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Affordable Care Act:

At a Glance

As your business's potential advisor, we believe it's important to inform you about the newly implemented Affordable Care Act (ACA) and it's our goal to provide you with the knowledge to make the most informed decisions for your business. In order to better understand how and when the Affordable Care Act (ACA) changes will take effect, Sentinel Solutions has provided this guide for your reference.

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Changes in Coverage

- Dependent children covered until age 26, except for the following states:

  New York: Coverage expansion through age 29 if the young adult's parent, and the young adult meet certain requirements.
  New Jersey: Permits young adults to continue coverage or become covered under a parent's group health plan as an over-age dependent until the young adult's 31st birthday.
  Illinois: Dependent veterans are covered up to the age of 30 who meet certain criteria.
  Ohio: Allows an unmarried, dependent child that is an Ohio resident or a full-time student to remain on parent's insurance up to age 28, or without regard to age if they are incapable of self-sustaining employment due to disability.
  Pennsylvania: An unmarried child may remain on parent's insurance up to age 30 if they have no dependents and are residents of Pennsylvania or are enrolled as full-time students.
  South Dakota: If the dependent remains a full-time student upon attaining age 24, but not exceeding age 29, the insurer shall provide for the continuation of coverage for that dependent at the insured's option.
  Wisconsin: Requires that coverage for unmarried dependents through a parent's insurance be offered up to age 27 if they are not offered insurance through an employer.

- Waiting period for new hires to be limited to 90 days. *Please see Appendix A on page 10 for further information.*
- Pre-existing condition exclusions eliminated for all.
- All small group (under 50) plans must include an approved list of essential benefits.
- Lifetime benefit limits & annual dollar limits eliminated for essential health benefits.
- Preventive care, women's services, generic contraceptives, aspirin (with a prescription) covered at 100%.
- Employers must limit healthcare Flexible Spending Accounts (FSAs) to $2,500.
- In-network out-of-pocket maximums, including deductibles and copays, cannot exceed $6,350 for individuals and $12,700 for families.

California

The new legislation (Senate Bill 1034) removes the state-imposed 60 day limit for the health coverage waiting period. Effective January 1, 2015, California employers may choose to impose a waiting period before employees are eligible for the group health plan of up to 90 calendar days as allowed under the federal ACA. This is intended to bring the state regulations in line with the ACA provisions.

Hawaii

Hawaii has a Prepaid Health Care (PHC) law. Employees who work 20 hours or more per week and earn a monthly wage of at least 86.67 times the Hawaii minimum hourly wage are deemed eligible after four consecutive weeks of employment. Health care coverage must then be provided to such eligible employees at the earliest enrollment date of the employer's health care contractor. This prepaid health care plan meets or exceeds the ACA standards.

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Reporting Requirements

- Employers are required to provide a Summary of Benefits & Coverage (SBC) to all covered participants upon renewal, hire or material change in benefits.
- Employers must notify employees of state exchange availability in new hire and COBRA letters.
- If insurance carriers do not meet annual medical loss ratio requirements, they must issue rebate checks to employers, and based on the employer's contribution structure, employees may be entitled to a portion of that rebate and it must be distributed within three months.
- Employers with more than 250 W-2s must list the total cost for medical coverage on all employees' W-2s in Box 12 Code DD.

Delayed Regulations

- Discrimination in favor of highly-compensated employees to be prohibited.
- All employers must list the total cost for medical coverage on all employees' W-2s, except those employers who file 250 or more W-2s.
- Employers with more than 200 employees must auto-enroll all employees.
- Employer Mandate for employers with 50-99 employees (delayed until 2016, if employer qualifies for the employer size transition rule).

Taxes

Patient-Centered Outcomes Research Institute (PCORI) Fee

Depending on plan year, self-funded plans are charged $1 per enrolled member per year (PMPY) for the first year or $2 PMPY for the second year. HRA plans are charged $1 per enrolled employee per year (PEPY) for the first year or $2 PEPY for the second year.

For a Self-Funded Plan and/or a HRA Plan Not Affiliated with a Self-Funded Plan

- Applicable dollar amount: For a plan year ending on or after October 1, 2012, and before October 1, 2013, the applicable dollar amount is $1.
- For a plan year ending on or after October 1, 2013, and before October 1, 2014, the applicable dollar amount is $2.
- In the IRS Notice 2014-56, issued September 18, 2014, the fee for the plan year ending on or after October 1, 2014 and before October 1, 2015 was announced. The fee will be $2.08 per covered life.

Taxes Continued:

ACA Insurer Fee

Total fee amount to be collected is $8 billion or 2.46% of premium – charged to fully insured carriers.

ACA Reinsurance Fee

$5.25 per member per month ($63 per member per year) – charged to Self-funded plan sponsors and fully insured carriers.

