Agenda

• Health care reform overview and update
• Health care reform: high employer cost impact
• 1 Year Later – a Mercer survey on PPACA employer experiences & thoughts
• Case studies
• Next steps
• Q&A
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Section #1

HEALTH CARE REFORM OVERVIEW AND UPDATE
Federal health care reform
Where are we now?

• Patient Protection and Affordable Care Act (PPACA) signed into law 3/23/10

• First wave of group health plan standards has been implemented by most plans (some non-calendar year plans may still be in the process)
  – Plans have decided whether or not to remain grandfathered
  – Some standards apply to all plans
  – Other standards apply only to new and nongrandfathered plans
  – Some delays and a steady flow of new guidance means that some additional work will be required of most plans
  – Many important questions remain
    - Essential benefits
    - Uniform benefit summary
    - Auto-enrollment
Key elements of health reform for employers

- Change in tax treatment for over-age dependent coverage
- Accounting impact of change in Medicare retiree drug subsidy tax treatment
- Early retiree medical reinsurance
- Medicare prescription drug “donut hole” beneficiary rebate
- Break time/private room for nursing moms

- Employers to distribute uniform benefit summaries to participants
- Employers to provide 60-day advance notice of material modifications
- Form W-2 reporting for health coverage (delayed until 2012 W-2 form typically provided in early 2013)
- Comparative effectiveness group health plan fees begin

- Health insurance exchanges
- Individual coverage mandate
- Financial assistance for exchange coverage of lower-income individuals
- Medicaid expansion
- HIPAA wellness limit
- Employer shared responsibility
- Additional reporting and disclosure

- Dependent coverage to age 26 for any covered employee’s child**
- No annual dollar limits**
- No pre-existing condition limits**
- No waiting period over 90 days**
- Additional new standards for new or “non-grandfathered” health plans, including limited cost-sharing and deductibles
- Health insurance industry fees begin

- $2,500 health FSA contribution cap (indexed)
- Employers notify employees about exchanges
- Medical device manufacturers’ fees start
- Higher Medicare payroll tax on wages exceeding $200,000/individual; $250,000/couples
- New tax on net investment income for taxpayers with incomes exceeding $200,000/individual; $250,000/couples
- Change in Medicare retiree drug subsidy tax treatment takes effect
- CLASS program may begin (date TBD)
- Auto-enrollment of full-time employees (applicability date TBD)
- Exchanges initial open enrollment period to begin

- 40% excise tax on “high cost” or Cadillac coverage

* Applies to all plans, including “grandfathered” plans, effective for plan years beginning on or after Sept. 23, 2010 (Jan. 1, 2011, for calendar year plans).
** Applies to all plans, including grandfathered plans, effective for plan years beginning on or after Jan. 1, 2014.
*** Delayed until regulations issued/date TBD
Federal health care reform
Late-breaking guidance

Automatic Enrollment – likely in 2014

- Employers will be required to automatically enroll newly-hired full-time employees in self-only medical coverage (and continue enrollment year to year for current enrollees)

- Per agency FAQs: Employers need not comply with the new automatic enrollment requirements until regulations are issued. The DOL expects to complete rulemaking by 2014
Federal health care reform
Late-breaking guidance

W-2 Reporting

• Employers will have to report the value of employer-sponsored health on employee W-2 forms
  – This is informational reporting only and won’t affect the tax treatment of employer-sponsored coverage

• Employers generally must report an employee’s 2012 employer-sponsored coverage on W-2 forms issued early in 2013
  – No W-2 reporting required in some cases, including:
    - if no W-2 is required (e.g., most retirees, surviving spouses)
    - COBRA continuation coverage or separate insured dental/vision contracts
  – For now, temporary exemptions include HRA coverage, W-2s provided mid-year to terminating employees, multiemployer plan coverage, non-integrated self-insured dental or vision coverage
  – Temporary exemption for employers required to file fewer than 250 Forms W-2

• Employer-sponsored coverage reported in Box 12 of W-2 using code DD
Federal health care reform
Late-breaking guidance

