Dissecting Health Reform
On a Company Level

Report on PPACA Impact

And

Potential Mitigation of Costs

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The information is compiled as an objective basis on the understanding of The Patient Protection and Affordable Care Act (PPACA) Public Law 111-148. We reserve the right to change, modify or correct any and all comments or conclusions expressed in the written objective observations should we be given additional information that would warrant such actions.

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Executive Summary

This white paper is designed to provide information and provoke a thought process for the top legal minds, top employee benefit organizations, insurance companies, contracted administrators and employers with the emphasis on helping the American people and the American businesses / employers in mitigation of the additional mandated fees, taxes and costs associated on PPACA (The Patient Protection and Affordable Care Act) from the review of the language in Public Law 111-148.

The impact of PPACA also known as "Obama Care", Affordable Care Act (ACA) is significant to the American Business environment and individuals in the employment sector. The effect of PPACA is significant to the economic and financial structure of American businesses as a cost of doing business.

Recently, on July 9, 2013, the IRS (Internal Revenue Service) delayed the future impact of the "Play or Pay" or "employer mandate" via Notice 2013-45 provisions of PPACA from a January 1, 2014 effective date to January 1, 2015 effective date. Although this extension effected many of the provisions of ACA, other provisions remain intact. This notice addressed the delay until 2015, and encourages employers and other reporting entities to voluntarily comply in 2014 with the reporting provisions. ***This delay has no effect on the effective date of other Affordable Care Act Provisions. The delay does not apply to the individual mandate, which takes effect in 2014.*** A link to the Notice 2013-45 is: http://www.irs.gov/pub/irs-drop/n-13-45.pdf.

The information contained in this report shows the potential mitigation of several of the additional cost imposed on the American business by PPACA.

The following areas have been reviewed on a comparative analytical base utilizing a forensic approach for possible mitigation of these expenses.

1. **Transitional Reinsurance Fee** - this fee is assessed on a per member basis, Employees + all dependents. This fees is **$63.00** per member per year or **$5.25** per member per month. (This fee applies to both fully insured and self funded plans).
2. **Patient Centered Outcomes Fee** - This fee is assessed on a per member basis, Employees + all dependents. This fees is **$2.00** per member per year. (This fee applies to both fully insured and self funded plans).

3. **Health Insurance Industry Fee** - This fee is assessed on the total premium of the plan. This will be included as an additional cost in the monthly full insured premium. This fee is **1.9%** of the premium monthly. (This fee applies to fully insured plans).
4. **Federal Facilitated Exchange User Fee** - This fee is assessed on the total premium of the plan. This will be included as an additional cost in the monthly full insured premium. This fees is **3.5%** of the premium monthly. (This fee applies to fully insured plans).

Additionally, mitigation for the employer mandate for “Play or Pay” has been analyzed and observations utilized for a formula based structure in the elimination of this expense to the American business.

This white paper details utilization of the potential ambiguitas nature of the law which on its merits may have an implication on the Letter of the Law, Intent of the Law and Spirit of the Law as it pertains to the ”rules” of engagement and enforcement of PPACA.

Attorney Response to questions posed

“This has been a very interesting discourse and exchange of ideas. As always, what we have provided before and provide now merely represents our opinion and does not in fact reflect the state of the law, or constitute a formal legal or consulting opinion.

The bottom line is that this is virgin territory. The law is new, the theories are untested, and there is no precedent. Your question, for instance, regarding whether the requirement that a plan’s renewal date be set prior to December 2012 is intriguing. The question really is, does “any” date need to be established prior to December, or does “the” date need to be established prior to December? To answer this, and the other questions you present, we can only rely upon our own ideas and, for instance, our own interpretation of the law’s intent. There are no hard and true facts, precedent, or case law we can rely upon!

We have not, and will not charge a fee for the materials exchanged or research performed for the reasons we’ve shared above. The following, meanwhile, as with all other correspondence we’ve provided to date, continues to represent our personal opinions in this matter. How you proceed in light of our opinion is entirely your decision. At this point, however, we believe that the only way to know anything for certain would be to either get a definite answer from the applicable regulators... or... try your theories

out in the real world. As mentioned, how to proceed is up to you. That being said, at this time we do not think we can add much more to the process. Please keep us in the loop and let us know how you proceed; we are curious to see how this shakes out."

HERE WE GO !!

Analysis Merits

The following are areas which in the analysis may have merit. Currently, the fully insured companies are sending email blast to their group clients, agents, brokers and consultants on avoiding the increase in cost due to PPACA (Obama Care). These blasts are specific to renewing on December 30, 2013 to avoid the increases.

With this in mind, the following structures could come into play for reducing the anticipated costs of PPACA. There are various areas of concern and clarification when viewing the various focuses of PPACA vs ERISA.

Letter of the Law
Intent of the Law
Spirit of the Law
Ambiguity of the Law

An area of concern with PPACA is the ambiguitas nature of the law which on its merits may have an implication on the Letter of the Law, Intent of the Law and Spirit of the Law as it pertains to the ”rules” of engagement and enforcement of PPACA.

The establishment of the renewal date must be in place prior to 12/27/2012 in order to qualify for transitional relief.

Attorney Response Transition Rules

“The transition rules say that if you maintained a fiscal year plan as of December 27, 2012, and all your full-time employees are offered affordable coverage that provides minimum value no later than that first day of the plan year that starts in 2014, penalties will not be assessed for the months prior to the first day of the plan year that starts in 2014 for:

1. Any employee (whenever hired) that would be eligible for coverage, as of the first day of the first plan year that begins in 2014 under the eligibility terms of the plan as in effect on December 27, 2012; and

2. Any other employees if (a) your fiscal year plan was offered to at least one third of your employees (full-time and part-time) at the most recent open season; or (b) your fiscal year plan covered at least one quarter of your employees; and (c) they would not have been eligible for coverage under any other of your group health plans that has a calendar year plan year.

Therefore, for any employees who are eligible to participate in the plan under its terms as of December 27, 2012 (whether or not they take the coverage), you will not be subject to a penalty for those employees until the first day of your fiscal plan year that starts in 2014 if they are offered affordable coverage that provides minimum value no later than that first day of the plan year that starts in 2014.

For any other employees that were not eligible to participate under the terms of the plan in effect on December 27, 2012, if you offered coverage under your fiscal year plan starting on July 1, 2012 to at least one third of your employees, or if your plan covered at least one quarter of all your employees, you can avoid liability for a penalty for those non-eligible employees until July 1, 2014 if 1) you expand the plan to offer coverage that is affordable and meets the minimum required value to the full-time employees who had previously not been eligible for coverage; and 2) they would not have been eligible for coverage under any other of your group health plans that has a calendar year plan year. For purposes of determining whether your plan covers at least one quarter of your employees, you may determine the percentage of employees covered as of the end of the most recent enrollment period prior to December 27, 2012, or any date between October 31, 2012 and December 27, 2012."

Questions for Review

If the plan was established in 2009 with a plan year of January 1 to December 31, does this not establish the plan and its renewal date prior to 12/27/2012?

If an employer / plan sponsor decides to change their effective date for legitimate business reason would this not be allowed if the original effective date was prior to 12/27/2012?

***Definition of Plan Year** - 1997 Quick Reference to ERISA Compliance - Panel Publishers - "The **plan year** is the calendar, policy, or fiscal year for which a plan's*

records are kept. (ERISA §3(39)). The plan year should be stated in the plan document and does not have to coincide with any insurance policies or other contracts relating to the plan."

Questions for Review

With the above definition using "policy", why would a plan not be able to utilize a true policy year which is defined within the plan document and as well corresponds to the plan deductible, out-of-pocket maximums on the same basis for coordination?

There is no definition that I can find which states the length of a plan year or policy year. There are short plan years, calendar plan years, fiscal plan years and policy plan years. Of which the duration of a short plan year or policy plan year has no definition. Thus, is a policy year one (1) month, twelve (12) months, fifteen (15) months, thirty (30) days, three hundred sixty five (365) days, three hundred seventy (370) days? Where is it defined for a plan year and or policy year?

The research did not find any prohibition of a employer / plan sponsor in changing their policy year or plan year anywhere in ERISA 1974.

Does PPACA and ERISA not conflict on the basis of a policy year / plan year with regard to a employer / plan sponsor from changing the plan year to a policy year for legitimate business reasons or does the "transition rules" utilizing the date of December 27, 2012 pre-empt ERISA?

Question for Consideration

Is there an existence of the ambiguitas nature of the law as it pertains to PPACA and ERISA?

In the research on the PPACA (The Patient Protection and Affordable Care Act) the following probabilities arose from the review of the language in Public Law 111-148.