The ACA requires contributions to be paid by health insurance issuers and self-funded group health plans to fund a transitional reinsurance program in place from 2014 to 2016. The program then pays insurers in the individual market that cover high risk individuals. The Department of Health and Human Service (HHS) establishes standards to determine high-risk individuals, a formula for payment amounts, and the contributions required of insurers, which must total $25 billion over the three years. For fully insured plans, each insurance carrier will collect the transitional reinsurance fee through premium rates. Self-funded plans fund and remit the reinsurance fee.

Fee amount

The reinsurance fee is assessed on a per capita basis and is $5.25 per member per month ($63 per member per year) in 2014. It decreases each year for the subsequent two years.

- In 2015, the fee is $3.67 per member per month ($44 per member per year) and is yet to be determined for 2016.

The health reform law specifies the total amounts of the reinsurance fee that must be collected for the Reinsurance Program:

2014	$12 billion
2015	$8 billion
2016	$5 billion
Total	**$25 billion**

Mandates

Individual Mandate

- January 1, 2014 or upon employer plan renewal date in 2014, if applicable - penalties delayed until April 1, 2014.
- Every individual must purchase health insurance or pay greater tax of $95 ($285/family) or 1% of annual income for 2014 (will increase each year).

Healthcare Exchanges

- State-based healthcare exchanges to open – one for small employers and one for individuals.
- Includes four benefits levels and financial subsidies for participants with certain income levels.

Employer Mandate

- "Pay or Play" – delayed until renewal date in 2015 if employer qualifies for fiscal year transition rules.
- Employers with 100 or more full-time equivalent employees to be taxed if they do not provide health insurance to at least 70% of employees with 30 hours of service per week or more (95% in 2016). First 80 employees are excluded (30 in 2016).
- Employers with 100 or more full-time equivalent employees to be taxed if they do not provide minimum coverage (60% of the actuarial value of the benefits) and charge over the maximum contribution for single coverage (9.5% of the employee's W-2 income). *Please see Appendix B on page 11 for further information.*

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Transition Guidance on Non-Calendar Year Plans for 2015 (U.S. Code 4980H)

Shared responsibility for employers regarding health coverage for employees

1 Pre-2015 Eligibility Transition Guidance

As of December 27, 2012 – Did you have a non-calendar year plan still in effect?

Yes

Was it still in effect on February 9, 2014?

If YES Has the plan year been changed to begin at a later date as of December 27, 2012?

If YES No transition relief is available to employers sponsoring non-calendar year plans that were first effective after December 27, 2012, or that were modified after that date to push back the first day of the plan year. These employers will be subject to the employer shared responsibility rules as of January 1, 2015.

No

Are all employees eligible for coverage under terms in effect as of February 9, 2014?

If YES If that plan was un-affordable, was it made affordable, and did it offer minimum value by the first day of the 2015 plan year?

If YES Will the employer offer coverage to a minimum of 70% of its full-time employees by the first day of the 2015 plan year?

If YES No section 4980H *assessment payments will be due for period before the first day of the 2015 plan year.

2 Significant Percentage Transition Guidance - All Employees

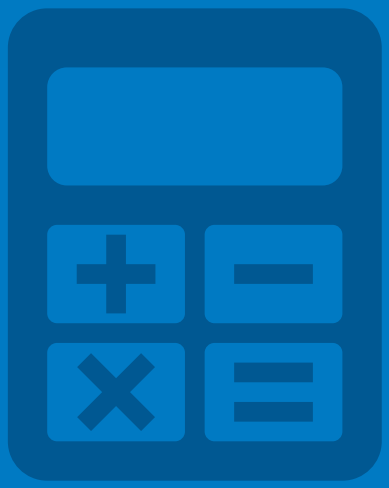
As of December 27, 2012 – Did you have a non-calendar year plan still in effect?

Yes

Was it still in effect on February 9, 2014?

If YES Has the plan year been changed to begin at a later date as of December 27, 2012?

If YES No transition relief is available to employers sponsoring non-calendar year plans that were first effective after December 27, 2012, or that were modified after that date to push back the first day of the plan year. These employers will be subject to the employer shared responsibility rules as of January 1, 2015.



No

Look back 12 months from February 9, 2014 – as of any date during this period, were at least 25% of employees covered under a non-calendar year plan OR was coverage offered to 33% or more of employees during Open Enrollment that ended prior to February 9, 2014?

If YES No section 4980H *assessment payments will be due for the months prior to 1st day of the 2015 plan year for employees who were offered affordable coverage with minimum value no later than the first day of the 2015 plan year, and who would not have been eligible for coverage under any group plan maintained by employer as of February 9, 2014 that has a calendar year plan year.

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3 Significant Percentage Transition Guidance - Full Time Employees

As of December 27, 2012 – Did you have a non-calendar year plan still in effect?

Yes

Was it still in effect on February 9, 2014?

If YES Has the plan year been changed to begin at a later date as of December 27, 2012?

