



HEALTH CARE REFORM

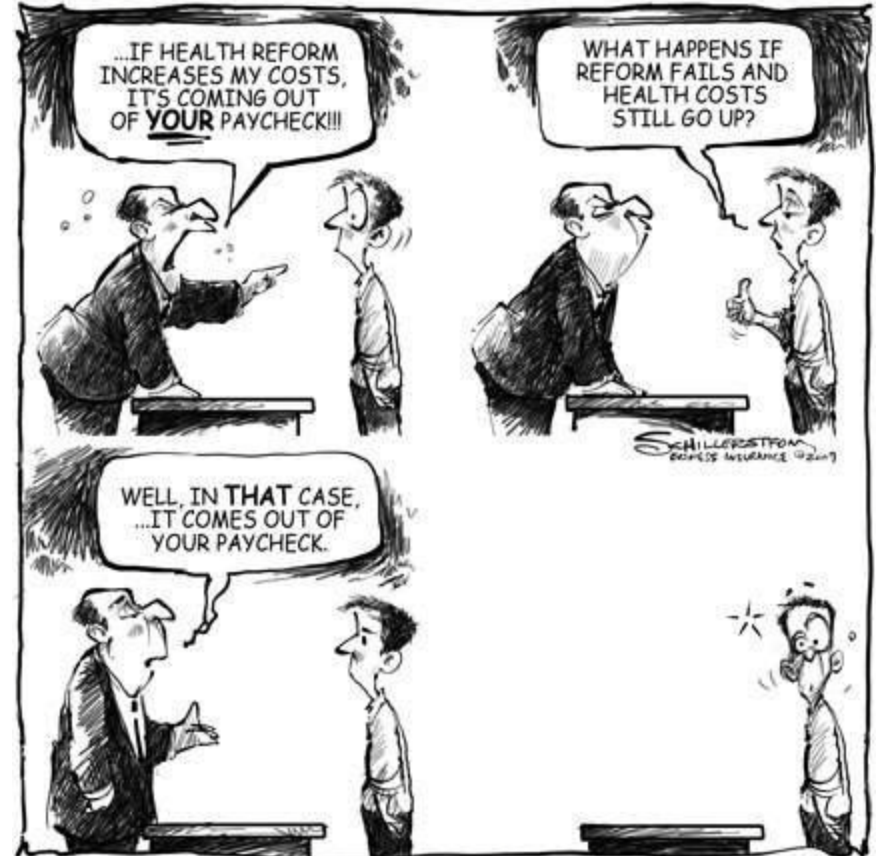
From Here to 2014

July 13, 2011





Health Care Reform





Health Care Reform

- Health Care Reform is continuing to evolve; there is daily speculation on forthcoming guidance and how various provisions will be implemented
- The ultimate fate of Reform will depend on court cases expected to be heard this fall, and the results of the next political election
- Given the current Senate structure and Obama's veto power, it is highly unlikely that PPACA will be repealed outside of the courts until the next presidential election
- Until the court cases and/or the next election, it is expected that the House will continue to attempt to slow down the implementation of PPACA primarily through limiting State and agency funding needed for implementation



Where Do We Go From Here?

- Health Care Reform Timeline
- Grandfathered Status
- Healthcare Coverage in 2014

The background of the slide is a light blue gradient. Overlaid on this are faint, semi-transparent images of the scales of justice and a caduceus (a staff with two snakes and wings). The scales are positioned on the left and right sides, and the caduceus is in the center-right. The text 'Health Care Reform Timeline' is centered in the middle of the slide.

