CHURCH PENSION GROUP

HEALTHCARE REFORM FOR THE CHURCH
Summer Conference Call Presentation - June 26, 2013

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Note: This transcription of the Healthcare Reform presentation to administrators on June 26, 2013 has been edited for clarity and ease of reading.

RENEE WARD: Hello everyone. Today I will be discussing select healthcare reform provisions with you. I am going to be starting with provisions for this year and then I will discuss those that you should be considering in 2014 and beyond.

The first provision that you should have on your 2013 checklist is the distribution of the required employee notice of the Health Insurance Marketplace. If your employer is subject to the Fair Labor Standards Act, which most employers are, the notice must be provided to your full-time and part-time employees, but not their dependents, by October 1, 2013. This is a notice that employers must provide, not the Medical Trust. After October 1st, you will need to provide this notice to all your new employees within 14 days from the date of hire.

The contents of the notice must include information about the existence of the Health Insurance Marketplace and that the employee may be eligible for a premium tax credit if they purchase coverage through the Exchange. That's going to be something Frank will be discussing next. And if they purchase the coverage through the Exchange, they are going to lose any employer contribution they would have otherwise received, and their contribution will have to be made with after tax dollars. Whereas, when they make contributions through their employer plan, they can use pre-tax dollars. So this is the general content of the notice; however, the notice also includes other information.

The Department of Labor issued model notices that you can use. However, the Medical Trust is currently working on preparing a notice that includes language relating to the Denominational Health Plan and specific instructions on how to complete the notice. So I would recommend that you wait until the Medical Trust makes this information available to you.

The next 2013 item relates to Form W-2 issues, which I know are near and dear to many of you. Under the Healthcare Reform Law, employers were required to report the value of health coverage provided to their employees on the Form W-2. Again, it does not mean the healthcare coverage is taxable. It's just a reporting requirement. However, the IRS provided relief for employers that participate in self-funded church plans like the Medical Trust plan. So, we had that relief for 2012 Form W-2 reporting. It looks like we will also have it for 2013, because the IRS has not issued guidance stating otherwise and they stated that they would provide at least

six months' notice. We are almost at that six-month mark, so it looks like the relief should apply for 2013. If we hear anything otherwise, we will let you know. So for 2013, will not need to report the value of the health coverage, but that could change in the future, so this is something you need to keep your eyes on every year.

The next item is a reminder to impute the value of the health coverage that is provided for your employees' non-dependent children who are age 27 or older. And I have on the slide, "or same gender spouses and domestic partners," but due to the recent Supreme Court ruling striking down DOMA, it looks like you may not need to report the value of the benefit provided to same gender, legally-married spouses. But there is going to be lots of guidance coming out after this Supreme Court ruling. But with respect to children, the Healthcare Reform Law only extended the tax free benefit of health coverage for adult children through age 26. As you know, the Medical Trust is more generous with the benefits. They provide benefit coverage to adult children through age 30. However, that is not a tax-free benefit, so that value should be imputed unless that child is a tax dependent of the employee.

And then, finally for 2013 Form W-2 issues, there is a new requirement that only applies to high-income individuals and those are individuals who if married are making $250,000 and if single $200,000. If you have employees that make more than $200,000, you will need to withhold a new Medicare tax. An additional .9 percent Medicare withholding will become applicable, again, only on the income over $200,000. It would not apply to any other employees making less and if they do make more than $200,000, that .9 percent does not apply to income below the $200,000 level.

There are various fees under the Healthcare Law. One of the fees is called the Comparative Effectiveness Research Fee and that is going to fund what's called the Patient Centered Outcomes Research Institute. The institute is going to research the effectiveness of medical treatments with the goal of increasing the quality of care. Somebody must pay for this research and so there is a fee that will apply to insured and self-funded plans, and it's going to be in effect for 2012 to 2019. It's not a high fee. It's one dollar per covered individual for the first year and then two dollars per covered life after the first year. This fee is actually paid by the plan sponsor. It is not something that you as the employer participating in the plan have to pay. There is also a filing requirement on a Form 720. Again the Medical Trust will handle the filing of this form and the payment.