Non-discrimination for non-grandfathered insured plans

• Plans cannot discriminate in favor of highly compensated individuals (HCI) in terms of eligibility to participate, waiting periods or benefits
  – HCI generally means top paid 25%
• Rules to be similar to those that already apply to all self-insured plans
• Failure to comply results in excise tax penalty of $100 per day for every non-highly compensated individual (people affected by the discrimination)
• IRS has delayed applicability until regulations are issued – likely fall of 2011 (for a 2012 effective date)
• IRS Notice 2011-1 – requested comments on the following:
  – Should “benefiting” include employer contributions and waiting periods as previously concluded under Section 105(h)?
  – Should there be exceptions for different geographies?
  – Any safe harbor designs?
  – Should coverage provided on an after tax basis be disregarded, as it is under Section 105(h)?
• Other unanswered questions
  – How should bargained employees be treated?
  – Can part-time employees be charged more for benefits?
Federal health care reform
Late-breaking guidance

Employer Shared Responsibility Provisions

• Federal agencies are asking for comments to help develop guidance on health care reform’s shared-responsibility provisions (employer mandate to provide coverage to full-time employees in 2014)

• Some highlights of IRS Notice 2011-36 include:
  – 130 hours of service in a calendar month would be treated as the monthly equivalent of at least 30 hours of service per week;
  – Lookback period. Employers could select a lookback period of 3 to 12 months to determine whether an employee averaged at least 30 hours of service per week (or 130 hours per month, if the alternative proposal is adopted)
    - Could allow employers to continue to exclude employee with irregular hours (i.e., on-call, temporary and seasonal employees) who don't work an average of 30 hours per week over the lookback period
  – Stability period. This period would run at least 6 months after the lookback period and couldn’t be shorter than the lookback period
Federal health care reform
What does the future hold for PPACA?

• The House of Representatives changed hands in the 2010 election, and passed a repeal of PPACA on Jan. 19, 2011 (245-189)
  – But given Democratic Senate and veto power of President Obama, repeal was never a likely outcome
  – But we’ve already seen slicing and dicing of the law
    - Form 1099 repeal
    - Free-choice voucher repeal

• Lawsuits challenging PPACA are proceeding
  – Likely to reach the Supreme Court

*Note:* Nothing that has happened so far – in courts or in Congress – changes employers’ obligations to comply with health care reform
Section #2

Health Care Reform: High Employer Cost Impact
Health Care Reform
The road to 2014

- Automatic enrollment for new full-time employees
- Shared responsibility obligations
- Health insurance exchanges
- Income-based assistance for exchange coverage
Health Care Reform
Employer shared responsibility

<table>
<thead>
<tr>
<th>Employer Shared Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>General rule</strong></td>
</tr>
<tr>
<td>Employers with 50 or more <em>full-time equivalent employees</em> may be subject to shared responsibility penalties if at least one <em>full-time</em> employee obtains exchange-based coverage and is eligible for financial assistance to better afford it.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Employers <em>offering</em> coverage to full-time* employees (and their dependents)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subject to penalties if either</td>
</tr>
<tr>
<td>– the plan’s share of total allowed benefit costs is less than 60% (“minimum value” test), or</td>
</tr>
<tr>
<td>– an employee’s contribution to self-only** coverage represents more than 9.5% of household income (“affordability” test)</td>
</tr>
<tr>
<td>Penalty is the lesser of: (1) up to $3,000 for each <em>full-time</em> employee eligible for income-based assistance, or (2) up to $2,000 for every <em>full-time</em> employee (minus the first thirty)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Employers <em>not offering</em> coverage to full-time* employees (and their dependents)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subject to penalty of up to $2,000 for each <em>full-time</em> employee (minus the first thirty)</td>
</tr>
</tbody>
</table>

* A full-time employee is one who, with respect to any month, is employed an average of at least 30 hours of service a week
** It appears that affordability test will be based on self-only contribution rates
Shared responsibility – Decision tree
Effective in 2014

1. Do you have 50 or more full-time equivalent employees?
   - Yes
     - You will not be subject to any Shared Responsibility penalty.
   - No
     - You will not be subject to any Shared Responsibility penalty.

