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December 17, 2012

MEMORANDUM

TO: Legislative Education Study Committee

FR: Mr. Ian Kleats

**RE: NATIONAL HEALTH INSURANCE IMPACT ON FY 14 INSURANCE
APPROPRIATION REQUESTS**

INTRODUCTION

During the September 2012 interim meeting of the Legislative Education Study Committee (LESC), Albuquerque Public Schools (APS) and the New Mexico Public Schools Insurance Authority (NMPSIA) presented their FY 14 insurance appropriation requests.

At that time, still pending the outcome of the November 2012 national election, it remained uncertain whether the federal *Patient Protection and Affordable Care Act* (PPACA) would be fully implemented. As a result, the complete budgetary impacts of the PPACA may not have been represented in the total request, and some additional costs could be possible resulting from the implementation of certain provisions of that law.

This staff report includes:

- prior FY 14 insurance appropriation requests for NMPSIA and APS;
- the Public Education Department (PED) FY 14 insurance recommendation; and
- background.

Staff from NMPSIA and APS will present information to the committee that details how their FY 14 budgets could be impacted by provisions of the PPACA.

PRIOR FY 14 INSURANCE APPROPRIATION REQUESTS FOR NMPSIA AND APS

New Mexico Public Schools Insurance Authority

For FY 14, effective October 1, 2013 through September 30, 2014, NMPSIA had requested an increase to its appropriation of approximately \$19.5 million to provide for the employer's share of increased insurance premiums for its members. The appropriation request considered a:

- 10.41 percent increase in health/medical insurance premiums;
- 6.0 percent increase in dental insurance premiums;
- zero percent increase in life, vision, and long-term disability insurance premiums; and
- 15 percent increase in risk insurance, which includes property and liability insurance and workers' compensation claims.

Albuquerque Public Schools

For FY 14, effective January 1, 2014 through December 31, 2014, APS had requested a total appropriation of approximately \$8.8 million to support the employer's share of increased insurance premiums. The appropriation request considered an:

- 8.6 percent increase in medical, dental, and vision insurance premiums; and
- zero percent increase for life and disability insurance premiums.

The FY 14 request had not included an appropriation request with regard to the risk program because the APS Board of Education had approved a draw from reserves to support the 5.0 percent increase in property and liability premiums and in workers' compensation claims.

Total FY 14 Appropriation Request

The total FY 14 appropriation request, including both NMPSIA's and APS's requests, amounts to approximately \$28.3 million to fund increased insurance premium contributions.

PED FY 14 INSURANCE RECOMMENDATION

The PED Public School Support and Related Services budget recommendation for FY 14 as presented to the Legislative Finance Committee at its December 2012 interim meeting proposes an increase of approximately \$17.6 million to fund increases in insurance costs. During that presentation, PED staff indicated that the proposed increase to funding is derived from a projected 7.9 percent increase in aggregate health care spending in the United States for 2014 as estimated by the Centers for Medicare and Medicaid Services.

Appropriations for projected increases in the employer's group health and risk insurance contribution rates of the state's public schools are funded through the State Equalization Guarantee distribution. Based on the share of preliminary funded program costs for the school year 2012-2013, APS would receive approximately \$4.5 million and NMPSIA would receive approximately \$13.1 million for increased insurance contributions under this proposal.

BACKGROUND

“Implementation Timeline of the Affordable Care Act, Selected Provisions,” contains a matrix detailing some provisions of the PPACA that will take effect in the current fiscal year and the next. (See Attachment)

