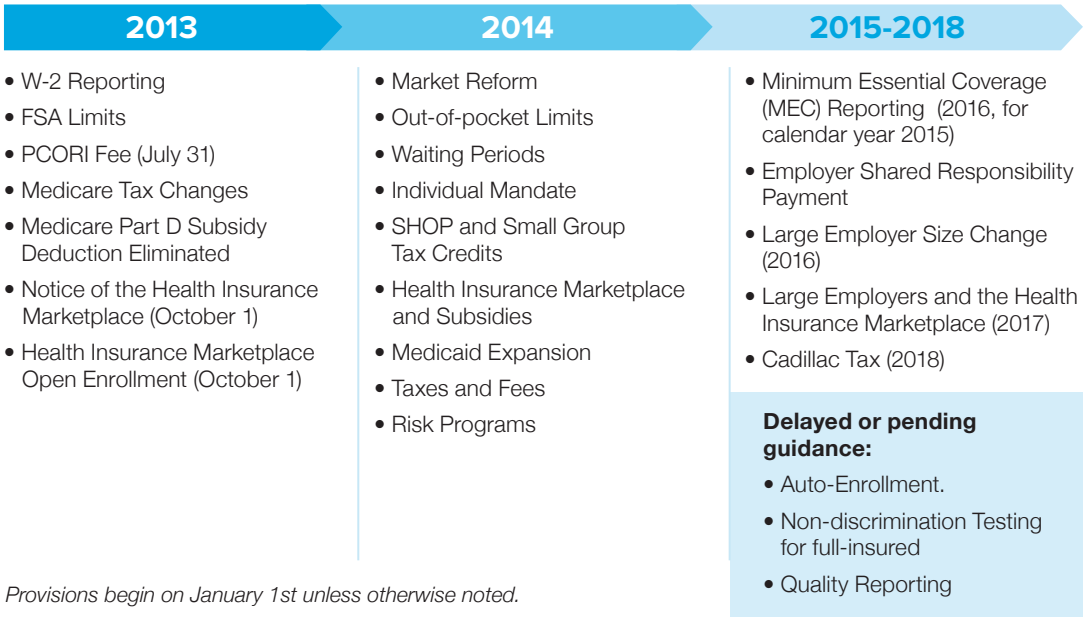
2015 – 2018: Solidifying Health Care Reform and Future Implementation

Upcoming Deadline: October 1, 2013

Notice of the Health Insurance Marketplace

Aflac has created the "Health Care Reform Communications Toolkit" to help you comply with this communications requirement. Available at aflac.com/HCR_Toolkit, these tools can be customized with your logo and used with your employees.

Figure 4: Implementation timeline at-a-glance



Provisions begin on January 1st unless otherwise noted.

2013: Preparing for Reform

W-2 Reporting

To help show how much health care coverage costs, employers who file 250 or more W-2s are required to report the total aggregate cost of major medical health benefits and certain pre-tax funded supplemental health coverage provided to each employee on their 2012 W-2 forms. This information must be reported in Box 12, using Code DD. The reporting is for informational purposes only and has no tax impact to the employer.

Note: Reporting is optional for employers who file fewer than 250 W-2s until further guidance is issued by the IRS.

Flexible Spending Account (FSA) Limits

For cafeteria plan years beginning on and after January 1, 2013, employer-sponsored cafeteria plans must limit employee annual salary reduction contributions to health FSAs to $2,500. The $2,500 limit applies to employee participants on a plan-year basis, and will be indexed for cost-of-living adjustments for future plan years.

Note: The limit does not apply to certain employer non-elective health FSA contributions, or to any contributions or amounts available for reimbursement under other types of FSAs (such as a dependent care FSA), health savings accounts (HSAs), health reimbursement arrangements (HRAs), or to salary reduction contributions to cafeteria plans used to pay an employee's share of health coverage premiums.

Patient-Centered Outcomes Research Institute (PCORI) fee:

Starting with plan years ending on or after October 1, 2012, issuers and plan sponsors are required to pay a new fee for each covered beneficiary with the fee going to the PCORI fund. The fee is treated as an excise tax and is filed through IRS Form 720. The PCORI fee is $1 per covered beneficiary for the first year, and for the first year was due July 31, 2013.

Medicare Tax Changes

A 0.9 percent additional Medicare tax goes into effect starting in 2013, raising the Medicare tax rate for certain earners from 1.45 percent to 2.35 percent. The additional Medicare tax applies to an individual's wages, Railroad Retirement Tax Act compensation, and self-employment income that exceeds a threshold amount based on the individual's filing status ($250,000 for married taxpayers who file jointly, $125,000 for married taxpayers who file separately, and $200,000 for all other taxpayers). It is paid solely by employees and does not have to be matched by employers; however, the employer is responsible for withholding the additional Medicare tax from wages or compensation paid to an employee in excess of $200,000 in a calendar year.

Medicare Part D Subsidy Deduction Eliminated

An employer offering retiree prescription drug coverage that is actuarially equivalent to the Medicare Part D coverage is currently entitled to a Retiree Drug Subsidy (RDS) payment. Additionally, prior to 2013, employers could deduct the entire cost of providing the prescription drug coverage, even though a portion of the cost is offset by the RDS payment. Health care reform retains the subsidy, but eliminates the ability to deduct the portion of the cost that is covered by the subsidies for taxable years starting on or after January 1, 2013.

Notice of the Health Insurance Marketplace

Employers are required to notify all current and new hires by October 1, 2013 about the availability of the Health Insurance Marketplace. The notice will need to include the following items:

- Availability of the Health Insurance Marketplace
- Description of the services provided by the Health Insurance Marketplace
- Contact information for the Health Insurance Marketplace consumer assistance
- Information disclosing that if the plan provided by the employer does not meet minimum value coverage requirements, the employee may be eligible for a premium tax credit and/or a cost-sharing reduction if he or she purchases a qualified plan through the Health Insurance Marketplace
- Information that if the employee purchases coverage through the Health Insurance Marketplace, the employee may lose his or her employer contribution toward health benefits

2014: Putting the Law into Practice

Health Insurance Marketplace Open Enrollment

On October 1, 2013, the Health Insurance Marketplace for individuals and Small Business Health Options Program (SHOP) Marketplace for small employers will be operational for open enrollment for coverage effective January 1, 2014.