2. Do you offer a health plan to all full time employees (FTEs) and their dependents?
   - Yes
     - You will pay a penalty fee of $2,000 annually for every FTE if at least one FTE receives income-based premium assistance to purchase coverage through the exchange. Penalties do not apply to the first 30 FTE’s.
   - No

3. Do all of your employees have a total household income that exceeds 400% of Federal Poverty Level
   - Yes
     - You will not be subject to any Shared Responsibility penalty.
   - No

4. Does the health plan offered to FTEs pay less than 60% of total benefit costs or is the required employee contribution for plan > 9.5% of total household income?
   - Yes
     - You will pay the lesser of $3,000 times the number of FTE’s receiving income-based assistance for exchange coverage; or $2,000 times the total number of full-time employees; first 30 FTE’s not counted.
   - No
     - You will not be subject to any Shared Responsibility penalty.
**Shared Responsibility**

2014 Affordability mandate – income segments*

**Income Segments Under Health Reform**

- **<138% FPL**
- **138-400% FPL**
- **>400% FPL**

**Shared responsibility penalties may apply**

<table>
<thead>
<tr>
<th>% of FPL</th>
<th>Single individual</th>
<th>Family of Four</th>
</tr>
</thead>
<tbody>
<tr>
<td>400%</td>
<td>$47,599</td>
<td>$97,690</td>
</tr>
<tr>
<td>300%</td>
<td>$35,699</td>
<td>$73,267</td>
</tr>
<tr>
<td>200%</td>
<td>$23,800</td>
<td>$48,845</td>
</tr>
<tr>
<td>150%</td>
<td>$17,850</td>
<td>$36,634</td>
</tr>
<tr>
<td>138%</td>
<td>$16,422</td>
<td>$33,703</td>
</tr>
</tbody>
</table>

*Note: Numbers based on Mercer forecasts for 2014 based on the current Federal Poverty Level; illustrative only*
## Health Care Reform
Health insurance exchanges

### Health Insurance Exchanges

| **General rule** | State-based health insurance exchanges to facilitate purchase of health insurance by individuals and small employers  
| | Initial open enrollment period to begin in late 2013 for individuals seeking exchange coverage effective in 2014 |
| **Eligible to enroll** | Individuals residing in the state who are lawful residents and not incarcerated  
| | Certain employer groups  
| | 2014-2015: Up to 100 employees (states may use 50 employee limit)  
| | 2016: Up to 100 employees  
| | 2017: State discretion to expand  
| | State flexibility to merge individual and employer exchanges |
| **Coverage** | Exchange-certified qualified health plans |
Financial assistance for certain people not Medicaid-eligible

- Federal premium tax credits and cost-sharing reductions
  - Household income \( \leq 400\% \text{ FPL} \)
  - No employer coverage available or
  - Employer coverage is unaffordable or does not meet minimum actuarial value
    - Plan must cover at least 60\% of the value of benefits
    - Employee contribution for self-only (it appears) coverage does not exceed 9.5\% of household income
  - If at least one full-time employee is eligible for premium tax credit or cost-sharing reduction, employer faces “shared responsibility penalties”
## 2014: Impact of the law
Most new requirements raise costs and risks

<table>
<thead>
<tr>
<th>Eligibility and enrollment¹</th>
<th>Plan design¹</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Individual mandate</td>
<td>- 60% plan value minimum</td>
</tr>
<tr>
<td>- Automatic enrollment</td>
<td>- Essential benefits are optional</td>
</tr>
<tr>
<td>- 90-day waiting period maximum</td>
<td>- Eliminate dollar limits, if covered</td>
</tr>
<tr>
<td>- Medicaid</td>
<td>- Deductibles up to $2,000/$4,000² (indexed)</td>
</tr>
<tr>
<td>- Exchange coverage premium tax credits</td>
<td>- Cost-sharing up to HSA limits² (indexed)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Premium contributions¹</th>
<th>Delivery and insurance¹</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Affordability based on employee-only contribution²</td>
<td>- Medicaid and public exchanges</td>
</tr>
<tr>
<td>- Dependent contributions can differ from employee contributions²</td>
<td>- Minimum loss ratios for insured plans</td>
</tr>
<tr>
<td>- For eligible workers in exchanges</td>
<td>- Individual non-group product regulations</td>
</tr>
<tr>
<td>- Shared responsibility tax for full-time</td>
<td>- Self-insured and insured group product rules</td>
</tr>
<tr>
<td>- Annual increase in thresholds and taxes</td>
<td></td>
</tr>
</tbody>
</table>

1. Partial list; some provisions apply differently for grandfathered and non-grandfathered plans; 2. Based on current interpretation
Section #3

