Affordable Care Act
Employer Shared Responsibility

Egyptian Area Schools Employee Benefit Trust
Board of Managers

March 20, 2013

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Insurance Market Reforms

- Important changes in individual and small group insurance markets (small group = up to 50 employees in 2014 and 2015; up to 100 employees after 2015)
- Plans must offer all Essential Health Benefits (EHB)
- State Insurance Exchanges ("marketplaces") for individuals and small employer groups to buy insurance
- Guaranteed Availability and Renewability – no underwriting
- Standard Benefit Plan Options
- Community Rating / single risk pool

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Insurance Market Reforms

Essential Health Benefits

- All Non-grandfathered individual and small group insurance policies, both inside and outside the exchanges, are required to include all EHB's.
  - Ambulatory patient services
  - Emergency services
  - Hospitalization
  - Maternity and newborn care
  - Mental health and substance use disorder services, including behavioral health treatment
  - Prescription drugs- at least one drug in each category or the equivalent of those offered in the stated proposed benchmark EHB plan- whichever is greater

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Insurance Market Reforms

Essential Health Benefits

- Required EHBs (continued)
  - Rehabilitative and habilitative services and devices
  - Laboratory services
  - Preventive and wellness services and chronic disease management
  - Pediatric services, including oral and vision care
- Specific EHB package required is determined based on a designated benchmark plan in each state.
- Self-funded plans such as the Trust are not required to offer EHBs.

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Insurance Exchanges

- Starting in 2014 individuals and small employer groups can purchase insurance through exchanges using a uniform application
- Exchanges must:
  - Certify health insurance plans offered as Qualified Health Plans (QHPs)
  - Provide consumer support for selecting coverage, including Medicaid and CHIP
  - Facilitate eligibility determinations for individuals for different options
  - Provide for enrollment in QHPs in the exchange
- All individuals will be able to buy insurance at standard rates, regardless of health condition
- Federal premium tax credit may subsidize the cost of individual insurance purchased on an exchange, depending on household income and access to employer coverage

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SHOP Exchanges

- Small Business Health Options Program (SHOP) exchanges will create a new option for small employers to offer coverage to employees
- Beginning in 2015 SHOP exchange must allow employer to designate coverage level (metal level) and then allow employees to choose among all of the QHPs offered through the exchange with the specified coverage level
- SHOP exchange will perform premium aggregation function so employer only has to remit premiums to one place
- For 2014 SHOP exchange can limit employees to single QHP selected by the employer

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Exchange Enrollment Periods (Individual Market)

Enrollment Period	Length	Dates	Effective Date
Initial	6 months	October 1, 2013 – March 31, 2014 (extended in final rule)	❖ Qualified individuals must select their QHP by the 15th of the month for coverage to be effective on the 1st of the following month. ❖ QHP selections made after the 15th become effective the 1st of the second following month.
Special	60 days	Period lasts 60 days from triggering event	Same as initial enrollment period.
Annual	53 days	October 15 – December 7 (Notice sent between September 1 and 30)	January 1st of new benefit year

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Standard Insurance Plan Options

Actuarial Value (AV)

- Non-grandfathered individual and small group insurance plans offered inside **and outside** the exchanges must meet specific actuarial value (AV) targets:
  - Bronze = 60% AV
  - Silver = 70% AV
  - Gold = 80% AV
  - Platinum = 90% AV
- Plans must be designed to pay the specified percentage of the total allowed costs expected to be incurred
- Catastrophic plans with lower AV permitted for young adults ages 21 to 30

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Modified Community Rating

- Prohibits insurers from charging individuals or small groups differently based on health status, occupation, gender, duration of coverage, credit worthiness or most other factors.
- Premiums can only be adjusted based on certain factors, including:
  - Family members – no additional cost for > 3 children under age 21
  - Geography – 13 rating areas in Illinois
  - Age – Maximum 3:1 ratio for age differences (highest cannot be more than 3 x the lowest rate)
  - Tobacco use – Maximum 1.5:1 ratio for tobacco use
- Insurance premiums are likely to increase for younger/healthy individuals and small groups, but could possibly decrease for older/sicker individuals and small groups.