If YES No transition relief is available to employers sponsoring non-calendar year plans that were first effective after December 27, 2012, or that were modified after that date to push back the first day of the plan year. These employers will be subject to the employer shared responsibility rules as of January 1, 2015.

No

Look back 12 months from February 9, 2014 - as of any date during this period , were at least 33% of employees covered under a non-calendar year plan OR was coverage offered to 50% or more of employees during the most recent Open Enrollment that ended prior to February 9, 2014?

If YES No section 4980H *assessment payments will be due for months prior to 1st day of the 2015 plan year for employees who:

- Were offered affordable coverage with minimum value no later than the first day of 2015 plan year.
- Would not have been eligible for coverage under any group plan maintained by employer as of February 9, 2014 that has a calendar year plan year.

*Assessment amounts vary - please consult http://www.irs.gov for table of applicable assessment

Important to Note

- If an applicable large employer does not satisfy each of the applicable tests described above, it must comply with the pay or play regulations beginning January 1, 2015.
- In order to take full advantage of the transition relief offered by the final pay or play regulations, the employer must comply with the ACA's requirements as of the first day of its 2015 plan year (for example, extending coverage to a sufficient number of full-time employees as of the first day of the 2015 plan year - generally, 70 percent in 2015 and 95 percent in later years).

Appendix A

Waiting Period

Effective January 1, 2015, groups are permitted to allow an employee to satisfy a reasonable and bona fide employment-based orientation period of no more than one month during which the employer and the employee would evaluate whether the employment situation was satisfactory for each party, and standard orientation and training processes would begin. If eligibility is based on an employee's having completed a reasonable and bona fide employment-based orientation period of one month or less, the maximum 90-day waiting period could then begin on the first day after the orientation period.

The proposed regulations provide that if there is not a corresponding date in the next calendar month upon adding a calendar month, the last permitted day of the orientation period is the last day of the next calendar month. For example, if the employee's start date is January 30, the last permitted day of the orientation period is February 28 (or February 29 in a leap year). Similarly, if the employee's start date is August 31, the last permitted day of the orientation period is September 30.

The final regulations clarify that compliance with the 90-day waiting period/orientation period final regulations does not ensure compliance with the employer mandate rules. Those rules state that the group will not be subject to a penalty for the first three full months of employment if the group provides affordable, minimum value coverage to newly-hired full-time employees by the first day of the fourth full calendar month of employment. Therefore, if the group has a one-month orientation period, the group may comply with both the 90-day waiting period/orientation period rules and the employer mandate by offering coverage no later than the first day of the fourth full calendar month of employment. However, the group may not be able to impose the full one-month orientation period and the full 90-day waiting period without potentially becoming subject to an assessable payment under the employer mandate. For example, if an employee is hired as a full-time employee on January 7, and the group offers coverage May 1 (the first day of the fourth month after the start date), the group complies with both provisions and would not be subject to an assessable payment under the employer mandate. However, if the group starts coverage May 7, which is 121 days after the date of hire, the group may be subject to an assessable payment under the employer mandate.

Appendix B

Smith & Downey Affordability - *Provided Smith & Downey, P.A.
The regulators issued new regulations that have been interpreted to provide the amounts paid by employers to employees who opt-out of the employer's health plan must be treated as additional employee contributions for purposes of the affordability component of the ACA's employer mandate rules.

This position is a radical departure from conventional notions of "employee cost," and therefore it is unlikely that employers with these arrangements have considered the cash-out amount available to employees who waive coverage as part of the cost calculation for employees who do not waive coverage. Nevertheless, this apparently is the position the regulators plan to take starting on January 1, 2015 when the affordability rules generally become effective. These rules are also applicable to many arrangements where the employer makes available consideration (e.g., "benefits credits") other than cash to employees who waive health plan coverage.

Although the text of the regulations is truly a singular model of non-clarity, the current consensus is that the meaning of the convoluted text is best illustrated by the following example:

- An employee's required contribution for individual coverage under the employer's health plan is $90 per month.
- The employer offers a cash opt-out payment of $50 per month to the employee if health plan coverage is declined.
- The "cost" to the employee for purposes of determining ACA affordability is $140 (not $90).

Employers that offer payments (or credits) for opting-out of health coverage should determine – sufficiently in advance of the effective date for their plan of the ACA affordability rules – the steps they should take to respond to these regulations and avoid ACA employer mandate penalties.

Employers that maintain a "no benefits" employment category also need to pay immediate attention to this development. (A "no benefits" practice is one where the primary distinction between an employee in one class of employee (a "benefits" category) and another (the employer's standard employment category) is that the latter gets more salary and no benefits and the former gets less salary but also receives benefits, all other aspects of employment being equal). These arrangements – and arrangements where government contractor employees are paid their "fringe rate" in cash – are particularly impacted by the new regulations.

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