



Health Care Reform

HR BENEFITS AUTHORITY – LIVE
a seminar series

The New Health Care Landscape





Today's Agenda

- ▶ Health Care Reform under the Patient Protection and Affordable Care Act (“PPACA”) – provisions effective January 1, 2014
 - Exchanges and Qualified Health Plans
 - Individual Mandate
 - Employer Mandate
 - Free Choice Vouchers
 - No-Pre-Existing Condition Exclusions
 - No Waiting Period in Excess of 90 Days
 - Annual Reporting Requirements
 - Coverage for Clinical Trials
 - Wellness Incentives
 - Guaranteed Availability and Renewability of Coverage
 - Cost Sharing Limitations
 - Planning and Practical Considerations
 - Questions



Health Benefit Exchanges

► Health Benefit Exchanges

- By January 1, 2014, each state will have to establish an American Health Benefit Exchange (“Exchange”) to facilitate the purchase of “*qualified health plans*” by individuals and small employers – generally employers with 100 or fewer employees
- If a state does not establish an Exchange, the Department of Health and Human Services (“HHS”) must establish the Exchange for the state
- Exchanges must provide for an initial enrollment period, annual open enrollment periods and special enrollment periods



Qualified Health Plan

- ▶ A **qualified health plan** is a health plan:
 - certified by the Exchange as providing an “*essential health benefits package*”, and
 - offered by a health insurance issuer that agrees to charge the same premium for the plan through the Exchange and outside the Exchange
- ▶ HHS is required to establish criteria for certifying a qualified health plan



Health Benefit Exchanges

- ▶ **Essential health benefits package** for a qualified health plan
 - a plan that provides “*essential health benefits*”
 - limits cost-sharing for coverage
 - provides four levels of coverage (*e.g.*, bronze 60%, silver 70%, gold 80% or platinum 90%)



Essential Health Benefits

▶ Essential Health Benefits

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder benefits
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care



Individual Mandate

- ▶ PPACA requires each citizen or national of the United States, or alien lawfully present and his or her dependents to maintain “*minimum essential coverage*” for each month starting after December 31, 2013 or incur a monthly penalty



Individual Mandate

- ▶ **Minimum essential coverage** means coverage under:
 - an “*eligible employer-sponsored plan*” (including a grandfathered plan)
 - a governmental plan
 - a government-sponsored program such as Medicare Part A, Medicaid, Children's Health Insurance Program, TRICARE, the veteran's health care program or the Peace Corps volunteers' health plan



Individual Mandate

- ▶ An **eligible employer-sponsored plan** is a self-funded group health plan or group health insurance coverage offered by an employer to its employees
- ▶ An eligible employer-sponsored plan *does not* include coverage only for accident or disability, workers' compensation, automobile medical payment insurance, limited scope dental or vision, specific disease or illness insurance, long term care, or similar limited benefits (*i.e.*, HIPAA excepted benefits)



Individual Mandate

▶ **Premium Credits and Cost-Sharing Subsidies**

- Certain Individuals with incomes between 100% and 400% of the federal poverty level will be able to receive premium credits and cost sharing subsidies to purchase health insurance through an Exchange
- In order to receive a credit or cost-sharing subsidy, an individual cannot be eligible for employer coverage that is minimum essential coverage
- Individuals must be a U.S. citizen or national or alien lawfully present in the United States to be eligible



Individual Penalty

► Penalty

- An annual penalty is assessed for each individual for whom minimum essential coverage is not maintained
- The penalty is the *lesser* of:
 - ◆ the annual amount of the “*monthly penalty*”, or
 - ◆ the national average annual premium for bronze level health plans offered through Exchanges



Individual Penalty

- ▶ The **monthly penalty** will be equal to 1/12 of the *greater* of :
 - the “*flat dollar amount*”
 - a “*percentage of income*”



Individual Penalty

- ▶ **Flat Dollar Amount** for each family is the *lesser* of:
 - \$95 for 2014 (\$325 for 2015 and \$695 for 2016) for each adult age 18 or older in the taxpayer's family who fails to maintain minimum essential coverage (the amount is reduced by 50% for individuals under age 18), or
 - 300% of the flat dollar amount for an adult