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ACA Impact on Individuals in 2014

New Coverage Options

- Medicaid expanded to 138% of federal poverty level (FPL) ($15,856 for individual and $32,499 for family of four in 2013)
- Guaranteed individual insurance at standard rates regardless of medical condition
- Premiums for insurance purchased through exchanges may be subsidized depending on income and access to employer plan

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ACA Impact on Individuals in 2014

Individual Penalty for Failure to Maintain Coverage

- All US citizens and legal residents are required to have minimum essential coverage (MEC) or pay penalty
- MEC generally includes any employer-sponsored medical coverage, COBRA, individual insurance policy, Medicare, Medicaid, CHIP, Tricare, VA coverage
- Penalty applies for any month without MEC if household modified adjustment gross income (MAGI) is above federal tax filing level
- Penalty is 1/12 of greater of $ amount or % of MAGI above federal tax filing threshold: 1% for 2014, 2% for 2015, 2.5% for 2016
- No penalty for short coverage gaps of less than 3 consecutive months or if coverage would cost more than 8% of household income

ACA Impact on Individuals in 2014

Federal Subsidies

- Premium tax credit up to 400% of FPL ($45,960 for individual and $94,200 for family of four in 2013)
  - Only available for coverage purchased in exchange, not employer plan
  - Only available if coverage offered by employer is not "affordable "or does not meet "minimum value" requirements
  - Sliding scale limits individual share of premium costs to a between 2% (up to 133% FPL) and 9.5% (300-400% FPL) of household income; subsidy pays the balance of premium

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ACA Impact on Individuals in 2014

Federal Subsidies

- Example:
  - Individual with annual income of $23,240 (200% of trended 2014 FPL): At 200% of FPL individual's premium is capped at 6.3% of income or $122/month; the balance of the premium will be paid by federal subsidy
- Subsidy may be advanced (paid directly to exchange) or refunded (claimed on tax return)
- Cost sharing subsidies up to 250% of FPL (assistance with out of pocket costs such as deductibles and co-pays)

Employer Mandate

Employer Mandate – Who is Subject to Pay or Play?

- Large employers must offer minimum essential coverage (MEC) to full-time employees in 2014 or pay penalty.
- An employer that employed an average of at least 50 **"Pay or Play Employees"** on business days during the preceding **calendar year** will be considered a **"Large Employer"** starting in 2014.
- Related employers must be aggregated in determining large employers.
- Mandate and penalties apply to tax-exempt and government employers including school districts.

Employer Mandate

Determine if you will be Subject to Pay or Play in 2014

- Determine the number of "**Full-Time**" employees each month for 2013
- Determine the number of "**Full-Time Equivalent**" (FTE) employees each month for 2013
- Determine the average number of Pay or Play Employees for 2013

Employer Mandate

Full-time Employee Calculation

- A full-time employee is an employee who works, on average, **30** hours per week or **130** hours per month
  - For hourly employees – count actual hours
  - For salaried employees – count actual hours or use equivalencies:
    - 8 hours per day worked
    - 40 hours per week worked
- Total the number of full-time employees each month in 2013 and divide that sum by 12 months to determine the total average number of full-time employees for the year.

If you average at least 50 full-time employees a month in 2013 you will be subject to Pay or Play in 2014.

Employer Mandate

Full-time Equivalent (FTE) Employee Calculation

An employer with fewer than 50 full-time employees must determine the number of any FTEs

- Who are FTEs?
  - All employees who were not full-time employees for any month in 2013
  - FTEs are determined on a monthly basis
- How do you calculate FTEs?
  - Calculate the total number of hours (but not more than **120 hours** for any one employee) for all employees who were not full-time employees for that month
  - Divide the total hours of service calculated above in each month by **120**

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Employer Mandate

Total Number of Pay or Play Employees for the Year

- First, for each month add the total number of full-time employees to the total number of FTEs (do not round any fractions for FTE totals)
- Next, add all the monthly totals together and divide by 12 to determine the average number of Pay or Play employees for the year
- If your final average number is less than 50 you are not subject to Pay or Play for the next calendar year

If your final average annual Pay or Play employee number contains a fraction, you may round down the fraction (49.99 becomes 49).