We can now move into 2014, which is an important year. Many of the key provisions that are contained in the law become effective this year. One thing to note is that two significant provisions, the Health Insurance Marketplace and the premium tax credits, are both effective in 2014. Frank will cover those, they are not part of my presentation, but we will get to them.

On the subject of fees for 2014, I wanted to let you know about another fee called the Transitional Reinsurance Fee. This is a fee that will fund the insurance pool and also pay back the government the $5,000.000 it paid out under an earlier program, called the Early Retiree Insurance Program. This is a three-year fee. It will end 2016, but as you see it's a much higher fee. It is estimated to be $63 per year for covered life. The Medical Trust, as plan sponsor, is the one obligated to pay this. So again, we wanted you to know that it is not something you need to worry about, as long as you are in our Medical Trust Plan, we'll be responsible for the payment of that fee.

MODERATOR: Renee, We've had a couple of questions. Can you review the reporting coverage for dependents over 27 one more time?

RENEE: Healthcare Reform provides an exclusion from income for a benefit provided to a child up to age 26. But after that age, the value of that benefit is taxable and so as the employer, unless that employee is the tax dependent of that employee, you will need to include on their Form W-2 the imputed income based on the value of that coverage. There are different ways to determine the value of the coverage. You generally should speak to your accountant. It's not always tied exactly to what that would cost. Because if you look at the cost sometimes it doesn't cost more to include that one individual in a family plan for example, but there is a value to that benefit. The IRS has not provided specific guidance on how to determine the value, so that's why I recommend that you speak to your accountants on how to determine it, and then include it as imputed income. Frank, do you want to add any more to that question?

FRANK: Just to clarify that you're talking about the [taxable value of the benefit] that comes after age 26. So since our plan covers dependents up to age 30, that means for dependents aged 27 to 30.

RENEE: Right.

MODERATOR: Renee, another question that we've gotten is does the $200,000 include housing allowance or not? Do you know how clergy are treated?

RENEE: Can we just state: "That is a good question. I do not know the answer to that question. Other sections of the law exclude housing but we will need to follow up on this one.

MODERATOR: Yes, and I'm thinking we might add it to the frequently asked questions.

RENEE: Okay, great. So, just when you thought school was out for the summer, I'm going to give you a short vocabulary lesson. This slide includes terms that we thought you really needed to understand, especially with many of the 2014 Healthcare Reform provisions. We will refer to these terms and I thought that it was important to just put them all on one slide. You may even be able to go back to them when these terms come up.

One term you'll see referred to often is, "minimum value" Basically, this term means that the plan will pay 60 percent of the plan cost. All the Medical Trust plans will provide minimum value. So when you see that requirement come up in the next few slides, if you're in the Medical Trust Plan, your plan provides minimum value.

The next term is "affordable coverage" and this comes up in various scenarios, the pay or play penalty, and for subsidies that Frank will talk about. An employee is going to be deemed to have affordable coverage if the employee's contribution for single-only coverage, not family coverage, does not exceed 9.5 % of their Form W-2 income. That's 9.5% of the household income for purposes of determining eligibility for premium tax credits, which Frank will discuss.

The next term is "minimum essential coverage." An individual must have, starting in 2014, minimum essential coverage in order to avoid paying a penalty. So as long as you're participating in a Medical Trust Plan, you will be deemed to have minimum essential coverage. Also considered minimum essential coverage is coverage provided through the individual market, the exchange, or through a government plan, which are all listed here.

And then finally is the concept of "essential health benefits." This term is used to refer to the ten statutory areas of coverage. They include services such as hospitalization, prescription drugs, mental health, and preventive services. And the plan must provide these essential health

benefits to be considered a qualified plan that can participate on the Exchanges. Also any plan that provides these benefits may not impose annual limits on these benefits. The Medical Trust plans do not impose annual limits on these essential health benefits.