Market Reform and Benefits Design Changes

Beginning in 2014, major medical health insurance plans must be guaranteed issued, renewable and available to individuals regardless of the applicant's health status or pre-existing conditions. Additionally, in the individual and small employer market, rates cannot vary

based on health status or gender, and rate fluctuations are limited to a few general factors: family size or tier, geography, age (ratio of highest rate based on age to lowest rate based on age cannot exceed 3:1), and tobacco use (ratio of highest rate for someone who smokes to lowest rate for someone who does not cannot exceed 1.5:1). For group plans, new rules allow for some rate differentiation (up to 30 percent; 50 percent for tobacco use) based on participation in wellness programs.

Did you know? *Prior to health care reform, only six states required insurers to provide guaranteed coverage to individuals. Also, the 1996 HIPAA law requires insurance companies to guarantee issue and renew coverage to small groups. As a result, states already have guaranteed coverage for small groups with two or more members.*[2]

Medicaid Expansion

In 2014, states have the option to expand Medicaid up to 133 percent Federal Poverty Level (FPL). Employees are eligible for premium subsidies only if they don't have access to Medicaid and their employer does not offer affordable, minimum value coverage. In states that opt out of the Medicaid expansion, low-income employees (who otherwise might have enrolled in Medicaid) might be eligible for subsidies through the Health Insurance Marketplace. Since employers with 50 or more workers are subject to penalties if any full-time employees receive a premium subsidy through the Health Insurance Marketplace, employers may face increased risk of penalties in states where Medicaid expansion does not occur.

Small Business Health Option Program (SHOP) Marketplace

Small employers* are eligible to participate in the SHOP Marketplace in 2014. Eligible employers that choose to offer insurance through the SHOP Marketplace are required to offer SHOP Marketplace insurance coverage to all full-time employees. Starting in 2015, the SHOP Marketplace will provide a premium aggregation service and will send a single invoice to the employer. The SHOP Marketplace offers two models:

1 | Employer-choice (available in 2014): The employer selects the plans, and employees can then choose from the employer's selected options.

2 | Employee-choice (delayed until 2015): The employer selects an actuarial value (metal) level, and employees can select from any available plans at the employer's selected metal level through the SHOP Marketplace.

**In 2016, employers with up to 100 employees will be considered small. However, in the case of plan years beginning before January 1, 2016, a State may elect to define small employer by substituting "50 employees" for "100 employees". Most states are using 50 employees to define a small employer.*

Small Employer Tax Credits

While tax credits became available to small businesses starting in 2010, beginning in 2014 small employer tax credit rates increase from 35 percent to 50 percent of the employers' cost of health insurance premiums for two consecutive years. The maximum credit will be available to employers with 10 or fewer full-time equivalent employees with average annual wages of less than $25,000.

Requirements include:

1 | Coverage must be purchased through the SHOP Marketplace

2 | Employer must cover at least 50 percent of the cost of single (not family) health care coverage for each employee

3 | Employer must have 25 or fewer full-time equivalent employees (FTEs)

4 | Employees must have average annual wages of less than $50,000

*Note: Small, tax-exempt employers such as charities may be eligible to an increase from 25 percent to 35 percent. As of 8/26/13, irs.gov states that businesses with **fewer than** 25 employees are eligible for these credits, however Internal Revenue Code Section 45R states that the term "eligible small employer" means an employer which has **no more than** 25 full-time equivalent employees for the taxable year. For more information about these credits, visit: irs.gov.*

Individual Mandate

In 2014, individuals must obtain minimum essential coverage or pay a penalty. The annual tax penalty is the greater of designated amounts based on year (see figure 5). Individuals may be exempt from the mandate for any of the following reasons:

- Where the consumer contribution exceeds 8 percent of household income (indexed after 2014)
- Coverage gap is less than three months
- Hardship situations as determined by the Department of Health and Human Services
- Religious exemptions
- Members of Indian tribes
- Not lawfully present in the United States
- Living abroad
- Incomes below tax filing threshold
- Incarcerated

Figure 5:

Penalty Type	2014	2015	2016+
Flat dollar amount (total capped at 300% of the per person adult amount)	$95	$325	$695
Percentage of taxable household income	1.0%	2.0%	2.5%

Health Insurance Marketplace and Subsidies

Effective 2014, individuals will have the opportunity to participate in the Health Insurance Marketplace. Advance Premium Tax Credits (APTC) are available through the Health Insurance Marketplace. APTCs are available to households with incomes between 100 and 400 percent of the FPL and who do not have access to affordable, minimum value employer coverage. Credits are based on the second-to-lowest-cost "silver" plan (70 percent actuarial value). There are also cost-share reductions available for households with incomes between 100 and 250 percent FPL, which lower the out-of-pocket expenses for low-income consumers when they select the silver plan.

Taxes and Fees

Starting in 2014, there will be three major tax/fee provisions that may impact employers (see figure 6).

Figure 6:

	Health Insurer Tax	Patient Centered Outcomes Research Fee	Reinsurance Fee
Who is impacted?	Fully Insured (Paid by Insurers)	Fully Insured and Self Insured	Fully Insured and Self Insured
When?	Beginning 2014	Beginning October 2, 2011, ends in 2019	2014-2016
How much?	*Estimated premium impacts 1.9% -2.3% increase in 2014, rises to 2.8% -3.7% by 2023	Annual fee on $1 per enrollee for plan years ending after October 1, 2012 and before October 1, 2013, then $2 per enrollee until 2019 (indexed after 2014)	For 2014, the fee for each plan is $63 per enrollee per year. Premiums increase in employer segments. Premiums decrease in individual market, since the program pays reinsurance for high risk individuals

Elimination of Mini-Meds and Limited Benefit Plans

In the past, employers with large, part-time or low-wage workforces and high turnover provided mini-med and limited benefit plans as an alternative to major medical insurance. However, due to significant benefits design changes, such as essential health benefits, metal levels and prohibition of annual dollar limits, these plans will be eliminated. Effective January 1, 2014 annual dollar limits on essential health benefits are not permitted in any market.