1 YEAR LATER – A MERCER SURVEY ON PPACA EMPLOYER EXPERIENCES & THOUGHTS
Health care reform: One year later
About the survey

• Designed to capture employers’ experiences with PPACA so far and their thinking about key provisions effective in 2014 and beyond

• Survey conducted by Mercer was fielded in June 2011

• 894 employers participated, with good distribution by size:
  – Fewer than 500 employees: 24% of participants
  – 500–4,999 employees: 52%
  – 5,000 or more employees: 24%

• 71 employers included in the retail/wholesale cut
Employers expect fewer employees to waive coverage after auto-enrollment begins

- Employers report that 12.9% of eligible employees, on average, waive health benefit coverage for themselves
- They anticipate that just 10.8% of employees, on average, will waive coverage after they begin auto-enrolling new full-time employees
- If this prediction holds, overall enrollment in employer-sponsored plans will increase by about 2%; *Retail employers predict a 5.5% enrollment growth*
- However, employees who have not elected coverage in the past will need to weigh the cost of coverage against the penalty for being uninsured
Retail Employers: Perspective on Exiting Medical Plan Coverage (and moving toward an exchange or the individual market)

- Not at all likely to terminate: 38%
- Very likely to terminate: 3%
- Likely to terminate: 14%
- Not very likely to terminate: 46%
Retail Employers: “Most likely” response to PPACA’s requirement that all employees working 30 or more hours per week be eligible for coverage

Based on employers that do not currently offer coverage to all employees working 30 or more hours per week

- Change workforce strategy so that fewer employees work 30+ hours / week  
  - 46%
- Make all employees working 30+ hours / week eligible for full-time employee plan(s)  
  - 25%
- Offer only a lower-cost plan for part-timers  
  - 21%
- Make no changes and pay penalty as necessary  
  - 7%
- Terminate medical coverage for all employees after exchanges become available  
  - <1%
Retail Employers: 40% of employers say their current health plan coverage would likely be considered unaffordable for at least some employees.
**Retail Employers: Likely employer actions with regard to coverage considered “unaffordable” to some employees**

Based on employers that say their medical plan will likely be considered “unaffordable” for at least some employees

<table>
<thead>
<tr>
<th>Action</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Add a less expensive plan with lower employee contributions than current plan(s)</td>
<td>47%</td>
</tr>
<tr>
<td>Raise employee cost-sharing (deductibles, etc.) to compensate for lower contributions</td>
<td>33%</td>
</tr>
<tr>
<td>Raise dependent contributions to compensate for lower employee-only contributions</td>
<td>33%</td>
</tr>
<tr>
<td>Use salary-based contributions (in a current or new plan)</td>
<td>17%</td>
</tr>
<tr>
<td>Lower the employee contributions in a current medical plan</td>
<td>20%</td>
</tr>
<tr>
<td>Make no (or minimal) changes and pay the shared responsibility penalty as necessary</td>
<td>13%</td>
</tr>
</tbody>
</table>
Anticipated cost increase in 2014 due to PPACA requirements

- No increase, already meet 2014 requirements: 15%
- Increase of less than 1%: 10%
- Increase of 1%-2%: 17%
- Increase of 3%-4%: 13%
- Increase of 5% or more: 15%
- Don't know: 29%
Likelihood of pursuing various cost-management approaches as a long-term response to health care reform initiatives

Employee health management is leading strategy by far

<table>
<thead>
<tr>
<th>likely to take action</th>
<th>strategy already in place</th>
</tr>
</thead>
<tbody>
<tr>
<td>Add or strengthen programs or policies to encourage more health-conscious behavior</td>
<td>92%</td>
</tr>
<tr>
<td>Reduce spending on dependent coverage in relation to employee-only coverage</td>
<td>37%</td>
</tr>
<tr>
<td>Add voluntary benefits to transition some non-medical, employer-paid benefits to voluntary</td>
<td>29%</td>
</tr>
<tr>
<td>Eliminate coverage for early retirees (among those currently providing coverage)</td>
<td>22%</td>
</tr>
<tr>
<td>Move to salary-based employee contributions</td>
<td>12%</td>
</tr>
<tr>
<td>Outsource benefits administration</td>
<td>6%</td>
</tr>
</tbody>
</table>
Considering a “defined contribution” approach as a way of managing health benefit cost