Health Care Reform Timeline



Health Care Reform

2010- 2011

2014

2012 - 2013

2015 - 2018

2010 - 2011

- Reinsurance program for retiree coverage
- Adult dependent coverage to age 26
- No lifetime limits on the dollar value of coverage
- No rescission of coverage except in cases of fraud or intentional misrepresentation
- No pre-existing conditions clauses for children
- Restricted annual limits on the dollar value of coverage
- Limits on referrals and authorizations



Health Care Reform

2010- 2011

2014

2012 - 2013

2015 - 2018

2010 - 2011

- Nondiscrimination rules for insured group health plans
- New internal and external appeals processes for plans
- Coverage for preventive benefits
- Minimum medical loss ratio for insurers
- Penalty for HSA distributions not used for qualified medical expenses increased to 20%
- Over-the-counter drugs not reimbursable through spending accounts unless prescribed by a physician



Health Care Reform

2010- 2011

2014

2012 - 2013

2015 - 2018

2012

- New patient-centered outcomes research fee of \$1 per covered life for plan years ending between October 1, 2012 and September 30, 2013 and \$2 per covered life for each plan year ending after September 30, 2013
- W-2 health care cost reporting required for 2012 plan year



Health Care Reform

2010- 2011

2014

2012 - 2013

2015 - 2018

2013

- State notification to the HHS regarding whether the state will operate a Health Benefit Exchange
- Health spending account contributions limited to \$2,500
- Increase Medicare Part A tax for highly paid individuals
- Notice to employees of Health Benefit Exchanges in 2014



Health Care Reform

2010- 2011

2014

2012 - 2013

2015 - 2018

2014

- Individual mandate to have health insurance
- State-based exchanges for individuals and small businesses
- Multi-state health plans within Exchanges
- Health premium and cost sharing subsidies
- Guaranteed availability of insurance
- No annual limits on coverage
- New fees on health insurance providers
- No waiting period beyond 90 days
- Mandated coverage for clinical trials



Health Care Reform

2010- 2011

2014

2012 - 2013

2015 - 2018

2014

- Essential health benefits package – four categories of plans (Bronze, Silver, Gold and Platinum) to be offered through the Exchanges
- Annual cost sharing will be limited to the HSA limits (\$5,950 individual/\$11,900 family in 2010) for fully-insured plans
- Fees assessed on employers if they do not offer coverage or offer coverage that is considered unaffordable and have employees in the Exchanges
- Employers may offer wellness rewards of up to 30% of the cost of coverage
- Employer coverage reported to the Treasury



Health Care Reform

2010- 2011

2014

2012 - 2013

2015 - 2018

2016

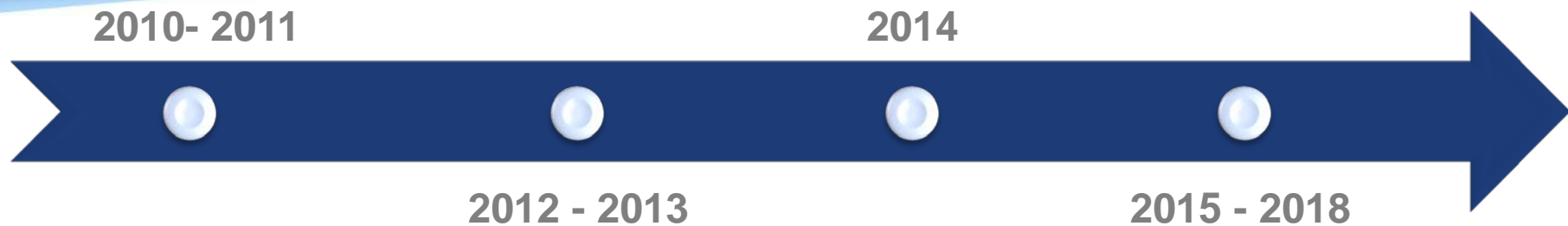
- Health care choice compacts – states will be permitted to form health care choice compacts and insurers will be allowed to sell policies in any state participating in the compact

2018

- Tax on high-cost insurance – excise tax on insurers of employer-sponsored health plans with aggregate expenses that exceed \$10,200 for individual coverage and \$27,500 for family coverage



Health Care Reform



Timing TBD

- Annual health plan uniform explanation of coverage
- Automatic enrollment
- Information on activities that improve quality of care annual report to DHHS
- Disclosure of certain enrollee information, including claims payment policies and practices and enrollee rights to DHHS and State insurance commissioner
- Information to enrollees on the amount of cost sharing for specific items or services



Grandfathered Status

Annual Decision

Should your organization maintain its grandfathered status?