Waiting Period Limits

The ACA restricts waiting periods to a maximum of 90 days, beginning January 1, 2014.

Out-of-Pocket and Deductible Limits

Health care reform requires out-of-pocket and deductible maximums to align with the annual HSA limits effective 2014. The deductible limit only applies to individual and small employer insured plans, but does not apply to grandfathered plans. The out of pocket limit applies to all non-grandfathered plans for fully insured and self-insured employers. Out-of-pocket costs or annual cost-sharing includes deductibles, copays, coinsurance and similar charges, as well as any other payment toward medical expenses that is considered an essential health benefit, but does not include balance billing.

Note: The limit on out-of-pocket maximums will be the same as the out-of-pocket maximum for HSA compatible high-deductible plans in 2014, but will be subject to inflation adjustment in 2015 and beyond. For 2014, the out-of-pocket maximum was $6,350 for single coverage and $12,700 for family coverage. The maximum deductible limit in 2014 will be $2,000 for single coverage and $4,000 for other tiers. These limits will also be subject to adjustment for inflation in 2015 and beyond. The out of pocket and deductible limits do not apply to grandfathered plans.

2015 – 2018: Solidifying Health Care Reform and Future Implementation

Shared Responsibility/Employer Payment (i.e. "Play or Pay")

Starting in 2015, employers with 50 or more FTEs will be subject to a shared responsibility payment if at least one full-time employee obtains a premium tax credit or a cost-share reduction through the Health Insurance Marketplace. The penalty calculation varies based on whether or not the employer offers affordable, minimum value coverage to substantially all full-time employees and their dependent children under the age of 26.

Minimum Essential Coverage Reporting

Employers providing minimum essential coverage must report information to the Internal Revenue Service (IRS) on the employees receiving coverage, dates of coverage and other information the IRS may require. The report must include the employer name, the employer paid portion of the premium, and other information the IRS may require with respect to the small employer tax credit. The annual reporting will begin in 2016 for the 2015 plan year. Statements are also to be furnished annually to employees by January 31st.

Figure 7: What defines a small employer?

SHOP Participation	Outside the Health Care Reform Marketplaces	Exception to Employer Shared Responsibility/Pay or Play Requirement	Small Employer Tax Credit	Exception to W-2 Reporting
• Small employer definition is 1-100, but states can use 1-50 until 2016. Almost all states currently use 1-50. If the Federal government is running the SHOP Marketplace, the state definition (50 or 100) applies. • If a state is running the SHOP, the state law rules for counting employees apply. For example, states might not count part-time employees. • If the federal government is running the SHOP Marketplace, federal rules apply that count the sum of total full-time employees (30+ hours per week) and full-time equivalents. This is the same rule that the IRS uses for the employer responsibility payment.	• Small employer definition is 1-100, but states can use 1-50 until 2016. Almost all states currently use 1-50. • The ACA counts the average of the total number of all employees employed on business days during the preceding calendar year. Each employee W-2 is considered one employee including part-time employees. • Applies for ACA reform provisions, such as benefit mandates. • State law rules may also apply.	• Small employer definition is 1-49. • Counts the sum of total full-time employees (30+ hours per week) and full-time equivalents. This is the same rule that will be used in federally run SHOP Marketplaces.	• Small employer definition is 1-25.* Average annual wages must be less than $50,000. • Count all hours worked for each employee (up to 2,080 hours per employee) and divide by 2,080. ** Note: As of 8/26/13, irs.gov states that fewer than 25 employees are eligible for these credits, however Internal Revenue Code Section 45R states that the term "eligible small employer" means an employer which has no more than 25 full-time equivalent employees for the taxable year. For more information about these credits, visit: irs.gov.*	• Less than 250 W-2s in the preceding year.

Note: The ACA and the IRS use different calculations for determining the number of employees. Employers may simultaneously qualify as a small employer under ACA, but be considered a large employer for IRS purposes. In addition, each state may use different counting rules for the purposes of pre-reform rating and rate reviews.

Small Employer Size Definition

Under the Affordable Care Act, a small employer is defined as 100 or fewer employees. Still, states may choose to define a small employer as 50 or fewer employees until January 1, 2016. Currently, most states define a small employer as having no more than 50 employees.

SHOP Marketplace Open to Large Employers

States have the option to expand the SHOP Marketplace to large employers with more than 100 employees effective January 1, 2017.

Cadillac Tax

Effective January 1, 2018, a 40 percent non-deductible tax will be imposed for health plans with a total value of more than $10,200 for individual and $27,500 for family coverage. This tax applies to the aggregate value of employer-sponsored coverage, as well as employer and employee contributions to Health Reimbursement Accounts (HRAs) or Flexible Spending Accounts (FSAs), employer contributions to Health Savings Accounts (HSAs), and coverage for on-site clinics. Separate vision and dental coverage will generally be exempt. Accident and disability coverage are also exempt. Other supplemental policies, such as Aflac products that provide hospital or other fixed indemnity coverage, or coverage for a specified disease or illness are exempt if paid for by employees on an after-tax basis.

Delayed or Still to be Determined Provisions

Auto-enrollment

Employers with more than 200 full-time employees must automatically enroll new, full-time employees into a health plan and continue enrollment for current employees. Enrollment may be subject to applicable compliant waiting periods. Employers must provide adequate notice and an opt-out option. This requirement applies to both fully- and self-insured employers. The effective date is unknown at this time, and employers do not need to comply until guidance is provided.

Non-discrimination testing for fully insured plans

Non-discrimination testing prohibits employers from discriminating in favor of highly compensated individuals for eligibility and benefits. This rule already applies to self-insured plans and will also apply to fully insured employers. Further guidance is expected regarding when this provision will take effect for fully insured plans.