After extensive reading of PPACA, a query was initiated and completed on the following: “Effective Date” this query resulted in 100+ hits. This query became an important part of the findings. An additional query was completed on the date “January 1, 2014”. This query had 39 matches. A comparative analysis of these terms to the act was pursued and the following was noticed from the key terms “on January 1, 2014” and “plan years beginning on or after January 1, 2014”. From this end the precursor for these key terms is “Effective Date”. The following were extracted from the PPACA Public Law 111-148 as an example of the comparative analytics.

```
Public Law 111-148
111th Congress
An Act
Entitled The Patient Protection and Affordable Care Act. <<NOTE: Mar.
23, 2010 - [H.R. 3590]>>

SEC. 1253. <<NOTE: 42 USC 300gg note.>> EFFECTIVE DATES.

    This subtitle (and the amendments made by this subtitle) shall become
effective for plan years beginning on or after January 1, 2014.

        Subtitle D--Available Coverage Choices for All Americans

             PART I--ESTABLISHMENT OF QUALIFIED HEALTH PLANS

SEC. 2711. <<NOTE: 42 USC 300gg-11.>>  NO LIFETIME OR ANNUAL LIMITS.

    ``(a) Prohibition.--
            ``(1) In general.--A group health plan and a health
        insurance issuer offering group or individual health insurance
coverage may not establish--
                    ``(A) lifetime limits on the dollar value of
                benefits for any participant or beneficiary; or
                    ``(B) except as provided in paragraph (2), annual
                limits on the dollar value of benefits for any
                participant or beneficiary.
            ``(2) Annual limits prior to 2014.--With respect to plan
        years beginning prior to January 1, 2014, a group health plan
        and a health insurance issuer offering group or individual
        health insurance coverage may only establish a restricted annual
        limit on the dollar value of benefits for any participant or
        beneficiary with respect to the scope of benefits that are
        essential health benefits under section 1302(b) of the
        PatientProtection and Affordable Care Act, as determined by the
        Secretary. In defining the term `restricted annual limit' for
```

> purposes of the preceding sentence, the Secretary shall ensure that access to needed services is made available with a minimal impact on premiums.

The following areas became prevalent in a forensic analysis of the language in PPACA. The following is a premiss which is also deemed a high probability of a basis for legal implementation of the following:

Since many of the areas in PPACA refer to the Effective Date for plan years beginning on or after January 1, 2014, and there is no effective date / renewal date in 2014, then the letter of the law is utilized and not the intent due to the following example:

Example

A company has a fiscal plan year July 1, 2013 to June 30, 2014. The application of the provisions as written in PPACA do not take effect until the "Effective Date for plan years beginning on or after January 1, 2014", meaning in this example July 1, 2014. With this being noted, if a plan has no renewal or effective date in 2014 then no provisions of PPACA can be applied to the employer or plan whether self funded or fully insured. The following provisions of PPACA have the effective date for plan years beginning on or after January 1, 2014.

ASSUMPTION: The Plan is amended to establish the renewal/effective date of December 31, 2013 with January 1, 2015 as the next renewal date. Thus, 2014 has neither a renewal or effective date. (Note: PPACA does not define a year / plan year or policy year). As with any plan, a short year may exist, a fiscal year, a calendar year or a policy year. There is no definition establishing a plan year, a fiscal year, a calendar year or a policy year - essentially, this could be 365 days, 366 days, 367 days or more for the effective plan whether self funded or fully insured. Thus, the following is applied based on the assumption which encompasses both self funded plans and fully insured plans.

The Grandfathered health benefit plan is still able to exist with the limitations established. The application of the unlimited and various other requirements for the plan are Effective Date for plan years beginning on or after January 1, 2014. A change in the plan would take effect on January 1, 2015 as this is the first effective date on or after January 1, 2014.

Mandated Fees / Taxes

Health Insurance Industry Fee also known as the Health Insurance Tax (HIT). This is estimated to increase the fully insured premiums by 1.9% to 2.3% in 2014 and, by 2023 increase premiums 2.8% to 3.7% (study by Oliver Wyman; October 31, 2011). The cost of this is not tax deductible.

Reinsurance Assessment Fee. This is applied to both the fully insured and self funded plans. In 2014 the annual fee assessed is $5.25 per covered person per month or $63 per year. This fee is tax deductible.

Patient-Centered Outcomes Research Institute Fee (PCORI). This is applied to both the fully insured and self funded plans. This fee may or may not apply to the effective date for plan years beginning on or after January 1, 2014. But, if it does it would only apply to the plan year ending on or after October 1, 2013, through September 30, 2014. The fee is $2 per covered person. Thus, there would be a calculation of fees for 2014 as the application date is prior to 2014.

Federally Facilitated Exchange User Fee. This applies only to fully insured plans. The amount is 3.5% of premium proposed for 2014. The ASSUMPTION is there is no premium proposed for 2014 and only for 2013 and 2015.

Full Time Equivalent (FTEs). This is based on 50 or more employees from PPACA based calculation. Effective for months beginning after December 31, 2013. This has a potential for the penalty to range from $2000 to $3000 per year based on the calculation dependent on the circumstances for application.

Section 4980H

Section 4980H was added to the Code by § 1513 of the Patient Protection and Affordable Care Act (Affordable Care Act) (enacted March 23, 2010, Pub. L. No. 111-148) and amended by § 1003 of the Health Care and Education Reconciliation Act of 2010 (enacted March 30, 2010, Pub. L. No. 111-152). [1] Section 4980H applies to "applicable large employers" (generally, employers who employed at least 50 full-time

employees, including full-time equivalent employees, on business days during the preceding calendar year).

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[1] Section 4980H was further amended by section §1858(b)(4) of the Department of Defense and Full-Year Continuing Appropriations Act, 2011 (enacted April 15, 2011, Pub. L. No. 112-10), ***effective for months beginning after December 31, 2013.***

Scenario - Self Funded Plan

The plan sponsor desires to change their renewal date and plan year to a policy year to December 30, 2013 through December 31, 2014. (The original plan year start was January 1, 2009). The deductibles, coinsurance, out-of-pocket maximums would also be changed within the plan document to correspond to the new "policy year". The policy year would further be documented within the plan document for the future plan year(s) to be on a January 1 to December 31 thereafter.

Question for Consideration

Can the plan change the basis of the "plan year" (January 1, to December 31) to a "policy year" (December 30, 2013 to December 31, 2014 and January 1 to December 31 thereafter), renewal date for a legitimate business reason thus, receiving the transitional relief and mitigation of the mandated fees and taxes?

Or, if not, would this be considered ambiguitas whether, Letter of the Law, Intent of the Law or Spirit of the Law as PPACA and ERISA conflict?

If considered ambiguitas then, enforcement may not be possible by HHS, DOL or IRS on PPACA as it is not clear and the interpretation can not be fully established.

The following is a supposition of a self funded plan currently in existence. This plan has a normal renewal date of January 1 and plan year January 1 to December 31. The plan went into existence January 1, 2009. The plan is a "Grandfathered Plan". The plan parameters are below.

	Current Plan	
Description	**In Network**	**Out of Network**
Annual Deductible	Single $2,000.00 Family $4,000.00	Single $4,000 Family $8,000
Annual Out-of-Pocket Maximum	Single $3,000.00 Family $6,000.00 Excludes prescription drug Co-Pays and all other Co-Pays	Single $6,000 Family $12,000 Excludes prescription drug Co-Pays and all other Co-Pays
Co-Insurance	Plan: 80% Member: 20%	Plan: 60% Member: 40%
Doctor's Office Visits	Co-Pay: $25 PCP; $25 Specialist	60% after deductible
Physician Care (Inpatient/ Outpatient/Other)	80% after deductible	60% after deductible
Diagnostic Tests In Doctor's Office (Same Site/ Same Day as Office Visit) **Other Laboratory**	Office Visit Co-Pay Deductible then 20%*	60% after deductible Deductible then 40%*
Inpatient Hospital (Semi-Private Room	80% after deductible the semiprivate room rate	60% after deductible the semiprivate room rate
Outpatient Hospital/Surgery	80% after deductible	60% after deductible
ER Physician Care	80% after deductible	60% after deductible
Emergency Room	$150.00 copayment then paid at 80%	$150.00 copayment then paid at 80%
Ambulance	80% after deductible $2,500.00 per ground trip maximum $10,000.00 per air trip maximum	80% after deductible $2,500.00 per ground trip maximum $10,000.00 per air trip maximum
Urgent Care Center (Facility)	$50.00 copayment.	60% after deductible
Mental Health	80% after deductible	60% after deductible
Allergy Injections	$25.00 copayment	60% after deductible
Maternity Care (See SPD for Specifics)	80% after deductible Dependent daughters not covered.	60% after deductible Dependent daughters not covered.

	Current Plan	
Description	**In Network**	**Out of Network**
Routine Well Child Care (0-18 Years Old)	$25.00 copayment	60% after deductible
Routine Well Adult Care (Over 18)	$25.00 copayment	60% after deductible
Autism Service (Benefits payable based on services rendered)	80% after deductible	60% after deductible
Durable Medical Equipment	80% after deductible $4,000.00 (excluding Prosthetic Devices and Medical Supplies) Calendar Year maximum	60% after deductible $4,000.00 (excluding Prosthetic Devices and Medical Supplies) Calendar Year maximum
Therapy Services (Per Visit; Physical, Occupational, Speech)	80% after deductible Maximum of 20 visits per calendar year, per therapy service type. Occupational 60 Visits Calendar Year maximum	60% after deductible Maximum of 20 visits per calendar year, per therapy service type. Occupational 60 Visits Calendar Year maximum
Chiropractic Care	$25.00 copayment 12 Visits Calendar Year maximum	60% after deductible 12 Visits Calendar Year maximum
Prescription Drugs		
30-Day Supply **Tier 1 - Generic** **Tier 2 - Formulary** **Tier 3 - Non-Formulary**	$10 $35 $50	Non-Participating Pharmacy Coverage includes ingredient cost and dispensing fees only
90-Day Supply (Retail or Mail Order) **Tier 1 - Generic** **Tier 2 - Formulary** **Tier 3 - Non Formulary**	$30 $105 $150	Not Applicable
Special Notes	None	None

The plan above meets the criteria as set forth with the “minimum value standard” and meets the “Maximum out of pocket limitations”. As a self funded grandfathered plan many of the PPACA requirements do not have to be met vs a fully insured plan.