Individual Penalty

- ▶ **Percentage of Income** is 1% of income over the income tax filing threshold for 2014 (2% for 2015, and 2.5% for 2016)
 - For 2010, the income tax filing threshold is \$9,350 for a single person or married person filing separately, and is \$18,700 for married filing jointly



Individual Penalty

- ▶ The penalty is assessed through the Internal Revenue Code and is accounted for as an additional amount owed when the individual files his or her annual income tax return
- ▶ Penalty amounts after 2016 will be indexed for annual cost of living adjustments



Individual Penalty

- ▶ Certain individuals are exempt from the penalty including individuals:
 - who qualify for a religious exemption
 - are incarcerated (other than those pending disposition of charges)
 - who are not lawfully present in the United States
 - who cannot afford coverage when their required contribution for employer-sponsored coverage or the lowest cost “bronze plan” in their local Exchange exceeds 8% of household income
 - with short coverage gaps of less than three months during a calendar year
 - who receive a hardship waiver
 - with income 100% below the poverty line
 - who have income less than the threshold amount for filing an income tax return



Employer Mandate

- ▶ A “*large employer*” that
 - Does not offer minimum essential coverage to its “*full-time employees*”
 - Offers “*unaffordable*” minimum essential coverage, or
 - Offers minimum essential coverage where the employer's share of the cost of coverage is less than 60%

is subject to an excise tax if any of its full-time employees, who qualify for a tax credit or cost-sharing reduction, purchase health insurance through an Exchange



Employer Mandate

▶ Large Employer

- Any employer with an average of at least 50 “*full-time*” employees in the previous calendar year

▶ Full-Time Employees

- Employees, other than seasonal employees, who are employed an average of at least 30 hours a week
- For purposes of determining if an employer is a large employer, each part-time employee is treated as a fraction of a full-time employee, determined by dividing his or her actual monthly hours by 120

▶ Unaffordable

- Means the contribution required to be paid by the employee for the employer-sponsored plan is more than 9.5% of the employee's household income



Employer Mandate

▶ No Coverage

- Employer offers no minimum essential coverage to its full-time employees
- At least one of these employees
 - ◆ enrolls in coverage through an Exchange, and
 - ◆ receives a premium tax credit or cost-sharing reduction



Employer Mandate

Penalty – Monthly excise tax equal to 1/12 of \$2,000 (\$166.67) for each full-time employee (not counting the first 30 employees)



Employer Mandate

▶ Example

- In 2014 Employer A fails to offer minimum essential coverage and has 100 full-time employees, ten of whom receive a tax credit for the year for enrolling in an Exchange plan
- For each employee over the 30-employee threshold, the employer owes \$2,000, for a total penalty of \$140,000 (\$2,000 multiplied by 70 (100-30))



Employer Mandate

▶ Unaffordable Coverage or Insufficient Cost Sharing

- Employer offers minimum essential coverage, but
 - ◆ “Unaffordable” to a full-time employee, or
 - ◆ Employer share is less than 60% of the cost of the coverage
- Unaffordable means the contribution required to be paid to be paid by the employee for the employer-sponsored plan is more than 9.5% of the employee's household income



Employer Mandate

Penalty - Monthly excise tax is equal to 1/12 of \$3,000 for each employee who receives coverage through an Exchange and a premium tax credit or cost-sharing reduction for that month. The monthly amount is capped at 1/12 of \$2,000 times the number of full-time employees not counting the first 30 full-time employees



Employer Mandate

► Example

- In 2014, Employer B offers health coverage and has 100 full-time employees, 20 of whom receive a tax credit for the year for enrolling in an Exchange offered plan
- For each employee receiving a tax credit, the employer owes \$3,000, for a total penalty of \$60,000
- The maximum penalty for this employer is capped at the amount of the penalty that it would have been assessed for a failure to provide coverage, or \$140,000 ($\$2,000$ multiplied by 70 ($100-30$))
- Since the calculated penalty of \$60,000 is less than the maximum amount, Employer B pays the \$60,000 calculated penalty