<table>
<thead>
<tr>
<th>Defined contribution approaches</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Keeping the employer contribution the same for all plans offered, so the employees pay more for more expensive coverage</td>
<td>26%</td>
</tr>
<tr>
<td>Providing employees with a fixed dollar subsidy to purchase coverage on their own</td>
<td>9%</td>
</tr>
<tr>
<td>Raising the employer contribution by a set amount each year regardless of the actual increase in plan cost; increases above that amount are paid by employees</td>
<td>8%</td>
</tr>
<tr>
<td>Some other defined contribution approach</td>
<td>11%</td>
</tr>
<tr>
<td>Not currently considering moving to a defined contribution approach</td>
<td>62%</td>
</tr>
</tbody>
</table>
Section #4

CASE STUDIES
1) RETAIL EMPLOYER
2) NON-PROFIT EMPLOYER
Financial Impact of Health Care Reform
Case Studies: Assumptions

- Modeling the financial impact of health care reform, particularly the shared responsibility provisions, requires setting many assumptions on employees’ total household income and anticipated participation levels in the employer plan and exchange.

- 2 case studies follow; these examples assume employers do not make plan changes before 2014 (unless required) and that current enrollment by plan option remains constant and that employer coverage affordability will be based on self-only contribution rates.

- 8% annual trend projection used through 2018; 6% thereafter.

- Salary/income levels and federal poverty level (FPL) assumed to increase 3% per year.

- Assume opt-outs who enroll elect lowest cost option, same cost and tier distribution as currently enrolled.

<table>
<thead>
<tr>
<th>Population</th>
<th>Medicaid Eligible* (Income below 138% of FPL)</th>
<th>Contributions Exceed 9.5% of Income Currently Enrolled</th>
<th>Contributions Exceed 9.5% of Income Current Opt-Outs</th>
<th>Contributions Below 9.5% of Income Currently Enrolled</th>
<th>Contributions Below 9.5% of Income Current Opt-Outs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enrollment Action Assumptions</td>
<td>Medicaid enrollment 100% of current opt-outs enroll in Medicaid 90% of currently enrolled stay enrolled</td>
<td>Exchange enrollment 100% move into exchange (all scenarios)</td>
<td>Exchange enrollment “Best” estimate: 50% Low: 50% High: 100%</td>
<td>Employer plan enrollment 100% remain in plan (all scenarios)</td>
<td>Employer plan enrollment “Best” estimate: 50% Low: 0% High: 100%</td>
</tr>
<tr>
<td>Household Income</td>
<td>50% of employees with spouse have additional income; 0% of employees without spouse have additional income; income equals 3 times salary at lowest salary levels (&lt;138% of FPL) grading down to 1.2 times salary at highest salary level ($100K+)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Medicaid eligibility threshold based on 133% of FPL with a 5% income disregard.
# Financial Impact of Health Care Reform
## Case Study Summary

<table>
<thead>
<tr>
<th>Employer Profile</th>
<th>Potential Responses to Shared Responsibility Penalty</th>
<th>Potential Responses to Excise Tax</th>
</tr>
</thead>
</table>
| Retail, 2,000 covered lives | • Increase benefit offerings to a minimum 60% relative value plan (eliminate mini-med or replace with HDHP)  
  • Consider salary banded contributions | • Manage trend increases to avoid tax in future |
  - Low cost, low participation, low average salary |
| Non-profit, 200 covered lives | • Offer low cost plan option  
  • Shared responsibility penalty may be lower cost than covering employees through plan | • Reduce benefit levels / plan cost |
  - High cost, high participation  
  - Low average salary |
Retail Employer
Low Plan Cost / Low Participation / Low Income

• 3,000 full-time employees
  – 2,000 covered in plan
  – 1,000 waived coverage

• Three options: 2 PPOs, 1 mini-med
  – PPO options have $2M lifetime maximum no longer allowed
  – Mini-med plan may not be allowed going forward due to annual
    maximums on essential health benefits

<table>
<thead>
<tr>
<th>Low PPO Plan Contributions</th>
<th>2011</th>
<th>2014 Projected</th>
</tr>
</thead>
<tbody>
<tr>
<td>EE Only</td>
<td>$104</td>
<td>$131</td>
</tr>
<tr>
<td>EE + Spouse</td>
<td>$229</td>
<td>$289</td>
</tr>
<tr>
<td>EE + Child(ren)</td>
<td>$187</td>
<td>$236</td>
</tr>
<tr>
<td>EE + Family</td>
<td>$364</td>
<td>$459</td>
</tr>
</tbody>
</table>
Retail Employer
Is Coverage Affordable?

