CalCPA ProtectPlus

Trusted Healthcare Plans for CPAs

SECOND EDITION

April 15 Will Look Like a Picnic

A HANDBOOK FOR CalCPA MEMBERS

HEALTH CARE REFORM — 2015+ HEALTH CARE REFORM REGULATIONS

WHAT CPAS NEED TO KNOW FOR:

- YOUR CUSTOMERS
- YOUR FIRM
- YOU

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Preface

The sky didn't fall on January 1, 2014, but there was certainly cost increases and chaos in the health care insurance market for many

Political slants seem to creep into any discussions of the Patient Protection and Affordable Care Act (ACA). Further clouding occurs as pundits, politicians and the media inter-mix terms, facts and opinions. We attempt here to provide valuable information in a politically neutral way. This second edition is presented about a year after the first and at a time that should assist in preparing for the next wave of changes that will hit the health insurance market January 1, 2015.

As of this writing, over 40 changes have been made to the law since it was originally passed. Most notably and recently, California passed SB1446 that delays many small employer ACA provisions until 2016, (most CPA firms and their clients are designated small employers under ACA). To address the ever shifting nature the law has shown to date, the CalCPA ProtectPlus web site contains updates, articles, blogs and FAQ's to supplement the information contained here. CalCPA's Group Insurance Trust has also presented CPE classes and other videos that are available to CalCPA members covering many ACA topics.

Although ACA introduces new regulations through the entire health care arena, for the most part, it set out to address the approximately 47 million uninsured. But the lead up to January 1, 2014 was chaotic and confusing for those individuals and groups who were already insured, fueled by change in general, but also by some very significant late regulatory changes in the law adopted by both California and the Feds. The term used in the industry is displacement, meaning any disruption to coverage caused by policy cancellations; provider network shrinkage; premiums increases or decreases; benefit changes; and new enrollment processes, especially those that malfunction. All of which occurred in the individual and small group markets this past health insurance season.

There are still many unanswered questions going into the fifth year after ACA's passage. Predictions of things like death panels seem to have faded while predictions of doctor shortages and higher costs for all are currently in the forefront. The first edition of this book asked "Will there be rapid cost increases and utter chaos in the health insurance market in a few short months, or will January 1, 2014 be yet another Y2K sky that does not fall?" Well the sky didn't fall, but there was certainly cost increases and chaos for many.

CalCPA established the Group Insurance Trust more than 50 years ago to serve as a uniquely dedicated resource for CalCPA members' health insurance needs. And, in today's rapidly changing environment of health care reform, this role is more important than ever.

If you have specific informational needs or questions, please contact the Group Insurance Trust of the California Society of CPAs (GIT). We have established a health care reform question and answer email "hotline" at ACA@calcpa.org—or you can simply give us a call at 650-522-3258.

Introduction

This book focuses on the key ACA elements that affect California CPAs.

The Patient Protection and Affordable Care Act (ACA) is exceedingly vast. It deals with all aspects of the medical delivery system including insurance. Combine this with the numerous changes California is implementing and the result is tens of thousands of pages, comprising both federal and state regulations.

This book focuses on the key elements that affect California CPAs. Therefore, we will concentrate on those ACA regulations that are being adopted and implemented in California. And, while other states may have slightly different implementations, they will not be specifically addressed here.

Our intent is that you may use this book as a reference for the areas that are of particular interest to you, or those areas that expressly affect you. For example, if you are with a small firm and do not have any "large employer" clients, the large employer sections may be of less value to you than the information on small employers.

Additionally, ACA—and health insurance in general—may introduce a number of new terms that you may not be entirely familiar with. We hopefully provide a good understanding and definitions of these new terms in the context of this book.

As mentioned in the preface, ACA and its related California regulations are still being issued—and we anticipate this will continue for some time. Therefore, this book is a snapshot as of this publication date and we will update using the CalCPA Protect Plus web site in between book editions. With ACA regulations still being issued and changed, verify the current regulations sighted here (IRS, HHS, DOI, DOL) before acting on a regulation for yourself or advising a client.

Identifying whether you are small group or large group is fundamental.

The first step in navigating ACA is to determine which set of rules to play under. For the most part, the regulations are determined by size. So, whether for yourself, your firm or in counseling a client, determine which of one of these three classifications will apply:

- Sole proprietors are classified as individuals under ACA; they have no W-2 employees.
- Small employers have between 2 and 49 employees.
- Large employers have over 50 full-time equivalent employees
  - Employers with 50 to 99 employees have a delay until 2016 certain ACA provisions

Identifying whether you are small group or large group is fundamental.

Small employers do not have a mandate, tax or penalty to provide coverage to their employees. A tax credit is available to encourage some small employers to offer health coverage to their employees.

Large employers, on the other hand, are subject to significant "play or pay" penalties, which may amount to as much as $3,000 per employee, per year for non-compliance.

Determining small or large can be very simple or complicated depending on the situation. These calculations are detailed in the small group section.

So, where do we start? Here is a timeline of where we have been—and where this is all going.

ACA TIMELINE

2010	2011	2012	2014	2015 and Beyond

• Dependent coverage thru age 26
• Preventative services with no cost-sharing
• Waive pre-existing for children
• Eliminate lifetime caps on essential benefits
	• Minimum Medical Loss Ratio (MLR) requirements	• Women's preventative services covered at 100%	• Individual Mandate
			• Health Insurance Exchanges
			• Small Group/Individual
			  • Eliminate health underwriting
			  • Adds limits on deductable/ OOP amounts
			  • Abolish pre-existing condition restrictions
			  • Premium Rating Rules
			• Eliminate annual spending caps
			• Expansion of Medicaid/Medi-Cal
				• Large Group Employer Penalties (play or pay)
				• (2016) Small employees 50-99 mandates
				• (2018) Cadillac tax

January 1, 2015 - the large employer mandate - "play or pay" - will be the last big provision to be implemented

To date, ACA has put in place:

- Extended dependent coverage thru age 25
- Eliminated annual and lifetime benefit maximums
- Mandated preventative services
- Individual mandate to purchase insurance or pay a tax
- Mandated benefits and benefit levels for individual and small employers
- Individual and small employer (SHOP) purchasing exchanges
- Elimination of preexisting condition restrictions
- Community rating and mandated rating methodologies for individual and small groups
- Deductible and out-of-pocket costs limitations
- Numerous taxes and penalties on individuals, employers, health plans, pharmaceutical and medical device suppliers

Left for a January 1, 2015 is the last big provision to be implemented, the large employer mandate – "play or pay."

2014 meant big changes for individuals and small groups. Here in California, like most of the nation, we experienced significant disruptions in premium rates when government imposed premium rating rules went into effect. These new rating rules, along with mandated (higher) benefit levels, limits on deductibles and out-of-pocket costs, pushed about half of the individual/small groups who previously had insurance, into more costly plans. The other half of these markets had the new math work in their favor and reduced their premium costs.

The individual mandate also began in 2014 although non-compliant individuals will not pay the tax/penalty until they file their 2014 returns in 2015. The individual mandate started out fairly straightforward; obtain health coverage or pay the tax. A number of exemptions have subsequently been issued that in some cases fix the legislation and in other cases water it down somewhat.

What's Not "Covered" in this Book

ACA is vast legislation and, as of this writing, some estimates of the federal regulations calculate it to be more than 15,000 pages—and growing.

And, once you throw in the California regulations, we have a mind-boggling number of regulations covering insurance, medical delivery, taxes, patient access—and the list goes on and on. So, while our Table of Contents defines what is covered in this book (no pun intended), we also thought it may be beneficial to list some of the items that **are not** specifically addressed. Hopefully, this will save you from rifling through these pages looking for information that is not here, and you can seek another source for your information needs.

For the most part we are not addressing:

- The macro-economics of funding and taxes of ACA. This writing focuses on the micro- economics on individuals/ Sole Proprietors and employer groups.
- The issues and changes surrounding medical delivery and access.
- Changes to Medicare and Medicaid/Medi-Cal
- Regulations not directly involved with the purchase of health plans by individual and groups. ACA has volumes of regulations to establish and run various government agencies, the Patient Centered Outcomes Research Institute as an example.
- Taxes on individuals and businesses included in ACA that are not associated with the individual mandate or "play or pay." For example, the taxes on health insurers, pharmaceutical and medical device suppliers.