Quality reporting

Health care reform requires employer health plans and health insurers to report care quality and health outcomes. The Department of Health and Human Services is expected to issue further guidance on this reporting requirement for group and individual health plans. Guidance is expected to include covered benefits and provider reimbursement structures that improve health outcomes, prevent hospital readmissions, improve patient safety, reduce medical errors, and implement wellness and health promotion activities.

3

Fundamental “Play-or-Pay” Considerations

Employer-sponsored benefits are an important indicator of employee satisfaction, not to mention the ROI of lower worker’s compensation claims, retention and productivity. Our experts have compiled key considerations, among many, for employers weighing whether to “play” or “pay.”

Figure 8: Fundamental Play or Pay Considerations

1 | Cost

Health care cost concerns are not new. In fact, health care spending has exceeded U.S. economic growth in every recent decade. Rising costs, along with an increasingly complex health care system, make it even more important for businesses and individuals to have a clear understanding of their health care benefits, to make smart benefits choices, and to wisely manage their health care dollars. For employers, health care reform presents multiple cost considerations, including:

Shared responsibility payment

An important cost consideration for large employers is a provision called the shared responsibility payment. Starting in 2015, employers with 50 or more full-time equivalent employees will be subject to a shared responsibility payment if at least one full-time employee obtains a premium tax credit or cost-share reduction through the Health Insurance Marketplace. While an employer's contribution to a health benefits plan is tax-deductible, the shared responsibility payment is not, and may actually increase an employer's cost.

The penalty calculation varies based on whether or not the employer offers affordable, minimum value coverage to substantially all full-time employees and dependents. If an employer fails to offer minimum essential coverage to such employees and dependents and even one full-time employee receives a premium tax credit through the public Health Insurance Marketplace, then the penalty is equal to $2,000 multiplied by the number of full-time employees. A different, generally lesser penalty applies when an employer offers minimum essential coverage, but the coverage does not meet minimum value requirements or is considered unaffordable. In this case, the employer will have to pay $3,000 for each

employee who purchases subsidized coverage. With the $3,000 penalty, the employer has offered coverage, but the coverage does not satisfy the minimum value and affordability tests. The total amount of the $3,000 penalty cannot be greater than the total penalty for failing to offer any coverage.

Figure 9:

Scenario	Calculation	Example
Employer fails to offer minimum essential coverage to substantially all full-time employees and their dependents	$2,000 X (Total number of full-time employees - first 30 employees)	Employer with 51 full-time employees: $2,000 X (51-30) = $42,000 Penalty is: $42,000
Employer offers minimum essential coverage that is either unaffordable or does not satisfy minimum value requirements.	Lesser of (a) and (b) (a) $2,000 X (Total number of full-time employees - first 30 employees) (b) $3,000 X (The number of full-time employees receiving a subsidy)	Employer with 51 full-time employees and 10 full-time employees obtain tax credits: (a) $2,000 X (51-30) = $42,000 (b) $3,000 X 10 = $30,000 Penalty is: $30,000

Dependent Coverage and Cost

The employer shared responsibility payment provision does not include a requirement to cover spouses. However, employers are required to make coverage available to dependents up to 26 years of age or face a penalty. In 2013, health care costs are expected to increase per employee by 5.3 percent (0.6 percent lower than in 2012). The average expected un-subsidized costs of individual coverage is projected at $11,607 ($8,911 employer share, and $2,696 employee share).[3]

Minimum Value and Actuarial Value

Actuarial value is relevant under health care reform for a number of purposes. The minimum value standard under the employer shared-responsibility requirement requires that the plan pay at least 60 percent of covered expenses. If a small employer purchases group health insurance (either through the SHOP Marketplace or through a private marketplace), health care reform requires that the plan have a minimum actuarial value of at least 60 percent (they may also have an actuarial value of 70, 80, or 90 percent).

Currently, the employer market offers an average of 83 percent actuarial value,[4] but often employees are not aware of the actuarial value of their health care coverage or their employer's investment. The 2013 Aflac WorkForces Report, a survey of over 5,200 workers across the United States, revealed 41 percent of employees say they do not truly understand their employer's contribution to their health care coverage. Especially as employees become increasingly aware of actuarial value standards, employers can leverage their investment by frequently and effectively communicating the value of the company's benefits coverage.

2 | Employer Size

Businesses, large and small, rely on health benefits to provide a unique competitive-edge in the battle to attract and retain talented workers. When it comes to making "play" or "pay" decisions, many new health care reform requirements, penalties and tax subsidies are determined by employer size, including:

Large Employers

Employers with 50 or more full-time equivalent employees are required to:

1 | Offer affordable, minimum value coverage or may be subject to penalties

2 | Not exceed certain out-of-pocket limits

Note: Large employers and self-insured plans are not required to provide essential health benefits, but if they do, those benefits cannot have any annual dollar or lifetime dollar limits. However day/visit limits are allowed. Public Health Services Act (PHSA) excepted benefits are not subject to health care reform changes, and are available to employers of all sizes, as well as individuals.

Small employers

Although employers with 50 or fewer full-time equivalent employees (FTEs) will not be penalized for not providing a health plan, still many small businesses may offer benefits as an important part of an employee's total compensation package. Employers with 50 or fewer employees will be eligible to purchase coverage through the Small Business Health Options Program (SHOP) Marketplace. Additionally, employers with 25 or fewer full-time equivalent employees* may be eligible for tax credits. Small employers offering employer-sponsored major medical insurance benefits are required to:

1 | Offer Essential Health Benefits

2 | Meet Actuarial Value Standards (Metal Levels)

3 | Not exceed certain specified deductible and out-of-pocket limits.

