



To: National Council
Chuck Ignolia

From: Avalere Health

Date: October 6, 2010

Re: Follow-up questions from Webinar

Attached are the Avalere responses to questions that were posed during or after the webinar.

Question: FSA question - can our employees use their unused FSA dollars from plan year 2010 to purchase OTC drugs until 3/15/11? (plan allows spend down until 3/15)

Answer: After December 31, 2010, employees will only be able to use their unused FSA dollars if the medicine or drug is a prescribed drug (regardless of whether the drug is available over-the-counter) or is insulin.

Question: How does this 30% reduction work ... employer picks up the 30% difference (pays more of the cost)? or insurance premium from insurance company is reduced?

Answer: The ACA permits employers to vary insurance premiums by as much as 30 percent for employee participation in certain health promotion, wellness and disease prevention programs. A reward may be in the form of a discount or rebate of a premium or contribution, a waiver of all or part of a cost-sharing mechanism (deductibles, copayments, and coinsurance), the absence of a surcharge, or the value of a benefit that would otherwise not be provided under the plan.

The exact nature of the 30 percent reduction would have to be negotiated between the employer and the health plan. There is no mechanism in the ACA that indicates the party responsible for the underlying cost.

Question: Are municipalities (state, county, etc) considered businesses for the purposes of the ACA?

Answer: Municipalities are considered employers from the standpoint of any of the employer requirements (this guidance comes from the National League of Cities).

Question: What recommendations do you have about an employer evaluating whether to continue offering a plan vs. paying the fee so the employee can buy coverage in the exchange?

Answer: Similar to how they would weigh their options today; an employer needs to individually make a decision about what is best for their employees. The ACA has several provisions that will ensure employees will be eligible to get coverage both within and outside the exchange regardless of whether their employer provides coverage. The exchange will provide a vehicle for small employers to easily compare and choose plans that are best for their employees.

Question: Re: wellness programs and incentives, if State law allows/limits these programs does Federal law take precedent or does State law govern?

Answer: The Federal law becomes the floor for such provisions. In other words, States will be able to increase wellness programs and incentives but cannot restrict them beyond what is outlined by Federal law.

Question: How does this apply to agencies who have a self-funded health plan and do not use community rated plans?

Answer: The provision that requires premiums in the individual and small group markets to vary only be family structure, geography, actuarial value of the benefit, age (3:1), and tobaccos use (1.5:1) only applies to insured plans in the large group market, and not self-insured plans.

Question: Will the med/loss ratio be assessed on an annual basis or will insurance companies be allowed to calculated med/loss period over a period of time, such as over 5 yrs?

Answer: The rebates owed for plan year 2011 will be calculated based on expenses incurred and premiums collected that year. Similarly, rebates owed for the plan year 2012 will be based on expenses and premiums from 2012. Rebates for 2013, however, will be based on aggregate data from 2011, 2012, and 2013.

MLRs will be calculated on an annual basis every December 31st, with the exception of incurred claims which must be reported to by March 31st of the following year. Rebates must be reported to the states by May 31st the following year, and paid to members by June 30th.

Question: What date in 2010 does the small employer tax credit begin? Do I count the number of staff I have on that date and their average wages or do I use another date?

Answer: The tax credit applies to taxable years beginning in 2010, including from January 1, 2010 to March 22, 2010 before enactment of the ACA. The credit is claimed on an eligible small employer's annual income tax return and offsets and employer's actual tax liability for the year.

The number of full time employees is determined by dividing the total hours of service by 2,080 (40 hours a week, by 52 weeks a year). The result, if not a whole number is then rounded to the next lowest whole number. Therefore, an employer with 25 or more employees may qualify for the credit if some of those employees are part-time. There are some exceptions: partners in a business and certain owners are not taken into account as employees.

For example: For the 2010 taxable year, an employer pays 5 employees wages for 2,080 hours, 3 employees wages for 1,040 hours and 1 employee wages for 2,300 hours. The employer's FTEs would be calculated as follows:

Employees	Number of Hours	Hours of Service
5	2,080	10,400
3	1,040	3,120
1	2,300*	2,080
Total Hours of Service		15,600
Full Time employees		7

* You count the lesser of 2,080 or hours actually worked

The average annual wages paid by an employer for taxable year is determined by dividing (1) the total wages paid by the employer during the employer's taxable year to employees taken into account by (2) the number of employer's FTEs. The result is then rounded to the nearest \$1,000.

For example: For the 2010 taxable year an employer pays \$224,000 in wages and has 10 FTEs. The employer's annual wage is \$22,000.

Question: How will provisions relate to partial self insured plans?

Answer: How ACA provisions will relate to partial self insured plans will depend on exactly how the plan is structured given that employers have ample flexibility in terms of which parts of plans they would want to self insure versus fully insure. Overall, pieces of the plan that are fully insured will have to comply with provisions that are required of all fully insured plans while pieces of the plan that are self insured will have to comply with provisions that are required of all self insured plans. There may however be some exceptions.