The next provision I would like to discuss is the employer shared responsibility provision, which is often referred to as the Pay or Play Penalty, but officially it is called the Employer Shared Responsibility Provision. This is a significant provision starting in 2014, effective January 1st. [Note: After this presentation, the government delayed this provision until 2015.] Large employers will pay a penalty if they do not offer healthcare coverage to any of their employees or if they offer coverage, but it's not affordable or does not provide minimum value, and the full-time employee received a premium tax credit on the exchange.

The regulations relating to this provision are extremely complicated. It would probably take over an hour to explain them all. We're only going to give you a high level summary today, but what I wanted to note is that the Medical Trust is working on a multi-part webinar that's going to go into further details on the pay or play rules. So after you hear my high level presentation on the topic, if you feel you need to understand it more, or you feel that your organization could possibly be subject to those provisions, you should plan to review the webinar when the Medical Trust announces its availability later this summer.

So who is considered a large employer? Who should be worrying about this provision? You are a large employer if you employ 50 or more full-time equivalent employees during one measurement period and that's where things can get a little complicated. This concept of a measurement period is referred to in this IRS notice posted here. You look first at your full-time employees, which are a little easier to identify. Those are employees working on average 30 or more hours a week. But then you also have to consider your full-time equivalent employees and how you do that is you have to add all the hours worked by your part-time employees in a month, and you have to divide that by 120. And you should note that the part-time employees are used to count whether you're a large employer.

I should also note too, when you're thinking about part-time employees, one thing that could be very helpful is there is an exclusion for seasonal employees if they work less than 120 days in a year. If those employees would have pushed you over the 50 employee threshold, you are able to exclude those seasonal employees. There are special rules relating to that I just wanted you to be aware of.

I wanted to go through an example with you to help make sense of these complicated rules. Assume you're an employer who has 40 full-time employees. They work on average more than 30 hours a week, but then you also have 30 employees who each work 15 hours per week. And in this case to simplify things, assume you do not offer any coverage. If you only look at your full-time employees, you would think, "I'm not a large employer. I don't need to worry about these rules." But you have to include part-time employees, so you may have to worry about them.

You need to look at your part-time employees and calculate the full-time equivalent employees. In this case, if they work 15 hours per week, they work 60 hours in a month. You multiply that by 30 (since you have 30 part-time employees) and divide by 120. You have 15 full-time equivalent employees. When you add them to your full-time employee account, you actually have 55 full-time employees under this provision. You are now a large employer and because you do not offer any coverage, if an employee goes to the exchange and gets a subsidy, you're going to be paying a penalty of $2,000 per employee. In this case, you have 40 full-time

employees. Note that you do not count the part-timers and you deduct the first 30. So you'd be paying $20,000 in fees.

Here's a handy calculator for those that are not strong at math. The calculator helps you do exactly what is done in this example. You can input information and it would calculate the number of employees. If you're not sure where you are, are you over above of below 50. The calculator will help you determine that and that will also be announced as an online tool at a later date.

Another significant provision for 2014 is called the "individual shared responsibility" provision, also referred to as the individual mandate. This is the provision that was held to be constitutional by the United States Supreme Court last year, which is a significant provision. And so basically, if an individual does not have minimum essential coverage, they will have to pay a penalty. But if they have the minimum essential coverage, they will not pay any penalty under this provision, and there are some exceptions to the penalty. One thing to note is that if a parent has dependent children, they have to ensure those dependent children have minimum essential coverage, whether it's through their employer plan or through a government plan, or they will have to pay the penalty on behalf of their dependent child. And again, if you're in the Medical Trust Plan, you will satisfy this requirement and will not pay a fee if the children are also in the Medical Trust Plan.

Recently, the agencies issued some regulations on wellness programs. There are generally two types of programs. There are the participatory bonus programs, which are the discount gym membership everyone has access to or an educational seminar on wellness. And then there are health contingent bonus programs, which are generally the ones where you provide rewards for meeting certain health factors, such as smoking cessation programs or meeting certain targets, such as losing weight, etc., and you give the employee a reduction on their contributions. The regulations really focus on are these health contingent bonus programs and they spell out the five requirements that are listed here. One of the more significant changes in the regulations is the rewards that you can provide for one of these programs. It's now 30 percent. It used to be 20 percent and it can be up to 50 percent if you offer a tobacco cessation program. The Medical Trust is not planning on offering any type of health contingent bonus program at this time, but we wanted you to be aware of these programs because some dioceses may be interested in doing this on their own.