Note: As of 8/26/13, irs.gov states that businesses with **fewer than 25 employees are eligible for these credits, however Internal Revenue Code Section 45R states that the term "eligible small employer" means an employer which has **no more than** 25 full-time equivalent employees for the taxable year. For more information about these credits, visit: irs.gov.*

Figure 10: Considerations by Business Size

Employer Size	
≤ 25 FTEs	May be eligible for Small Employer Tax Credits
1-50	• Considered small employer • Eligible to participate in SHOP • No shared responsibility payment if less than 50 FTEs • Benefit plans must comply with Essential Health Benefits requirements and Actuarial Value/Metal level requirements
51-100	• Considered small employer beginning 1/1/2016 (or earlier at state option) • Eligible to participate in SHOP beginning 1/1/2016 (or earlier at state option) • Benefit plans must comply with Essential Health Benefits requirements and Actuarial Value/Metal level requirements beginning 1/1/2016 (or earlier at state option) • Beginning Jan 1, 2015, the shared responsibility payment applies if the size is at least 50 FTEs
100+	• May be eligible to participate in SHOP beginning 1/1/2017 • Beginning in 2015, the shared responsibility payment applies if the size is at least 50 FTEs

Health care reform expands access to health care coverage, and reform guarantees access and renewal of health care to all individuals regardless of their health condition. This means that both high and low risk (and high and low cost) employees will have the opportunity to purchase coverage on the individual market.

For the first time, employees who do not have access to employer-sponsored coverage will have available health insurance options in the new market, regardless of their health status or pre-existing conditions.

3 Guaranteed Issue in the Individual Market

Small Business Tax Credits

Small employers purchasing employee benefits through the SHOP Marketplace may receive tax credits for up to 50 percent of the cost of providing employer-sponsored health coverage These tax credits may offer a cost-effective way to boost total workforce compensation.

4 Federal Premium Tax Credits

Advance Premium Tax Credits (APTC)

Employees with household incomes between 100 percent and 400 percent of the federal poverty level (FPL) may be eligible for tax credits through the Health Insurance Marketplace, making coverage cheaper through the Health Insurance Marketplace rather than their employer. However, employer-sponsored insurance (ESI) affects employee eligibility for available tax credits, and could determine whether employees will receive credits, as well as whether their employer is penalized. The table below shows employees' eligibility for subsidies based on the available ESI coverage.

Figure 11:

Employer Sponsored Insurance Scenario	Eligibility for APTCs
Employee is not eligible for ESI	Yes
ESI does not meet affordability requirements	Yes
ESI does not meet minimum value requirements	Yes
Employee is eligible, ESI is affordable and offers minimum value coverage, no dependent coverage available	Employee not eligible Dependents are eligible
Employee and dependents eligible. Employee coverage affordable, dependent coverage is unaffordable	Employee and dependents are not eligible
Eligible for COBRA and other continuation of coverage	Yes, if it is a former employee who is not enrolled in the coverage. No, if an active employee.

5 | Recruiting, retention and productivity

Employee benefits are a key indicator of employee satisfaction, retention and productivity. The 2013 Aflac WorkForces Report, revealed that workers who are extremely or very satisfied with their benefits program are three times more likely to stay with their employer than those workers who are dissatisfied with their benefits program.[5]

Though employers have long recognized the importance of employee benefits, now – more than ever – benefits will make a big difference for employee satisfaction, retention and productivity. In fact, nearly 1-in-2 U.S. employees say that improving their benefits is one thing their employer can do to keep them in their job (see "Benefits Matter").[5]

Benefits Matter[5]

Nearly 1-in-2
U.S. employees (47%) say that improving their benefits is one thing their employer can do to keep them in their job.

Workers who are extremely or very satisfied with their benefits program are
3 times more likely
to stay with their employer than those workers who are dissatisfied with their benefits program.

59% of employees believe they'd be at least somewhat likely to accept a job with a more robust benefits package but lower compensation.

6 | Workforce Demographics and Preparedness

While health care reform is expanding access to individuals and those who may not have had access to health care in the past, many will continue to see higher co-pays, premiums, deductibles and other out-of-pocket expenses.

Workforce demographics such as household income will have an impact on eligibility for affordability programs such as Medicaid or APTCs. Low-wage employees may benefit more from the Health Insurance Marketplace subsidies than the employer contribution from employer-sponsored coverage.

It may be surprising that many workers are unprepared when it comes to additional health expenses. The estimated out-of-pocket costs for a patient who suffers a heart attack are $5,000 to more than $8,000 over the expected year of treatment.[6] Still, the Aflac study found 46 percent of workers have less than $1,000 in savings for out-of-pocket health costs, and 25 percent of those have less than $500.[5] No one likes to imagine themselves or their loved ones becoming sick or injured, but being prepared can be critical to getting better and bouncing back to enjoy the things that matter most.

Employers may consider adjusting their employment structure (number of part-time employees), additionally implementing supplemental policies outside of a Health Insurance Marketplace to help employees cope with daily living expenses and out-of-pocket costs associated with accidents or illnesses. These policies pay ***in addition*** to major medical insurance, including policies that may be in place through marketplaces.

Post-reform Factors

After health care reform is implemented, there are many factors that may come into play that will impact employers and their decisions regarding employer-sponsored benefits. While it is still too early to tell, a few important factors to watch include:

- Leveraging opportunities to differentiate your business from competitors
- Viability of marketplaces and quality of coverage employees can buy on their own
- Quality of care and care continuity
- Affordability of plans for employees
- Employee expectations, uncertainty and reactions to choices
- Administrative burdens due to provisions such as auto-enrollment and reporting

4

Employer-Sponsored Benefits Strategies

Health care reform developments will give employers several options for major medical insurance coverage for their employees, which can be reviewed and adjusted on an annual basis.

SHOP Marketplace

Self-Insure

Private Marketplace

Maintain Grandfathered Status

Hybrid Approach

Adjust Current Plan

Discontinue Coverage

Small Business Health Options Program (SHOP) Marketplace

The SHOP Marketplace is an online market where small businesses and their employees will have access to private health insurance coverage. In most states, eligible businesses will need to have 1-50 employees.* Employers with up to 100 employees can participate in the SHOP Marketplace beginning in 2016. States may allow large employers in 2017.