Most Common Questions of 2014

Can the employer pay for the employee to buy from the exchange?

One of the most common questions we are asked is "can't an employer just pay for their employee to go the exchange and buy a (subsidized) health plan?" In other words, can employers reimburse employees for coverage purchased on the ACA exchanges? While it seems this topic is constantly battered around as way to beat the ACA system the guidance on this issue is very clear and these types of arrangements are not allowed.

Previously, employers were able to provide health insurance by reimbursing their employees for their own individual (non-group) health insurance on a pre-tax or tax-free basis. Typically known as a defined contribution health plan, since the beginning of 2014, these plans have been strictly prohibited.

Pre ACA IRS rules permitted individual health insurance premium reimbursement by employers. An employer was allowed to reimburse an employee's premiums, (whether paid directly to an insurance company or reimbursed), for non-employer sponsored hospital and medical insurance, and exclude the reimbursement from the employee's gross income.

The vehicles used for these employer payment plans, (as they are known) are health reimbursement arrangements (HRAs) and premium reimbursement accounts (PRAs). Employers were permitted to reimburse individual health insurance premiums on a pre-tax (if employee was contributing to a PRA) or tax-free basis (if employer was reimbursing using either an HRA or a PRA). By using these vehicles, employers could deduct any money they contributed to their employees' health insurance premium cost as a business expense.

> **Note:** another vehicle sometimes touted as usable for individual premium reimbursements, post ACA, are health flexible spending accounts (FSA). But IRS regulations state: **"You cannot receive distributions from your FSA for… amounts paid for health insurance premiums"** so an FSA is also not an option.

To fill the PRA's cavity, **ACA includes specific language that PRA's cannot be used to pay for exchange/marketplace premiums.**

HRA's could not be completely outlawed to reimburse for individual premium purchases because many are used for supplemental and specialty insurance; which include dental, vision, disability and accident insurance, (think AFLAC). So the regulators defined HRA's into two classes: integrated and standalone. Integrated in its simplest definition means that it exists with an employer sponsored "qualified" medical plan, thus meeting ACA's requirements.

Without the attachment to a qualified plan, HRA's are defined as "standalone" and do not meet ACA's standards in that they:

- Violate the annual and lifetime limit prohibition
- Do not provide minimum benefit coverages (mandated benefits) including preventative services

Therefore standalone HRA's do not satisfy compliance with the large employer mandate

So it is very clear that HRA's, PRA's and FSA's cannot be used to reimburse individual premiums in a tax advantaged manner.

Most Common Questions of 2014—continued...

Why the high volume of ACA changes and delays in implementing the law?

- Limited resources for implementing the law
  - The need to prioritize limited resources
- Certain provisions of the law did not have apparent or practical implementation methods
- Ambiguity in the law and related delays by the regulatory agencies in issuing guidance
- Technological limitations, such as the "glitches" in the computer systems as they related to the healthcare exchanges
  - And data sharing amongst government and private computer systems
- Complaints from various influential and vocal groups, both political and non-political
- Undue hardships placed on employers and / or employees
  - Additional time and / or funding required to comply
- Tax and reporting requirements needing to be defined – some very different than anything that has been implemented before
- Political reasons

Remember, in the preface we said we will try to not be political, but when discussing the changes and delays, politics certainly come to the forefront. So hopefully this is an impartial narrative on the politics involved with the delays and changes.

HHS, IRS, DOL and the president state they are merely making corrections, adjustments and temporary postponements. ACA enthusiasts object because they want all the provision implemented on-time, ASAP. ACA opponents in addition to objecting to various provisions (or the law in its entirety) say these change/delay tactics are illegal and unconstitutional.

To begin with, the law is complex and cumbersome, (over 900 pages itself) and its content is controversial to say the least. It lays out a framework, in some cases without important details. Much of it was developed without industry input on how and/or what could be practically implemented; and within reasonable periods of time. Add in people and businesses figuring out over time how this all effects them, and the regulators and politicians have reacted. With over 40 delays and changes here are some of the more significant ones:

Large Employer Mandate. Originally to be implemented in January 2014, the 100+ employers are delayed to January, 2015 and 50-99 until January, 2016.

California Small Employer Grandmothering. SB1446 delays key provisions effecting benefits and rates for approximately half of California's small employer population through December 2015.

Medicare Advantage Patch. We said we were not going to cover Medicare, but this is a big change. So without going into detail, ACA Medicare Advantage program cuts, which would have likely eliminated the program, have been cancelled, with money coming from other sources to fund the program.

SHOP. Small employer exchanges (SHOP) were supposed to be up and running in the fall of 2013. California's SHOP is operating but not in full mode. The Federal exchange and many states are slated to be operational for January 2015 effective dates.

What's New for 2015?

January of 2014 was originally the major implementation date for a number of key ACA provisions. With the delays and changes some significant ACA provisions are now scheduled to be implemented in January 2015.

Large Employers - Employer Mandate

The employer mandate, or as it is commonly referred to "play or pay", requires large employers to provide access to qualified coverage to their employees and dependents or pay a fine/tax.

All penalties are based on full-time employees only, those working 30+ hours a week on average.

There are no requirements to offer coverage to part-time or seasonal employees, although they are used in the calculation to determine if an employer is classified as large or small.

If an employer does not offer minimum essential coverage (MEC) they may be penalized. So what is MEC? MEC is a health plan with at least a 60% actuarial value and is affordable.

> Note the difference in minimum standard of coverage with individual and small employer plans. Small employer and individual coverages require a minimum actuarial value of 58% of essential benefits (60% + or – 2%). While large employer plans are a minimum 60% actuarial value.

Coverage is deemed affordable if the employee premium contribution is less than 9.5% of household income. ACA's requirement to use household income creates a problem because employers would not know their employees household income. So the IRS issued a safe harbor that allows the 9.5% calculation to be based on the employees W-2 income with that employer. There are current court cases challenging the IRS's changing of this provision of the law.

The figures and dates below have been changed by the regulators a number of times. As of this writing, these are the current regulations.

Employer Mandate

Employer Size	2015	2016
1-49	No Mandate	No Mandate
50-99	Not required	Must offer coverage to 95% of full-time EE's and dependents
100 or more	Must offer coverage to 70% of full-time and dependents	Must offer coverage to 95% of full-time EE's and dependents

Penalty

Coverage is not offered and at least one employee receives a premium subsidy on an individual plan they purchase from an exchange	$2,000 per FTE less the first 80	$2,000 per FTE less the first 30
Coverage offered is not affordable or does not provide minimum value	Lessor of $3,000 per FTE receiving a subsidy or $2,000 per FTE, less the first 80	Lessor of $3,000 per FTE receiving a subsidy or $2,000 per FTE, less the first 30

Employer Reporting Requirements

Final regulations were issued on March 10, 2014 regarding ACA reporting requirements.

Employer reporting requirements have gone through a number of iterations to address repetitive, cumbersome or impractical mandates.

The U.S. Department of the Treasury issued final regulations on March 10, 2014, regarding ACA reporting requirements which are under Sections IRS Code sections 6055 and 6056 of the Internal Revenue Code. The Reporting Requirements originally were intended to take effect on January 1, 2014, but employers received relief this past year when Internal Revenue Service (IRS) Notice 2013-45 delayed the effective date and enforcement until January 1, 2015.

Originally there were two separate forms - one for each section. They have now been combined into a single form with two sections: top (6056) and bottom (6055). Self-insured employers complete both sections of the form, and those that do not self-insure, only complete the bottom section 6055 portion.

Basically, to enforce the employer mandate and police the individual mandate, employers (and health issuers) are required to report the employees who are offered coverage. The IRS has downsized the number of reporting elements to focus on just those needed for enforcement. For example reporting on employee's part-time/full-time status, employers share of total allowed costs and length of waiting periods have been eliminated. They have also provided for streamlined reporting that does not require employee coverage month reporting. The streamlined reporting can be used if the employer offers qualifying coverage to at least 95% of their employees and the employee contribution is ≤9.5% of federal poverty level.