Premiss questions - If the organization desires to change their effective date / plan year from January 1 through December 31 to a policy year December 31, 2013 through December 31, 2014 and January 1 to December 31 thereafter:

Would this allow the retention of the “Grandfathered Plan Status” through the new policy year without changes to the “Plan” due to the non existence of the “2014 Plan”?

The deductible calculation is changed from a “calendar year” to a “Policy year”. The plan sponsor currently pays 100% of the eligible employee single costs.

With this in mind, would this not avoid the increases in plan cost as depicted by the “fully insured carriers” and allow for the “transitional relief”?

Since the renewal date was established prior to December 27, 2012 and the desire of the “Plan Sponsor” to change their “plan year” to a “policy year” as stated above, would this not qualify for the transitional relief?

If the above meets the criteria to avoid the mandated fees / taxes as listed below whether a self funded plan or fully insured plan apply for avoidance with the exception of the PCORI mandated fee / tax?

The Grandfathered plan is still able to exist with the limitations established. The application of the unlimited and various other requirements for the plan are Effective Date for plan years beginning on or after January 1, 2014. A change in the plan would take effect on January 1, 2015 as this is the first effective date on or after January 1, 2014.

The following fees as applied based on the presumptions for plan year change to a policy year, a question arises as to the applicability of the fees utilizing a new policy year established by the employer / plan sponsor of December 30, 2013 to December 31, 2014.

Health Insurance Industry Fee also known as the Health Insurance Tax (HIT). This is estimated to increase the *fully insured premiums* by 1.9% to 2.3% in 2014 and, by 2023 increase premiums 2.8% to 3.7% (study by Oliver Wyman; October 31, 2011. The cost of this is not tax deductible.

If the fully insured plan established the policy year December 31, 2013 to December 31, 2014 would the HIT apply?

Reinsurance Assessment Fee. This is applied to *both the fully insured and self funded plans*. In 2014 the annual fee assessed is $5.25 per covered person per month or $63 per year. This fee is tax deductible.

If the self funded or fully insured plan established the policy year December 31, 2013 to December 31, 2014 would the TRF apply?

Patient-Centered Outcomes Research Institute Fee (PCORI). This is applied to *both the fully insured and self-funded plans*. This fee may or may not apply to the effective date for plan years beginning on or after January 1, 2014. But, if it does it would only apply to the plan year ending on or after October 1, 2013, through September 30, 2014. The fee is $2 per covered person. Thus, there would not be a calculation of fees for 2014 as there is no date for 2014 in the ASSUMPTION. The deductibility of this fee is not currently known.

It is understood this fee would apply to both the self funded or fully insured plan based on the original effective date of this Letter of the Law.

Federally Facilitated Exchange User Fee. This applies only to *fully insured plans*. The amount is 3.5% of premium proposed for 2014. The ASSUMPTION is there is no premium proposed for 2014 and only for 2013 and 2015. The deductibility of this fee is not currently known.

If the fully insured plan established the policy year December 31, 2013 to December 31, 2014 would the Federally Facilitated Exchange User Fee apply?

Since these fees /taxes /penalties are the Letter of the Law and the transitional relief date of 12/27/2012 for establishing a renewal date is the Letter of the Law, and the plan established the above scenario for changing their plan renewal date to a policy year, which the original renewal date was established prior to 12/27/2012, could this if not allowed for avoidance for these costs be considered ambiguitas?

If the fully insured carriers are currently stating to renew on December 30, 2013 to avoid the increased cost of PPACA, is this not meeting the premiss of and application of the Letter of the Law to avoid the above fees /taxes /penalties?

The following pertains to the “Play or Pay”.

Full Time Equivalent (FTEs). This is based on 50+ employees. Effective for months beginning after December 31, 2013. This has a potential for the penalty to range from $2000 to $3000 per year based on the calculation and or a plan offered or not.

The calculation is straight forward for establishing the Full time equivalents for the employer.

Question for Consideration

If an employer has “Full Time Employees” who work 30 hours or more per week and are age 65 or older and have Medicare A and B, and are eligible for the employers health plan, *can these individuals be subtracted from the calculation of the employers FTE?*

The following chart shows there are a total of 65 employees with the FTE calculation showing 61.

Of the 52 full-time employees 12 are 65 or older with Medicare A and B. Can those medicare employees be subtracted?

If so, then the calculation in the below chart would show 49 FTE and fall below the 50 or more?

Additionally, there are 7 additional part-time employees who work less than 30 hours which are 65 or older and have medicare A and B - could these be subtracted from the FTE calculation?

Calculation chart including medicare participants.

Category	Data Analysis
Total Full Time Employees	52
Total Part Time Employees	13
Total Employees	65
Full Time Equivalent Employees	61
Full Time Equivalent Employees for "Play or Pay"	31
Pay or Play Penalty	$62,066.67
Hours Requirement for Participation	FAIL
Waiting Period for Health Plan Participation	PASS
Individual Deductible	PASS
Family Deductible	PASS
Benefit Calculation % of Allowed Benefits Paid	PASS
% of Employee Contribution Exchange Pass or Fail	PASS

Calculation chart excluding medicare participants.

Category	Data Analysis
Total Full Time Employees	52
Full Time Medicare Age 65+ with Parts A&B	12.00
Total Part Time Employees	13
Part Time Medicare Age 65 + with Parts A&B	7.00
Total Employees Age 65 + With Parts A&B	19
Full Time Equivalent Employees Less Medicare	42.70
Full Time Equivalent Employees for "Play or Pay"	12.70
Pay or Play Penalty	N/A
Hours Requirement for Participation	FAIL
Waiting Period for Health Plan Participation	PASS
Individual Deductible	PASS
Family Deductible	PASS
Benefit Calculation % of Allowed Benefits Paid	PASS
% of Employee Contribution Exchange Pass or Fail	PASS

This calculation subtracts out the Full Time, (+> 30 hours per week), employees who are (= > age 65) with Medicare Parts A & B as well as calculates the subtraction of the part time employees (< 30 hours per week) 65 (+) with Medicare Parts A & B and the full time equivalence calculation.

This calculation may serve to show, if (= > Age 65) with Medicare A & B are cut from the calculation and those who are full time are moved to a part time status of (< 30 hours per week) will affect the calculation of the "Play or Pay".

This may be significant if employers take this approach with their health benefit plans. This approach has many distinguishing effects to the fully insured health plan and self funded health plan. This creates a reduction in average age of the group and provides a basis for reduction of risk exposure. Additionally, the claims impact is reduced for both medical and prescription claims.

Questions Posed and Attorney response regarding Medicare for employees (= > Age 65)

"Below is some information from the AARP website that you may find helpful:

[http://www.aarp.org/health/medicare-insurance/info-03-2011/ask-ms-medicare-question-94.html

Q. I am 65 and plan to keep working for some years. I have health insurance from my employer. Do I have to sign up for Medicare Part B now?

A. Probably not. In most cases, for as long as you have group health insurance provided by an employer for whom you are *still* working, you can delay enrolling in Part B, which covers doctors visits and other outpatient services and requires a monthly premium. When you eventually retire, or leave work, you'll be entitled to a special enrollment period of eight months to sign up for Part B without incurring a late penalty.

This also applies to most people who are covered beyond age 65 by insurance from the employer of their working spouse.

But, there are some exceptions:

- **If the company or organization you work for has fewer than 20 employees,** your employer may require you to sign up for Part B when you turn 65. If so, Medicare would become your primary coverage (meaning it pays bills first) and your employer coverage would be secondary. In this case, you need to find out exactly how your employer plan will work with Medicare.
- **If you are in a same-sex marriage or relationship and receive health insurance from your partner's employer as his or her dependent,** you will not be entitled to a special enrollment period if you delay signing up for Part B—even if you are legally married under the laws of your state or country. So to avoid late penalties in the future when your partner stops work, you should sign up for Part B at age 65.

Will I get the same health benefits at work as I get now?

By law, people who continue to work beyond age 65 still must be offered the same health insurance benefits (for themselves and their dependents) as younger people working for the same employer. So your employer cannot require you to take Medicare when you turn 65 or offer you a different kind of insurance — for example, by paying the premiums for Medicare supplemental insurance or a Medicare Advantage plan — as an inducement to enroll in Medicare and drop your employer plan. However, this law (known as ERISA) applies only to employers with 20 or more workers. So if you work for a smaller business or organization, you may be required to enroll in Part B at age 65.

Do I need to do anything about Part B at age 65 if I continue to be insured at work?

It depends on whether you're already receiving Social Security retirement benefits. If you are, Social Security will automatically enroll you in Part A and Part B just before your 65th birthday. The letter sent to you with your Medicare card explains your right to opt out of Part B if you have employer insurance. To opt out, follow the instructions included in that letter within the specified deadline.

Should I still sign up for Medicare Part A?

With one exception (see next item), there's no reason not to enroll in Part A, which covers hospital stays, around the time you turn 65 because if you contributed enough Medicare payroll taxes while working there are no premiums for Part A.

You can sign up for Part A during your initial Medicare enrollment period, which runs for seven months, starting three months before the month of your 65th birthday and ending three months after that month. Just call Social Security, which handles Medicare enrollment, at 1-800-772-1213 and schedule an appointment for an interview, which can be done on the phone or at your local Social Security office. This interview gives you the opportunity to make sure that an official enters into your record the fact that you have declined Part B because you have health insurance through the current employment of you or your spouse. You may be required to provide documents showing you have this coverage.

What if I have a health savings account at work?

You need to be careful if your employer insurance takes the form of a high-deductible plan with a health savings account. Under IRS rules, you cannot continue to contribute to an HSA if you are enrolled in Medicare (even Part A) or, after age 65, are receiving Social Security retirement or disability benefits. You can draw on funds already in your account, but you cannot add to them. For details, see "Can I Have a Health Savings Account as Well as Medicare?"