Grandfathered Status

- Various surveys indicate that more than 50% of employers remained grandfathered in 2011 and that this number is expected to erode each year
- A recent SHRM survey performed in conjunction with the International Foundation of Employee Benefit Plans (IFEBC) showed that 30% of employers plan to maintain their grandfathered status for more than 3 years
- The primary reason for the erosion is that allowable plan design changes and employer contribution percentage changes are measured back to March 23, 2010



Grandfathered Status

- Group Health Plans (GHPs) that were in effect on March 23, 2010, the date of PPACA enactment, are exempt from many of the law's health care reforms if their grandfathered status is maintained
- To maintain grandfathered status, a plan must
 - Continuously cover at least one individual
 - Maintain records documenting the terms of the plans
 - Provide a statement regarding the plan's grandfathered status in any plan materials provided to participants



Grandfathered Status

- A plan will lose its grandfathered status if any of the following changes are made to the plan as it was in effect on March 23, 2010
 - Eliminate a particular benefit to diagnose or treat a condition
 - Increase the coinsurance
 - Increase a deductible or out-of-pocket payment maximum by more than medical inflation plus 15%
 - Increase a copay by the greater of (a) medical inflation plus 15%, or (b) \$5 increased by medical inflation
 - Decrease an employer contribution rate for any tier of coverage by more than 5 percentage points
 - Add or reduce an annual or lifetime limit



Grandfathered Status

- Additional impermissible changes include
 - Transfer employees into a plan (or benefit option) without a bona fide employment based reason
 - Enter into a business restructuring for the purpose of covering new individuals under a grandfathered plan

- Self-funded collectively bargained plans must satisfy grandfathered plan requirements in order to maintain grandfathered status



Grandfathered Status

Implementation Year	Requirements That Do <u>Not</u> Apply to Grandfathered Plans
2011	<ul style="list-style-type: none">▪ No cost sharing for preventive care▪ Limits on required referrals and authorizations▪ Quality of care reporting to HHS▪ Transparency reporting to HHS▪ Internal and external appeals process changes▪ Nondiscrimination for fully insured plans
2014	<ul style="list-style-type: none">▪ Cost sharing limitations for fully insured plans▪ Coverage for participation in clinical trials▪ Wellness incentives▪ Certain annual reporting

- Guidance has not yet been issued on the 2014 requirements or on the 2011 quality of care reporting or transparency reporting



Grandfathered Status

Plan Feature	Permissible changes from plan in effect on March 23, 2010
Coinsurance	No Change
Deductible	Increase by medical inflation plus 15%
Out-of-Pocket Maximum	Increase by medical inflation plus 15%
Copay	Increase by greater of medical inflation plus 15% or \$5 plus medical inflation
Annual or Lifetime Limit	No Change
Employer Contribution Percentage	Decrease by up to five (5) percentage points for each coverage tier within each plan offered