Effective 2014, the maximum waiting period that an employer can impose for health coverage is 90 days. That is the maximum period under the law, but note that the Medical Trust Plan does not provide a waiting period for those DHP eligible employees. They need to be put in the plan as soon as possible. You cannot wait 90 days.

This slide is intended to notify you that health reimbursement arrangements will be impacted in 2014 by the prohibition on annual limits. Basically, stand-alone health reimbursement arrangements will no longer be permitted. An employer is only going to be able to offer what's called Integrated Health Reimbursement Arrangements after January 1, 2014. And it's considered integrated if it's only available to employees who are covered by the primary group health plan coverage or through a spouse's coverage, so it must go hand in hand with a group health plan. You can't offer an HRA for an employee that receives coverage through the Health Insurance Marketplace. However, there is a special rule that will allow the use of any unused amounts that were credited to the HRA, as long as that HRA was established prior to January 1, 2014. If you have an integrated HRA, that can continue after January 1st. If you do have an HRA, make sure it is an integrated one and not a stand-alone HRA.

We will now discuss the Small Employer Tax Credit. Effective January 1, 2014, there is a new eligibility requirement. Only employers who purchase insurance on the Exchanges through what are called SHOPS, which are plans available on the exchange for smaller employers, will be eligible for the small employer tax credit. We have communicated in the past that the Medical Trust is not eligible to participate on the Exchanges because as a church plan, we can't offer our plans to the public. We can only offer our plans to church employees and their dependents. Therefore, employers that are participating in the Medical Trust Plan will not have access to the small employer tax credit for 2014 to 2016. This credit ends in 2016.

The Church Alliance is working on legislation that if enacted would make the credit available to our employers and I will give you an update at the end of this presentation on that legislation.

You should note, though, that the small employers that are eligible this year can still apply for a 2013 credit, which is generally filed in 2014. We have a memo that goes into details on who's eligible for this credit. It's a great memo and provides instructions on how to apply for the credit. If you can potentially be eligible, we recommend you go to and review that memo [on cpg.org]. Those that are filing, or have filed in the past, you should note that for 2013, due to the sequester in Washington, the credit is going to be reduced by 8.7% this year. And so you will most likely see this reflected in the form for this year and if we hear anything different, since Congress could take action before the end of the year, we'll let you know.

Let's now move on to 2015 and beyond. I wanted to let you know about the automatic enrollment provision that will apply for large employers. If you are a large employer under this provision, you'll be required to automatically enroll your full-time employees in health coverage and provide them with notice that they can opt out. In this case, the definition of large employer is different. It's not 50 employees. It's 200 employees. It was originally going to be effective 2014, but the IRS had not issued regulations, so they pushed this off and it's not going to be effective until the guidance is issued, which we expect sometime in 2014. The earliest effective date for this provision we expect will be 2015.

Another provision that the Medical Trust is monitoring closely is a provision that is not effective until 2018. We refer to it as the Cadillac tax and it's basically a 40% excise tax that will be required to be paid on any amount that's considered an excess amount and that is any cost of coverage that exceeds $10,200 for single coverage and $27,500 for family coverage, which will be adjusted. We expect that that amount will also be adjusted for our plans because our average age is a little higher, but we anticipate that by 2018 this could be a significant issue, or at least require a payment of this tax in some places, since our plans are very rich plans. So the Medical Trust is monitoring this. Things could change from now to 2018. It's not a very popular provision in the Act. It will affect many employers, but again, it is something we are watching closely.