Implementation Timeline of the Affordable Care Act, Selected Provisions

Effective Date	Provision
1 9/23/2012	1 Uniform Coverage Summaries for Consumers This provision of the Affordable Care Act (ACA) that requires private individual and group health plans to provide a uniform summary of benefits and coverage (SBC) to all applicants and enrollees. The intent is to help consumers compare health insurance coverage options before they enroll and
2 1/1/2013	2 State Notification Regarding Exchanges Deadline for states to indicate to the Secretary of Health and Human Services whether they will operate an American Health Benefit Exchange.
3 1/1/2013	3 Itemized Deductions for Medical Expenses Increases the threshold for the itemized deduction for unreimbursed medical expenses from 7.5% of adjusted gross income to 10% of adjusted gross income; waives the increase for individuals age 65 and older for tax years
4 1/1/2013	4 Flexible Spending Account Limits Limits the amount of contributions to a flexible spending account for medical expenses to \$2,500 per year, increased annually by the cost of living adjustment.
5 1/1/2013	5 Employer Retiree Coverage Subsidy Eliminates the tax-deduction for employers who receive Medicare Part D retiree drug subsidy payments.
6 1/1/2014	6 Expanded Medicaid Coverage* Expands Medicaid to all individuals not eligible for Medicare under age 65 (children, pregnant women, parents, and adults without dependent children) with incomes up to 133% FPL and provides enhanced federal matching payments for new eligibles. *State option: No indication of NM's course of action.
7 1/1/2014	7 Individual Requirement to Have Insurance Requires U.S. citizens and legal residents to have qualifying health coverage (there is a phased-in tax penalty for those without coverage, with certain exemptions).
8 1/1/2014	8 Employer Requirements Assesses a fee of \$2,000 per full-time employee, excluding the first 30 employees, on employers with more than 50 employees that do not offer coverage and have at least one full-time employee who receives a premium tax credit. Employers with more than 50 employees that offer coverage but have at least one full-time employee receiving a premium tax credit, will pay the lesser of \$3,000 for each employee receiving a premium credit or \$2,000 for each full-time employee, excluding the first 30 employees.

Implementation Timeline of the Affordable Care Act, Selected Provisions

Effective Date	Provision
9 1/1/2014	<p>Guaranteed Availability of Insurance (Pre-existing Conditions) Requires guarantee issue and renewability of health insurance regardless of health status and allows rating variation based only on age (limited to a 3 to 1 ratio), geographic area, family composition, and tobacco use (limited to 1.5 to 1 ratio) in the individual and the small group market and the Exchanges.</p>
10 1/1/2014	<p>No Annual Limits on Coverage Prohibits annual limits on the dollar value of coverage.</p>
11 1/1/2014	<p>Temporary Reinsurance Program for Health Plans Creates a temporary reinsurance program to collect payments (fees) from health insurers in the individual and group markets to provide payments to plans in the individual market that cover high-risk individuals.</p>
12 1/1/2014	<p>Fees on Health Insurance Sector Imposes new fees on the health insurance sector.</p>
13 1/1/2014	<p>Wellness Programs in Insurance Permits employers to offer employees rewards of up to 30%, potentially increasing to 50%, of the cost of coverage for participating in a wellness program and meeting certain health-related standards; establishes 10-state pilot programs to permit participating states to apply similar rewards for participating in wellness programs in the individual market.</p>
14 1/1/2014	<p>Health Insurance Premium and Cost Sharing Subsidies Provides refundable and advanceable tax credits and cost sharing subsidies to eligible individuals. Premium subsidies are available to families with incomes between 133-400% of the federal poverty level to purchase insurance through the Exchanges, while cost sharing subsidies are available to those with incomes up to 250% of the poverty level.</p>
15 1/1/2014	<p>Health Insurance Exchanges Become Active Creates state-based American Health Benefit Exchanges and Small Business Health Options Program (SHOP) Exchanges, administered by a governmental agency or non-profit organization, through which individuals and small businesses with up to 100 employees can purchase qualified coverage. Exchanges will have a single form for applying for health programs, including coverage through the Exchanges and Medicaid and CHIP programs.</p>

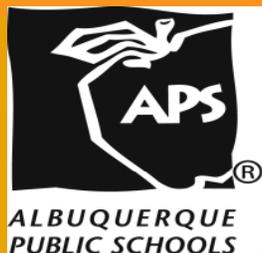
ALBUQUERQUE PUBLIC SCHOOLS

Impact Of Health Care Reform

Presented to the Legislative Education Study Committee

Representative Rick Miera, Chair

December 17, 2012



This material and any accompanying remarks are provided for informational purposes only and nothing contained in either should be taken as a legal opinion or as legal advice

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PAY OR PLAY MANDATE -2014

Coverage must be offered, sufficient and affordable to avoid penalties of \$2,000 or \$3,000 per employee

- Minimum Value benefits
- Coverage is at least 60% of the mandated actuarial value of benefits – “Minimum Value”
- Coverage is unaffordable if self only coverage costs EE more than 9.5% of modified gross income

PAY OR PLAY MANDATE COMPLIANCE ISSUES

If an employer is subject to the rules, penalties apply for full time employees (including seasonal employees)

- Those who work an average of 30 hours per week or more
- Potential to use a look-back option – “Measurement Period”
 - Look back 3 – 12 months
 - Apply results to the following 6 – 12 months – “Stability Period”

We are analyzing payroll records to determine the number of newly eligible employees, but we believe the number will be small.