Grandfathered Status

- Medical Inflation – CPI – Bureau of Labor Statistics

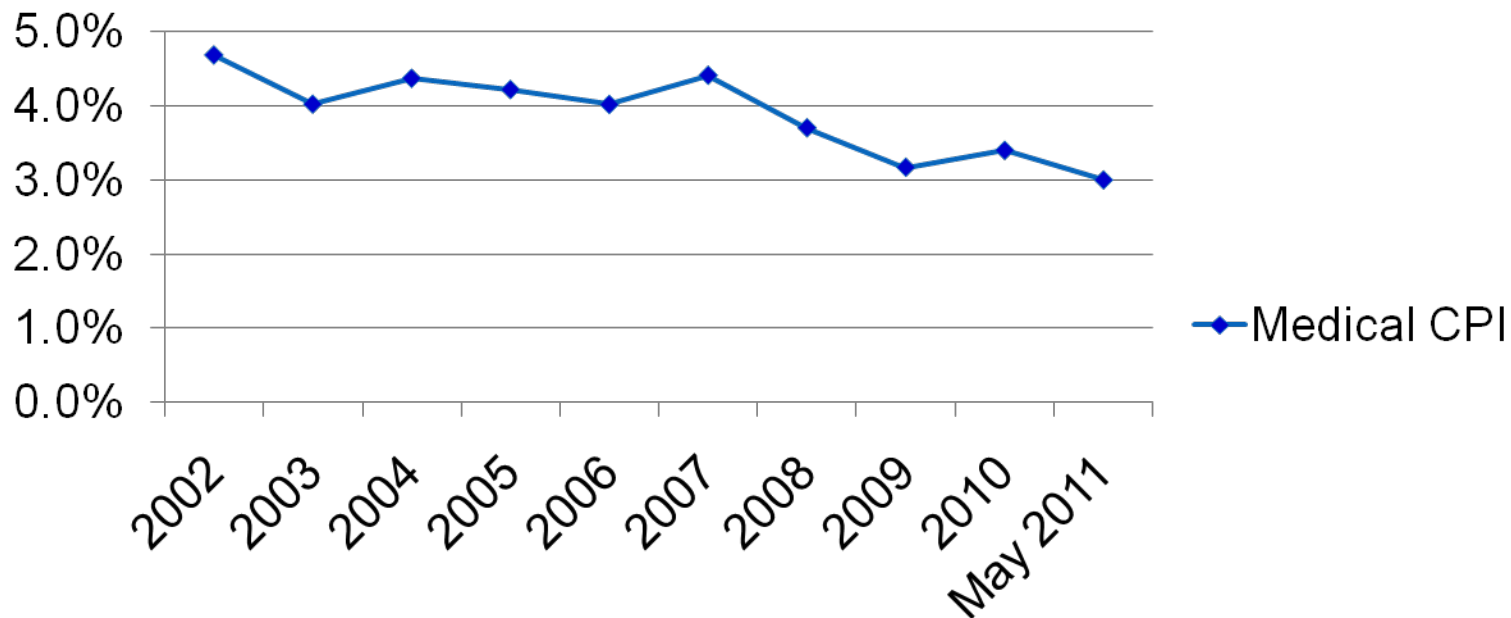
The CPI measures inflation at the retail level, and reflects the average price change over time for a constant quality, constant quantity market basket of goods and services.

For the medical care categories the Consumer Expenditure Survey (CE) collects information on household out-of-pocket expenses. Medical care expenditures eligible for the CPI include out-of-pocket expenses paid by the consumer. These include fees (not recouped through health insurance) that consumers paid directly to retail outlets for medical goods and to doctors and other medical providers for medical services, as well as health insurance premiums that consumers paid (including Medicare Part B).

To arrive at the consumer out-of-pocket medical expense, the CE nets out direct insurance reimbursements to the consumer from the total amounts paid by the consumer. Since medical care only includes consumers' out-of-pocket expenditures (and excludes employer provided health care), its share in the CPI is smaller than its share of gross domestic product (GDP) and other national accounts measures.

Grandfathered Status

- Medical CPI for the twelve months ending in May 2011 is 3.0%
- Medical CPI since March 2010 is 3.2%
- Medical CPI for 2002 – May 2011



Bureau of Labor Statistics

Grandfathered Status

- Permissible Changes – Example with Medical Inflation of 3.0%

Plan Feature	Permissible Change	PPO In-Network	
		3/23/2010	Permissible
Coinsurance	No change	80%	80%
Deductible	Increase by medical inflation plus 15%	Single - \$300 Family - \$600	Single - \$355 Family - \$710
Out-of-Pocket Maximum	Increase by medical inflation plus 15%	Single - \$1,250 Family - \$2,500	Single - \$1,480 Family - \$2,960
Copay	Increase by greater of medical inflation plus 15% or \$5 plus 3%	PCP - \$25 Specialist - \$40	PCP - \$30 Specialist - \$47
Lifetime Limit	No Change	Unlimited	Unlimited