I referred earlier to the Church Alliance healthcare bill. The Church Alliance is a coalition of various church denominations who work together on legislation or issues that impact church plans in general. The Church Alliance healthcare bill would be an amendment to the healthcare reform law, and is intended to treat the employers and the individuals who purchase coverage through our Medical Trust Plan as if they are purchasing coverage through the health insurance Marketplace or Exchanges. If the bill passes, the eligible participants in the Medical Trust Plan will have access to the premium tax credit that Frank will discuss and then small employers would, if eligible, continue to access small employer tax credit through 2016.

I wanted to give you an update on the bill. We have been working on this bill for some time. It was finally introduced in the Senate as S.1164. It was introduced on June 13th, by Senator Pryor, a Democrat from Arkansas, and Senator Coons, a Democrat from Delaware. We were very happy that it was introduced, but there is still a significant amount of work ahead of us, as the hardest part is getting the support of Republicans. We still feel that they want this law repealed and are not very receptive to amendments to the law, but we are going to be putting forth a significant outreach effort to gain their support and hope that it gets first approved through the Senate and then through the House, which will also be a challenge. So we will also continue to keep you updated on the progress of this bill as it moves forward. That is the end of my presentation. So I'm going to hand it off to Frank.

FRANK ARMSTRONG: Hi, everybody. That was a lot of information. We're going to be reposting all this information. Every one of these provisions will be available in some form on our website and some of them in much greater detail. Are there any questions that you already have that we should answer now?

MODERATOR: Yes. Is a large employer considered a diocese plus parishes or at the parish level?

RENEE WARD: The question is how do you determine the employer? How do you count your employees? Who's included in your employees when you count? It's a common question and it's more complicated because we're dealing with churches and the guidance tells you to look at your controlled group. In the for-profit world that's generally easy to do. For churches it's hard. For church organizations, the guidance says that you can apply a good faith, reasonable effort to determine who's part of your controlled group. And it's not just based on who does payroll.

You actually have to look at IRS Notice 89-23. Under 89-23, you look to two main items. First, do you appoint more than 80 percent of the trustees, or directors of that organization? If you do, that entity would be considered part of your controlled group and you would need to count those employees. Second, do you provide more than 80 percent of the funding for the entity and have control over day to day management of the entity? If so, then those employees should be counted in your determination of whether or not you're a large employee. So it's complicated. I would highly recommend that you'd work with your chancellor looking closely at notice 89-23 to see who is part of your controlled group. But again, the IRS is allows churches to applythis good faith reasonable approach so you have some flexibility. I hope that answers the question.

MODERATOR: The next question is, if the dependent is over 26, is an employee also, does that have to be reported to the employed parent covering the dependent? The employee is not receiving the benefit on his own, but under his parent's plan.

RENEE WARD: So he's not receiving it as an employee? He opted out as the employee?

MODERATOR: Yes.

RENEE WARD: That one is not as clear cut. I've never seen any specific guide. The conservative approach would be in that case they're not receiving it as an employee benefit, which would be tax-free. They're receiving it as an adult child and then those rules would generally be the ones to follow. But in that case I've never seen any clear guidance from the IRS and they may want to talk to their tax advisor.

MODERATOR: We have one other question, at the age 26 at the exact date of birth or when they turn 27 or at the end of the calendar year?

RENEE WARD: If you will turn 27 by the end of this calendar year, you would need to include the value of the coverage for that individual. You look at when you'll turn 27. If you turn 27 on December 30th, then you need to include that.

FRANK ARMSTRONG: I'm going to talk about the health insurance marketplace. I'm going to speak at a high level and highlight some things to be addressed in one of our calls either at the end of July or August, when we will have more time devoted to some specifics around what we're seeing in certain states, as we're pulling information together.

This is Frank Armstrong's definition of a health exchange – three things to point out in this session. Initially we're looking at where qualified health plans will shop their wares. Next, the goal of the Exchange is to drive market competition and to neutralize design. The more confusing thing for people has been how to compare the value of Plan A to plan B. A key piece of these exchanges is neutralizing the design differentiation of the plans. Finally, we have the three basic types of Exchanges. Each state has a decision to make. Some of them have decided to set up their own Exchange and receive federal funding. Some are looking at the federal Exchange and that'll be the default, where the feds direct the exchange options. A handful is doing the in-between with the partnership Exchange. The state will handle some functions, and the Department of Health and Human Services will handle some others. These states are saying, we'll let the federal government take administrative functions like billing, but we want control of the types of plans that are offered on the Exchange and some other things associated with that. Even within the states that set up their own state Exchanges, the structure will differ based upon how much work the state does in terms of qualifying what health plans will be on their Exchanges.