You'll be able to sign up for Part A without risking a late penalty during the same special enrollment period when you enroll in Part B, after you finally stop working.

If you are married to somebody who has an HSA at work, and you are covered by that plan, it doesn't make any difference whether you are enrolled in Medicare or not — you can still use the HSA for your medical needs. The IRS rule applies only to the working employee who is contributing to the plan.

Will I need Part D prescription drug coverage?

Probably not. If your employer plan offers prescription drug coverage that is "creditable" — meaning that Medicare considers it at least of equal value to Part D coverage — you don't need to enroll in a Part D drug plan at age 65. Instead, when your employer coverage ceases, you'll be entitled to a two-month special enrollment period to sign up with a Part D plan without penalty. Your employer plan can tell you whether it's creditable or not. If it's not, you would need to enroll in Part D during your initial enrollment period at age 65 to avoid late penalties if and when you eventually signed up.

What if my employer offers me COBRA or retiree health benefits?

It's confusing, but different rules apply to Part B and Part D in either of these situations:

Part B: You can delay Part B enrollment without penalty *only* while you or your spouse is still actively working for the employer that provides your health insurance. But if you receive COBRA benefits — a temporary extension of your employer coverage that usually lasts 18 months — or retiree benefits, by definition you are no long working for this employer. So if you wait until these benefits have expired before enrolling in Part B, you won't qualify for a special enrollment period. Instead, you'd likely pay late penalties, and you would be able to enroll only during the general enrollment period that runs from Jan. 1 to March 31 each year, with coverage not beginning until the following July 1.

Part D: As long as your COBRA or retiree drug coverage is creditable, you do not need to enroll in Part D until these benefits end, as explained above.

Patricia Barry is a senior editor with the AARP Bulletin.]"

Question for Consideration

With the above example which can change the costs of the health plan by reducing the hours of those (= > Age 65) to (< 30 hours per week) for purposes of avoidance of having (= > 50 employees) for purpose of the calculation of the FTE and potential corresponding liability of the "Play or Pay" be exercised by employers due to PPACA?

In light of the question above, would this pose possible discrimination litigation to employers who exercise this structure based on a class of employees?

If this does pose discrimination litigation, then would this pose litigation on other employees reduced in hours who are (< Age 65) in transitioning from (= > 30 hours per week) to (< 30 hours per week)? --Or--

Will this likely be the structure employers may use if there is no discrimination or possible litigation for changing one or both classes of employees meaning those (= > Age 65) or (< Age 65)?

Has PPACA produced an ambiguitas nature of the Law as it pertains to classes of employees or age?

A. Section 4980H

Section 4980H was added to the Code by § 1513 of the Patient Protection and Affordable Care Act (Affordable Care Act) (enacted March 23, 2010, Pub. L. No. 111-148) and amended by § 1003 of the Health Care and Education Reconciliation Act of 2010 (enacted March 30, 2010, Pub. L. No. 111-152).[2] Section 4980H applies to "applicable large employers" (generally, employers who employed at least 50 full-time employees, including full-time equivalent employees, on business days during the preceding calendar year).

_____

[2] Section 4980H was further amended by section 1858(b)(4) of the Department of Defense and Full-Year Continuing Appropriations Act, 2011 (enacted April 15, 2011, Pub. L. No. 112-10), ***effective for months beginning after December 31, 2013.***

The 9.5% of cost calculation of single coverage as an affordable basis for the employee who is eligible for coverage is also a factor. As this is also effective January 1, 2014.

Two Methods of contribution formulas

Traditional formula - employer/sponsor establishes a contribution formula based on premium for employer coverage only. The employee is responsible for any costs associated with dependent coverage. Assume a $300.00 per month premium for employee only coverage with the employee contribution of $150.00 per month. In this method, the employee is paying 50% of the cost for employee only coverage. Assuming the employee hourly wage is $7.25 per hour based on a 30 hour work week - the employee monthly income using the factor of 4.33 to encompass a 52 week work year. The employees monthly income is $941.78. The contribution required is $150.00 per month. The percentage required for participation is 16%. This fails the 4980H of the maximum of 9.5%.

New Formula - employer/sponsor establishes a formula for calculation of the contribution requirements for participation in the employee only coverage. This calculation is designed to not only meet the "9.5%" but also to avoid any eligible employee from receiving a "credit or subsidy" from the exchange and avoiding an employer penalty. The understanding is if the employee has to contribute more than 9.5% of their employer provided income (W2) to participate in the "Minimum Value" (Bronze) health plan or lowest cost health plan, that participant would be able to go to the exchange and if qualified to receive a subsidy then the employer

would have to pay $3,000 per year or $250 per month for each of the full time employees receiving a subsidy from the exchange.

Secondly, if the employee falls between 8% and 9.5% and fits the federal poverty level definition, then the employer may also have to pay $3,000 or $250 per month for each full time employee meeting this criteria and receives a subsidy.

Thus, the employer can place a contribution formula which in its merit can avoid any of the exchange subsidy or other penalties that could be assessed.

Since the formula from PPACA is based on letter of the law with the parameters based on the employer provided income, the following exists.

The minimum wage is $7.25 per hour. The full time basis is 30 hours per week. The employer establishes a formula which provides the following. Secondly, the calculation is based on an employee making $30.00 per hour working 30 hours per week. (Assumes 4.33 weeks per month as factor - based on 52 weeks per year).

The cost of the employee only coverage employee contribution for the qualified health plan offered is 8% of gross pay (W2) to a maximum of $150 per month.

Hourly Wage	Formula	Cost per Pay	Calculated Monthly	Cost per Month max $150
$7.25	8% to a maximum $150 per month	$17.40	$75.34	$75.34
$30.00	8% to a maximum $150 per month	$72.00	$311.76	$150.00

Based on this formula and the existence of the “Minimum Value Standard” plan being the lowest cost and qualified health plan meets the criteria so no full time employee can receive a subsidy from the “Exchange” thus, the avoidance of any penalty being assessed ie $3,000.00 or $250.00 per month.

Additionally, the employer offers the plan to 100% of the eligible employees meeting the criteria set forth by PPACA thus the elimination of not meeting the “Non Discrimination Rules” of 95%.

The 8% keeps the employee exempt from the individual mandate should they decide to waive coverage from the employer/sponsor plan. The employee could still apply for exchange coverage using the premium assistance tax credit, enroll in the employers health plan despite the cost, or remain uninsured without paying a penalty.

SAMPLE REPORT ON PPACA IMPACT

to a

Small Employer

(Information utilized in this analysis is based on an actual small employer data set which utilizes a self funded health benefit plan. The impact viewed is substantial for budgeting the additional cost to cover those employees who work 30 to 39 hours per week. The current plan provides for only those working 40 hours or more to qualify for the health plan. The employer currently pays 100% of the employee cost to the health plan and offers the plan to 100% of those eligible for the health plan).

Note: the algorithms utilized will show the employer currently FAILS based on the rules of the eligibility 30 hours vs 40 hours, thus opening them up to penalties in the “Play or Pay” on the full time employees.

Example of Findings PPACA Calculation

The following is based on the information provided and the calculations per PPACA Law for Health Plans effective on or after January 1, 2014.

Category	Data Analysis
Total Full Time Employees	52
Total Part Time Employees	13
Total Employees	65
Full Time Equivalent Employees	61
Full Time Equivalent Employees for "Play or Pay"	31
Pay or Play Penalty	$62,066.67
Hours Requirement for Participation	FAIL
Waiting Period for Health Plan Participation	PASS
Individual Deductible	PASS
Family Deductible	PASS
Benefit Calculation % of Allowed Benefits Paid	PASS
% of Employee Contribution Exchange Pass or Fail	PASS

If any of the above calculations state "FAIL" the penalties will apply specific to those categories.

For a complete analysis and consultation on how to mitigate these areas which show "FAIL", contact F. Randall Childers, Jr., CFC for the proper structure of the plan parameters. A full report on XYZ Corporation is available with an engagement of F. Randall Childers, Jr., CFC.

Preliminary Information

The Patient Protection and Affordable Care Act was passed by Congress and then signed into law by President Barack Obama on March 23, 2010. The Affordable Care Act was challenged in the Supreme Court of the United States and on June 28, 2012 a decision was rendered to uphold the health care law. The Affordable Care Act is also referred to as “Obama Care”. Through this documentation it will be referred to as “PPACA”.

PPACA has two distinct avenues, the Employer provisions and plan provisions. Each of these have “penalties”, “fees” and/or “taxes” associated with PPACA. The provisions do not reward employers for compliance with PPACA and requires payments via fees, taxes and penalties to be paid because you are an employer and have employees.

This report is designed to educate XYZ Corporation with regard to its standing as an employer with employees and to show the cost, financial impact, associated with PPACA.

This report is broken down into distinct components to understand the differences in each of the avenues - Employer and Plan as well as information on options to mitigate most of the cost associated with PPACA.

This report will only refer to plan designs as minimum or medal plans as distinguished by the Exchange programs. The Medal plans will be referred to as: Bronze (minimum), Silver, Gold and Platinum (Maximum). These will be referred to as illustrative only.

The Plan XYZ Corporation currently has may be a “Grandfathered” or “Non-Grandfathered” plan. This report does not distinguish which plan designs XYZ Corporation is providing to its employees if any.

The first area to discuss is the Employer fees and the determination if XYZ Corporation is considered a “Large Employer”.