Grandfathered Status

- Permissible Changes – Employee/Employer Premium Cost Share

Family Tier	2010 PEPM Budget Rates	2012 Projected PEPM Rates
EMPLOYEE ONLY	\$425	\$496
FAMILY	\$1,180	\$1,376

Employee contribution share may increase by up to 5 percentage points for each coverage tier within each plan offered	Employee Contribution			
	3/23/2010		Permissible	
	\$	%	\$	%
EO - \$80	EO – 18.8%	EO - \$118	EO – 23.8%	
FAM - \$299	FAM – 25.3%	FAM - \$418	FAM – 30.3%	

Non-Grandfathered Plans

- Can make any desired changes to plan design and/or employee contributions as long as compliant with PPACA requirements
 - No annual limits
 - No lifetime limits
 - No pre-existing conditions clauses
 - Dependents covered until age 26
 - Coverage for preventive benefits
- Cost savings will depend on changes made
- Competitive benchmarking, financial concerns, and attraction and retention goals will need to be taken into account in developing plan designs and employee contribution requirements

What Do We Do Now?

- Review the plan changes implemented since March 23, 2010
 - Plan design
 - Employer/Employee share of premium/budget rate
- Determine the additional changes that are permissible under the grandfathering rules
- Determine the savings to your organization that result from the permissible changes
- Balance employee relations and financial goals



Health Coverage in 2014



Health Coverage in 2014

- Predictions of employer strategies regarding whether or not to provide health coverage in 2014 are controversial
- A recent McKinsey survey of 1,300 U.S. employers showed that 30% of employers either “definitely or probably” will stop offering employer-sponsored health coverage after 2014
- A recent SHRM survey performed in conjunction with the International Foundation of Employee Benefit Plans (IFEBP) showed that less than 1% of employers plan to stop offering health coverage in 2014



Health Coverage in 2014

- To make the decision to offer coverage in 2014, it will be important to understand the impact of Health Care Reform on both the employee and employer
- To understand the cost of coverage for employees under PPACA, it is key to delineate between cost sharing – out-of-pocket expenses when an individual utilizes the health plan – and premiums

Do any of the following apply?

- You are part of a religion opposed to acceptance of benefits from a health insurance policy
- You are an undocumented immigrant
- You are incarcerated
- You are a member of an Indian tribe
- Your family income is below the threshold requiring you to file a tax return (\$9,350 for an individual, \$18,700 for a family in 2010)
- You have to pay more than 8% of your income for employer health insurance or the lowest cost bronze plan, after taking into account any employer contributions or tax credits

Yes

There is no penalty for being without health insurance

No

2014 – Individual Requirement to Have Coverage

Were you insured for the whole year through a combination of any of the following sources?

- Medicare
- Medicaid or the Children’s Health Insurance Program
- TRICARE (for service members, retirees, and their families)
- The veteran’s health program
- Peace Corps volunteers’ health plan
- A plan offered by an employer, including grandfathered health plans
- Insurance bought on your own that is at least at the Bronze level