** Although exchanges can be open to employers with up to 100 employees, federal and state exchanges can keep the cap at 50 employees until 2016. The method of counting employees varies based on whether the SHOP Marketplace is operated by a state or the federal government. If it is the state, state law rules apply. If federal, counting includes full-time equivalent employees as under the shared-responsibility penalties.*

SHOP Marketplace	
Coverage	• Starting in 2014, businesses have the option to choose a qualified health plan (QHP) to offer to their workforce (employer choice). • Beginning in 2015, an employer can choose the level of coverage to offer their workforce, and employees will be able to select from multiple QHPs (employee choice). • QHPs will include essential health benefits and will meet actuarial value level requirements.
Compliance	• Employers will need to comply with all applicable federal and state laws and rules, including ACA provisions. • Employers need to be aware of all the ACA compliance requirements, specifically the benefit mandates, and grandfathering if applicable, that directly affect them. • Employers must notify employees regarding the availability of the Health Insurance Marketplace and subsidies that could help lower the cost of insurance coverage (by October 1, 2013, and for all new employees at the time of employment).
Tax Credits	• A small employer may receive tax credits based on eligibility. - Employer must cover at least 50 percent of the cost of single (not family) health care coverage for each employee. - Employer must have fewer than 25 full-time equivalent employees (FTEs). - Employees must have average annual wages of less than $50,000.
Administration	• On October 1, 2013, open enrollment begins for small businesses with coverage effective dates beginning 1/1/2014. • Employers will need to submit an application online along with a list of eligible employees, and use one of the other consumer assistance functions (call center, agents, navigators, and in-person assistors) to check eligibility. • In 2015, when employee choice is implemented, the SHOP will provide employers with a single invoice and collect payments. • Employers will need to perform payroll deductions, and work with SHOP to reconcile enrollment information, billing and termination functions.
Employee Tools and Resources	• Employees will use SHOP consumer assistance during open enrollment. • Employees will need to submit an application for enrollment and select the plan. • If the employer selects Employee Choice (available in 2015), the employees will need to use appropriate decision support tools and select the plan that best fits their needs. • Employees may be required to use the SHOP for all updates, special enrollments, terminations and other applicable functions.

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Small Business Health Options Program (SHOP) Marketplace (continued)

Supplemental Insurance Protection	• The SHOP will offer stand-alone voluntary dental coverage that employees can select. • Other voluntary coverage may be available directly from the employer. • Even though purchasing insurance benefits through the SHOP, employers who choose this option can consider other voluntary coverage to provide employees with a comprehensive benefits package. • These policies can be bought separately to help employees to cover out-of-pocket costs associated with illness or injury.
Penalties	• Starting in 2015, employers with at least 50 full-time equivalent employees may be subject to shared responsibility penalties if coverage does not meet affordability or minimum value requirements.

Self-Insured

Self-funded health care insurance plans offer an alternative to traditional health care models. In a self-funding model, the company is responsible for covering all claims in the health care plan, and controls any premium reserves.

Self-Insured	
Coverage	• The employer provides minimum value coverage that meets affordability requirements • Self-insured are not subject to some of the ACA benefit reforms. • With no annual or life-time dollar limits on essential health benefits covered under the plan, employers may need to consider an appropriate level of stop-loss coverage.
Compliance	• The employer will not need to comply with some of the ACA provisions, such as essential health benefits, insurer tax, medical loss ratios (MLR) and deductible limits. • The employer will need to comply with all applicable federal and state laws and rules, including some of the new ACA provisions • Employer needs to be aware of all the ACA compliance requirements, specifically the benefit mandates, and grandfathering if applicable, that directly affect them. • Employer should have notified employees of the availability of the Health Insurance Marketplace and subsidies that could help lower the cost of insurance coverage by October 1, 2013. All new employees must receive this information within the first two weeks of employment.
Tax Credits	• Employers will not be eligible to receive tax credits. • Employees may be eligible to receive tax subsidies through the government marketplace if their employer's coverage does not provide affordable, minimum value coverage.
Administration	• The employer will continue to use their current practices to work with issuers to obtain and maintain coverage. • Starting in 2016, the employer will submit required reporting to the Internal Revenue Service.
Employee Tools and Resources	• Employees will use current practices for open enrollment and select from the available health plan choices that are made available by the employer. • Employees may use a single seamless process to obtain a full benefits package including voluntary benefits.
Supplemental Insurance Protection	• The employer can provide voluntary benefits to workers along with the self-funded plan for comprehensive coverage. • These policies can be bought separately to help employees to cover out-of-pocket costs associated with illness or injury.
Penalties	• Starting in 2015, employers with at least 50 full-time equivalent employees may be subject to shared responsibility penalties if coverage does not meet affordability or minimum value requirements.

Private Marketplace

In the post-reform environment, private marketplaces (also known as exchanges) will become a viable option with the guaranteed issue of coverage and an employer's ability to provide a defined benefit or defined contribution toward employee coverage. Employers of all sizes can choose the private marketplace to provide employee benefits packages.

Private Marketplace	
Coverage	• Employees will be able to obtain coverage regardless of health status beginning 2014. • The employer can choose which coverage model they want to offer their workforce: defined contribution (a specific dollar amount employees can choose towards a plan) or defined benefits (specific plan(s) employees can choose from). • Plans will vary based on model choice, and specific details provided by the marketplace.
Compliance	• An employer will need to comply with all applicable federal and state laws and rules. • The employer will need to comply with the new Affordable Care Act (ACA) benefit mandates including metal levels and/or minimum value requirements. • The employer needs to be aware of all the ACA compliance requirements, specifically the benefit mandates, and grandfathering, that directly affect them. • Employers must notify employees regarding the availability of the Health Insurance Marketplace and subsidies that could help lower the cost of insurance coverage (by October 1, 2013, and for all new employees at the time of employment).
Tax Credits	• Employers will not be eligible to receive tax credits.
Penalties	• Starting in 2015, employers with at least 50 full-time equivalent employees may be subject to shared responsibility penalties if coverage either does not meet affordability or minimum value requirements.
Administration	• Employers will need to submit employee information to the private marketplace. • Depending on the marketplace, it may issue employers a single invoice and collect payments. • Employers will need to perform employee payroll deductions to pay premiums. • Employers will work with the marketplace to reconcile enrollment information, billing and termination functions. • Private marketplaces may assist in meeting the compliance reporting requirements that are in place for employers starting in 2016.
Employee Tools and Resources	• Employees use the private marketplace during open enrollment. • Employees will submit an application for enrollment and select the plan. • Employees may be required to use the private marketplace for all updates, special enrollments, terminations and other applicable functions.
Supplemental Insurance Protection	• Private marketplaces may have a full benefits package including voluntary coverage, but it will vary depending on the marketplace. • These policies can be bought separately to help employees to cover out-of-pocket costs associated with illness or injury.