Employer Mandate

► Notification

- The employer will be notified if one of its employees is determined to be eligible for premium assistance credit or a cost-sharing reduction and will receive notification of the appeals process established for employers notified of potential liability for payments



Free Choice Vouchers

- ▶ Employers offering minimum essential coverage through an eligible employer-sponsored plan and paying a portion of that coverage must provide “*qualified employees*” with a voucher whose value can be applied to the purchase of health coverage through the Exchange



Free Choice Vouchers

► Qualified Employees

- employees with household incomes less than 400% the federal poverty level,
- whose share of the cost of the coverage exceeds 8% but is less than 9.8% of their household incomes, and
- who are not enrolled in the employer's plan



Free Choice Vouchers

- ▶ The amount of the voucher will need to be equal to the highest monthly portion of the cost of the employer-sponsored plan that the employer would have paid if the employee was covered under the plan
- ▶ For plans with multiple options, the employer contribution amount is based on the plan option in which the employer pays the largest portion of the cost
- ▶ The employee would present the free choice voucher to the Exchange to apply to the monthly premium for the Exchange coverage in which the employee enrolled
- ▶ The employer will have to pay the amount of the free choice voucher directly to the Exchange



Free Choice Vouchers

- ▶ If the amount of the voucher exceeds the cost of the coverage under the Exchange, the Exchange will pay the excess directly to the employee
- ▶ The amount of the free choice voucher used by the employee to purchase coverage on the Exchange is not treated as taxable income to the employee but any excess refunded to the employee is taxable
- ▶ The amount of the voucher is deductible by the employer under Code Section 162



No Pre-Existing Condition Exclusion

▶ Pre-Existing Condition Exclusion

- HIPAA currently permits pre-existing condition limitations up to 12 months (18 months for late enrollees) for conditions that the individual received medical advice or services in the six months before his or her enrollment date
- The 12-month period (and 18-month period) must be reduced by any previous creditable coverage



No Pre-Existing Condition Exclusion

- Beginning January 1, 2014, group health plans and health insurers will no longer be able to impose pre-existing condition limitations for adults (the pre-existing condition limitation for children under age 19 is eliminated for plan years beginning on or after September 23, 2010)
- No longer a need for HIPAA certificates of creditable coverage, but the PPACA did not eliminate this requirement, so it appears that certificates will still need to be issued



No Waiting Period In Excess of 90 Days

► **Waiting Periods**

- Effective January 1, 2014, a group health plan or health insurer may not require any waiting period that exceeds 90 days



Annual Reporting – Insurer Reporting

- ▶ For calendar years beginning after December 31, 2013, insurance carriers and self-funded group health plans that provide minimum essential coverage to any individual must file an annual report with the IRS that includes:
 - the name, address, and taxpayer identification number of the primary insured, and the name and taxpayer identification number of each other individual obtaining coverage under the policy or plan;
 - the dates during which the individual was covered under the policy or plan during the calendar year;
 - whether the coverage is a qualified health plan offered through an Exchange; and
 - the amount of any premium tax credit or cost-sharing reduction received by the individual with respect to such coverage



Annual Reporting – Insurer Reporting

- ▶ To the extent health coverage is through an employer-provided group health plan, the insurer is also required to report:
 - the name, address and employer identification number of the employer;
 - the portion of the premium, if any, required to be paid by the employer; and
 - any other information the IRS may require to administer the new tax credit for eligible small employers
- ▶ This information must also be provided to covered individuals by the January 31 following the calendar year



Annual Reporting – Employer Reporting

- ▶ Each “*large employer*” and each employer who offers free choice vouchers must report certain health insurance coverage information to both its full-time employees and to the IRS
- ▶ A **large employer** is any employer with an average of at least 50 full-time employees in the previous calendar year