2014 Medicaid / Exchange Qualification (Annual Income Breakpoints in '000s)

- **Employee Only**
  - Medicaid Eligible: $0 - $20
  - Affordable Coverage: $20 - $150

- **Employee + Child(ren)**
  - Medicaid Eligible: $0 - $30
  - Affordable Coverage: $30 - $150

- **Employee + Spouse**
  - Medicaid Eligible: $0 - $40
  - Affordable Coverage: $40 - $150

- **Employee + Family**
  - Medicaid Eligible: $0 - $50
  - Affordable Coverage: $50 - $150

Legend:
- Medicaid Eligible
- Exchange (Triggers Surcharge)
- Affordable Coverage
Retail Employer

- Employer likely to experience relatively high cost increase (22%) due to reform beginning 2014
  - High variation in potential results (from slight to a 42% increase) depending on assumptions about increased participation levels and total household income

**Will opt-outs decide to take employer’s plan?**

**How many employees will be eligible for Medicaid or Exchange?**

<table>
<thead>
<tr>
<th>Plan Migration Summary</th>
<th>2014 Enrollment After Reform</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
</tr>
<tr>
<td>Before Reform Enrollment</td>
<td></td>
</tr>
<tr>
<td>Opt-Outs</td>
<td>1,000</td>
</tr>
<tr>
<td>Employer Plan</td>
<td>2,000</td>
</tr>
<tr>
<td>Total</td>
<td>3,000</td>
</tr>
</tbody>
</table>
Retail Employer

- Shared responsibility penalties may come into play if full-time employees with household incomes at or below 400% of federal poverty level elect coverage through exchange and plans either become unaffordable or cover less than 60% of benefits under the plan.

<table>
<thead>
<tr>
<th>Current Plan Status</th>
<th>2014 ER Plan Net</th>
<th>After Tax</th>
<th>After Tax</th>
<th>Pre-Tax Total ('000s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opt Outs</td>
<td>0</td>
<td>$0</td>
<td>$3,000</td>
<td>$0</td>
</tr>
<tr>
<td>Single Coverage</td>
<td>0</td>
<td>$0</td>
<td>$3,000</td>
<td>$0</td>
</tr>
<tr>
<td>Dependent Coverage</td>
<td>0</td>
<td>$0</td>
<td>$3,000</td>
<td>$0</td>
</tr>
</tbody>
</table>

For cost comparisons, plan costs should be reduced by (1 – tax rate) to be on a comparable basis with the estimated penalty.

*In Case Study #1, contributions are affordable so no penalties are assumed and the total cost shown here is $0.*

- And, eventually this employer will pay an excise tax on the higher cost PPO plan unless changes are made.

<table>
<thead>
<tr>
<th>Tax begins in 2018…</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
<th>2025</th>
<th>2030</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Year of Tax (highest cost plan)</td>
<td>$34</td>
<td>$38</td>
<td>$43</td>
<td>$493</td>
<td>$1,671</td>
</tr>
<tr>
<td>EE Only</td>
<td>2024</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EE+Family</td>
<td>2018</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Retail Employer

- How will this employer’s cost change?
  - Increased participation in plan and potential for more covered dependents
  - Some offsetting savings from migration to Medicaid
  - Shared Responsibility Penalty will not apply if coverage is offered that is “affordable” and pays more than 60% of total benefit costs
  - Plan design changes required now through 2014