Maintain Grandfathered Status

An employer-sponsored health plan can be grandfathered if it covered employees when the ACA was enacted (March 23, 2010), and if the plan does not make certain material changes that lower benefits or employer contributions, or increase employee paid deductible, coinsurance or copayment costs to the employee. While grandfathered plans may have lower rates (at least in the initial years), they are not required to include some of the new ACA benefit reforms.

Maintain Grandfathered Status	
Coverage	• Employers will continue to offer the pre-reform grandfathered benefit plans. • The benefit plan cannot change in certain ways (see list below).
Compliance	• The employer will need to comply with all applicable federal and state laws and rules, including some of the new ACA provisions, including the prohibition on annual and lifetime limits on essential health benefits, the prohibition on pre-existing condition exclusions, requirements for coverage of adult children to age 26, and the 90-day limitation on waiting periods. • Employees need to be notified of the grandfathering status. • The employer must notify employees regarding the availability of the Health Insurance Marketplace and subsidies that could help lower the cost of insurance coverage (by October 1, 2013, and for all new employees at the time of employment). • Grandfathered plans are exempt from certain health care reform provisions, such as: - Certain benefit mandates, such as essential health benefits or requirements to cover preventive benefits with no cost-sharing - Clinical trial coverage - External appeals process - Non-discrimination testing for fully insured plans - Maximum out-of-pocket and deductible limits - Some of the additional reporting and disclosures - Guaranteed availability and renewability • Grandfathered plans may change insurance companies, as long as there is no change in coverage as described below. • Grandfathered plans cannot: - Significantly cut or reduce benefits - Raise employee co-insurance charges - Significantly raise co-payment charges (15% more than medical trend since 2010) - Significantly raise deductibles (15% more than medical trend since 2010) - Significantly lower employer contributions (more than 5% of proportional cost share for any coverage category) - Add or tighten an annual limit on what the plan pays - Starting in 2014, no annual dollar limits
Tax Credits	• Employers will not be eligible to receive tax credits. • Employees may be eligible to receive tax credits through the Individual Exchange if their employer's coverage does not provide affordable, minimum value coverage.
Penalties	• Starting in 2015, employers with at least 50 full-time equivalent employees may be subject to shared responsibility penalties if coverage is either does not meet affordability or minimum value requirements.

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Maintain Grandfathered Status (continued)

Administration	• The employer will continue to use their current practices to work with issuers to obtain and maintain coverage. • The employer will submit required reporting to the Internal Revenue Service starting in 2016.
Employee Tools and Resources	• Employees will use current practices for open enrollment and renew coverage from the available health plan choices that are made by the employer. • Employees may use a single seamless process to obtain a full benefits package including voluntary benefits.
Supplemental Insurance Protection	• Employers will have the ability to revise their voluntary benefits package, even though the medical benefits package is grandfathered. • These policies can be bought separately to help employees cover out-of-pocket costs associated with illness or injury.

Hybrid Approach

The objective with a hybrid approach is to minimize penalty exposure and to meet the employees' health benefits needs. Employers have the option to restructure or classify the workforce based on the workforce demographics and select a combination of the benefits designs to meet both business and workforce needs.

Hybrid Approach	
Coverage	• Coverage options could range from employer sponsored benefits that meet the minimum value and affordability requirements to exchange-based individual coverage, depending on the options that the employer selects.
Compliance	• The employer will need to comply with all applicable federal and state laws and rules. • The employer will need to comply with the new Affordable Care Act (ACA) benefit mandates including metal levels and/or minimum value requirements. • The employer needs to be aware of all the ACA compliance requirements, specifically the benefit mandates, and grandfathering if applicable, that directly affect them. • Employers must notify employees regarding the availability of the ·Health Insurance Marketplace and subsidies that could help lower the cost of insurance coverage (by October 1, 2013, and for all new employees at the time of employment).
Tax Credits	• Employers will not be eligible to receive tax credits. • Employees may be eligible to receive tax credits through the Individual Exchange if their employer's coverage does not provide affordable, minimum value coverage.
Penalties	• Starting in 2015, employers with at least 50 full-time equivalent employees may be subject to shared responsibility penalties if coverage does not meet affordability or minimum value requirements.
Administration	• Administration could range from the business' current practices to using Marketplace-based processes depending on the options selected by the employer. • The employer will submit required reporting to the Internal Revenue Service starting in 2016.
Employee Tools and Resources	• Employees may need to use resources provided by the employer, a private marketplace or the Health Insurance Marketplace tools, depending on the employer's choice of plan options.
Supplemental Insurance Protection	• The employer can consider providing voluntary benefits regardless of the options selected to help provide workers a comprehensive benefits package. • These policies can be bought separately to help employees to cover out-of-pocket costs associated with illness or injury.

Adjust Current Plan

Many businesses may already offer benefits that meet or exceed federal standards, or can meet the standards with minor adjustments. These companies may find they can capitalize on going above and beyond to help protect workforce health and wellbeing.