Annual Reporting – Employer Reporting

- ▶ Information required to be reported:
 - the name, address and employer identification number of the employer
 - a certification as to whether the employer offers its full-time employees and their dependents the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan
 - the number of full-time employees of the employer for each month during the calendar year
 - the name, address and taxpayer identification number of each full-time employee employed by the employer during the calendar year and the number of months, if any, during which the employee (and any dependents) was covered under a plan sponsored by the employer during the calendar year



Annual Reporting – Employer Reporting

- ▶ Employers who offer minimum essential coverage must also report:
 - the length of any waiting period with respect to such coverage;
 - the months during the calendar year during which the coverage was applicable;
 - the monthly premium for the lowest cost option in each of the enrollment categories under the plan;
 - the employer's share of the total allowed costs of benefits under the plan; and
 - in the case of an employer that provides vouchers, the option for which the employer pays the largest portion of the cost of the plan and the portion of the cost paid by the employer in each of the enrollment categories under each option



Annual Reporting – Employer Reporting

- ▶ The employer is required to report to each full-time employee the information included in the return with respect to that employee, along with the name, address and contact information of the reporting employer, on or before January 31 of the year following the calendar year for which the information is required to be reported to the IRS



Coverage for Clinical Trials

- ▶ Group health plans or health insurers providing coverage to an individual eligible to participate in an approved clinical trial may not deny or limit coverage of routine patient cost for items and services associated with participation in the clinical trial
- ▶ Group health plans and health insurers will need to allow the individual to participate in the clinical trial and may not discriminate against that individual for participating in the clinical trial
- ▶ Requirement does not apply to grandfathered plans



Wellness Incentives

- ▶ PPACA increases the reward limitation for HIPAA wellness programs from 20% of the cost of health coverage to 30% of the cost (based on the COBRA premium)
 - DOL/IRS/HHS may increase this reward up to 50%
 - Does not apply to grandfathered plans
 - Does not address potential ADA issues with wellness benefits for employer sponsored plans



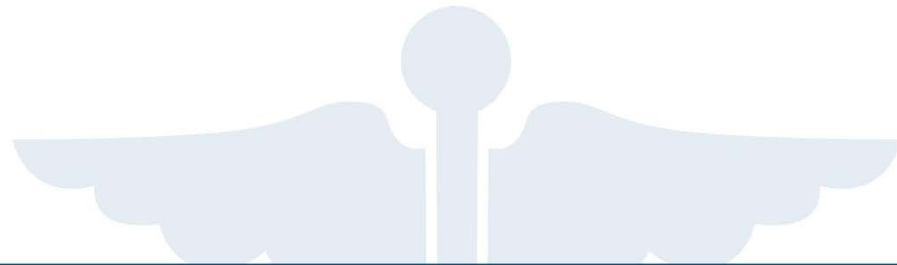
Guaranteed Availability and Renewability of Coverage

- ▶ Health insurance issuers in the individual and group markets in a state must accept every small employer and individual who applies in the state
- ▶ Once the policy is in force, the insurers will need to renew the coverage upon request
- ▶ The insurer is not required to accept applications outside of open enrollment or special enrollment periods
- ▶ Insurers must also establish enrollment periods for COBRA qualifying events



Cost Sharing Limitations

- ▶ Group health plans may not have annual cost-sharing provisions that exceed the limitations for qualified health plans offered through the Exchanges
 - The annual out-of-pocket maximums cannot exceed the individual and family limits for high-deductible health plans that are in effect at that time
 - The deductibles may not be higher than \$2,000 for single coverage or \$4,000 for family coverage (as indexed) but this appears to apply only to fully insured plans offered in the small group market
 - Does not apply to grandfathered plans



Health Reform Planning & Practical Considerations





Health Reform Timeline Review

Summary of Major Provisions – Grandfathered Plans

2011

- No lifetime limits on essential benefits
- Annual limits on essential benefits restricted
- No rescission of benefits
- No reimbursement of OTC drugs without a prescription
- No pre-ex for children under 19
- Coverage extended for dependent children until age 26
- Additional explanation of coverage requirements (earliest)
- Fully insured plans subject to rebates based on loss ratio
- HSA penalties change
- Additional W-2 reporting
- New HHS, state and public reporting
- Automatic enrollment (earliest)
- Simple cafeteria plans (small employers)