<table>
<thead>
<tr>
<th>2014 Cost Impact Drivers (figures in '000s)</th>
<th>&quot;Best Estimate&quot;</th>
<th>% Change</th>
<th>Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Migration Into Employer Plan From Opt-Outs (individual mandate)</td>
<td>$2,072</td>
<td>20.0%</td>
<td>$$$$$</td>
</tr>
<tr>
<td>Migration Out of Employer Plan Into Medicaid (Medicaid expansion)</td>
<td>($60)</td>
<td>-0.6%</td>
<td>savings</td>
</tr>
<tr>
<td>Migration Out of Employer Plan Into Exchange</td>
<td>$0</td>
<td>0.0%</td>
<td>-</td>
</tr>
<tr>
<td>Shared Responsibility Penalties</td>
<td>$0</td>
<td>0.0%</td>
<td>-</td>
</tr>
<tr>
<td>Required Plan Design Changes</td>
<td>$132</td>
<td>1.3%</td>
<td>$</td>
</tr>
<tr>
<td>Dependent Eligibility Expansion to Age 26</td>
<td>$94</td>
<td>0.9%</td>
<td>$</td>
</tr>
<tr>
<td>Total</td>
<td>$2,237</td>
<td>21.6%</td>
<td>$$$$$</td>
</tr>
</tbody>
</table>

Cost impact shown: $ to $$$$$
$: < 3% of pre-HCR cost
$: >3%, < 10%
$: >10%, < 20%
$: > 20%
Case Study 2: Non-Profit Employer
High Plan Cost / High Participation / Low Income

- 250 full-time employees (200 covered in plan, 50 waivers)
- Two fully insured plan options (HMO and PPO)
  - Both plan options comply with 2011 minimum benefit standards
  - HMO has lowest employee contributions; used for determining “affordable” coverage in 2014
  - Assumes HMO is available to all employees

<table>
<thead>
<tr>
<th>HMO Plan Contributions</th>
<th>2011</th>
<th>2014 (projected)</th>
</tr>
</thead>
<tbody>
<tr>
<td>EE Only</td>
<td>$122</td>
<td>$154</td>
</tr>
<tr>
<td>EE + Spouse</td>
<td>$360</td>
<td>$454</td>
</tr>
<tr>
<td>EE + Child(ren)</td>
<td>$265</td>
<td>$333</td>
</tr>
<tr>
<td>EE + Family</td>
<td>$549</td>
<td>$691</td>
</tr>
</tbody>
</table>
Non-Profit Employer
Is coverage affordable?

2014 Medicaid / Exchange Qualification (Annual Income Breakpoints in '000s)

- Employee + Family
- Employee + Child(ren)
- Employee + Spouse
- Employee Only

- Medicaid Eligible
- Exchange (Triggers Surcharge)
- Affordable Coverage
Non-Profit Employer

- Employer likely to experience moderate increase (9.5%) due to reform beginning 2014, with moderate variation in potential results (from a slight decrease to a 20% increase) if plan is retained, depending on assumptions on increased participation levels or total household income of employees

- Shared responsibility penalties, which are not tax deductible, will not have as much a financial impact as with for-profit employers; in 2014, it will be materially cheaper to cover employees through exchange (but fewer employees covered in benefits plan may have other consequences)

- **Will opt-outs decide to take employer’s plan?**

- **How many employees will be eligible for Medicaid or Exchange?**

<table>
<thead>
<tr>
<th>Plan Migration Summary</th>
<th>Total</th>
<th>2014 Enrollment After Reform</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Opt-Outs</td>
<td>Medicaid</td>
</tr>
<tr>
<td>Before Reform Enrollment</td>
<td>Opt-Outs</td>
<td>50</td>
</tr>
<tr>
<td></td>
<td>Employer Plan</td>
<td>200</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>250</td>
</tr>
</tbody>
</table>
Non-Profit Employer

- Shared responsibility penalties will not have a significant financial impact

<table>
<thead>
<tr>
<th>Shared Responsibility Penalty / Enrollment Breakdown</th>
<th>tax rate: 0%</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Current Plan Status</td>
<td>2014 ER Plan</td>
<td>After Tax 2014</td>
</tr>
<tr>
<td>Enrollment</td>
<td>Net PEPY</td>
<td>2014 Penalty</td>
</tr>
<tr>
<td>Opt Outs</td>
<td>1</td>
<td>$0</td>
</tr>
<tr>
<td>Single Coverage</td>
<td>4</td>
<td>$5,555</td>
</tr>
<tr>
<td>Dependent Coverage</td>
<td>0</td>
<td>$0</td>
</tr>
</tbody>
</table>

For cost comparisons, plan costs should be reduced by (1 – tax rate) to be on a comparable basis with the estimated penalty.