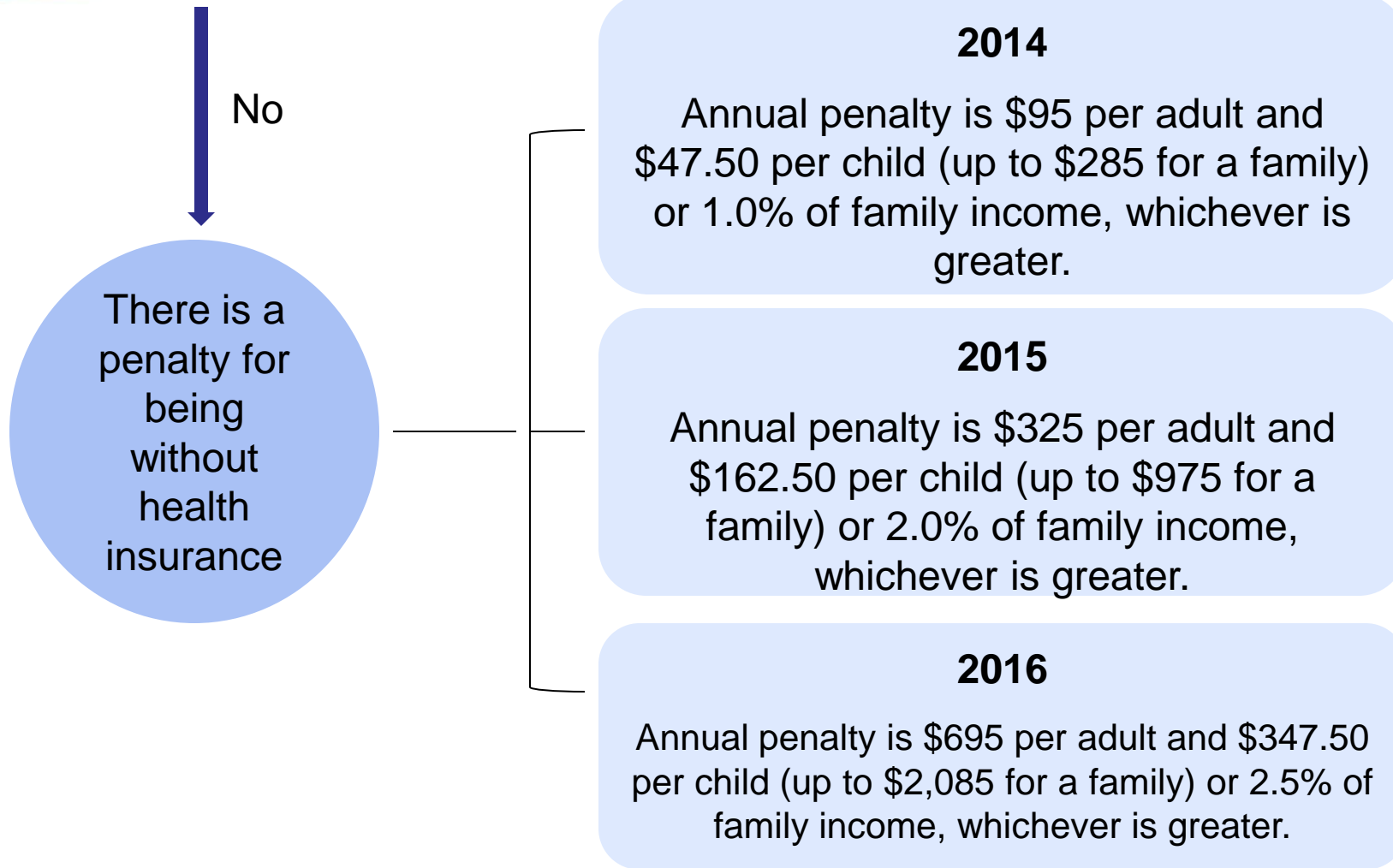
Yes

The requirement to have health insurance is satisfied and no penalty is assessed



No

2014 – Individual Requirement to Have Coverage





2014 – Individual Requirement to Have Coverage

Penalties will be pro-rated by the number of months without coverage. There is no penalty for a single gap in coverage of less than 3 months in a year. The penalty cannot be greater than the national average premium for a Bronze level coverage in an Exchange. After 2016, the penalty amounts are increased annually by the cost of living.

Potential Employee Cost

- Premiums for health insurance bought through Exchanges will vary by age, location and possibly tobacco status.
- The Congressional Budget Office estimates that the national average annual premium for Bronze coverage in an Exchange in 2016 will be \$4,500 - \$5,000 for an individual and \$12,000 - \$12,500 for a family.
- Annual cost sharing (out-of-pocket expenses) within the plan will be limited to the HSA limits (\$5,950 individual/\$11,900 family in 2011).
- Based on these numbers, without subsidies, the annual cost (premiums plus cost sharing) for a Bronze level plan could be around \$11,000 for individuals and \$25,000 for families that incur significant health expenses.