TRANSITIONAL REINSURANCE PROGRAM

- HHS has issued additional guidance
 - 3 year transitional reinsurance program
 - Help to stabilize the individual health insurance market from 2014 – 2016
 - Funded by contributions from insurers and self funded group health plans
 - Estimated annual per capita rate of \$63 for 2014
 - Payment due in January 2015
 - Fee applies to all participants in group health plans providing major medical coverage including dependents
 - 2014 estimated cost
17,322(current participants) X \$63. = \$1,091,286
- Not included in the October request for FY 14 funding**

PCORI FEE

- Patient-Centered Outcomes Research Institute
 - Previously referred to as Comparative Effectiveness Research Fee (CER)
- Annual Fee required under PPACA
- \$1 per covered person for the first year
 - Plan year that ends after September 30, 2012
- \$2 per covered person indexed plan years ending after September 30, 2014
- Fee paid by plan sponsors of self-funded plans

MIGRATION ISSUES

APS currently has 17,322 total members

- 2014 Plan Year Projected Medical, RX and Dental \$440.94 PMPM
- Assuming 2% growth
 - 346 new members
 - \$1,830,782M annual additional cost
- Assuming 5% growth
 - 866 new members
 - \$4,582,248M annual additional cost

APS PY COSTS 2013 VS 2012

2013 PY Gross Plan Costs estimated increase 6.3% over 2012 PY Gross Plan Costs

■ 2013 Assumptions

- No enrollment growth
 - Trend rates
 - Current Presbyterian trend rate 6%
 - Current Lovelace trend rate 7%
 - Current Express Scripts / Medco trend rate 5%

■ APS 2013 Plan Changes to mitigate increase

- \$1.34M in plan changes
- \$2.065M in contribution increases

2013 Plan Design Changes

HIGH PLAN ONLY

	SAVINGS/CONTRIBUTIONS
• Increase Advance Radiology Copay to \$100	\$20,000
• Increase Physician Specialist Copay to \$40	\$270,000
• Increase Urgent Care Copay to \$50	\$250,000
• Raise Outpatient Surgery Copay to \$250	\$304,000
• Increase ER Copay from \$120 Copay to \$150	128,000
• Raise RX Copay Min/Max by \$5.00 on Brand Drugs	\$250,000
• Raise Specialty Drug Copay to \$100, and raise out of pocket maximum to \$1,000	\$102,000

LOW PLAN ONLY

• Raise Deductible from \$150/\$300/\$450 to \$300/\$600/\$900	\$20,000
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BOTH PLANS

• Raise Lovelace Employee Contributions to Match Presbyterian	\$515,000
• Raise Employee Contributions by 2%	<u>\$536,000</u>

TOTAL

\$2,395,000

APS PY COSTS 2014 VS 2013

2014 PY Gross Plan Costs are estimated to increase \$7,225,000 over 2013 PY Gross Plan Costs

■ 2014 Assumptions

- 2% enrollment growth
- Trend rates
 - Current Presbyterian trend rate 6%
 - Current Lovelace trend rate 7%
 - Current Express Scripts /Medco trend rate 5%
 - PCORI Fee Included

■ Not included in FY 2014 LESC Funding Request

- Transitional Reinsurance Program Fee = \$1.1M
 - Half of this should be added to current request
- Migration / Enrollment growth
- Upswing in Trend Rates
- Risk of Loss of Pre-existing Conditions Limitation

WHAT WE KNOW

There are known knowns. These are things we know that we know. There are known unknowns. That is to say, there are things that we know we don't know. But there are also unknown unknowns. There are things we don't know we don't know.