The ACA calls for employers and insurers to report information including:

- For Internal Revenue Code Section 6055:
  - Information about the entity providing coverage, including contact information. Which individuals are enrolled in coverage, with identifying information and the months for which they were covered.
- For Internal Revenue Code Section 6056:
  - Information about the employer offering coverage, including contact information and the number of full-time employees.
  - For each full-time employee, information about the coverage (if any) offered to the employee, by month, including the lowest employee cost of self-only coverage offered.

W-2 reporting

An employer is not required to issue Form W-2 solely to report the value of the health care coverage for retirees, other employees, or former employees to whom the employer would not otherwise provide a Form W-2.

Employers are required to report the value of the health care coverage in Box 12 of the W-2, with Code DD to identify the amount. There is no reporting on the Form W-3 of the total of these amounts for all the employer's employees.

In general, the amount reported should include both the portion paid by the employer and the portion paid by the employee. An employer is not required to issue Form W-2 solely to report the value of the health care coverage for retirees, other employees, or former employees to whom the employer would not otherwise provide a Form W-2. The coverages that are to be included are contained in the table below:

Form W-2 Reporting of Employer-Sponsored Health Coverage

COVERAGE TYPE	FORM W-2, BOX 12, CODE DD		
	REPORT	DO NOT REPORT	OPTIONAL
Major medical	X		
Dental or vision plan not integrated into another medical or health plan			X
Dental or vision plan which gives the choice of declining or electing and paying an additional premium			X
Health Flexible Spending Arrangement (FSA) funded solely by salary-reduction amounts		X	
Health FSA value for the plan year in excess of employee's cafeteria plan salary reductions for all qualified benefits	X		
Health Reimbursement Arrangement (HRA) contributions			X
Health Savings Arrangement (HSA) contributions (employer or employee)		X	
Archer Medical Savings Account (Archer MSA) contributions (employer or employee)		X	
Hospital indemnity or specified illness (insured or self-funded), paid on after-tax basis		X	
Hospital indemnity or specified illness (insured or self-funded), paid through salary reduction (pre-tax) or by employer	X		
Employee Assistance Plan (EAP) providing applicable employer-sponsored healthcare coverage	Required if employer charges a COBRA premium		Optional if employer does not charge a COBRA premium
On-site medical clinics providing applicable employer-sponsored healthcare coverage	Required if employer charges a COBRA premium		Optional if employer does not charge a COBRA premium
Wellness programs providing applicable employer-sponsored healthcare coverage	Required if employer charges a COBRA premium		Optional if employer does not charge a COBRA premium
Multi-employer plans			X
Domestic partner coverage included in gross income	X		
Governmental plans providing coverage primarily for members of the military and their families		X	

Form W-2 Reporting of Employer-Sponsored Health Coverage

COVERAGE TYPE	FORM W-2, BOX 12, CODE DD		
	REPORT	DO NOT REPORT	OPTIONAL
Federally recognized Indian tribal government plans and plans of tribally charted corporations wholly owned by a federally recognized Indian tribal government		X	
Self-funded plans not subject to Federal COBRA			X
Accident or disability income		X	
Long-term care		X	
Liability insurance		X	
Supplemental liability insurance		X	
Workers' compensation		X	
Automobile medical payment insurance		X	
Credit-only insurance		X	
Excess reimbursement to highly compensated individual, included in gross income		X	
Payment/reimbursement of health insurance premiums for 2% shareholder-employee, included in gross income		X	
OTHER SITUATIONS	**REPORT**	**DO NOT REPORT**	**OPTIONAL**
Employers required to file fewer than 250 Forms W-2 for the preceding calendar year (determined without application of any entity aggregation rules for related employers)			X
Forms W-2 furnished to employees who terminate before the end of a calendar year and request, in writing, a Form W-2 before the end of that year			X
Forms W-2 provided by third-party sick-pay provider to employees of other employers			X

The chart was created at the suggestion of and in collaboration with the IRS' Information Reporting Program Advisory Committee (IRPAC). IRPAC's members are representatives of industries responsible for providing information returns, such as Form W-2, to the IRS. IRPAC works with IRS to improve the information reporting process.

Source: http://www.irs.gov/uac/Form-W-2-Reporting-of-Employer-Sponsored-Health-Coverage

Employer Exchange Notice Requirement

The ACA requires employers covered by the Fair Labor Standards Act to provide each employee with a written health care exchange notice that:

- Notifies employees of the existence of the exchange, including a description of the services provided by the exchange and the manner in which the employee can contact the exchange to request assistance;
- Explains that if the employer's plan pays less than 60 percent of the total allowed costs of benefits provided under the plan, then the employee may be eligible for a premium tax credit if the employee purchases a qualified health plan through an exchange; and
- Informs employees that if they purchase a qualified health plan through the exchange, then they may lose the employer contribution (if any) to any health benefits plan offered by the employer and all or a portion of such contribution may be excludable from income for federal income tax purposes.

HHS has published a model notice that is available on the GIT web site. This notice is required to be provided to all new hires. All employees were to have received the notice in 2013.

Individual Health Insurance

The most significant changes in the California health insurance marketplace may be in the individual market, in 2014 and beyond are in the ....

THERE ARE IN EXCESS OF 12,000 SOLE PROPRIETORS PRACTICING IN CALIFORNIA. Historically, health insurance has presented challenges for this segment of the market because risk is not spread over a number of employees, as is the case with group health insurance.

Definition of a Sole Proprietor (For Health Insurance)

Practicing CPAs that do not have any W-2 employees are classified as individuals (sole proprietors). A group may only have one enrollee in a plan. But, if there are additional W-2 employees who waive coverage, it is a group plan.

If a CPA has any W-2 employees—even if they have other coverage or opt out of health benefit plans by waiving coverage—they are still classified as group. For example, if a CPA has two clerical employees and they are both covered under a spouse's health insurance plan, the CPA firm would be a group of three (3) with only one enrollee. This example is not a sole proprietor for the health insurance definition and discussion here.

How ACA Changed Individual Health Insurance

Sole proprietors are treated as individuals under ACA.

Under pre-ACA California regulations: Individuals (sole proprietors) are:

- Individually underwritten
- Applicants are accepted or rejected based on health history
- Rates are based on:
  - > health history
  - > age
  - > geographic area

Individuals with pre-existing and/or chronic health conditions might not have been offered a health insurance policy by a commercial carrier, or may be offered coverage at a significantly higher premium price over a healthier applicant.

Historically, painfully high annual rate increases and benefit plan design changes made the individual market extremely turbulent. For the relatively healthy, they had to continually go through extensive underwriting processes in order to obtain the carrier's best "street rate." Those who could not pass through underwriting were stuck with rate increases significantly above the group or healthy individual marketplace. Because of their career stage, demographically, sole proprietors tend to be a bit older than the average CPA (and the general population) and—with age—comes a greater likelihood of illness and disease.

ACA extensively changed the individual market in California because it combines provisions for guarantee issue (no medical underwriting), community rating, essential benefits and a marketplace to buy.

There are three important financial components of the individual market under ACA:

- The individual mandate tax (penalty)
- Premium tax credits
- Cost sharing subsidies

These legislative mandates made coverage accessible to all; however, many predict that long term cost increases may result.

Individual Mandate - Penalty/Tax for Not Purchasing Health Insurance

Individuals are required to have minimum essential coverage beginning January 1, 2014.

ACA CONTAINS A PENALTY—RULED A TAX BY THE SUPREME COURT IN THEIR JUNE 2012 DECISION—FOR INDIVIDUALS WHO DO NOT COMPLY. This penalty will be paid as a federal tax liability on income tax returns and is enforced by the IRS. Individuals that fail to pay the penalty will not be subject to criminal penalties, liens or levies. However, the penalty will be payable for the 2014 tax year (generally, taxes filed in 2015).