So we will see two basic types of Exchanges. The clearing house model basically accepts any qualified health plan and lets market forces determine whether or not anybody enrolls in those plans based upon how they're rated, how good the networks are, and brand name of that health plan and that sort of thing. The active purchaser model is much more pro-active. It's more of a competitive model where the state Exchange will knock out some health plans and/or negotiate price before plans are even put out on the Exchange. An example of this is California, which is getting quite a bit of press on their Exchange. Thirty-three different health plans sent in proposals to be on the Exchange and California only accepted 13. They knocked some out due to price, and some due to the way they were packaging their overall offerings. There will be no Aetna, no Cigna, no UnitedHealthcare on the California exchange in 2014. There will be Blue Cross and certain local options. Healthnet is on there, Kaiser is on there, but 20 of the 33 they knocked out right away. Due to this active purchaser model, California did a lot of negotiation at the front and from political pressures as well as other things have driven rates to a lower level than I expect to see in other Exchanges.

Some plans are limiting the size of the network to keep the price down. Some plans show that about 80 percent of network providers are in the Exchange plan network. The issue is going to be what providers are not in the plan. I think we'll see some very different network arrangements and that'll drive the price. I was looking at some of the rates on the California exchange and for the same silver plan for the 13 health plans that are out there, there's about a 40 percent differential between the lowest and highest rates, for the same actuarial value plan. You can see that the health plans are struggling with how to set these prices.

The next slide shows a picture of which states have selected what type of Exchange. Out of those 17 states choosing to set up state Exchanges, six of them are following the active purchaser model, like California. So California, Massachusetts, New York, Oregon, Rhode Island, Vermont, are deploying the active purchaser model. I expect that we'll see very different type of plans and rating in those markets even vs. the other state based exchanges, let alone the federal exchange.

I will lay out what the Exchange is supposed to do. The first thing is to certify that the plans meet qualified health plan requirements, which we'll cover on the next slide. Second, they're required to set up all the tools and put information together that make plan comparison easy for purchasers. Third, they have to calculate the cost of coverage, including premium tax credits. Most of them are on an age-rating basis. The regulation on premium tax credits was about 87 pages long and that's one of the key reasons why you'll see articles speaking about the cost to build these Exchanges. It's just more complex than I think most of these entities were thinking about when they were thinking about what an Exchange would look like, how it would operate. Fourth, the plans need to have price and quality rating. Fifth, they must coordinate enrollment with Medicaid. Sixth, they must provide what's called Navigators and In Person assisters. There is online assistance, as well as being able to call somebody up and help walk you through how to fill out the form for premium tax credit, etc.. Another key point is that all Exchanges need to be financial self-sustaining by 2015. Some of the Exchanges received sizable funding from the federal government to set them up. They are given a year to figure out how to operate on a break even basis going forward. I'd expect that means some of that cost is going to be passed along in some way, shape, or form to the health plans and the health plans will have to build some of that into the price at some point.

The QHP requirements define the essential health benefits package that Renee spoke about earlier. The one point I want to make is that each state will determine its own bench marks. So the states will select the bench marks that the guidance defined, but they can adjust those, as long as they cover all the EHBs and that will become the modified bench mark for that state. And so we could see 51 different compilations of the EHB package.

The cost share of plans is limited in terms of how high your deductibles can be, how high your out-of-pocket maximum can be, and how copays and coinsurances need to be counted towards the out-of-pocket going forward. Plans have to meet certain actuarial values, metal levels, which I will speak about on the next slide. The way the plans are rated will also change. In most states, health plans were unlimited in how they measure the rate of a 60-year-old vs. a 25-year-old. Now that is at most a 3:1 ratio. And plans can no longer rate based upon somebody's health status, any health factors, and they have to accept all pre-existing conditions. Lastly they need to meet the minimum loss ratio standards, which are 80 percent for individual and small group plans and 85 for large group plans.