2013

- Elimination of tax deduction for Medicare Part D retiree drug subsidy
- Contributions to Health FSA capped at \$2,500
- Additional Medicare Part A taxes for highly paid individuals
- Notice of coverage options for employees (including Exchanges)

2014

- No pre-existing condition exclusions
- No waiting periods beyond 90 days
- Exchanges for Qualified Health Plans (individuals/small employers)
- Report Employer Health Coverage to Secretary of Treasury
- Free choice vouchers
- Individual mandate or tax penalties
- Employer mandate or tax penalties

2017/2018

- Exchanges expanded to large employers at State's discretion
- Excise tax on high cost coverage (Cadillac tax)



Health Reform Timeline Review

Additional Provisions for Plans **Not** Grandfathered

2011

- Limits on out-of-pocket expenses
- Limits on deductibles – small group
- Limits on required referrals and authorizations
- No cost sharing for certain preventive care and immunizations
- Fully insured plans subject to additional nondiscrimination testing
- Appeals process changes



Implications for Planning

▶ 2010

- Amend plans for 2011 changes and communicate to employees
 - ◆ Remove Lifetime Maximum
 - ◆ Change Definition of Dependent
- Prepare for administrative requirements in 2011

▶ 2011 / 2012

- Implement required plan design changes, reporting and disclosure changes and automatic enrollment as requirements become effective
- Amend plans in 2012 for 2013 changes and communicate to employees
- Prepare for administrative requirements in 2013

▶ 2013

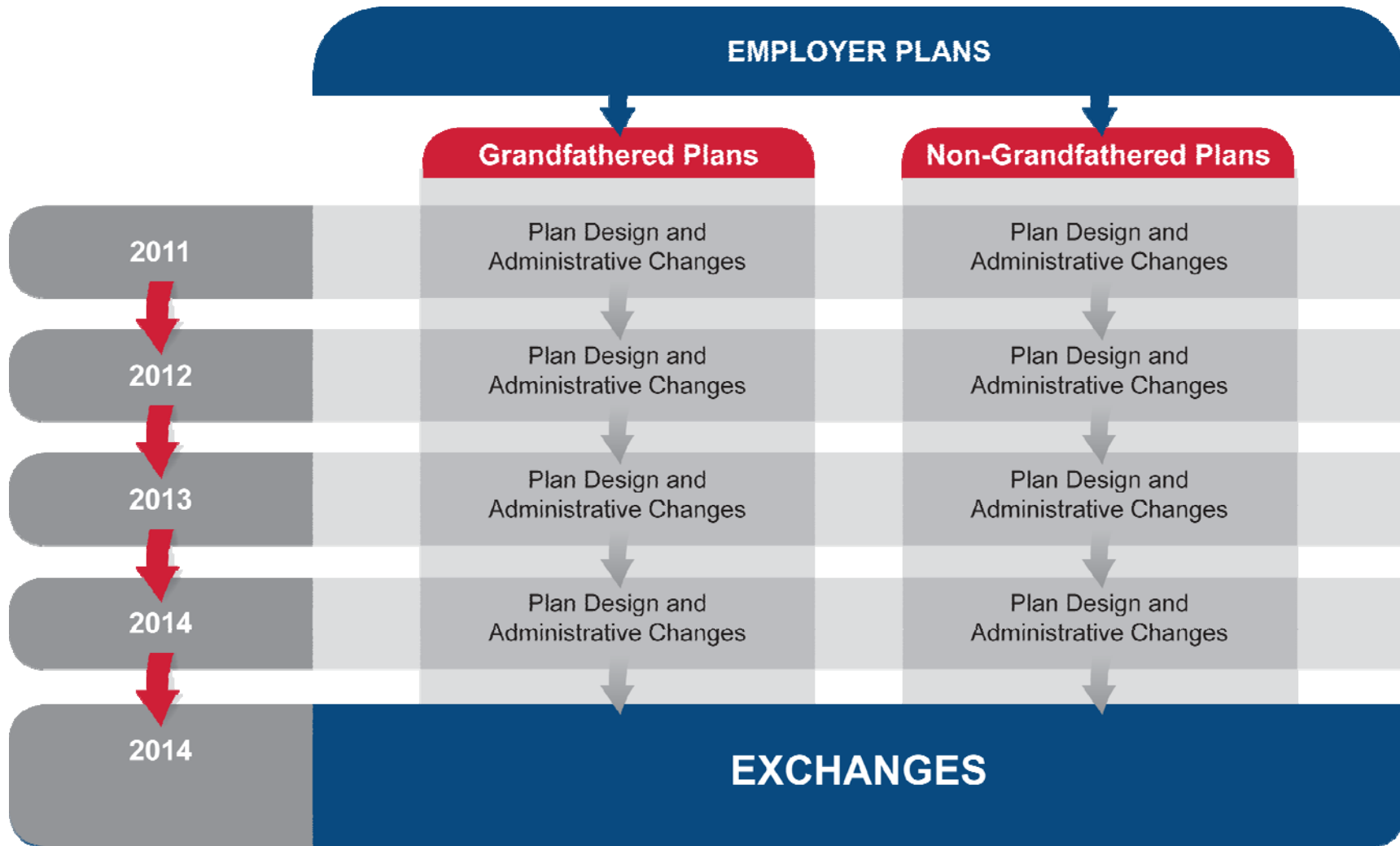
- Implement required FSA plan design change (\$2,500 cap)
- Implement additional Medicare taxes for highly paid employees
- Send out notice of coverage option for employees under Exchange
- Amend plans for 2014 changes and communicate to employees