There is a short list of people that are exempt from the individual mandate:

- Individuals with a religious conscience exemption (applies only to certain faiths)
- Incarcerated individuals
- Undocumented aliens
- Individuals who cannot afford coverage (i.e. required contribution exceeds 8% of household income)
- Individuals with a coverage gap of less than 3 months
- Individuals in a hardship situation
- Individuals with income below the tax filing threshold
- Members of Indian tribes

The annual penalty is the *greater* of a flat dollar amount per individual *or* a percentage of the individual's modified adjusted gross income. For any dependent under the age of 18, the penalty is one half of the individual amount.

TABLE SP 1

YEAR	FLAT DOLLAR AMOUNT	% OF INCOME
2014	$95	1%
2015	$325	2%
2016	$695	2.5%
After 2016	Inflation Indexed	2.5%

The flat dollar penalty is capped at 300% of the flat dollar amount. For example: A family of five (two parents and three children under 18) would have a flat dollar penalty of $285 in 2014 due to the cap.

The percentage of income calculation is the applicable percentage of a household's income that is in excess of the tax-filing threshold. Using an example of a tax filing threshold of $10,000 and household income of $50,000, the percentage would be 1% of the difference between $50,000 or $400. Because the percentage penalty ($400) is greater than the flat dollar penalty for 2014 ($285), they would pay the percentage penalty.

The annual penalty is capped at an amount equal to the national average premium for a bronze level plan of coverage, available through the state Exchanges. Note: As of this writing we have not seen this amount published.

ACA provides two subsidies for individuals in the form of a premium tax credit and cost-sharing subsidy

ACA premium tax credits are advanceable and refundable federal tax credits that are used to pay for health insurance purchased through a state or federally-run Health Exchange. This means the individual (non-group) health plan must be purchased through Covered California. Plans purchased outside of the California exchange will be ACA-compliant in every way, but will not qualify for subsidies. These tax credits begin in 2014 for individuals and their families.

TO QUALIFY FOR PREMIUM TAX CREDITS, AN INDIVIDUAL MUST:

1. File income taxes – Premium credits are distributed directly to health plan issuers in advance, but must be reconciled on the individual's annual tax returns. (See section on surprise tax).

2. Enroll in a plan through Covered California – the California health insurance exchange.

3. Not be eligible for other acceptable coverage and may not be eligible for Medicare, Medicaid, Children's Health Insurance Programs (CHIP), military service plans, or an employer-sponsored plan. ***Exceptions: individuals who are eligible for employer-sponsored plans, but the coverage costs more than 9.5% of their household income, or if the plan has an actuarial value of less than 60% qualify for premium tax credits through Covered California.***

4. Not receive an employer contribution toward an exchange plan; Individuals enrolled in qualified health plans (QHP) offered through the Exchange that their employers contribute toward will not be eligible for premium credits.

5. Have income between 100% and 400% of the Federal Poverty Level (FPL); no credits available.

NOTE: *Incomes under approximately 133% of FPL are eligible for Medicaid/Medi-Cal.*

ACA Subsidies — Premium Tax Credits—continued...

FOR REFERENCE, THE 2012 FEDERAL POVERTY GUIDELINES FOR CALIFORNIA (AND THE 48 CONTIGUOUS STATES)

TABLE SP 2

NUMBER OF PERSONS IN HOUSEHOLD	100% FPL	400% FPL
1	$11,170	$44,580
2	$15,130	$60,540
3	$19,090	$86,360
4	$23,050	$94,200
5	$27,010	
6	$30,970	
7	$34,930	
8	$38,890	
For families/households with more than 8 persons, add $3,960 for each additional person		

REQUIRED PREMIUM PAYMENTS FOR SUBSIDIZED PLANS ARE ALL BASED ON SILVER PLANS (70% ACTUARIAL VALUE). The amount of the subsidies are different for each individual because they are calculated by subtracting the amount the individual is required to pay in premiums from the cost of the second lowest cost silver plan offered on the exchange in your rating area. The table below shows the amount of annual premium payments required by individuals/families.

TABLE SP 3

FPL	PERCENTAGE OF INCOME	ANNUAL PREMIUM PAYMENT REQUIRED - SILVER PLAN			
		INDIVIDUAL	2-PARTY	3-PARTY	4-PARTY
133.01%	3.0%	$487	$656	$824	$992
150%	4.0%	$650	$874	$1,099	$1,323
200%	6.3%	$1,365	$1,836	$2,307	$2,778
250%	8.05%	$2,180	$2,932	$3,685	$4,438
300%	9.5%	$3,087	$4,152	$5,218	$6,284
350%	9.5%	$3,601	$4,845	$6,088	$7,332
400%	9.5%	$4,115	$5,537	$6,958	$8,379

FOR EXAMPLE, A FAMILY OF FOUR WITH INCOME OF $94,200 WOULD PAY $8,379 IN ANNUAL PREMIUM PAYMENTS FOR THE SECOND LOWEST COST SILVER PLAN ($698/MONTH). If the individual chooses a higher or lower cost Bronze, Silver, Gold or Platinum plan, the premium is adjusted by the difference with the second lowest cost Silver.

ACA Subsidies — Cost Sharing Subsidies

In addition to the tax credits that reduce monthly premium payments, individuals under 250% of the FPL will also receive cost-sharing subsidies that reduce the amount of out-of-pocket expenses when medical care is received.

THIS APPROACH EFFECTIVELY INCREASES THE ACTUARIAL VALUE OF THE PLAN; THEREFORE, INDIVIDUALS UNDER 250% OF THE FPL CAN ONLY PURCHASE SILVER OR BRONZE PLANS. This is because the cost-sharing subsidy will increase the actuarial value of Gold and Platinum plans close to—or at 100%. Cost-sharing subsidies are offered by the federal government to reduce the amount of money you have to pay for health care expenses, such as copayments or coinsurance.

For cost sharing subsidies the health issuers will adjust copayments and deductibles for individuals, and then receive reimbursement from the government.

Although it is possible for you or your group to keep the same health plan you have, this will be an extremely uncommon occurrence in the post 2015 market.

ACA DOES MAKE A PROVISION FOR "GRANDFATHERED" PLANS, BUT MOST HEALTH ISSUERS HAVE HAD TO MODIFY THEIR OFFERINGS TO MAKE THEM ACA- COMPLIANT IN WAYS THAT HAVE REMOVED THE GRANDFATHER STATUS. Accordingly, we will not go into all the details of grandfathered plans in this document. The easiest way to find out if your plan is grandfathered (or not) is to ask your carrier or consult your plan materials.

As mentioned earlier, California SB1446 creates "grandmother" plans for approximately half of the small employer market. This law allows small employers under specified conditions to keep non-ACA compliant plans through December 2015.

ACA DEFINES FOUR STANDARD PLANS OF BENEFITS TO BE OFFERED BEGINNING IN 2014. THEY DEFINE THE PLANS BY ASSOCIATING A METAL NAME/LABEL TO A LEVEL OF COVERAGE, AS FOLLOWS:

Platinum Plan	90% Actuarial Value
Gold Plan	80% Actuarial Value
Silver Plan	70% Actuarial Value
Bronze	60% Actuarial Value

What is actuarial value? ACA defines actuarial value as the amount of essential benefits costs a plan will cover on an average population. So, a silver plan will cover 70% of a credible population's health care cost. The other 30% consists of the covered party's out-of-pocket expenses, which are deductibles, coinsurance and co-payments. Actuarial value does not include premium payments. ACA mandates that co-payments are applied to an out-of-pocket expense, which will be a change for most health plans.

Each person enrolled in a plan will not necessarily have the exact actuarial value percentage of medical expenditures provided or reimbursed. Actuarial value is an expected measure across an entire (credible) population. For example, if someone enrolls in a silver plan with a $2,000 deductible and incurs only $1,000 in medical expenses, they may receive no benefit reimbursements from the plan, while someone incurring $1M of medical expenses may have in excess of 99% of the total medical costs in benefits received. Actuarial value is the average expected coverage across a large population. The higher the actuarial value, the more coverage you are purchasing—and the more expensive the premium payments.

Catastrophic Coverage Plans

We also want to mention ACA's allowance for Catastrophic coverage plans for individuals ages 29 and under (< 30).