Donald Rumsfeld

IMPACT TO APS OF PPACA

KNOWNNS

- Free preventive screenings, Women's Preventive services package including contraceptives, PCORI Fee, Dependent Children to age 26
 - Cost Approximately \$1M - \$1.5M
- Transitional Reinsurance Fee 2014 =\$1,091,286

KNOWN UNKNOWNNS

- Migration of members to APS's Plan
- Impact of Cost Shifting to Trend Rates
- How will 105h be changed?
- Loss of Pre-existing Conditions Limitations Exclusion – Cost?
- Current non-benefited members who work over 30 hours a week

UNKNOWN UNKNOWNNS

- What new regulations will come out of HCR?
- Will Safe Harbor Measurement Period rules be changed?
- Others?

**Prepared by Segal, Presented by
NMPSIA**

**Review of the Affordable Care Act Provisions
Impacting NMPSIA and School Districts**

Gary Petersen, FCA, ASA, MAAA, Vice President & Consulting Actuary,
The Segal Company

December 2012

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In 2012

➤ **Comparative Effectiveness Research Fees:**

- Applies to insured and self-funded plans
- In 2012 the fee is \$1.00 times average number of covered lives (employees plus dependents)
- For future years the fee is \$2.00 times average number of covered lives
- Fee sunsets with the plan year ending after 10-1-19

➤ **Quality Reporting for Non-Grandfathered Plans.** Awaiting regulations

In 2013

➤ **W-2 Reporting:** For employers with 250 or more employees, form W-2 reporting on the value of employer-sponsored coverage **is required starting Jan 2013**. W-2 reporting prior to this date is voluntary.

- Reporting the value of health coverage is an information item (**but not a taxable income item**) on employees' W-2 forms at the end of the year
- All employers that provide “applicable employer-sponsored coverage” during the year are subject to this requirement, including federal, state and local government entities, church/religious organizations, and employers that are not subject to the COBRA
- Report the employer plus employee contributions (**e.g. applicable COBRA Premium Rates**)

In 2013

- **Fees on Medical Devices and Rx:** new excise tax (fee) in 2013 on medical-device manufacturers and brand prescription-drug makers could cause increased claim costs for health plans
 - The fee is 2.3% of the sales price of any taxable medical device by the manufacturer or importer of the device
 - Medical devices include a wide range of products, such as surgical gloves, dental instruments, wheelchairs, coronary stents, artificial knees and hips, defibrillators, cardiac pacemakers, irradiation equipment, and advanced imaging technology
 - Certain devices exempt such as eyeglasses, contact lenses, hearing aids, OTC tests/devices
 - The tax could cause increased claim costs for health plans (we have assumed in our projections that our trend assumption covers them implicitly)

In 2013

➤ Notice about State Health Insurance Exchange:

- Employers will be required to notify employees of the availability of Health Insurance Exchanges (referred to as HIX)...awaiting more guidance.
- Employers must give employees written notice of a health insurance exchange, for all new hires starting March 1, 2013, and for all existing employees on or by that date.
- Written exchange notices must include information:
 - that an exchange exists, (including a description of the services provided by the exchange and contact information to request assistance);
 - to explain if the employer plan's is "unaffordable" (the plan pays on average, less than 60% of covered health care expenses), and if so, that the employee may be eligible for a premium tax credit (a subsidy) or a cost-sharing reduction if the employee gets coverage through the exchange; **Note: NMPSIA satisfies the "affordability test"**
 - that if the employee purchases coverage through the exchange, he or she may lose their employer contribution to employer-sponsored coverage and that there might be tax implications for the employee
- Awaiting more regulations on these notice requirements

In 2013

➤ Payroll Tax:

- Under current law, employers and employees each pay a payroll tax of 1.45% to finance Medicare Hospital Insurance (Part A).
- The Medicare Part A payroll tax increases by 0.9% for high income workers with wages over \$200,000 for individuals and \$250,000 for families, effective for tax years after 12-31-12.
- For employers the 1.45% tax remains the same, but for high income employees, the payroll tax will increase from 1.45% to 2.35% for the portion of their wage income over the threshold amounts.
- Assure the payroll department and affected employees are aware of this required change.

➤ Expansion of FICA

- A new 3.8% Medicare contribution tax is imposed on the unearned (passive) income of high-income individuals over the following levels:
 - High income means people with a modified adjusted gross income that exceeds \$200,000/individual or \$250,000/married couples filing jointly, and \$125,000/married individuals filing separately.
 - Passive income includes investment income, interest, dividends, royalties, capital gains, annuities, etc.
 - This new tax will be incorporated into an individual's income tax filing.