The following information was provided and analyzed utilizing the formulas extracted from PPACA encompassing, full time employees, part time employees, hours utilized in compiling the information from the import of information provided by John Doe, HR Director from XYZ Corporation, 850 Any Street, Any City, KY 42001.

Statistical Information

Category	Full Time = > 30 Hours	Part Time < 30 Hours	Totals
Employees	52	13	65
Full Time Equivalent	52	9.033	**61.033**

Employer Calculation and Cost Results.

There are **two categories** and **two options under each category** as to how the Full Time Equivalent penalty will apply, commonly known as “Play or Pay”. These are based on the employer being considered a “Large Employer”. The “Large Employer” under PPACA is defined as having 50 or more Full Time Employees.

This calculation encompasses employees who work 30 or more hours per week with the addition of the “Part Time - Full Time Equivalent (FTE)” calculation. Part -Time employees are defined as those working less than 30 hours per week. The Part Time - FTE calculation consists of: the number of Part-time workers multiplied by the aggregate number of hours worked per week divided by 120.

This calculation can be done from an annual basis by taking the total number of hours worked in a calendar year divided by 12 multiplied by the number for Part-time workers divided by 120. This calculation provides the number of Part-Time FTE. This is added to the Full time employees giving the true full time equivalent for determination of a “Large Employer)

The calculation shown for XYZ Corporation is based on the following from the information provided. (*Full Time 52 + Part time (Full Time Equivalent)) 9.033 - 30 = 31 x $2000 (Potential penalty) =* ***$62,066.67****.*

Calculation Table "Play or Pay"

Category	Calculation FTE
Full Time Employees = > 30 Hours	52
Part Time (FTEs)	9.033
Credit (30)	-30
Full Time Equivalent	31
Penalty "Play or Pay"	$2,000.00
Total Potential Penalty Employer	**$62,066.67**

The following section will describe how and when the penalty can be applied. The descriptions are broken into two categories:

3. Employer Does Not Offer Health Coverage
4. Employer Offers Health Coverage

The application is important when making a decision on the "Play or Pay" rules established by the PPACA Law. It is important to look at the big picture when making the decision on Offering Health Coverage or Not to Offer Health Coverage.

How the FTE penalty is applied

(This penalty is only applied to full time employees not to part time employees).

Employer does not offer health coverage

1. No full time employees receive credits from the exchange. **No Penalty is Assessed.**
2. One or more full time employees receive credits for exchange coverage. The annual penalty for XYZ Corporation is based on the FTE penalty calculated which is FTE 31 x $2000 = **$62,066.67**. This penalty would not vary if *only one employee received the credit* from the exchange. The penalty is assessed monthly which would apply to XYZ Corporation for $5,172.22.

Employer offers health coverage

1. No full time employees receive credits for exchange coverage. **No Penalty is Assessed.**
2. One or more full-time employees receive credits for exchange coverage. The *actual number of full-time employees receiving credits* are used in the penalty calculation for XYZ Corporation. The Penalty applies and can be substantial. The following is based on XYZ Corporation assuming 31 FTE.

   (a) 31 x $2,000 = **$62,066.67**

   (b) # FTEs receiving credit from the Exchange X $3,000.

To understand the impact to XYZ Corporation with 31 FTEs and have 10 FTEs who receive premium credits from the exchange, the fine is calculated as:

- *10 FTEs x $3,000 or $30,000. IF XYZ Corporation FTE Amount of **$62,066.67** is greater than the # of FTE's receiving the credit then the penalty is the lesser of the two.*

- *30 FTEs x $3,000 or $90,000. IF XYZ Corporation FTE Amount of **$62,066.67** is greater than the # of FTE's receiving the credit then the penalty is the lesser of the two.*

*The Following information will describe the various fees associated to the Fully Insured Health Plan and or the Self Funded Health Plan on calculating the additional cost to the health plan. These are know as **plan fees**.*

Health Plan Fees from PPACA

The following are fees which are added to the current health plan offered by XYZ Corporation. These fees will not apply if XYZ Corporation does not offer health benefits to the full time employees. However, if no plan is offered, it only takes one full time employee to purchase from the exchange and receive a credit which will cost XYZ Corporation **$62,066.67** annually or **$5,172.22** monthly. This is known as “Play or Pay”.

The following fees are described and their application to either a fully insured plan or self funded plan.

1. **Transitional Reinsurance Fee** - this fee is assessed on a per member basis, Employees + all dependents. This fees is **$63.00** per member per year or **$5.25** per member per month. (This fee applies to both fully insured and self funded plans).
2. **Patient Centered Outcomes Fee** - This fee is assessed on a per member basis, Employees + all dependents. This fees is **$2.00** per member per year. (This fee applies to both fully insured and self funded plans).
3. **Health Insurance Industry Fee** - This fee is assessed on the total premium of the plan. This will be included as an additional cost in the monthly full insured premium. This fee is **1.9%** of the premium monthly. (This fee applies to fully insured plans).
4. **Federal Facilitated Exchange User Fee** - This fee is assessed on the total premium of the plan. This will be included as an additional cost in the monthly full insured premium. This fees is **3.5%** of the premium monthly. (This fee applies to fully insured plans).

The following chart shows the impact of these Plan Fees and the Employer potential penalties “Play or Pay” for XYZ Corporation.

The following chart shows the impact for **XYZ Corporation** of PPACA using a Self Funded Medical Plan Approach.

Self Funded Plan - The current plan maximum cost is **$268,678.80.** The total members eligible for the health plan is **61**. The plan fees assessed, based on current participation, by PPACA is **$3,510.00**. The Pay or Play Full Time Equivalent employees are **31** which has a potential additional cost of **$62,066.67** annually. This is considered a maximum basis for cost if the number of employees receiving coverage from the exchange and receiving a credit. Fee will not apply if the employee gets coverage from the exchange and receives no credit. The cost of the self funded plan will increase by a minimum of **$3,510.00** based on current participation.

NOTE: The potential exists to mitigate the plan costs from PPACA. The plan cost will range from the Fully Insured Plan of $18,018.66 to the Self Funded Plan of $3,510.00.

The following table uses the annualized health plan cost as provided by XYZ Corporation which may or may not include the additional full time employees (= > 30 hours). Based on the information provided XYZ Corporation is a Self Funded Health Plan thus, the applicable fees and "Play or Pay" is the potential of additional cost in fees and or "Play or Pay" cost.

The following chart shows the potential impact of PPACA. The actual participation in the health plan will be the actual impact based on the fees. The “Play or Pay” and fees potential cost will not change unless an increase or decrease in full time employees and or full time equivalent employees occurs.

Categories	Self Funded Health Plan
Covered FT Employees	52
Dependents	2
Total Lives Covered	54
Annual Health Plan Cost	**$268,678.80**
Transitional Reinsurance Fee	$3,402.00
Patient Centered Outcomes Fee	$108.00
Health Insurance Industry Fee	**N/A**
Federal Facilitated Exchange User Fee	**N/A**
Total Fees	$3,510.00
Full Time Equivalent	31
Pay or Play Cost	$62,066.67
Total Additional Potential Fee Cost and Pay or Play - PPACA	$65,576.67
Current Annual Premium	**N/A**
Total Cost Potential 2014	$334,255.47
% Increase from Fees	1.31%
% Increase Potential Non-Compliance	24.41%

The following chart will show the potential impact of costs with the addition of the new eligibility rules established by PPACA Law. This calculation is taking the current participating employees and comparing to the potential new participants (Employees working 30 or more hours per week). This will show a gross impact assuming all full time employees are participating. *This calculation does not include the additional fees from PPACA and only includes the current Employee Premium on the lowest plan offered.*

Categories	Current Participation	New Participation PPACA	Totals
Employee	28	19	47.00
EE Only Premium	$350.00	$350.00	$350.00
Total Gross	$9,800.00	$6,650.00	$16,450.00
Less Employee Contribution	$0.00	$0.00	$0.00
Employer Cost Monthly	$9,800.00	$6,650.00	**$16,450.00**
Employer Cost Annually	$117,600.00	$79,800.00	**$197,400.00**

Compare to “Play or Pay” $62,066.67 for new participants.

Fully Insured vs Self Funded

The following is an illustration on the impact to the cost of PPACA based on the fees as it pertains to a comparison in cost of a fully insured plan vs a self funded plan. The fees have been calculated and totaled as it relates to the Fully Insured and Self Funded Plan categories. (Factors assumed for Employee + Children (2) and Employee+Spouse (2) and Family (3). Based on the make up of dependents for Employee+Children and Employee + Family, the calculations below should be increased to reflect the actual number of dependents in the calculation.

Category	Employee	Employee + Children	Employee + Spouse	Family
Monthly Premium	$350.00	$489.00	$512.00	$880.00
Transitional Reinsurance Fee	$5.25	10.50	10.50	15.75
Patient Centered Outcomes Fee	$0.17	$0.34	$0.34	$0.50
Health Insurance Industry Fee	$6.65	$9.29	$9.73	$16.72
Federal Facilitated Exchange User Fee	$12.25	$17.12	$17.92	$30.80
Fully Insured Plan	**$374.32**	**$526.25**	**$550.49**	**$943.77**
Self Funded Plan	**$355.42**	**$499.84**	**$522.84**	**$896.25**
Difference $	**$18.90**	**$26.41**	**$27.65**	**$47.52**
Difference %	**5.32%**	**5.28%**	**5.29%**	**5.30%**

The self funded plan offers many advantages vs the fully insured plan, not only from a cost basis but also a retention basis.

