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HEALTH CARE REFORM

What Health Care Reform Means for Me

A Summary of 2014 Impacts on Employees

November 2013

The impact of health care reform on employees in 2014 requires you to take action — enroll yourself in minimum essential coverage or pay a penalty.

The Patient Protection and Affordable Care Act, also known as health care reform or the Affordable Care Act, was enacted on March 23, 2010, and has been amended many times already. In its current form, the law has resulted in a steady stream of regulations and guidance as various governmental entities clarified employers' requirements under the law over the past three years. The aspect of the legislation that will affect you as an individual is known as the individual mandate, and is effective Jan. 1, 2014. At that time, most Americans will be required to purchase health insurance coverage that meets a certain minimum standard. If such coverage is not purchased, individuals will pay an additional tax on his or her 2014 personal income tax return filed in 2015.

As your employer, we continue to implement provisions to comply with the requirements of the health care reform law. This summary focuses on the changes that affect you as an individual, as well as changes in the benefit programs we offer in 2014. We encourage you to pay careful attention to your health care benefits so you can keep up with the changes.

What coverage must I carry to avoid paying a penalty?

Nearly all Americans are required to carry "minimum essential coverage" or pay a penalty beginning in 2014. Most employer-sponsored group health insurance qualifies as minimum essential coverage, as does governmental coverage (like Medicare, Medicaid, CHIP and TRICARE), retiree coverage, COBRA coverage and individual policies. The coverage we offer you qualifies as minimum essential coverage. If you decide not to take our coverage, the penalty amount applies if you go without minimum essential coverage for at least three months in 2014 (you cannot have a gap in coverage for more than a continuous three-month period). The penalty assessed when you file your taxes will be the greater of a flat dollar amount or a percentage of income amount, illustrated in the table below.

	Flat Dollar		Percentage of Income
Year	Adults in household	Children in household 18 Years or Younger	Calculated when filing taxes for the applicable year*
2014	$95	$47.50	1 %
2015	$325	$162.50	2 %
2016	$695	$347.50	2.5 %

*The penalty amount is determined by subtracting exemptions and standard deductions from household income. The resulting figure is multiplied by the percentage of income. If this figure is greater than the flat dollar amount, the taxpayer pays the percentage of income penalty.

Do I have to take the coverage my employer offers me?

No. But you should be aware that in most cases, the election you make is considered irrevocable and cannot be reversed if you change your mind. If you decide not to take employer-sponsored coverage in 2014, you should purchase coverage elsewhere, such as through a health insurance exchange, discussed next.

In some cases you could experience either a HIPAA special enrollment right or qualifying event that would allow you to enroll in our coverage midyear. Examples might include if you get married, have a baby or adopt a child midyear, qualify for premium assistance through CHIP or lose coverage (through Medicaid or another employer-sponsored plan). If the plan we offer is a non-calendar year plan, we may elect to include an optional Section 125 qualifying event to allow you to enroll or drop our coverage midyear. Importantly, not paying premiums for an individual policy or having a change in financial condition will not allow you to join our plan midyear. Ask your Human Resources representative for more information about this. In all cases, we are not permitted to retaliate against you for choosing to enroll in coverage somewhere other than our plan.

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Where can I get coverage if I waive my employer's coverage?

The federal government and states have set up online public health insurance exchanges. You may hear these referred to as marketplaces. There are also many private exchanges and marketplaces being formed.

Importantly, the public exchanges set up and administered by the federal government and the states are the only avenue for qualifying employees to receive assistance with paying premiums and reducing other cost-sharing normally associated with health insurance (including deductibles, co-payments and co-insurance) in the form of advance tax credits and subsidies. These are not available in private exchanges. Income parameters and other eligibility requirements apply to qualify for a tax credit or subsidy. To qualify for subsidies, an employee must have household income of between 100 percent and 400 percent of the federal poverty line. Plus, the cost of health insurance premiums must exceed 9.5 percent of household income.

What should I consider when deciding whether to enroll in coverage offered through my employer versus an exchange?

Employer-sponsored coverage is generally subsidized by the employer offering the coverage. This means the cost to you is most likely less than it would be if you purchased it on your own. In many cases, the amount of the employer contribution is more than the federal subsidy or tax credit that you would qualify for through a public exchange. Another reason to consider keeping employer-sponsored coverage is the tax implications of paying for coverage on your own. Coverage purchased through a public exchange cannot be paid on a pre-tax basis. However, paying for coverage offered through your employer can be done on a pre-tax basis. Depending on the amount of premiums paid and your individual effective tax rate, you may see a significant savings in your taxes by paying for employer-sponsored coverage on a pre-tax basis. Finally, allowing us, as your employer, to handle the design choices and narrow down the network of providers, as well as issue the required tax filings, can relieve you of many of the tasks that are inherent when purchasing coverage on your own.

Besides the individual mandate, what else goes into effect in 2014?

Additional major provisions will go into effect in 2014, and continue through 2018. As always, you need to be actively involved with your benefits program. Much will happen behind the scenes, but you can be assured your benefits will comply with the new laws. Other requirements that you will see going into effect in 2014 include:

- **Elimination of certain benefits limits and exclusions:** Lifetime limits on certain essential health benefits were already eliminated, and annual limits on essential health benefits are phased out in 2014. Also, individuals of any age can now obtain coverage regardless of any pre-existing health conditions (previously only applied to under age 19).
- **Cost-sharing limitations:** You may see lower deductibles or lower out-of-pocket limits on plans offered on the exchanges, as well as adjustments in our plan as we incorporate new limits.
- **Limits on waiting periods:** Once you satisfy the eligibility requirements for coverage, we must allow you to enroll in coverage no later than 90 days after becoming eligible. Enrollment in the plan on the first of the month following 90 days is no longer allowed.
- **Increases in fees and taxes:** Insurers and employers also have many other fees and taxes to pay beginning in 2014. As a result, you may see overall increases in the cost of health care from the prices you pay today.
- **Wellness incentives:** As a way to reward you for your healthy choices, the federal government is increasing the amount of wellness incentives that we are allowed to offer you. While not all employers will implement these incentives, many employers may decide to encourage healthy behaviors as an alternative to the increasing cost of health care.