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Employer Mandate

Employer Penalty A – No Coverage Offered

- Large employer does not offer minimum essential coverage (MEC) to **95%** of full-time employees (or all but 5 full-time employees) and their children to age 26; not required to offer coverage to spouses
- For any month at least one full-time employee enrolls for subsidized coverage through an exchange
- Annual penalty of $2,000 for each full-time employee in excess of 30 employees, including employees with employer plan coverage
- Penalty is calculated monthly based on full-time employees each month over 30 x $166.67 ($2,000/12)
- FTEs do not count for penalty purposes, only for determining large employer status

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Employer Mandate

Employer Penalty B – Coverage Offered but Not Affordable

- Large employer offers MEC to at least **95%** of full-time employees (or to all but 5 full-time employees) and children to age 26
- But MEC offered does not provide "minimum value" or is not "affordable"
- For any month at least one full-time employee enrolls for subsidized coverage through an exchange
- Annual penalty of $3,000 per full-time employee who obtains subsidized coverage through an exchange
- Penalty is calculated monthly based on employees who obtained subsidized coverage in that month
- Penalty cannot exceed penalty for offering no coverage

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Employer Mandate

Affordable Coverage

- ACA says coverage is not affordable if it costs the employee more than 9.5% of household modified adjusted gross income (MAGI), including income of family members
- Proposed Regulations provide that for this purpose 9.5% applies to cost of **single coverage** only; employees may be charged full cost of coverage for dependents without causing it to be deemed unaffordable
- If employer offers more than one plan option, affordability may be tested using **lowest cost option** that provides minimum value

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Employer Mandate

Affordable Coverage

- Proposed Regulations permit using safe harbors instead of household income (all pro-rated for months of coverage):
  - 9.5% of employee's W-2 wages as reported in Box 1 (this excludes pre-tax deferrals to 401(k) plans and cafeteria plans from wages); or
  - 9.5% of employee's rate of pay on the first day of the year (monthly salary or hourly rate x 130 hours/month) (with this safe harbor the rate of pay may not be decreased during the year); or
  - 9.5% of 100% of federal poverty level (FPL) for a single individual ($11,490 for 2013; 9.5% is $1,092/year or $91/month for single coverage) .
- Employer may use different safe harbors for different reasonable categories of employees.

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Employer Mandate

Affordable Coverage

- Impact on Eligibility for Subsidy
  - For purposes of being eligible to buy subsidized coverage on an exchange, employer coverage is deemed affordable if employee cost for single coverage does not exceed 9.5% of household income
  - Dependents cannot qualify for subsidy to buy coverage on exchange if employee has affordable coverage, even if the employee has to pay full cost of dependent coverage on the employer plan
  - Offering affordable coverage to low paid employees with families will disqualify them from receiving federal subsidies

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Employer Mandate

Minimum Value

- Plan must pay at least 60% AV (60% of the total allowed cost of covered services expected to be incurred). This may be established :
  - Using HHS minimum value calculator by entering key plan design features (deductibles, coinsurance and out-of-pocket costs) for core services;
  - Matching a check-list of design-based safe harbors to be published by HHS and IRS for core services;
  - Certification by an independent actuary.
  - All Plans offered by the Trust provide minimum value.
- Employer contributions to HSAs and HRAs count toward minimum value
- Self-insured employer health plans and large insured health plans are not required to provide EHBs to provide minimum value.

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Employer Mandate

Minimum Essential Coverage

- Future regulations are expected to provide guidance on what is required to be MEC
- Employer-provided medical coverage can qualify as MEC even if it does not provide minimum value
- At this point no minimum level of benefits is prescribed, but MEC does not include "excepted benefits" such as accident or disability plans, specified illness plans, dental plans, vision plans, flexible spending accounts, etc.

Employer Mandate

Application of Pay or Play Penalties in a Controlled Group

- Proposed Regulations provide that within a "controlled group" of employers, the mandate and penalties apply separately for each employer member of the group. Must aggregate to determine large employer status but may disaggregate for penalties.
- Each employer in the group may exclude, inadvertently or intentionally, up to 5% or 5 full-time employees.
- Example: If only one employer in the group does not offer coverage to 95% of its full-time employees (or all but 5 employees), the $2,000 no coverage penalty applies only for the full-time employees of that entity, not all full-time employees in the entire group.

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Employer Mandate

Application of Pay or Play Penalties in a Controlled Group

- The 30 "free" employees rule is applied pro rata based on the portion of the group's full-time employees employed by each member.
- Example: If there are 150 full-time employees in the controlled group and one employer with 50 full-time employees does not offer coverage to its employees, the penalty for that employer would be $2,000 x 40 employees (50 – 10 free employees).
- Generally, each school district with its own school board should be considered independent and not a member of a controlled group.