THIS PLAN WILL ONLY BE AVAILABLE THROUGH COVERED CALIFORNIA AND ONLY AS INDIVIDUAL POLICIES; THEY MAY NOT BE OFFERED UNDER A GROUP PLAN. Catastrophic plans will cover three preventative care visits per year, but all other services will be subject to a very high deductible and out-of-pocket maximum. Plans have not been released at this writing, but they are expected to have deductibles at or near the mandated maximum out-of-pocket limit of $6,350. This is intended to provide relatively inexpensive coverage for younger individuals. Catastrophic plans will have lower actuarial values than Bronze plans.

Just to mention, because of widespread policy cancelations and technical enrollment issues in the individual market, Covered California offered catastrophic plans to people over age 20 to prevent gaps in coverage during the first quarter of 2014.

Individual Premium Rates Under ACA

ACA significantly changes the rating methodology for the California individual market.

WHEN ALTERATIONS ARE MADE TO PREMIUM CALCULATION METHODS, THERE WILL BE DISPLACEMENT, which means that—for people with existing coverage—the same coverage may cost less, about the same—or more than the current premium; just because of the method, not the underlying health benefit cost structures. The media sometimes refers to this as the "winners and losers."

ACA Rating Method

The regulations that went into effect in 2014 require community rating to establish a base rate and then apply an adjustment factor to the base rate for age and region.

(NOTE: ACA ALSO ALLOWS ADJUSTMENTS FOR WELLNESS PROGRAMS AND TOBACCO USERS, BUT CALIFORNIA DID NOT ADOPT TOBACCO). Community rating means that each health plan issuer calculates their base rate for their entire population of California individuals, where before they could classify individuals into rating groups. The age adjustments are limited to a 3 to 1 ratio from youngest to oldest at specified relativities for each age. The geographic boundaries of the regions are prescribed by the California regulators, with the factors (relativities) determined by each carrier.

YET ANOTHER CHANGE WILL BE TO THE METHOD OF CALCULATING FAMILY COVERAGE. CURRENTLY, MOST PLANS PROVIDE FOR A TIERED STRUCTURE OF FAMILY RATES.

Typical tiered structures are:

- Single coverage
  - Plus spouse
  - Plus child
  - Plus children (any number)
- Family coverage - spouse & child(ren)

ACA will incrementally age-rate each adult and each of the first three (3) children added to coverage. For families with more than three children, the oldest three are used for calculating the family premium rate.

ACA provides for a maximum age rating variance of 3 to 1 (for adults).

THIS MEANS THAT RATES FOR 65+-YEAR-OLDS CAN ONLY BE THREE TIMES THAT OF A 21-YEAR-OLD. Most carriers' current age-rate bands vary from 5-1, to 7-1. ACA's mandated 3 to 1 maximum is commonly referred to as "crushing the age bands."

The net effect of the crushing will raise premium rates for the younger age bands and lower the oldest ages slightly. Somewhere in the middle of the age curve, the factor will remain the same. This age band method is just one component of the new premium calculation method but it contributes to younger age bands seeing significant 15%-35% increases based on this modification.

If you would like to read additional details on the possible long term outcomes of the mandated ACA rating methodology, there are a number of studies published by various actuarial consulting firms over the past few years that can be accessed by web searches.

Obtaining Individual Health Coverage in 2015

With ACA's elimination of preexisting conditions limitations, individual enrollments are only allowed during regular open enrollment periods or if you qualify during a special enrollment period.

THE REGULAR OPEN ENROLLMENT PERIOD WILL BEGIN NOVEMBER 15, 2014 AND RUN THROUGH FEBRUARY 15, 2015. As displayed in a previous section, tax penalty for not complying with the individual mandate increase to 2% of MAGI in 2015.

If you do not qualify for a subsidy you may obtain coverage directly through any carrier offering individual health plans in California. Whether you qualify for a premium subsidy or not, you may purchase an individual health plan through Covered California.

Even if you qualify for a subsidy, Covered California may not necessarily be the best choice depending upon your particular needs.

THE MAIN DETERMINANT WILL BE IF YOUR EXISTING (OR DESIRED) DOCTORS AND/OR HOSPITAL ARE INCLUDED IN THE COVERED CALIFORNIA PLAN'S PROVIDER NETWORK.

Many of the health plans participating in Covered California offer plans that utilize provider networks that are may be limited in some regions of the state. Second, is preference for the service of a particular health plan issuer. On a statewide basis, Anthem Blue Cross, Blue Shield of California and Health Net are participating in Covered California individual plans. CIGNA, United HealthCare and Aetna are the most notable plans that are not participating. There are also another dozen regional health plans that are participating. For a number of reasons, CalCPA's Group insurance Trust does not participate in Covered California.

Whether you qualify for a subsidy or not, you should get premium quotes and plan options from the traditional markets and Covered California.

The premium rates will be the same for plans purchases "on the exchange" and directly from a carrier "off the exchange." Additionally, carriers are offering "non-exchange" products only available directly from them.

PURCHASING FROM COVERED CALIFORNIA IS A THREE-STEP PROCESS.

1. Complete and submit an application. This can be done via paper/mail or online.

2. Covered California will process the application, calculate the subsidy (if any) and return the plans available in your region with the corresponding premiums.

3. Evaluate, make plan selections and submit enrollment information to Covered California.

Covered California also has a tool on their web site to estimate subsidy and premium costs.

For the Individual exchange, once a plan is selected, the health issuer (Blue Shield, Health Net, etc.) will bill, collect and administer the policy.

Note: If an individual has access to group coverage through a spouse or parent, this should be explored and evaluated.

Finally—and possibly most importantly—you should evaluate the network of doctors and hospitals, as well as the net premium costs (either subsidized or not).

Please remember, Covered California is using the second lowest cost Silver plan as the basis for all subsidies. Many people may find that a Silver plan with its 70% actuarial value may provide less than expected coverage levels. Also, the second lowest cost plan may be using a very limited network. However, increasing benefit levels (to a Gold or Platinum plan) and provider access can significantly increase the premium cost.

The first step is to determine if you qualify for an ACA premium subsidy. Use **TABLE SP2** above to calculate if you qualify for a subsidy and **TABLE SP3** to determine the approximate amount of required premium payments. Covered California has an online calculator which will display the estimated premium cost.

coveredca.com/shopandcompare/

Small Firms (Small Group Health Plans)

Small groups are, by far, the largest segment of CPA firms.

THIS SECTION COVERS THE CHANGES THAT THE CALIFORNIA SMALL GROUP MARKET SEGMENT WILL SEE UNDER ACA 2014—AND BEYOND.

Identifying whether you are a small employer or large group is fundamental. Small employers do not have a mandate, tax or penalty to provide coverage to their employees. The carrot ACA provides small employers is a tax credit to offset a portion of the premium costs for a limited period of time. The tax credit is detailed below.

Large employers, on the other hand, are subject to significant "play or pay" penalties, for not providing "affordable" and "credible" coverage—to the tune of as much as $3,000 per employee, per year for non-compliance.

How ACA Changes Small Group Health Insurance

California's small group market already employs many of the key provisions being introduced nationally by ACA.

THESE INCLUDE COMMUNITY RATING AND GUARANTEED ISSUE (NO MEDICAL UNDERWRITING), WHICH WILL CAUSE SIGNIFICANT DISPLACEMENT IN STATES THAT CURRENTLY DO NOT HAVE THESE REGULATIONS. Because of the vast diversity of these state regulations, we will be focusing specifically on the California market in this text.

California has chosen to operate its own Small Health Options Program (SHOP), which is the exchange Covered California for small groups. A majority of states have chosen not to operate a SHOP, leaving the federal Department of Health and Human Services (HHS) to set up an exchange in their state. HHS and Covered California have announced a delay until January of 2015 effective dates for the multicarrier shopping features. The exchanges have singular health plan purchasing available in 2014.

Prior to 2014, any small group in California can obtain coverage. Health issuers can alter their rate, based on group size and health status, with a maximum of plus and minus 10%; meaning rates can vary no more than 20%. Rates also vary by rating region and age of the employees enrolling.