Potential Employee Cost

Tax credits and cost sharing subsidies will be available to eligible individuals. Premium subsidies will be available to families with incomes below 400% of the federal poverty level to purchase insurance through the Exchanges. Cost sharing subsidies will be available to those with incomes up to 400% of the poverty level.

KFF Study: Deductibles Within Exchange Plans

- The Kaiser Family Foundation commissioned 3 actuarial firms to project what the deductibles and coinsurance will be under the Exchange plans

Plan	Out-of-Pocket Maximum		Actuarial Research Corp		Aon Hewitt		Towers Watson	
	Level	Amt	Ded	Coins	Ded	Coins	Ded	Coins
Bronze	HSA Level	\$6,350	\$6,350*	0%	\$4,350	20%	\$2,750	30%
Silver	HSA Level	\$6,350	\$4,200	20%	\$2,050	20%	\$1,850	20%

* Firm unable to construct a plan design within the constraints of the required actuarial value and out-of-pocket maximum.

2011 Poverty Guidelines – 48 Contiguous States*

Family Size	Household Income			
	100%	133%	250%	400%
1	\$10,890	\$14,484	\$27,225	\$43,560
2	\$14,710	\$19,564	\$36,775	\$58,840
3	\$18,530	\$24,645	\$46,325	\$74,120
4	\$22,350	\$29,726	\$55,875	\$89,400
5	\$26,170	\$34,806	\$65,425	\$104,680
6	\$29,990	\$39,887	\$74,975	\$119,960
7	\$33,810	\$44,967	\$84,525	\$135,240
8	\$37,630	\$50,048	\$94,075	\$150,520
For each additional person, add:	\$3,820	\$5,081	\$9,550	\$15,280

*Alaska and Hawaii have separate schedules with higher household income numbers.

CBO: Example of Subsidies in the Exchange



	Family at 150% of FPL	Family at 250% of FPL	Family at 350% of FPL
	Year 1	Year 1	Year 1
Family Income	\$30,000	\$50,000	\$70,000
Federal Poverty Level (FPL)	\$20,000	\$20,000	\$20,000
Income as % FPL	150%	250%	350%
Share of Income Required to Enroll in a Silver Plan	4.0%	8.2%	9.5%
Enrollee's Payment	\$1,200	\$4,025	\$6,650
Total Premium for the Silver Plan	\$15,000	\$15,000	\$15,000
Federal Subsidy	\$13,800	\$10,975	\$8,350

Per the Kaiser Family Foundation survey, the average cost for family coverage in an employer provided health plan in 2010 was \$3,600.

Do Not Offer Health Coverage

Fee of **\$2,000 per full-time employee, excluding the first 30 employees**, if at least one full-time employee enrolls in coverage in an Exchange and receives a premium tax credit or cost sharing subsidy.

Tax credits and cost sharing subsidies will be available to eligible individuals. **Premium subsidies will be available to families with incomes below 400% of the federal poverty level** to purchase insurance through the Exchanges. **Cost sharing subsidies will be available to those with incomes up to 400% of the poverty level.**



Do Not Offer Coverage in 2014

- Potential for significant savings to Employer
- Employees will have to buy coverage on the Exchange with or without a subsidy
- Expectation from employees will be that compensation and/or other benefits will be increased
- Compensation and benefit comparisons will become more important than ever in job decisions
- Competitive stance for attracting and retaining employees will be key in decision not to offer coverage – Who goes first in your industry or geographic area?