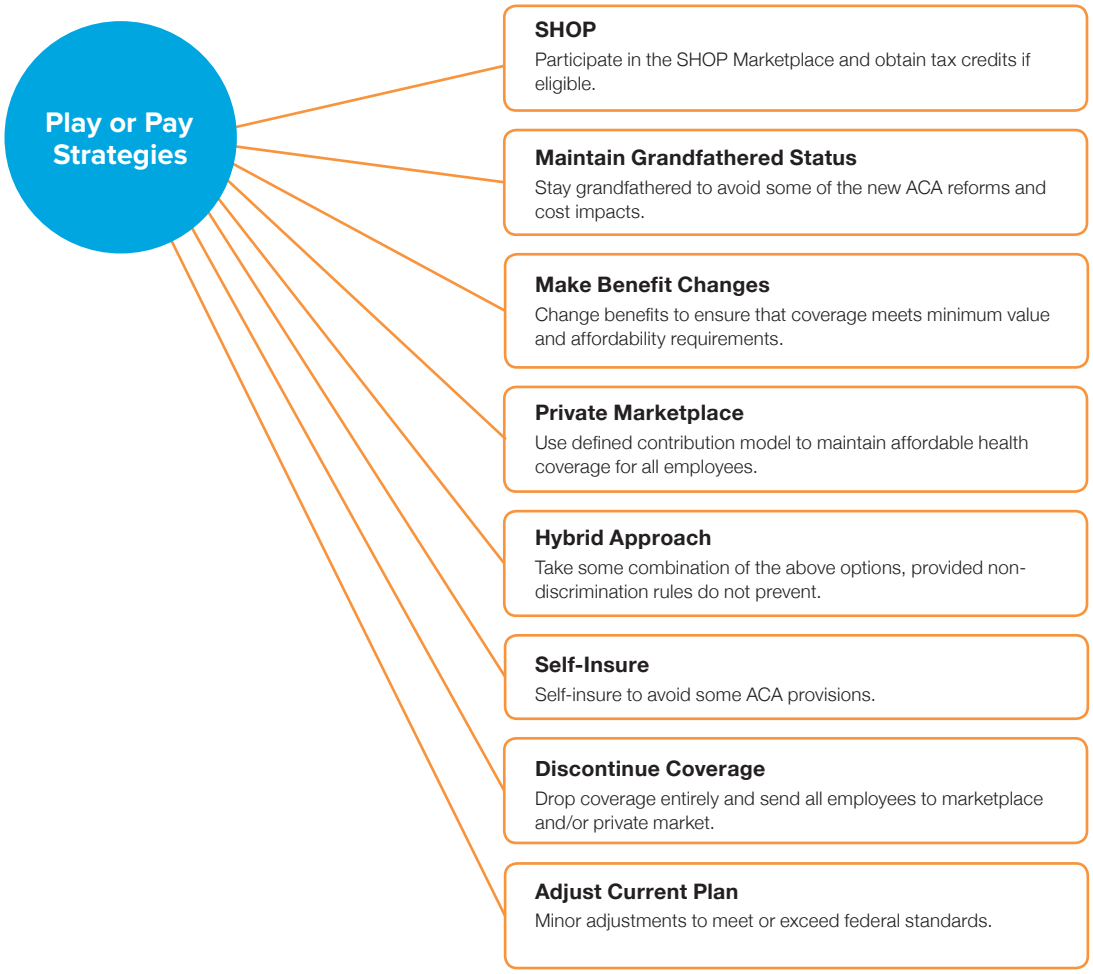
Considerations	
Coverage	• The employer provides minimum value coverage that meets affordability requirements.
Compliance	• The employer will need to comply with all applicable federal and state laws and rules. • The employer will need to comply with the new Affordable Care Act (ACA) benefit mandates including metal levels and/or minimum value requirements. • The employer needs to be aware of all the ACA compliance requirements, specifically the benefit mandates, and grandfathering if applicable, that directly affect them. • Employers must notify employees regarding the availability of the Health Insurance Marketplace and subsidies that could help lower the cost of insurance coverage (by October 1, 2013, and for all new employees at the time of employment).
Tax Credits	• The employer will not be eligible to receive small business tax credits. • Employees may be eligible to receive Health Insurance Marketplace subsidies if their employer's coverage does not provide minimum value or affordability requirements.
Penalties	• Starting in 2015, employers with at least 50 full-time equivalent employees may be subject to shared responsibility penalties if coverage either does not meet affordability or minimum value requirements.
Administration	• The employer will continue to use their current practices to work with issuers to obtain and maintain coverage. • Starting in 2016, the employer will submit required reporting to the Internal Revenue Service.
Employee Tools and Resources	• Employees will use current practices for open enrollment and select from health plan choices that are made available by the employer. • Employees may use a single seamless process to obtain a full benefits package including voluntary benefits.
Supplemental Insurance Protection	• The employer can provide voluntary benefits to workers along with the current health plan. • These policies can be bought separately to help employees cover out-of-pocket costs associated with illness or injury.

Discontinuing Coverage

In spite of the many advantages of providing workforce benefits, some employers may choose to drop health insurance coverage fully or partially. Employers may also benefit from restructuring the work force to minimize the impact of the pay-or-play penalty (i.e. number of hours employees work). Employers offering limited benefit plans may consider dropping coverage as an alternative.

Discontinuing Coverage	
Coverage	• Employees can obtain coverage in the Individual Market – both private marketplaces and the public Health Insurance Marketplace.
Compliance	• Employer will no longer need to comply with requirements that are applicable to employer providing health plans. • Employers must notify employees regarding the availability of the Health Insurance Marketplace and subsidies that could help lower the cost of insurance coverage (by October 1, 2013, and for all new employees at the time of employment).
Tax Credits	• Employers will not be eligible to receive tax credits. • Employees may be eligible to receive subsidies based on household income level and other eligibility requirements through the Health Insurance Marketplace.
Penalties	• Starting in 2015, employers with at least 50 full-time equivalent employees may be required to pay a shared responsibility payment, if any of the full-time employees receives a subsidy through the Health Insurance Marketplace.
Administration	• Employers will need to provide appropriate communication, education and support to help employees obtain coverage in the individual market.
Employee Tools and Resources	• Employees will need to use the Health Insurance Marketplace during open enrollment and special enrollment periods to obtain coverage if they are eligible for subsidies. • Employees may also use the private marketplaces for enrollment during designated open enrollment or special enrollment periods.
Supplemental Insurance Protection	• The employer can continue to provide voluntary benefits regardless of discontinuing major medical coverage. • These policies can be bought separately to help employees cover out-of-pocket costs associated with illness or injury.

Figure 12: Employer-sponsored benefits strategies



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