When reviewing the self funded plan vendor architecture, most plan sponsors have the ability to improve the out comes based on the vendor architecture and utilization of a fully transparent contracting with application of the “New Matrix” as described in the book “Forensics of a Medical Plan - Dissecting Health Benefits on a Company Level”. It is highly recommended for plan sponsors to utilize this book as a reference in structuring the self funded health plan and vendor architecture. This reference book will provide better results for the self funded plan.

Employer Requirements Reporting

Information on Minimum Essential Coverage

Every person (including employers, insurers, and government programs) that provides minimum essential coverage to any individual must provide a return to the IRS, (*Section §1502 of P.L. 111-148, which creates Section 6055 of the IRS Code of 1986)*. This information must also be provided to each primary insured person along with contact information.

- Name, address and tax identification number of the primary insured and others covered under policy;
- The period for which each individual was provided coverage;
- Whether or not the coverage is a qualified health plan offered through and exchange and, if so, the amount of any advance payment of any cost-sharing reduction or premium tax credit;
- For coverage provided through a group plan of an employer, the portion of the premium, if any, paid by the employer; and
- Other information required by the Secretary of the Treasury.

Minimum Essential Coverage Table Sample

Name	Address	Tax ID	P = Primary Insured or D= Dependent	Coverage Period	Exchange Qualified Health Plan Offered Through Exchange	Premium Portion Paid by Employer Group Health Plan
Mickey Mouse	1234 International Drive, Orlando, FL 12345	123-45-6789	P	January 1 to December 31	N	$350.00
Minnie Mouse	1234 International Drive, Orlando, FL 12345	987-65-4321	D	January 1 to December 31	N	$0.00
Donald Duck	1235 International Drive, Orlando, FL 12345	234-56-7890	P	January 1 to December 31	N	$350.00

This table is a sample. The table for XYZ Corporation may be different by the addition of the columns for advance payment of cost sharing reduction and or premium tax credit.

Health Insurance Information Provided by Employers to Employees

Requires employers to provide employees at the time of hiring written notice of;

- The existence of an exchange, including services and contact information;
- Eligibility information for premium credits and cost-sharing subsidies, if the employers' plans' share of total allowed cost of benefits provided is less than 60%;
- Notice that the employee may lose any employer contribution if the employee purchases a plan through the exchange.

Sample Notification Written Notice

This is notification as required by the Patient Protection Affordable Care Act (PPACA) from XYZ Corporation to inform you as a new hire on Health Insurance availability.

The XYZ state has an exchange available which will provide you information on choices of coverage available and any potential credits available. The XYZ State provides Navigators to help you with your questions. You may contact them at 1234 State Drive, Any City, Any State, Zip or toll free (888) 123-4567. You may also visit their web portal www.stateexchange.XX.gov.

XYZ Corporation meets the minimum requirements set forth under the Patient Protection Affordable Care Act (PPACA). The XYZ Corporation plans' share of total allowed cost of benefits PASS this requirement. The contribution formula established by XYZ Corporation PASS the requirements of the Patient Protection Affordable Care Act (PPACA).

As an employee of XYZ Corporation you may lose any employer contribution if you purchase a plan through the exchange.

Should you have any questions please feel free to contact: John Doe, HR Director, XYZ Corporation, 850 Any Street, Any City, KY 42001 or by phone at (270) XXX-XXXX.

Information Provided by Certain Employers to Full Time Workers

Large employers (defined as those with more than 50 full-time equivalent employees must provide a return to the IRS per *(Section §1514 of P.L. 111-148, which creates Section §6056 of the Internal Revenue Code of 1986)*. The employer must also provide its full-time employees the specific information included in the return for that individual, along with contact information. *(See IRS Notice 2012-33)*.

- Name, date, and employer identification number of the employer;
- A certification as to whether the employer offers its full-time employees (and dependents) the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan;
- The length of any waiting period, months of coverage was available, and monthly premiums for the lowest cost option;
- The employer's share of total allowed cost of benefits (i.e., the percentage of covered benefits paid for by the plan);
- The number of full-time employees, and the name, address and tax identification number of each full time employee; and
- Additionally, an offering employer must provide information about the plan for which the employer pays the largest portion of the costs (and the amount for each enrollment category).

Table Transmission to IRS on Full Time Workers Sample

Date	Monday, March 25, 2013	
Employer Name	XYZ Corporation	
Employer Identification Number	12-3456789	
Certification of minimal essential coverage	Minimum essential coverage Employer Sponsored Plan - PASS	
Waiting Period	Maximum 90 days - PASS	
Months coverage available	January 1 to December 31	
Monthly Premium Lowest Option	$350.00	
Total Allowed Cost of Benefits	Minimum 60% Allowed cost of benefits - PASS	
Number of Full Time Employees	52	
Enrollment categories	**Plan Cost**	**Employer Share**
Employee Only	$350.00	$350.00
Employee + Children	$489.00	$350.00
Employee + Spouse	$512.00	$350.00
Employee + Family	$880.00	$350.00
Employee Name	**Employee Address**	**Tax Identification Number**
Mickey Mouse	1234 International Drive, Orlando, FL 12345	123-45-6789
Donald Duck	1235 International Drive, Orlando, FL 12345	234-56-7890

This table is an illustration of the requirements in providing the return to the Internal Revenue Service per *(Section §1514 of P.L. 111-148, which creates Section §6056 of the Internal Revenue Code of 1986).*

This table may also be used in providing the specific information to the individual full time employee. *(See Internal Revenue Service, Notice 2012-33).*

The format on the transmission has yet to be determined. However, it should be be provided in a secure basis to avoid interception and potential identity theft.

It is recommended that XYZ Corporation have an institutional coverage of a potential breach of transmitted information. Contact Randall Childers Consulting to discuss the application of the Institutional Coverage option available.

Mitigation to “Play or Pay”

PPACA has set out a specific set of rules with regard to the percentage of pay for the Health Benefit Plan. If the percentages are exceeded on the “Self Only Premium” compared to the gross income of the participant then the “Play or Pay” rules becomes effective.

If the plan contribution requirements for self-only coverage exceeds 9.5% of the employees income and the plan offered by XYZ Corporation pays for less than 60% of the covered expenses on at least one full time employee and the employee obtains a premium credit from the exchange then the “Play or Pay” is invoked.

To avoid this circumstance, a contribution formula should be created based on the minimum plan such as a “Bronze Plan” should be invoked. The proper formula can be established over the full time employees for self only coverage.

Constructing and implementing the language within the plan documentation and coordination with the architectural vendors for the health plan is vital in implementing the non-existence of the 2014 plan year in avoidance of the above mentioned calculations on the self funded and fully insured health plans. There is a great significance in this analysis as employers who can self fund their health plan and assume the risk associated will substantially help them selves and will continue a basis of affordable coverage for the members of the health benefit plan for changing to a policy year of December 31, 2013 through December 31, 2014 renewing on January 1, 2015 through December 31, 2015 thereafter.

The impact of the proposed structure is monumental to the United States of America and provides a level of stability if only for a one year period to the economic base of the Employer and economy.

Through the Forensic comparative analytics of PPACA, a structure exists to mitigate the plan fee costs for 2014 and the impact of the “Play or Pay” contained in the PPACA Law. F. Randall Childers, Jr. CFC, Certified Forensic Consultant specializing in Health Benefit Plans, analyzed The Affordable Care Act (PPACA) and presented the forensic

findings for the legal application. Between the forensics and the legal basis of application, a potential mitigation exists for 2014. For more information on the application structures contact Randall Childers Consulting, F. Randall Childers, Jr., CFC, randall_childers@me.com

I reserve the right to change, modify or correct any and all comments or conclusions expressed in my written observations should I be given additional information that would warrant such actions.

F. Randall Childers, Jr., CFC

Suggested Reference: Forensics of a Medical Plan - Dissecting Health Benefits on a Company Level. by: F. Randall Childers, Jr. This may be ordered by going to the website: www.forensicsofamedicalplan.com. Amazon.com, Barnes & Noble.com, iBooks and many others or through your local book store.

Self Funding vs Fully Insured

In this review a basis for self funding is established in controlling health benefit plan cost for the employer and the participants of the health benefit plan.

Protectionism for State and/or Federal Health Exchanges

The Patient Protection and Affordable Care Act (PPACA) passed by Congress and then signed into law by President Barack Obama on March 23, 2010. The Affordable Care Act was challenged in the Supreme Court of the United States and on June 28, 2012 a decision was rendered to uphold the health care law. The Affordable Care Act is also referred to as “Obama Care”. Through this documentation it will be referred to as “PPACA”.