The health plans are also eligible for three different risk mitigation programs designed to limit some of the expected adverse selection and to encourage health plans to be as aggressive as they can at rating and participating. These risk mitigation programs would dispel some of the concern that plans would be selected by high risk populations. The challenge is that it's not going to be a zero sum game. Each health plan is trying to figure out what share of the population will get enroll in their plans. Some plans will be in the Exchange for the first couple years and I expect some will fade away. During the first one or two years, all else equal, risk mitigation programs may allow some health plans to rate eight to ten percent lower than they normally would based upon the underlying risk selection. When the mitigation programs are gone, the plans will have to build something back in.

Actuarial value is the percentage of total cost of benefits paid by the health plan. For every dollar that comes in, the actuarial value is defined by how much is paid in benefits and how much is paid by the participant, and it's all based upon averages – the average claims distribution. The metal designs are all targeted at a certain actuarial value. The bronze is the lowest at 60 percent and, as Renee said, that's the minimum value that has to be offered for QHP. They go up - 70, 80, 90 – in terms of silver, gold, and platinum. And what I have on this slide is just a sample. This isn't anything that's required in terms of deductible, out-of-pocket maximums, or the plan's co-insurance. But the platinum plan at the 90 percent actuarial value could look something like $175.00 deductible, $1,500.00 out-of-pocket maximum and 85 percent co-insurance. A silver plan could have to have a $1,000.00 deductible, $5,000.00 out-of-pocket max, and co-insurance at 60. That means the individual's cost share is 40 percent. Then you see the bronze with a deductible of $3,000.00 with 50 percent co-insurance. And as Renee said before, our plans are much richer than most of these.

Looking at what California and Oregon have made available, they have different ways of getting to that 70 percent for their silver plans. California plans seem to be loading more into the deductible. Their base silver plan is $2,000.00 deductible, $250.00 copay for hospital, $250.00 for imaging, MRI, $45.00 for primary care visits, $65.00 for specialty care and separate $250.00 deductible on brand medications and copays after that. Oregon plans show $2,500.00 deductible and 50 percent co-insurance with out-of-pocket max up to the $6,400.00 level. There will be different designs options to choose from, but you'll see that deductibles will be materially higher and the share of the co-insurance will be higher than the plans that we typically have offered in the past. Note that the rules allow 2 percent, plus or minus 2 percent around these metal values, so a silver plan can be from 68-72 percent.

The next slide shows a picture of where some the medical trust plans stack up in terms of actuarial value – going across from left to right starting with the bronze, with some of the Medical Trust plans. The brackets on each one show the plus or minus 2% range. The High Deductible Health Plan is just below the silver plan at around 67%. And you see that other than HDHP and the EPO 75/50, all of our plans are gold or gold plus. Our 80% co-insurance plans are right at that gold level and our 90 percent plans are in between gold and platinum. Our 100% plans are either at the platinum level or above platinum and then we have some Kaiser EPO plans above that. When we start comparing what's on the marketplace and the Exchange, there will be a wider variety of options that can be offered in the market – off the Exchange vs. what's on the Exchange.

I want to spend a little bit of time talking about the premium tax credits. This is another pretty complicated topic that we will dig into more detail on another call and have some additional information posted on our website in probably a month or so. But the point we want to make is that premium tax credits will be out there starting in 2014, but an individual must meet all of these criteria in order to have access to them. Household income will need to be between 100-400% of the federal poverty level. They'll have to file a tax return a joint return if married. They'll have to purchase through an individual Exchange – not the small group exchange – one of the individual Exchanges that are out there. On top of that, they can't have affordable minimal essential coverage offered to them through their employer, as Renee covered before. So, if they have access through an employer to a plan that's at least 60% actuarial value and they're not required to pay more than 9.5% of their household income for single coverage, they will not be eligible for that premium tax credit even if their income falls between 100 and 400 percent of the federal poverty level.