In 2013 or 2014?

➤ **Automatic Enrollment:** employers with more than 200 full-time employees that offer employees enrollment in a health benefit plan are required to automatically enroll new full-time employees in a medical plan

- Automatic enrollment only applies to employers who have more than 200 full time employees (full time defined as employees who work more than 30 hours per week)
- Requires an employer to provide adequate notice and the opportunity for an employee to opt out of any coverage in which the employee was automatically enrolled
 - Employee can opt out of coverage and elect another option, or opt out altogether.
- Until implementation regulations are issued, employers are not required to comply with the automatic enrollment requirement (which was to be effective 3-1-2013)

In 2014

➤ Changes in 2014, including:

- **No pre-existing condition limitation for any plan participant** (currently applies to individuals over age 19)
- For benefits-eligible individuals, **no waiting period for coverage in excess of 90 days** (waiting for final regulations, Notice 2012-58 and 2012-59 issued in August)
- The level of **penalties/incentives for wellness plans can increase to 30%** from 20%. This may be expanded to 50% at the discretion of the Secretary of HHS
- **Limit to cost-sharing for essential benefits:**
 - In 2014, PPACA will require employers with non-grandfathered plans to offer, and employees to be covered by, a health plan that provides “essential benefits” with **cost sharing limits no greater than those in a High Deductible Health Plan (HDHP) with a Health Savings Account** (2013 limit is \$6,250/individual, \$12,500/family)
 - **Deductibles for non-grandfathered plans may not exceed \$2,000 (single coverage) or \$4,000 (family coverage).** This provision may have been overridden by recent regulations. Awaiting guidance on whether this deductible impacts self-funded plans.

In 2014

- The legislation requires coverage of **clinical trials** beginning January 1, 2014 for non-grandfathered plans.
 - This requirement does not apply to grandfathered plans.
- **EDI Certification:** When rules on HIPAA Electronic Data Interchange (EDI) are announced, plan sponsors or their administrators must certify compliance.
- **Employer Reporting to IRS:** Unclear exactly when the IRS will require reporting of certain information on employer-provided health care coverage and the furnishing of related statements to employees
 - Reporting is related to information for each individual for whom minimum essential coverage is provided, waiting periods, monthly premium for lowest cost option, etc.
 - Applies to large employers (those with at least 50 employees)
 - Awaiting regulations

In 2014

- Beginning in 2014, medical coverage will be available from a [Health Insurance Exchange \(HIX\)](#) for eligible individuals and small businesses
 - Individuals can purchase medical plan coverage through the Exchange.
 - Due to underwriting restriction which preclude many current underwriting practices, coverage is expected to be more expensive than what is available to healthy individuals in the individual health care market today
 - Price compared to group employer market will vary by individuals age and coverage selected

In 2014

➤ Individual mandate:

- Individuals will be required to obtain minimum essential health coverage or pay a monthly tax penalty for each month without coverage
- Penalties for non-compliance (annualized)
 - 2014 - the greater of: \$95 per adult and \$47.50 per child (up to \$285 for family), or 1% of adjusted household income
 - 2015 - the greater of: \$325 per adult and \$162.50 per child (up to \$975 for family), or 2% of adjusted household income
 - 2016 - the greater of: \$695 per adult and \$347.50 per child (up to \$2,085 for family), or 2.5% of adjusted household income
 - Indexed thereafter
- Currently the penalty will be paid as a federal tax liability on income tax returns and will be enforced by the Treasury Dept.
 - Interestingly, IRS cannot file a tax lien to collect unpaid tax.
 - Appears IRS can only withhold unpaid tax from a tax refund or SS check, or write a letter requesting payment.
 - For healthy people, paying the penalty may be less expensive than paying for coverage

In 2014, District Requirements Applicable 1/1/2014

➤ No Coverage Penalty (also known as “Pay or Play”)

- If an employer does not offer full-time employees (and their dependents) an opportunity to enroll in employer coverage, and at least one full-time employee enrolls in the Exchange and the employee receives government subsidies to pay for Exchange coverage, then the employer is subject to a penalty.
- The **penalty is \$2,000** for each of an employer’s full-time employees.
- In calculating the penalty, however, the first 30 employees are excluded.
- Employers can avoid this penalty by offering health coverage to full-time employees.