▶ 2014

- Implement additional reporting and administrative requirements to support plan administration



Health Reform Between Now & 2014





Health Reform in 2014

HEALTH BENEFIT EXCHANGES

Large Employer Options

OFFER

Employer-Sponsored Health Coverage

Offer vouchers or pay penalties as applicable

Vouchers

- ★ Must offer free choice vouchers to employees whose
 - Income is less than 400% of the FPL, and
 - Premium cost for the employer plan exceeds 8%, but is less than 9.8%, of household income

or

Penalties

- ★ Penalty of \$3,000 for each FT employee who receives a federal subsidy on the Exchange, up to a cap of \$2,000 per FT employee (based on total number of full-time employees). Penalty may be assessed if
 - Employer coverage is considered unaffordable, and
 - Employee opts out of employer plan, and
 - Employee opts in to the Exchange and receives a federal subsidy
- ★ Unaffordable means the employee's premium for the employer plan exceeds 9.5% of the employee's household income
- ★ Employee is eligible to receive a subsidy if household income is 400% or less of the FPL

- ★ Penalties and/or vouchers only required for employees with household incomes up to 400% of the FPL
- ★ Penalty and/or voucher requirements based on employee contribution as a percent of household income. When percentage is
 - less than or equal to 8.0% - no penalty or voucher
 - greater than 8.0% up to and including 9.5% - voucher
 - greater than 9.5% up to 9.8% - voucher or penalty
 - 9.8% or greater - penalty

DON'T OFFER Employer-Sponsored Health Coverage

- ★ Penalty of \$2,000 per FT employee per year if one or more FT employees who were not offered coverage receives a federal subsidy on the Exchange
- ★ Federal subsidies are available to individuals earning up to 400% of the FPL if the premium for health coverage under the Exchange is unaffordable
 - Coverage is considered unaffordable if the premium exceeds a certain percentage of household income according to a federally prescribed schedule



Health Reform in 2014

- ▶ Financial analysis of health penalties
 - What if I don't offer health insurance coverage?
 - ◆ Play or Pay Analysis
 - What if I do offer health insurance?
 - ◆ Affordability Analysis