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Employer Mandate

Assessment of Penalty

- If any employee qualifies for and enrolls for subsidized coverage through an exchange, IRS will notify the employer of potential liability for penalty.
- IRS contact for a given year generally will not occur until after the due date for individual tax returns and after the due date for employers to report to IRS full-time employees and coverage offered.
- Employers will have an opportunity to respond before penalty is assessed (for example, by showing that employee declined affordable coverage offered by the employer).
- If IRS determines employer is liable for payment, IRS will send notice and demand with instructions for payment.

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Identifying Full-time Employees

Full-time Employees

- A full-time employee for any month is an employee employed on average at least 30 hours per week (or 130 hours per month).
- If a new employee is reasonably expected to work 30 hours per week, to avoid penalty coverage must be offered to employee and dependent children effective not later than after **90 days** of employment.
- Cannot wait until first of month after 90 days of employment to provide coverage. Failure to offer coverage for any day in a month is treated as failing to offer coverage for the entire month.
- Employers are free to offer coverage to employees working less than 30 hours per week, but 90 day maximum waiting period applies for all employees eligible under plan eligibility rules.

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Identifying Full-time Employees

Variable Hours Employees

- Variable Hours Employee are employees who work varied hours such that the expected average hours per week cannot reasonably be determined in advance, such as substitute teachers.
- For these employees, instead of looking at full-time status month to month, and offering coverage month to month, the employer has the **option** to determine average hours over a "measurement period" of from 3 to 12 months.
- If employee's average hours equal or exceed 30 hours per week over the measurement period, the employee is considered full-time for a "stability period" of at least 6 months or the length of the measurement period, if longer, regardless of actual hours worked in the stability period.
- If employee's average hours are below 30 per week over the measurement period, the employee is not considered full-time for a stability period that is not longer than the measurement period (but stability period may be one month longer than employee's initial measurement period).

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Identifying Full-time Employees

Variable Hours Employees

- Employer may have different measurement and stability periods for salaried and hourly employees and for each group of collectively bargained employees.
- Employer will have a different "initial measurement period" for new employees (e.g., first 12 months of employment) and "standard measurement period" for ongoing employees (e.g., plan year or period ending up to 90 days before plan year begins).
- Employer may have an "administrative period" of up to 90 days between the end of the measurement period and beginning of the stability period, subject to limits.
- For ongoing employees, measurement period normally should correlate with open enrollment period for coverage.

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Identifying Full-time Employees

Variable Hours Employees

Example: Ongoing Variable Hours Employee
Assume plan year begins September 1, open enrollment begins August 1, and employee has been employed for at least one standard measurement period

- Standard measurement period is July 1 through June 30
- Administrative period is July 1 to September 1
- Stability period is the plan year
- In July Employer determines whether employee averaged 30 hours per week during the preceding standard measurement period.
- If employee averaged 30 hours he is considered full-time and must be offered coverage during open enrollment beginning August 1 for coverage effective September 1. Coverage will continue throughout the plan year stability period regardless of actual hours worked in the year.
- If employee did not average 30 hours in standard measurement period he will not be considered a full-time employee throughout the stability period, regardless of actual hours worked in the year.

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Identifying Full-time Employees

Variable Hours Employees

Example: New Variable Hours Employee

- Initial measurement period is first 12 full months of employment
- Administrative period is month following initial measurement period
- Stability period is 12-month period beginning after administrative period
- At end of first 12 months Employer determines if employee averaged 30 hours per week during the initial measurement period.
- If employee averaged 30 hours, he is offered coverage effective the first day of the following month (i.e., after 13 months of employment) and continuing for 12-month stability period.
- Employer will also measure this employee's hours over the overlapping standard measurement period to determine whether to offer coverage for the next full plan year. Even if employee does not average 30 hours over the standard measurement period, he is still eligible for coverage for the duration of his first 12-month stability period.
- If at any time during the initial measurement period the employee is moved to a full-time position, to avoid penalty coverage must be offered effective no later than the first day of the fourth month after the change to full-time employment.

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Identifying Full-time Employees

Variable Hours Employees

- Hours of service include all **paid** non-work time (vacation, holidays, paid leave, disability leave)
- Special Unpaid Leave: Unpaid hours for jury duty, FMLA and USERRA leave must be credited if employee returns without a break. Employer can either:
  - Exclude the leave period from average hours in measurement period; or
  - Credit leave period with average hours worked during non-break period, no maximum.
- Academic Year Rule: Hours must be credited for educational employees for non-working periods of more than 4 weeks in academic year. Employer can either:
  - Exclude the leave period from average hours in measurement period; or
  - Credit leave period with average hours worked during non-break period, up to 501 hours.
- Regulations include rules for rehires/returns from unpaid leave:
  - Employee may be treated as a new hire after a 26-week break;
  - Employer may elect to use rule of parity which allows treatment as new hire after a break not shorter than 4 weeks or the immediately preceding period of employment, if longer.