Premium rates are age-banded with the spread from 20-year-olds to 65-year-olds, typically in the 5-6 to 1 range. Under ACA this ratio is mandated at 3 to 1, with specified relativities for each age in the "age band curve." First, a 3 to 1 ratio does not reflect the actual cost variance between younger and older age bands. Second, the move from current ratios to the mandated 3 to 1 causes disproportionate premium increases, especially for the younger age bands. A number of actuarial consulting firms have published studies on how this mandate will play out from a premium cost standpoint. While too early to tell the long term effects, we have seen this mandate to contribute to an overall premium increase in the 10% to 30% range for the younger age bands, and zero to 5% reductions in the older bands.

Another significant rating factor change that hit in 2014 was the change geographic rating areas. California previously limited the number of rating territories to nine non-contiguous areas. However, health issuers drew their own territory boundaries and determined territory relativities (the factor to adjust the base rate for each rating area). In 2014, California began drawing (mandating) 19 rating area boundaries that all must use. Health issuers will still determine their own territory relativities. The boundary changes cause significant premium increases and decreases for certain groups, depending on where they are located and how much their area relativity changes.

Definition of Small Group

It is important to determine your classification as a small or large group as defined by ACA.

WHY? ACA— WHILE DICTATING SMALL GROUP RATING PROVISIONS AND PROVIDING TAX CREDITS (SUBSIDIES) TO CERTAIN SMALL BUSINESSES—DOES NOT MANDATE COVERAGE OR EMPLOYER CONTRIBUTIONS TOWARD QUALIFIED HEALTH PLANS. In contrast, large group plans are subject to a number of new administrative regulations, reporting requirements, mandated contributions, taxes and penalties for non-compliance.

For 2014 and 2015, small firms are defined as having 2-49 full time employees during the preceding calendar year. This will be expanded to 2-100 employees under ACA in 2016. Accordingly, large employers are defined as those with more than 50 full-time equivalent employees during the preceding calendar year. Both full-time and part-time employees are included in the calculation. Seasonal employees may be included, depending upon the amount of hours worked.

Note that a recent ACA change exempts 50-99 employee firms from the employer mandate until 2016. At that time these firms will be subject to the employer mandate and will have to provide small employer compliant plans to their employees.

Determining if a firm is small or large can be either fairly simple or somewhat complex.

The simplest scenario would be a firm that had no more than 49 (or 100 for 2015) employees, (combined part-time and full-time) anytime during the preceding calendar year or, more than 50 (or 100 for 2015) full-time employees each month over the preceding calendar year.

For firms under 50 full-time employees with part-time and/or seasonal employees, ACA uses a full-time equivalent calculation to determine the number of employees to apply against the threshold.

SMALL EMPLOYER / LARGE EMPLOYER DETERMINATION

Full-time + Part time + Seasonal monthly average ≤ 49 = Small employer

Full-time equivalent calculation
IRS publication IRS 2012-58

Full-time monthly average ≥ 50 = Large employer

Calculating Full-time "Equivalent" Employees

Full-time employees are defined as those working 30 or more hours per week.

» Exclude seasonal employees who work less than 120 days during the year.

Part-time employees are defined as those working less than 30 hours per week.

» They are included as a group. Accumulate all of the hours worked by this class in a month and divide by 120 to calculate the full time equivalent.

Example:

» Full-time employees	= 27
» Part-time employees	= 35
» Total part-time monthly hours	= 2,640 hours
» Divide 2,640 by 120	= 22 full-time equivalents of part-time
» Total full-time equivalent employees	= 49 (27 full-time + 22 equivalents)

What about variations? You simply repeat this calculation for each month and average the months for the preceding calendar year.

This is, of course, a fairly simple example. IRS Notice 2012-58 describes many of the possible variations you may encounter including employees migrating from seasonal to part-time, part-time to full-time, different reporting periods and many others.

Small Business Tax Credit

ACA includes a small business tax credit.

THE CREDIT, WHICH WAS FIRST AVAILABLE FOR THE 2010 TAX YEAR, IS DESIGNED TO HELP LOW-TO MODERATE-INCOME WORKERS OBTAIN HEALTH INSURANCE THROUGH AN EMPLOYER SPONSORED PLAN BY GIVING THE EMPLOYER A FINANCIAL INCENTIVE TO CONTRIBUTE TO THE PREMIUMS. Through 2013 the credit will be available for any health plan purchased by a small employer. However, beginning in January 2014, the health plan must be purchased through Covered California to qualify for the small group tax credit. In addition, the credit is available for a maximum of two consecutive years starting in or after 2014.

The tax credit diminishes over a minimum of 10 employees, to a maximum of 40 employees and average employee income of $25,000 to $50,000 per the table below.

TABLE SG 1

AVERAGE SALARY	NO. OF EMPLOYEES							
	10	12	14	16	18	20	24	25
$25,000	50%	43%	37%	30%	23%	17%	3%	--
$30,000	40%	33%	27%	20%	13%	7%	--	--
$40,000	20%	13%	7%	--	--	--	--	--
$49,000	2%	--	--	--	--	--	--	--
$50,000	--	--	--	--	--	--	--	--

Small Business Tax Credit—continued...

Small business may be eligible to receive a tax credit if it pays at least 50% of the self-only health insurance premiums, and has 25 or fewer full-time employees with an average salary of less than $50,000 a year.

ONLY PAYMENTS MADE THROUGH A QUALIFYING ARRANGEMENT (A UNIFORM PERCENTAGE PAID TOWARD THE EMPLOYEE PREMIUM) ARE ELIGIBLE FOR THE TAX CREDIT. For the purpose of this credit, Health Reimbursement Accounts (HRAs), Health Flexible Spending Accounts (FSAs) and Health Savings Accounts (HSAs) are not considered qualifying arrangements.

Eligible businesses include taxable employers; and employers that are organizations described in § 501(c) and exempt from tax under § 501(a) (tax-exempt employers). A sliding scale determines the eligible credit amount for a business. The credit is less for tax exempt employers.

The following individuals are not eligible for the small business tax credit:

- Sole proprietors
- Partners in a partnership
- Shareholders owning more than 2% in an S corporation
- Owners of more than 5% of other businesses
- Family members of the above individuals also are not eligible

Obtaining Small Employer/Group Health Coverage in 2014

The following outline assumes that a small employer is, or will be providing a health plan to their employees.

MUCH HAS BEEN WRITTEN ABOUT EMPLOYERS CANCELLING EXISTING PLANS AND SENDING THEIR EMPLOYEES TO THE INDIVIDUAL EXCHANGE TO OBTAIN COVERAGE. While this tactic will be tried by some, it has not been widespread to date, most likely due to the financial and employee relations downsides.

For January 1, 2014 and subsequent effective dates, small employers can obtain a qualified health plan from one of three sources:

1. Direct or with the assistance of your broker from **CalCPA ProtectPlus**.

2. From the regular commercial market (e.g., Blue Cross, CIGNA, Blue Shield, Kaiser, etc.) directly or with the help of a broker.

3. Direct or with the assistance of your broker from Covered California—the California health insurance exchange created by ACA.

Whether you qualify for a premium tax credit or not, you may purchase a small group health plan from any of these sources. To obtain the premium tax credit you must purchase through Covered California.

ACA does not mandate that small employers provide access to an affordable health plan as large groups are required to do.

AFFORDABLE FOR LARGE GROUPS (UNDER ITS SIMPLEST DEFINITION) MEANS AN EMPLOYEE CONTRIBUTION TOWARD EMPLOYEE-ONLY PREMIUMS (SINGLE COVERAGE) DOES NOT EXCEED 9.5% OF HOUSEHOLD INCOME.

For small employers offering plans, employee premium contributions are governed by carrier underwriting requirements and nondiscrimination rules.

For most plans, employers must contribute at least 50% of the employee only (single) coverage to be compliant. The contribution can be a fixed dollar amount as long as it is over the 50% threshold for all employees and complies with the nondiscrimination rules.

Also for most plans, at least 75% of the employees must participate. CalCPA ProtectPlus and Kaiser (and, possibly, some others) allow this participation across all carrier's plans offered, while others require at least 75% in their own plans. This means if you offer CalCPA ProtectPlus and a Kaiser HMO option, that 75% participation is required between the two plans in total.