Eliminate Health Coverage

- ▶ Play or Pay Savings Analysis
 - Calculate the company's current cost of health care coverage
 - Forecast the company's cost in 2014
 - Subtract the tax penalty for eliminating coverage
 - Subtract the value of the lost tax deduction for providing health care cost to determine the net, tax-adjusted savings
- ▶ Employer could choose to return some or all of the savings to employees in the form of higher compensation



Eliminate Health Coverage

Play or Pay Illustration

Assumptions	
Number of Full-Time Employees (FTEs)	2,000
2010 Company Health Cost Per FTE	x \$ 7,500
2010 Company Health Care Spend	\$ 15,000,000
Annual Medical Trend Rate	7.0%
FTE Population Growth	2.0%
Effective Corporate Tax Rate	30.0%

As illustrated, the savings for eliminating health care coverage is significantly diminished after the loss of the tax deduction is factored in.

Financial Forecast	2010	2011	2012	2013	2014
Company Annual Cost (thousands)	\$ 15,000,000	\$ 16,050,000	\$ 17,174,000	\$ 18,376,000	\$ 19,662,000
Number of FTEs	2,000	2,040	2,081	2,122	2,165
Cost / FTE	\$ 7,500	\$ 7,868	\$ 8,254	\$ 8,658	\$ 9,082

Estimated Savings in 2014 For Eliminating Health Plan		Financial Assumptions and Methodology	
Company's 2014 Annual Cost	\$ 19,662,000	2010 Company budgeted cost trended at 7.0% per year	
Less: Non-Deductible Tax Penalty	- \$ 4,185,000	(2,165-30) x \$2,000	
Gross Savings	\$ 15,477,000		
Less: Loss of Tax Deduction	- \$ 5,899,000	Company's Annual Cost x Corporate Tax Rate of 30%	
Tax Adjusted Savings	\$ 9,578,000		
Divided by: Number of FTEs	÷ 2,165	Based on a 2% per year increase in FTEs	
Tax Adjusted Savings Per FTE	\$ 4,424		



Offer Health Care Coverage

- ▶ **Affordability Analysis**
 - Identify the employees earning under 400% of the Federal Poverty Level (FPL)
 - Stratify employees by coverage classification (e.g., single and/or dependent coverage)
 - For each individual, determine whether the contribution rate for health care coverage exceeds 9.5% of their income
- ▶ The Company has a potential liability of \$3,000 for each of these individuals if they were to decline the Company's health coverage, enroll in an Exchange and receive a Federal subsidy



Offer Health Care Coverage

As illustrated, employers may be liable for penalties because their coverage is considered “unaffordable” to a portion of their employee population.

Affordability Analysis

Employee Contribution Rates		
	Monthly	Annual
Employee Only	\$120	\$1,440
Employee + 1	\$240	\$2,880
Employee + Family	\$350	\$4,200

Employee Population Summary	
Total Employees	2,000
Employees Below 400% of the FPL	64
Employees Under 400% of the FPL whose contribution exceeds 9.5% of Wages	34

Demographic Analysis by Coverage Tier	Employee Only	Employee +1	Employee +2	Employee +3
2009 Federal Poverty Level (FPL)	\$10,830	\$14,570	\$18,310	\$22,050
400% of FPL	\$43,320	\$58,280	\$73,240	\$88,200
No. Employees Below 400% of FPL	22	16	18	8
Average Wage for Employees below 400% of the FPL	\$24,000	\$27,000	\$28,000	\$37,000
9.5% of Average Income	\$2,280	\$2,565	\$2,660	\$3,515
Company 2010 Annual EE Contribution	\$1,440	\$2,880	\$4,200	\$4,200
No. Employees Whose Contribution Exceeds 9.5% of Wages	3	11	14	6



Additional Planning Considerations

- ▶ Much uncertainty remains concerning the consequences of Health Reform – particularly with respect to the pieces that become effective in 2014 and later
- ▶ In addition to numerous regulatory ambiguities, there are many unanswered questions regarding the cost of coverage on the Exchanges and how they will work in practice
- ▶ In addition to cost, many work force and competitive market issues come into play in determining whether to continue health care coverage including attraction, retention, health and productivity



Questions