In Case Study #2, penalties and plan costs can be compared without a tax adjustment (non-profit example) and the total cost is a net decrease of $8,000.

- And, ultimately this employer will pay some excise tax on the higher cost plan if current plans are maintained

<table>
<thead>
<tr>
<th>Excise Tax (figures in ’000s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Tax begins in 2018</strong>...</td>
</tr>
<tr>
<td>2018</td>
</tr>
<tr>
<td>2019</td>
</tr>
<tr>
<td>2020</td>
</tr>
<tr>
<td>2025</td>
</tr>
<tr>
<td>2030</td>
</tr>
</tbody>
</table>

First Year of Tax (highest cost plan)
EE Only | 2018
EE+Family | 2018
Non-Profit Employer

• How will this employer’s cost change?
  – Increased participation and potential for more dependents
  – Some offsetting savings from migration to Medicaid and Exchange
  – Minimal shared responsibility penalties
  – Any plan design changes required now through 2014

<table>
<thead>
<tr>
<th>2014 Cost Impact Drivers (figures in '000s)</th>
<th>&quot;Best Estimate&quot;</th>
<th>% Change</th>
<th>Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Migration Into Employer Plan From Opt-Outs (individual mandate)</td>
<td>$149</td>
<td>10.0%</td>
<td>$$$</td>
</tr>
<tr>
<td>Migration Out of Employer Plan Into Medicaid (Medicaid expansion)</td>
<td>($20)</td>
<td>-1.4%</td>
<td>savings</td>
</tr>
<tr>
<td>Migration Out of Employer Plan Into Exchange</td>
<td>($22)</td>
<td>-1.5%</td>
<td>savings</td>
</tr>
<tr>
<td>Shared Responsibility Penalties</td>
<td>$14</td>
<td>0.9%</td>
<td>$</td>
</tr>
<tr>
<td>Required Plan Design Changes</td>
<td>$0</td>
<td>0.0%</td>
<td>-</td>
</tr>
<tr>
<td>Dependent Eligibility Expansion to Age 26</td>
<td>$20</td>
<td>1.4%</td>
<td>$</td>
</tr>
<tr>
<td>Total</td>
<td>$141</td>
<td>9.5%</td>
<td>$$</td>
</tr>
</tbody>
</table>

Cost impact shown: $ to $$$$  
$: < 3% of pre-HCR cost  
$$: >3%, < 10%  
$$$$: >10%, < 20%  
$$$$$: > 20%
Section #5
NEXT STEPS
**2014: Impact for employers that offer benefits**

**New costs from enrollment increases and taxes**

<table>
<thead>
<tr>
<th>Sources of new costs</th>
<th>Risk factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>✔ More employees enrolling</td>
<td>• High employee opt-out/waiver rate</td>
</tr>
<tr>
<td>✔ More dependents enrolling</td>
<td>• High dependent opt-out rate</td>
</tr>
<tr>
<td>✔ New benefit requirements may increase plan costs</td>
<td>• Low-value plans</td>
</tr>
<tr>
<td>✔ Raising employer contributions to exceed affordability levels</td>
<td>• Low employer contributions</td>
</tr>
<tr>
<td>✔ New taxes</td>
<td>• High premium tax credit eligibility</td>
</tr>
<tr>
<td>✔ High-cost plan excise tax (2018)</td>
<td>• High plan costs and trend</td>
</tr>
</tbody>
</table>

**Cost impact will vary by industry and workforce segment**

*Cost mitigating strategies are available*
Things to do to prepare for 2014…
Develop a strategy now!

• **Update contribution strategies** – many employers will reduce spending on dependent coverage in relation to employee-only coverage; generous plans will be “dependent magnets”

• **Decide on a default Plan for 2014** – what plan will you auto enroll employees in? How many additional employees will you cover?

• **Anticipate employee interest in new options** – Eligibility for expanded Medicaid? Interest in subsidized coverage in the Exchanges?

• **Optimize or Exit** – pay the penalty or optimize health plans to meet minimum plan and contribution requirements; enable access to public programs
Questions & Answers

For additional questions or assistance, contact…

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  – (949) 222-1340 or mike.sinkeldam@mercer.com

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  – Senior Actuary
  – (213) 346-2215 or bill.scott@mercer.com
Services provided by Mercer Health & Benefits LLC.