District Counsel should carefully review non-benefit eligible employee status to determine if any options exist short of making all 30 hour employees benefit eligible

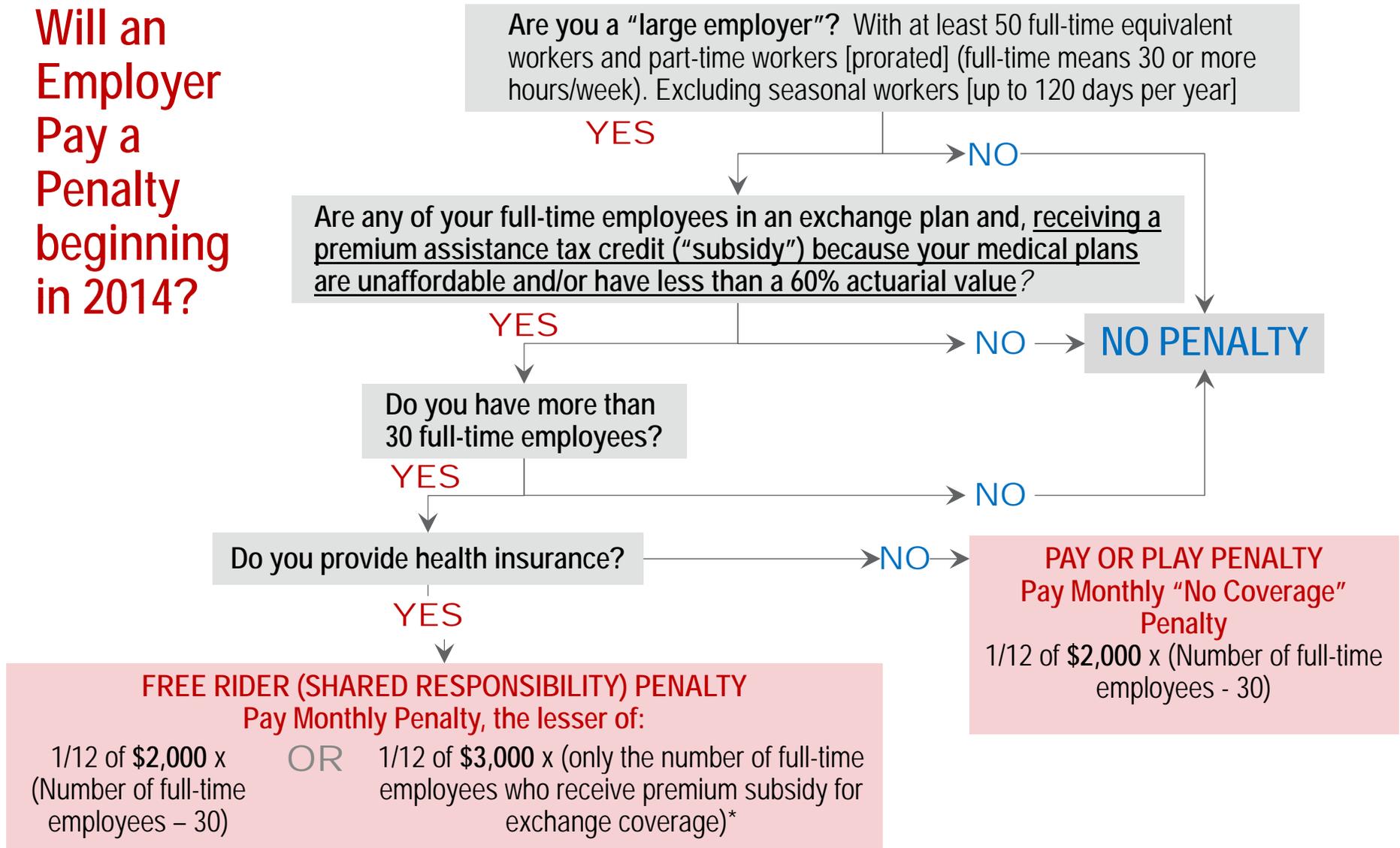
In 2014, District Requirements Applicable 1/1/2014