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Some Transition Rules

- **50 Employee Test:** Employers can use any 6-consecutive month period in 2013 (instead of full year 2013) to determine whether they have an average of 50 employees to be considered a large employer for 2014 only. After 2014 the average must be determined over the entire prior year.
- **Multiemployer Plans:** At least through 2014, an employer will not be subject to penalty with respect to any full-time employee for whom the employer is required to make contributions to a multiemployer plan if the plan offers affordable coverage which provides minimum value to the employee and children to age 26 and complies with the 90-day limitation on waiting periods.

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Some Transition Rules

- **Fiscal Year Plans:** Employer will not be subject to penalties before the first day of the 2014 plan year for:
  - Employees who would have been eligible for coverage under the eligibility rules in effect December 27, 2012, but are not enrolled, if plan offers affordable, minimum value coverage by the first day of the 2014 plan year.
  - If plan covered at least one-fourth of the employer's employees or coverage was offered to at least one-third of employees (full-time and part-time) at the most recent open season before December 27, 2012 and plan offers affordable, minimum value coverage to full-time employees by first day of the 2014 plan year.

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Some Transition Rules

- **What this Means for Trust Employers**: A district that offers affordable, minimum value coverage to full-time employees by September 1, 2014 will not be subject to penalties for months before September 1, 2014 for:
  - Employees who would have been eligible for the employer plan under eligibility rules in effect in December 2012 but did not enroll.
  - Employees (such as substitutes) who were not offered coverage if employer plan covered at least one-fourth of employees or was offered to at least one-third of employees at the fall 2012 open enrollment.

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Action Steps for Employers

- Determine whether the employer meets the 50 employee threshold to be a "large employer" subject to the mandate.
- If large employer has variable hours employees, determine methods for measuring full-time status for such employees:
  - Determined status month to month or use lookback measurement period/stability period safe harbors
  - Count actual hours or use safe harbor equivalencies
- Begin tracking hours and maintain documentation.
- Identify full-time employees for 2014.

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Action Steps for Employers

- Does employer offer MEC to at least 95% of its full-time employees (or all full-time employees except 5)?
- If not, decide whether to offer coverage to remaining full-time employees or pay the $2,000 no coverage penalty.
- Determine method for measuring affordability and whether coverage offered is affordable for all full-time employees.
- If test is not satisfied, consider adding lower cost plan option or modifying employee cost-sharing structure to make employee coverage affordable.
- Consider whether subsidized exchange coverage may be more favorable for some employees. Employer is not subject to penalty when a non full-time employee obtains subsidized coverage.

Action Steps for Employers

- If coverage is not affordable for some full-time employees, compare the cost of increasing employer share of premium cost to the cost of paying the $3,000 unaffordable coverage penalty for employees who may be eligible to elect subsidy.
- During open enrollment in 2014, document that full-time employees have been offered coverage; require employees who do not enroll to sign waivers.
- Amend employer policies if necessary to incorporate changes in enrollment rules (e.g., if coverage is offered to variable hours employees after initial measurement period).

Considerations for the Trust

- Change Plan names? Trust plans do not meet corresponding ACA metal plan AV requirements, so may be confusing.
- Should the Trust cover all EHBs (such as pediatric dental) to offer coverage comparable to what will be offered in the small group insurance market?
- Will availability of coverage through the exchange cause districts to drop employer coverage?
  - Small districts will not be subject to penalty if drop coverage
  - Larger districts may find $2,000 per full-time employee cheap compared to providing coverage, but the penalty will rise in future years.
  - Districts are unlikely to be able to drop current coverage without providing some corresponding benefit to employees. Adding dollars to taxable pay is less valuable than providing non-taxable health coverage.
  - Changes will be subject to negotiation.