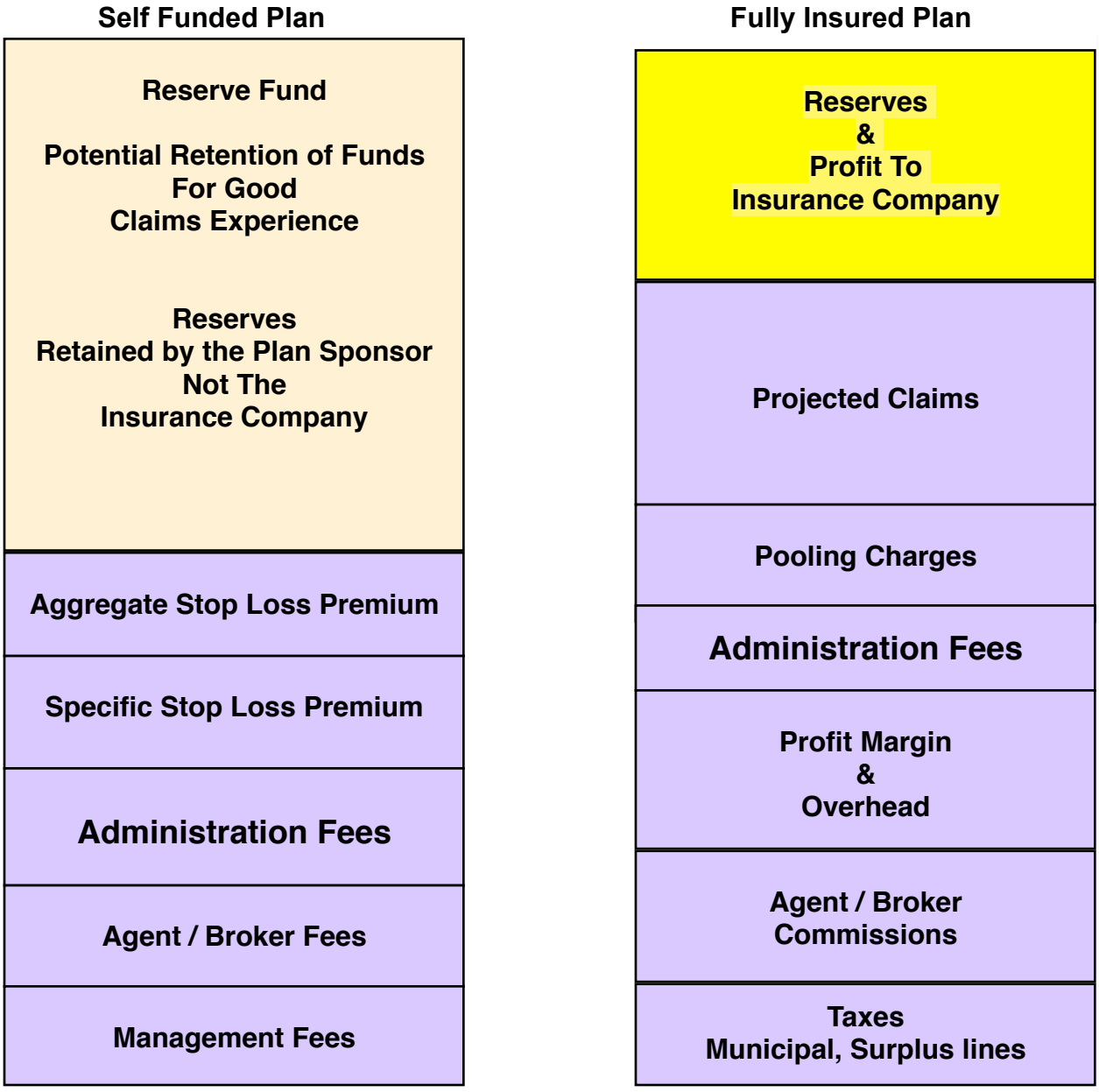
The NAIC with several of the various states insurance commissioners have taken to protectionism of “PPACA” or commonly know as “Obama Care” to protect the Health Exchanges by trying to implement restrictions on Stop Loss Coverage for employers sponsoring self funded health plans. This is primarily to force small employers and their employees to the health exchanges. While this is an ongoing base, it is important to understand why employers who can establish self funded plans want to do so. The following is an overview of the differences.

Prior to The Patient Protection and Affordable Care Act there was minimal activity to restrict Stop Loss coverage for employers sponsoring self funded health plans.

In the following example Self Funded vs Fully Insured, the components of the structure are the same with the difference being who owns the plan. In the self funded plan the employer / plan sponsor owns the plan. In the fully insured plan the insurance company owns the plan and the employer with their participants are simply members of the plan. The other substantial difference is who retains the surplus of the plan. In the self funded plan, the plan retains the surplus for good experience. In the fully insured plan, the insurance company keeps the surplus as profits.

There are other significant differences in the architectural structures which drives the cost of the health plan whether self funded or fully insured.

Self Funded Vs. Fully Insured Plan

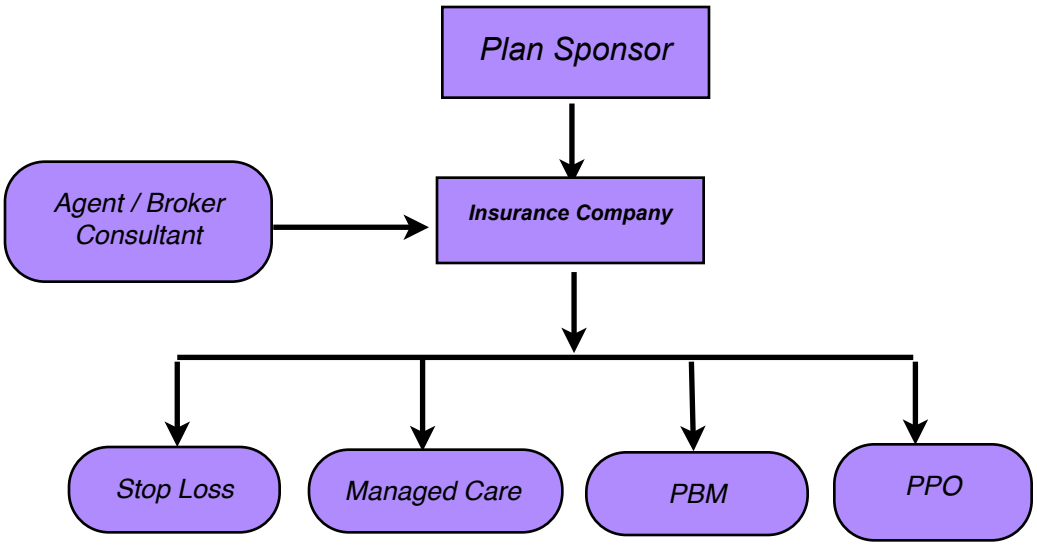


This chart shows the break down of the structure of a Self Funded Plan and a Fully Insured Plan. The Self Funded Plan provides an upside for retention of dollars as well as reduces the Fixed Cost or Hard Dollars. In the fully Insured Plan there is no upside as you have 12 cancelled checks to show for the plan which is all fixed cost or hard dollars.

Structure of Matrixes

There are substantial differences in the matrix of a fully insured health plan and that of a properly structured self funded plan. We will refer to these as the Traditional Matrix (Fully Insured Health Plan" and New Matrix (Self Funded health Plan).

Traditional Matrix

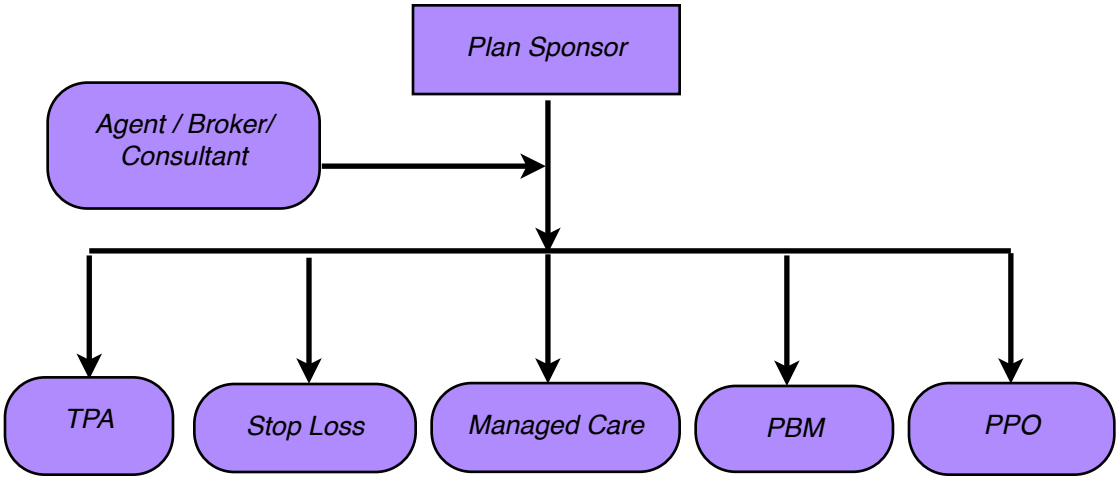


With the Traditional Matrix is contracting with the Insurance Company for the health plan. The Insurance Company is directly contracting with the various vendors to the plan. The Agent / Broker / Consultant is receiving compensation with the contracting with the Insurance Company with either fees and/or commissions.

The compensation for the Insurance Company as well as the Agent / Broker / Consultant may not be fully disclosed in this model due to arrangements with the various vendors. The Insurance Company may have non transparent agreements which provides additional compensation whether disclosed or non-disclosed with the vendors. As the Plan Sponsor with the traditional matrix the Insurance Company is controlling the Plan and the Vendors to the Plan.

Notice the vendor Stop Loss. Fully Insured carriers utilize this type of protection for themselves with either an internal basis or external basis to protect against the losses. In the same way, a Plan Sponsor will use to protect them from the potential losses of their Self Funded Plan.

New Matrix for a Self Funded Plan



This is the New Matrix for a Self Funded Medical Plan. The difference is how each of these components are handled in the architecture and contracting to the Plan Sponsor.

Note: In the past the TPA/ASO would have presented each of these components as part of their "Quote" to the Plan Sponsor. The Plan Sponsor would only see the numbers in the quote and not what is going on behind the scene. What is not shown in the quote is the additional income via fees, markups, commissions, rebates etc. that are being received by the various vendors to the TPA/ASO, Agent, Brokers and Consultants. The following structures will describe each of the functions in the New Matrix above.

This matrix is the new structure for employer sponsored self funded health plans. The Plan Sponsor contracts with each entity directly giving total control on the benefit plan. The Agent / Broker / Consultant is the conduit in the architecture of the structure bringing the various partners/vendors to the Plan Sponsor. This structure allows for total transparency in cost and compensation with each vendor partner.