To put some numbers to that – the chart in the middle shows a sample family of four at different levels of adjusted gross income, $48,000, $70,000, and $96,000. So $40,000 is 200%

of the federal poverty level and the maximum premium that that individual has to pay is 6.3% of 48,000. The 6.3% is calculated. Six point three percent of $48,000 is the $3,000 number on the right of the slide. The most that that individual will pay for silver coverage on the Exchange – they'd have to purchase silver coverage – will be $3,000. However, they will have to forfeit any employer contribution if they go the Exchange. If they aren't paying more than 9.5% of 48,000 for their employer-based coverage, they will not be eligible for the individual premium tax credit.

At an adjusted gross income of $70,000 and $96,000, the maximum premium jumps to 9.5%. Doing the math, the maximum contribution would be $6,600 and $9,000. As you see, as income gets between 300-400% of the federal poverty level, the subsidies are not as deep as below 300%. The other thing to keep in mind is that the 399% person will not be eligible for that tax credit unless they are already required to pay over $9,000 for single coverage for a minimum value plan. The last rule to point out is there are additional subsidies on top of the premium subsidy for certain individuals. They're going to vary based upon the household income vs. the federal poverty level, but in addition to having a maximum premium contribution cap, there can also be low cost sharing limits in the plan itself and it reduced out-of-pocket maximums. These are all grade schedules based upon the person's AGI vs. the federal poverty level.

We've done some work to size this up in terms of the percentage of the DHP population that would be eligible for premium tax credits based upon all this criteria. The Church Alliance bill, if passed, will impact the discussion, but under current guidelines, members enrolled in the DHP will have to meet these four criteria. We looked at 13,800 current employees enrolled in the DHP, using information we have and complementary data we purchased regarding household income in certain parts of the country.

First we exclude employees who are working and are 65 and over. They are eligible for Medicare, so they will not be eligible for premium tax credits. Anyone eligible for any form of government-sponsored healthcare is not eligible for the premium tax credit. That reduces our eligible population. Then, we eliminate 8,600 because the adjusted gross income estimates that we have show them to be above 400% of the federal poverty level. That leaves about 4,000. The next criteria is whether they have access to affordable minimum coverage. All of the DHP plans meet the minimum value so the key question is, are any employees required to pay more than 9.5% of their income for single coverage? Although we don't have contribution information on all the employees, we have a sense of the percent of cost sharing and we built that into the modeling.

After applying all these criteria, less than 5% of the DHP population will be eligible without us getting relief in the Church Alliance bill. But if that bill passes, we still have to offer plans that have minimum value, but any of our employees that have adjusted gross incomes under 400% of the federal poverty level would be eligible to receive the premium tax credit for their Medical Trust plans. The 3.6%, or 500, would jump up to 15-20 percent [note: additional analysis after the teleconference suggests the number is closer to 10-12% that would qualify for a meaningful premium tax credit], which is a more material number. That is why we are lobbying along with the Church Alliance to get that relief. In the meantime, we're going to continue to pull information off of the Exchanges that develop and then we'll be able to share some more definitive information about some of the Exchanges that are emerging.

MODERATOR: Thanks, Frank. I had another question. This was from Adriane Marr. She has folks who live in one state and work in the other. Which Exchange would pertain in that situation?

FRANK: I will check this answer, but I'm pretty sure it's the state of residence not the state of employment.

RENEE: Frank, I think that's right. It's generally the state of residence, but my understanding also. We can confirm.

MODERATOR: Okay. I had another comment indicating that she filed for the small employer tax credit for 2010, 2011, and 2012 just recently and had the expectation that she would not get any money, but she did get money for all three years. So she just wanted everyone to know that.

RENEE: You know that's interesting. I've heard that before. It seems as if they are not being too strict about the timing of the request. So I'm not surprised to hear that, but that is good to share with everyone.

~~~ End of Call ~~
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