We will not attempt to provide every instance of compliance and noncompliance with the ACA nondiscrimination rules here.

OVERALL, EMPLOYERS WILL BE PROHIBITED FROM PROVIDING BETTER ELIGIBILITY, HEALTH BENEFITS, OR EMPLOYER CONTRIBUTION TO HIGHLY COMPENSATED INDIVIDUALS AND OWNERS. Differences based on age, years of service, or compensation is not permissible. Waiving of a probationary period for key employees will also not be allowed. The Department of Labor has suggested violators could face fines of up to $100 a day for each employee who is discriminated against.

Kaiser for Small Groups

Kaiser has traditionally been a low cost provider to many small groups due to their medical delivery model – Staff Model Health Maintenance Organization (HMO).

PEOPLE EITHER PREFER KAISER OR NOT - some people like Kaiser's medical delivery methodology, while others will not even consider it. Kaiser will most likely continue to be the lowest cost HMO provider in the small group market, even under ACA's the new benefit and pricing regulations.

The Small Employer Health Options Program (SHOP) will vary from state to state with 30+ states being administered by the federal government – Department of Health & Human Services (HHS).

WE WILL ONLY ADDRESS COVERED CALIFORNIA HERE.

Even if you qualify for a tax credit, Covered California may not necessarily be the best choice depending upon your firm's specific needs. First, the tax credit may not be substantial enough to drive your firm to change plans or carriers. Changing provider networks and plans is always disruptive, even in simple cases. Primary evaluation criteria must be the provider network, benefits and actuarial value of the plans being considered in regards to the premium cost. Evaluating just based on cost is like evaluating pre-tax instead of after-tax.

Many of the lower cost plans are using skimpy prescription drug benefits and limited provider networks. Many of the health plans participating in Covered California offer plans that utilize provider networks, referred to as skinny networks. If you are moving from a carrier's full panel to a skinny network, your group could have significant displacement from their current providers and limited access to the top facilities. Blue Shield, Kaiser and Health Net are the three state-wide carriers participating in the exchange, along with a number of regional players. This leaves some of the biggest in the industry not in the exchange, namely, Blue Cross, CIGNA and United. For a number of reasons, CalCPA's Group insurance Trust is not participating in Covered California at this time.

Whether you qualify for a tax credit or not, you may obtain premium quotes and plan options from the traditional markets, CalCPA ProtectPlus and Covered California.

Purchasing from Covered California is a three-step process.

1. Complete and submit an application. This can be done via paper/mail or online.
    a. The application is quite extensive, depending on the number of employees.
2. Employer chooses
    a. The level of plan to be offered to their employees (Platinum, Gold, Silver or Bronze)
    b. The amount of employer premium contributions
        i. A dollar amount or percentage of premium
3. Each employee then chooses a plan/insurance carrier within the metallic plan level selected by the employer
    a. The employees are shown the amount of premium contribution they are required to make for each plan/carrier

For the SHOP exchange, once the employees select their plans, Covered California will administer the eligibility changes, billing, collecting and eligibility reporting to the health insurance companies. The health insurance companies will administer claims and provide claims customer service. This method of administration may prove to be inefficient with significant timing and communication issues.

The Group Insurance Trust will (continue to) offer a number of PPO, HSA and HMO plans outside of the exchange.

HSA PLANS ARE VERY POPULAR WITH CPA FIRMS. ProtectPlus uses Anthem Blue Cross's provider network, the largest and most comprehensive available in the State of California.

CalCPA ProtectPlus offers a simple and straight forward process. You may get a quote and purchase a plan directly from the Trust, or if you use a broker you may instruct your broker to provide you a quote from CalCPA ProtectPlus.

You may shop (no pun intended), buy and enroll 100% electronically from the CalCPA ProtectPlus web site or submit and handle all interactions with the Trust by paper, or somewhere in between depending on your firms administrative preferences.

In addition to quality plans and premium rates, CalCPA ProtectPlus offers unparalleled service. LiveHealth Online telemed services, integrated HSA/HRA plans and complimentary COBRA services are a few of the Trust's value-adds. Just ask any of your peers who are with one of our Participating Employers for a reference. Visit the Trust's website to get a quote and to learn more about our plan offerings at : **cpaprotectplus.com** or **call 800-556-5771.**

In 2014 Health Net introduced, in certain geographic areas, some very aggressively priced plans.

TO ACCOMPLISH THIS THEY HAVE USED TACTICS IN THEIR NEW ACA COMPLIANT RATE FILINGS NOT USED BY OTHER CARRIERS. No one will know if their bet will pay off until the ACA market stabilization results are in. Looking at the basic economics, one may ask how Health Net could be priced 10% or 20% below Anthem, Blue Shield CIGNA or United. It certainly is not based on a competitive advantage in provider contracts, which these other carriers would typically have on them. So, if you choose a Health Net plan, know that it may be short lived and you may have to change carriers in the near future.

2013 Early Renewals – SB1446

Many health issuers including CalCPA ProtectPlus offered small groups (early) renewals during 2013, when the group would normally renew and have open enrollment in 2014 (January 1, 2014).

THE PURPOSE OF THIS TACTIC IS TO OPERATE UNDER THE EXISTING SET OF LEGACY RATE STRUCTURES FOR AN ADDITIONAL YEAR.

Approximately half of the small employer market chose to early renew, primarily due to hefty premium increases brought on by the ACA rating rules and benefit mandates. SB1446 passed in July, 2014, extends these legacy policies for one additional year through December 31, 2015. The groups and policies governed under SB1446 are being referred to as “grandmother” plans to differentiate from ACA’s “grandfather” plans which do not have an expiration date.

For groups that were advantaged by using the early renewal tactic, the economic pain of transitioning to the new higher ACA rates and benefits has been postponed for another year.

Advising Clients

Individual Clients - If you have clients who are self-employed with no W-2 employees, much of the discussion on sole proprietors (individuals) presented here is applicable to them (except they cannot apply for coverage from CalCPA ProtectPlus). Otherwise, the processes are the same.

THE FIRST STEP IS TO DETERMINE IF THE INDIVIDUAL QUALIFIES FOR AN ACA SUBSIDY.

If qualified for a subsidy, the individual must purchase through Covered California (California insurance exchange) to obtain it. Subsidies are not available in California through the traditional commercial health insurance market.

Whether they qualify for a subsidy or not, they should also get quotes from the traditional insurance market (off the exchange). There will be greater choices of plans and rates off of the exchange. The plan of benefits and, especially the provider networks of doctors and hospitals, need to be carefully evaluated. As mentioned in prior sections, many of Covered California lower cost plans utilize limited provider networks or have limited geographic coverage.

Note: if an individual has access to group coverage through a spouse or parent, this should be taken into consideration and evaluated as a possible avenue to obtain coverage.

Purchasing from Covered California is a three-step process.

1. Complete and submit an application. This can be done via paper/mail or online at www.coveredca.com.

2. Covered California will process the application, calculate the subsidy and return the plans available with the corresponding premiums.

3. Make plan selections and submit enrollment information to Covered California.

For the Individual exchange, once a plan is selected, the health insurance company will administer the policy, (billing, collecting, enrollment changes, etc.). This differs from the small group (SHOP) exchange where Covered California will provide policy administration and coordinate with the insurance companies.

If someone is to receive a subsidy, they should thoughtfully calculate their 2014 estimated household income.

AND IF THEY HAVE ENROLLED, ARE RECEIVING A SUBSIDY AND THEIR INCOME HAS CHANGED FROM THE ORIGINAL ESTIMATE, THEY SHOULD CONTACT COVERED CALIFORNIA to alter their subsidy or at least be aware that they will have to repay a portion of the subsidy if their income has risen over the estimate.

Purchasing subsidized insurance between October 1, 2013 and December 31, 2013 for a January 2014 effective date creates an interesting timing issue. Subsidies will initially be calculated based on 2012's gross income and/or 2014 estimated income. Recall that the subsidy calculation is the difference between the premiums for Covered California's second lowest cost Silver plan (in a particular region) and the amount of premium contribution required by the FPL table.