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Considerations for the Trust

- Will availability of coverage through exchanges eliminate the need to allow retirees to participate (if the IMRF coverage rule is changed)?
- At this point there is no good way to estimate how the cost for coverage in the exchange will compare with the Trust's premiums.
- Initially, uncertainty about the exchanges may limit attrition, but as employees and districts become knowledgeable about the options (and if the exchange works as hoped) there may be more movement.
- Amend the Plan to allow employees to add or drop coverage at January 1 each year without a qualifying event to coincide with open enrollment on exchanges.
  - Drop coverage 1/1/2014 to go to an exchange
  - Add coverage 1/1/2014 to avoid individual penalty for no coverage

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Other ACA Requirements

Key ACA Provisions Deferred Pending Guidance

- **Nondiscrimination Rules** for nongrandfathered insured health plans
  - Nondiscrimination rules are already in effect for self-funded health plans, but there is considerable uncertainty as to how these rules apply
  - Districts will likely be required to change any cost-sharing practices which favor administrators/highly compensated employees to avoid additional tax penalties
- **Automatic Enrollment** of employees in health plans (but employees must be given the opportunity to opt out)

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Cafeteria Plan Transition Rule

Cafeteria Plan Elections

- Under current Regulations, availability of coverage through an exchange is not an event that permits employees to change cafeteria plan salary reduction elections.
- Employers may (but are not required to) amend **fiscal year cafeteria plans** by December 31, 2014 retroactive to the first day of the 2013 plan year to allow employees to change their elections prospectively to:
  - drop employer plan coverage one time during the 2013 plan year, and/or
  - enroll in an employer health plan during the 2013 plan year to avoid the individual responsibility payment.

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ACA Notice and Reporting Requirements

- Annual W-2 reporting of value of coverage provided, starting with W-2 issued in January 2013 for coverage provided in 2012
- Summary of Benefits and Coverage (SBC) must be provided to employees in standard format, starting with enrollment periods for plan year beginning in 2013
- Must provide employees 60-days advance notice of any benefit changes

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ACA Notice and Reporting Requirements

- ACA required employers to give employees notice of coverage available through exchanges by March 1, 2013.
- Regulations have not been issued so federal regulators have extended the effective date. Regulators intend to issue a model notice and instructions before October 1, 2013 when the exchanges are supposed to open.
- Insurers and plans must report annual enrollment count to HHS for transitional reinsurance fee by November 15, 2014, 2015 and 2016; Proposed Regulations include permitted methods for counting covered lives.

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ACA Notice and Reporting Requirements

- Employers must report to IRS starting for 2014:
  - Health coverage offered
  - Premium for lowest cost option
  - Employer's share of total costs of benefits
  - Waiting period
  - Full-time employees for each month
  - Name, address and TIN for each full-time employee and months the employee was covered under employer plan
- Employers must report to HHS and/or exchanges any time upon request to verify if employee has affordable employer coverage.

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New ACA Fees

Comparative Effectiveness Research Fee

- Used to fund Patient-Centered Outcomes Research Institute
- Payable for each plan year or policy year **ending** after October 1, 2012 and before October 1, 2019
- First payment due July 31 after end of plan year (7/31/2014 for Trust)
- Fee is payable by health insurance issuers and plan sponsors of self-insured health plans, including retiree-only plans; excludes excepted benefits
- Annual fee is $2 (indexed) times the average number of covered lives ($1 for plan/policy years ending before October 1, 2013)
- Regulations prescribe options for counting lives and rules for aggregating plans
- Fees are treated as excise taxes, and will be reported annually and paid on IRS Form 720

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New ACA Fees

Transitional Reinsurance Fee

- Payable for three calendar years beginning in 2014
- First payment due around January 15, 2015 for 2014
- Used for transitional reinsurance program for insurance issuers covering high risk individuals in the individual market
- Fee is assessed against health insurance issuers and self-insured plans providing major medical coverage (excludes certain excepted benefits, HSAs, FSAs, EAPs, HRAs integrated with a group health plan)
- Applies on a per capita basis for all covered lives, including covered dependents and COBRA beneficiaries (but excludes retirees for whom Medicare is primary)
- Regulations prescribe rules for counting lives and aggregating plans (e.g., employer offers HRA with medical plan)
- Amount to be set annually; for 2014 fee is $5.25 per month per covered person ($63 per year), over $1 million for Trust

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New ACA Fees

Health Insurance Provider Fees

- Another new fee is payable only by insurance carriers for insured plans, not by self-funded plans
- This fee is based on an aggregate dollar amount set by statute and allocated based on each insurer's proportionate share of net premiums
- Estimated to be 1.9% to 2.3% of premium in 2014 and expected to rise to as much as 3.7% by 2023
- A separate "user fee" applies to insurers offering coverage through the exchanges, estimated to be about 3.5% of premium
- These additional costs for insurers should make the Trust even more cost-effective for districts relative to insured plans

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