➤ Unaffordable Coverage (also known as “Free Rider”) Penalty

- The Free Rider penalty applies to employers with 50 or more FTE (part time employees are counted for purposes of determining if this provision applies)
- If an employer offers full-time employees and their dependents an opportunity to enroll in employer coverage, that alone will not necessarily avoid penalties, because, the coverage offered must be both affordable and valuable
- If at least one full-time employee enrolls in the Exchange and the employee is able to receive a government subsidy because the employer’s coverage is considered either **unaffordable or low-value**, then the employer is subject to a “free rider” penalty **Note: This will be a concern for non-benefit eligible employees at the District that meet definition of full-time employees.**
- The **penalty is \$3,000** for each full-time employee who is certified to receive a government subsidy
 - “Full time” means an employee who is employed for 30 or more hours per week

Simplifying a Complex Process

Will an Employer Pay a Penalty beginning in 2014?



Source: Congressional Research Service (CRS) analysis of P.L. 111-148 and P.L. 111-152.

In 2014

- An employee is eligible for **government subsidized coverage** in an Exchange (the premium assistance tax credit) if:
 1. the employer sponsored medical plan is unaffordable: annual employee premiums/contributions for the single coverage option with the lowest cost is more than 9.5% of the employee's household income, **or**
 2. the medical plan options do not provide at least minimum value (*i.e.* provide coverage that has an actuarial value less than 60%) **NMPSIA coverage meets the minimum value test**
- Person must have household income between 100% and 400% of the federal poverty level (FPL), must not be incarcerated or be enrolled in Medicare, Medicaid, CHIP, Tricare, VA, IHS. Must be a US citizen or legally documented immigrant.

Pass/Fail Test for Affordability: Is a members annual contribution for the lowest cost single coverage that meets the “value test” (i.e. the Presbyterian Low Option Plan) divided by .095 less than annual household income (can use W-2 wages [as reported in Box 1] as a safe harbor estimate for household income)?

In 2014, 2015 and 2016

➤ Temporary Reinsurance Fee

- Insurers and third party medical plan claims administrators must pay fees to help finance state-established reinsurance programs to cover high cost individuals
- The state run reinsurance programs are meant to stabilize the individual insurance market from 2014 thru 2016. Fee decreases annually and sunsets after 2016.
- **The amount of the federally established fee is based on a \$5.25 per capita contribution rate for each person enrolled in the plan who resides in a particular state**
 - National contribution rate is set by HHS but each state has the option to collect additional amounts for administrative expenses
 - Rates to be adjusted by HHS on an annual basis
 - First estimate of rates and method of payment due to be released in October 2012 and finalized in January of 2013
- HHS will collect fees beginning January 15, 2014 and quarterly thereafter
- Self-insured and insured group health plans are not eligible to receive any reinsurance payments

In 2017

- Employers with more than 100 employees may be eligible to purchase medical plan coverage as a plan sponsor through the Exchange starting in 2017 (if their state approves large employers to purchase coverage in the Exchange)
 - If adopted, it appears rules may preclude experience rated group insurance policies
 - Will likely encourage employers with more than 100 employees to consider self funding if they are philosophically committed to supporting employee “wellness” since rates in insured plans would not be based on the groups experience

In 2018

➤ Excise Tax (a “Cadillac Tax”) on High Cost Health Plans

- There will be a 40% excise tax on the value of medical plans that cost above a certain threshold. Excludes dental and vision.
 - The initially published threshold in 2018 is \$10,200/year for an employee less than age 55 or who is Medicare eligible, and \$27,500/year for a family. (Multiemployer plans use \$27,500 for both single and family coverage.)
 - In future years, threshold amounts will be indexed for inflation. This means to check your plans for excise tax potential each year.
 - The excise tax is imposed on the excess benefit provided to employees, comparing the cost of coverage provided to the annual threshold limits above.
 - Liability for the excise tax is determined on a monthly basis.
 - Employees over age 55 who are not Medicare eligible retirees and employees in high risk professions like electricians/telecommunication line workers, will have higher thresholds.
 - » e.g. \$11,850/ year for single retiree and employee in high risk professions; \$30,950/year for family retirees and employees in high risk professions
- Can delay or avoid Cadillac tax for several years beyond 2018 by reducing or eliminating future health care benefits as necessary
- Consider tracking the value of plans annually and developing a response strategy when projection cost hits 80% of the threshold.