Since people who receive subsidies through the exchange in 2014 will be subsidized, based on estimated 2014 income, the IRS will true up the 2014 subsidy to actual 2014 income. When the individual files their 2014 tax return (by April 15, 2015), they will calculate their actual subsidy based on actual 2014 income and then pay or receive any variance. Since premium subsidies diminish (on a sliding scale) as income rises, anyone earning more income than the estimated 2014 income used to calculate the subsidy will have to pay back the difference on their 2014 tax return. This could turn out to be quite a surprise for folks who work more hours, get a big raise/promotion, or who change to a higher paying job. Of course, someone with lower than estimated income will receive an additional subsidy/tax credit.

Congress has already updated the maximum payback amounts twice and there are special rules that protect people who marry or divorce from being required to pay back subsidies because their marital status changes.

Tax/Subsidy Surprise - 2014 Tax Return—continued...

Congress has adopted four thresholds for repaying the subsidies. For example, a family of four with income:

- Less than $47,000 would have to repay a maximum of $600.
- Between $47,000 and $70,000, the repay is capped at $1,500.
- Between $70,000 and $94,200, the repay cap is $2,500.
- Families making more than four times the poverty level have to repay the entire subsidy. There is a separate table for individuals and families of two and three.

For many people receiving subsidies they may be in for quite a surprise. This is because the subsidy they receive in 2014 will be in the form of a reduction to the premiums they pay to health insurance carriers. Since the money never actually passed through their hands, it may not be apparent to them; and they may not understand why they're paying a tax on money they never had.

We do not yet know, at this writing, what may prevent people from low-balling their estimated 2014 income to receive a bigger subsidy and then benefitting from the cap on the repayment. However, the IRS is usually pretty good at establishing rules against folks gaming the system in this way. Congress may also raise the caps as budget money tightens. The recoupment program is currently estimated to recover over $40 billion by 2023.

The first step is advising small employer clients to properly classify (or verify) that they are governed under the small employer ACA rules rather than large group.

THIS DETERMINATION CAN BE SIMPLE AND STRAIGHTFORWARD IF THE EMPLOYER HAS 49 OR FEWER EMPLOYEES. Any combination of full-time, part-time and seasonal employees exceeding 49—for any part of the preceding calendar year—requires a full-time equivalent calculation (detailed in the small employer section).

Small employers do not have a mandate, tax or penalty to provide coverage to their employees. ACA provides small employers, with fewer than 25 lower wage workers, a tax credit to offset a portion of the premium costs for a limited period of time (2014 & 2015). The tax credit qualification and calculation is detailed in the small employer section. Large employers, on the other hand, are subject to significant "play or pay" penalties, for not providing "affordable" and "credible" coverage, as much as $3,000 per employee per year for non-compliance.

Changes for 2015

WITH THE PASSAGE OF SB 1446, 2015 MAY BE A STATUS QUO YEAR FOR CALIFORNIA SMALL EMPLOYERS. APPROXIMATELY HALF OF SMALL GROUPS MIGRATED TO ACA COMPLIANT PLANS DURING THE LAST YEAR. The other half, which were disadvantaged in some way by ACA new rules under SB 1446, are "grandmothered" or allowed to continue with non-ACA complaint plans through December 31, 2015. In most instances this will lock the employer into their current benefit plan for one year because it will be expensive to change carriers or plans. Certainly if a company's demographic has changed since they early renewed last year, giving them an equal or better rate in an ACA compliant plan than their legacy plan, they will have options available.

Many of ACA's small group regulations have been the law in California since the mid 90's. Guarantee issue with no pre-existing condition limitations and community rating are examples that created access for all small groups.

The biggest changes will be in two areas affecting rates, and a third, which limits plan designs that may force some groups into more expensive plans.

First, California currently allows rates to vary plus/minus 10% (20% total spread) based on health status of the group. This is called a Risk Adjustment Factor (RAF). RAFs are eliminated under ACA. So groups who currently have a RAF lower or higher than 1.00 will have their rates adjusted up or down accordingly at renewal. This means groups that have a 0.9 RAF will have around a 10% increase without taking into account medical inflation. And groups at 1.10 will see their annual medical inflation rate increase buffered by the reduction in RAF.

Second, ACA mandates a rating methodology that limits the ratio of age band rates. This means that the 20-year-old age band cannot be less than a 3 to 1 ratio lower than the 65-year-old age band. Currently most carrier's rates use somewhere around a 5 to 1 ratio.

The effect of this method change will be to increase the rates for relatively younger groups and many actuaries believe (for a variety of reasons) that this change increases rates across all age bands.

Third, ACA limits deductible and maximum out-of-pocket expenses for small employer plans. Out-of-pocket costs are limited to $6,350 for single and $12,700 for family coverage. It is currently not certain what California will enact, but the federal ACA regulations also limit deductibles to $2,000 for most small employer plans.

Many carriers offer, and small employers have purchased plans that exceed these new limits. Small employers and their employees that are forced to move into lower deductible and lower maximum out-of-pocket plans could see significant increases as they are forced to purchase higher levels of coverage. Many health savings account (HSA) plans may be affected as well.

If an employer qualifies for a tax credit, they must purchase their plan through Covered California to obtain the tax credit.

EVEN IF THEY QUALIFY FOR A TAX CREDIT IT MAY NOT BE SIGNIFICANT ENOUGH TO WARRANT THE DISRUPTION OF CHANGING PLANS AND GOING THROUGH PURCHASING, ENROLLMENT AND ADMINISTRATIVE PROCESSES OF COVERED CALIFORNIA. REMEMBER THE CREDIT IS ONLY FOR TWO CONSECUTIVE YEARS.

Whether they qualify for a tax credit or not, they should get quotes from the regular commercial market. There will be more choice of plans and rates off the exchange. Also off the exchange, the carriers themselves will be administering the policies.

Whether on or off the exchange, the provider network of doctors and hospitals need to be carefully evaluated. A recent trend to reduce premium costs has been to use limited networks of doctors and hospitals. Also, outside of the big names (Anthem, Blue Shield, CIGNA, etc.) many of the plans may offer limited geographic coverage.

ACA significantly changes the nondiscrimination rules and many small employers will find they are not compliant.

AND, OVERALL, EMPLOYERS WILL BE PROHIBITED FROM PROVIDING BETTER ELIGIBILITY, HEALTH BENEFITS, OR EMPLOYER CONTRIBUTION TO HIGHLY COMPENSATED INDIVIDUALS AND OWNERS. Differences based on age, years of service, or compensation is not permissible. Waiving of a probationary period for key employees will also not be allowed.

If your small employer client has a "different" plan or contribution scheme for the owners or executives, it needs to be reviewed against the new standards. The fines can be significant. The Department of Labor has suggested violators could face fines of up to $100 a day for each employee discriminated against.

Definitions and other Tidbits

Essential Benefits

ALL PLANS IN THE INDIVIDUAL AND SMALL EMPLOYER MARKET, RENEWED ON OR AFTER JANUARY 1, 2014 MUST INCLUDE THESE TEN ESSENTIAL BENEFITS.

SB1446 allows certain employers to stay in plans without the essential ten until December 31, 2015.

1. Ambulatory patient services
2. Emergency services
3. Hospitalization
4. Maternity and newborn care
5. Mental health and substance use disorder services,
6. Prescription drugs
7. Rehabilitative and habilitative services and devices
8. Laboratory services
9. Preventive and wellness services and chronic disease management
10. Pediatric services, including oral and vision care

Grandfathered / non-grandfathered plans

Under ACA, plans in effect as of March, 2010, are deemed grandfathered. As long as a grandfathered plan in-force it is exempt from the following ACA provisions:

- Preventative Services
- Non-network emergency services
- Annual limits
- Rate reviews (10% unreasonable)
- Discrimination rules

Plans can lose grandfather status if they make benefit changes outside of parameters defined by HHS.

Grandmothered Plans

SB1446 creates grandmothered plans in California's small employer market.

PLANS THAT WERE IN-FORCE AS OF DECEMBER 31, 2013 ARE EXEMPT FROM CERTAIN BENEFIT AND RATING PROVISIONS of the California insurance code through December 31, 2015.