The vendors in this model must perform, especially the TPA / ASO as they are now a provider to the plan and not controlling the partners / vendors as with insurance companies on fully insured plans for their financial gain. The TPA/ASO only receives their disclosed Fees. All stop loss and vendor agreements are net of commissions allowing a pure rate on the stop loss without mark up or commissions. The PBM, Prescription Benefit Manager, is contracted to pay 100% of the rebates to the Plan.

This structure allows for accountability and transparency in all aspects of the plan. If a vendor is not performing then a new vendor can be put in without jeopardizing the architecture or integrity of the plan. All vendors utilized are chosen in their ability to help control cost and provide outstanding service to the Plan Sponsor and the participants in the self funded health plan.

The following will discuss each of the architectural vendor components of a fully insured plan and a self funded plan with respect to controlling costs. The discussion will consist of Plan, Prescription Benefit Managers (PBM), Stop Loss, Managed Care (UR/PreCert/DM/CM and networks whether PPO, ACO, HMO etc. This discussion will also describe the off book ledger profits from these architectural vendors and how this profit is applied to fully insured carriers which do not apply to the Minimum Loss Ratios (MLR) to the insurance carrier for the 80% and 85% cost for claims vs premiums. This is substantial and an area which has not been addressed in PPACA.

Comparative Fully Insured vs Self Funded

Plan Comparative

Fully insured health plans have full containment of all parameters of the Plan Document, Protection of insurance company assets contained due to the simple nature they control all vendor architecture to the fully insured health plan. The insurance company assumes 100% risk of the plan.

Self funded health plans require the employer also known as the plan sponsor / administrator / fiduciary to develop the plan for the benefit of their employees / participants. This plan is normally developed under ERISA 1974. The employer takes 100% of the risk of the plan. Once the plan is designed, an optional stand alone risk management basis exists for the plan and that is Stop Loss coverage with it having internal options for the plan -- *Specific Coverage* which protects against losses to the plan based on thresholds or risk protection on each member of the plan. *Aggregate Coverage* for the plan in protection of risk for the plan as a whole.

Stop Loss Comparative

Fully insured health plans will utilize a type of stop loss coverage to protect them against losses. This is normally done and has many different terms utilized within the fully insured environment such as “Pooling Levels”. This is an agreement done by the insurance company. Normally, there is a % received back to the insurance company contracting for this coverage as well as a % for good experience (favorable loss ratios) which becomes an internal profit center and not calculated against the Minimum Loss Ratio (MLR). The funds from this are received by the insurance company normally in a “off book ledger” compensation/profit. The external basis for calculation of the MLR is the gross premium of the health plan vs claims and management of claims. The internal basis is not credited to the insured plans in the offset of costs.

Self Funded health plans may or may not utilize stop loss based on size and is an option for risk management. Self funded health plans do not utilize a % back as compensation. In the New Matrix contracting with stop loss is done on a net basis thus,

no compensation. Additionally, stop loss carriers will have a favorable renewal for good experience which is passed along to the plan.

Based on this comparative, the self funded plan will be more favorable in the control of risk and cost vs fully insured plans.

For employers wanting to utilize stop loss as a risk management basis for the self funded health plan should not be limited to certain minimum levels as a protectionist basis from the various NAIC state insurance commissioner members trying to utilize this to protect the “Health Exchanges”. The protectionism potentially taking place is due to the Health Exchanges not being competitive in the health benefit market place. To keep cost down for all types of plans whether fully insured, self funded, state or federally run health exchanges or Co-ops a competition must exist between all.

PBM Comparative (Prescription Benefit)

Fully insured health plans will contract directly with the Prescription Benefit Management Company for the prescription benefit portion of the insured health plan. In this structure, “Rebates” from the manufactures are are derived which are considered refunds. These “Rebates” are paid to the insurance company as well and not passed along to offset cost of the insured plans. These “Rebates” are another form of “off book profit” to the insurance company and are not calculated to reduce the costs of the premiums. Additionally, a margin sharing may exist between the insurance company and the PBM which becomes another revenue source as an “off book ledger” profit center. The gross cost of the prescriptions are utilized as part of the gross claims for the cost of claims in calculation of the MLR.

Self Funded health plans will contract directly with the Prescription Benefit Management Company for the prescription benefit portion of the vendor architecture of the self funded health plan. In this structure, “Rebates” from the manufactures are derived which are considered refunds. These “Rebates” are paid to the self funded health plan as refunds and calculated back into the self funded health plan to reduce losses and improve loss ratios. The calculation of the rebates back to the plan reduce the risk exposure of the self funded health plan and improve the loss ratios. (Important note for plan sponsors - make sure your agreement includes 100% of the rebates and not the terms eligible rebates).

Managed Care Comparative

The managed care vendor normally provides the following. Utilization Review and PreCertification (UR PreCert), Case Management (CM), and Disease Management (DM) as a basis for vendor services to the health benefit plan.

Fully insured health plans will contract directly with the Managed Care Company for Utilization Review and PreCertification (UR PreCert), Case Management (CM), and Disease Management (DM). There is normally a per employee per month (pepm) fee for the (UR PreCert) as well as the (DM). The (CM) is normally done on an hourly rate but can be done on a pepm basis. A mark up or a revenue sharing is normally done by the insurance company on the managed care. These mark ups or revenue sharing are paid to the insurance company and not passed along to offset cost of the insured plans. These mark ups or revenue sharing are another form of “off book profit” to the insurance company and are not calculated to reduce the costs of the premiums. In case management, this cost if an hourly basis is calculated into the cost of the claim vs the pepm basis which is not calculated in to the claim. The gross cost of the managed care are utilized as part of the gross cost in calculation of the MLR and not offset by the revenue sharing.

Self Funded health plans will contract directly with the Managed Care Company or Utilization Review and PreCertification (UR PreCert), Case Management (CM), and Disease Management (DM). This agreement is normally done on a net pepm basis thus keeping the cost of these services down. Thus, there is no revenue sharing or mark ups due to the net vendor architectural contract directly with the plan sponsor health benefit plan. This allows for reduction of cost compared to the fully insured health benefit plan. Note: The services are the same, the difference is the cost calculated.

Network Comparative

A network whether a PPO, ACO, or HMO is an access point to an in network benefit.

Fully insured health plans will have either their own network, contract with an external network or a combination. This also becomes an internal “profit center” or “off book ledger” basis for profits. These cost may have increase or mark ups from the net

internal cost and the markup cost being calculated on a gross basis for the inclusion in the insurance premium.

Self Funded health plans will contract on a net basis either directly with the network or through an aggregator on the net cost. By doing this, the self funded health plan reduces its cost for this vendor architecture.

Networks only provide a discount to an in network benefit. The actual savings for health benefit claims comes from good claims management, billing review of charges etc.

With the above information on the fundamental vendor architecture to the health benefit plans, cost reductions are better with self funded health benefit plans. Utilizing the new matrix allows a plan sponsor for the health benefit plan to replace on a "plug in" any vendor to the plan which is not performing without jeopardizing the integrity of the health benefit plan. *The plan sponsor has no say in the vendor architecture of the fully insured health plan.*

For the reasons explained above, PPACA and the NAIC are trying to restrict employers from providing self funded health plans by restricting stop loss. The bottom line is that the Exchanges will not be able to compete with employers who establish self funded health plans.

There are many more areas within the structures of the self funded health plan to implement and put in the right vendor architecture. The information contained in the self funded vs fully insured is derived from sections of "Forensics of a Medical Plan - Dissecting Health Benefits on a Company Level". This book is an excellent guide for those companies who are self funded or contemplating implementation of a self funded health plan.

It is important to note who's plan is it: the insurance company, the contracted administrator or the government. In the self funded plan, you are the owner.

Reference: Forensics of a Medical Plan - Dissecting Health Benefits on a Company Level. by: F. Randall Childers, Jr. This may be ordered by going to the website: www.forensicsofamedicalplan.com. Amazon.com, Barnes & Noble.com, iBooks and many others or through your local book store.

About the Author

F. Randall Childers, Jr. graduated from Hanover College with a BA in Business Administration in 1983. Mr. Childers is a ACFEI Certified Forensic Consultant specializing in Health Benefit Plans, and licensed as: Third Party Administrator, Employee Benefits Consultant and Life and Health Insurance Agent. 29+ years of experience in employee benefits.

He has authored a book - Forensics of a Medical Plan "Dissecting Health Benefits on a Company Level".

He has developed the forensic tools for the investigation and dissecting health benefit plans.

He is available to help you with your health plan by consulting, evaluation, structuring or at the highest level of forensics. He is available to consult with you as a *second opinion* on your health benefit plans as well.

He is a member of NAIFA, National Association of Insurance and Financial Advisors and currently serves on the Board of Directors Louisville Metro as President as well as Chairman of Health. This includes Legislative Advocacy, Public Relations, Educational Programming, and Professional Development.

Mr. Childers has designed a model for Medical Plans which allows the Plan Sponsor total control of their benefit plans. This model has been proven to reduce excess cost in the administration of the programs as well as claims. All of the organizations which have utilized this Model have reduced their cost across the board.

Through his experience of 29+ years, Mr. Childers has worked with and structured, analyzed and provided forensic reviews of corporate health benefit programs within the goals, objectives and timelines set forth by the Plan Sponsors in a comprehensive basis from plan design to the benefit delivery system.

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Forensics of a Medical Plan: Dissecting Health Benefits on a Company Level @ www.forensicsofamedicalplan.com