Do Not Offer Coverage in 2014

■ Simplified Example

	2011	2012	2013	2014
Annual Cost	\$ 8,600,000	\$ 9,288,000	\$ 10,031,000	\$ 10,835,000
No. of FTEs	1,000	1,000	1,000	1,000
Cost/FTE	\$ 8,600	\$ 9,288	\$ 10,031	\$ 10,835
Trend		8%	8%	8%

2014 Costs	\$ 10,835,000
Penalty (Fee assessment of \$2,000 on 970 employees)	\$ 1,940,000
Gross Savings	\$ 8,895,000
Loss of Tax Deduction (Assumes 38% Corporate Tax Rate)	\$ 3,380,100
Net Savings	\$ 5,514,900
Savings/FTE	\$ 5,515



Do Not Offer Coverage in 2014

- Will the savings be shared with your employees?
- If the savings are shared, how will this be accomplished?
 - Increase pay – savings returned to employees in the form of higher pay will be taxable to the employee and to the employer (FICA/FUTA)
 - Offer additional benefits
 - Higher 401(k) match
 - More ancillary benefits – both voluntary benefit and traditional carriers are developing gap plans that don't qualify as a health plan and are designed to fill in where Exchange plans require significant cost sharing
 - Offer an access only health plan for which employees pay 100% of the cost



Do Not Offer Coverage in 2014

- If the savings are shared, how will this be accomplished? (continued)
 - Offer a defined contribution H&W plan – Give employees a certain amount of money with which they can purchase an Exchange plan, purchase other employer-provided benefits, or take as cash (cash will be taxable)
 - Fund an HRA from which employees can pay for Exchange premiums, an employer-provided access only plan, and/or out-of-pocket health expenses
 - Allows for tax deduction for employer (FICA/FUTA)
 - No legal maximum on employer contribution
 - No pre-funding – only fund what employee actually submits for reimbursement
 - Can, but do not have to, allow funds to carry over from year to year



Do Not Offer Coverage in 2014

- If the savings are shared, how will this be accomplished? (continued)
 - Fund an HSA from which employees can pay for Exchange premiums, an employer-provided access only plan, and/or out-of-pocket expenses
 - Allows for tax deduction for employer
 - Annual maximum allowable contributions – \$3,050 individual and \$11,900 family in 2011
 - Only employees with High Deductible Health Plans are eligible for HSAs – must track plan employee is in to determine HSA eligibility
 - Must fully-fund plan each year – money becomes employees'
 - Carry over from year to year

Offer Coverage

If your plan is considered unaffordable, and at least one employee is receiving a tax credit or subsidy and is participating in an Exchange, fee of the lesser of \$3,000 for each employee receiving a tax credit or subsidy or \$2,000 for each full-time employee, excluding the first 30 employees.

Your plan will be considered unaffordable if employee premium exceeds 9.5% of the employee's household income.

Tax credits and cost sharing subsidies will be available to eligible individuals. **Premium subsidies will be available to families with incomes below 400% of the federal poverty level to purchase insurance through the Exchanges. Cost sharing subsidies will be available to those with incomes up to 400% of the poverty level.**



Offer Coverage in 2014

- Will your organization have to pay a penalty?
 1. Are there employees who are eligible for subsidies due to an annual income of less than 400% of the Federal Poverty Level?
 2. Is your plan considered unaffordable for those employees who are eligible for subsidies?

For an employee earning \$40,000 per year, the cost of coverage could be up to 9.5% of income or \$3,800 annually/\$317 monthly before the coverage is considered unaffordable



Offer Coverage in 2014

- Potential penalty for most employers – if an employee who is eligible for the premium or cost sharing subsidy enrolls in an Exchange

Penalty = Lesser of

Total No. of Employees



\$2,000

OR

No. of Employees for Whom Coverage is Considered Unaffordable



\$3,000



Next Steps

- Determine financial and employee relations goals for the health plan
- Review benchmarking for competitive stance on plans
- If currently grandfathered, determine if employee relations and financial goals can be maintained under grandfathered status – alternative plan design scenarios, projected costs and potential employee contributions
- Determine grandfathered status for 2012
- Begin laying out options for 2014 – prepare management for the tough decisions ahead
- Caveat everything with the potential for political and legal changes

