The New Health Reform Law: Now and Going Forward

August 2012

What's Happening in Washington!

Political Landscape

In Washington:

- Washington's political dynamic is fractured
- Compromise is extraordinarily difficult--moderates are unable to move
- House actions are tempered by conservative pressure and tight Democratic majority in the Senate and President Obama
- Both parties trying to balance delivering on promises now and goals for 2012 elections

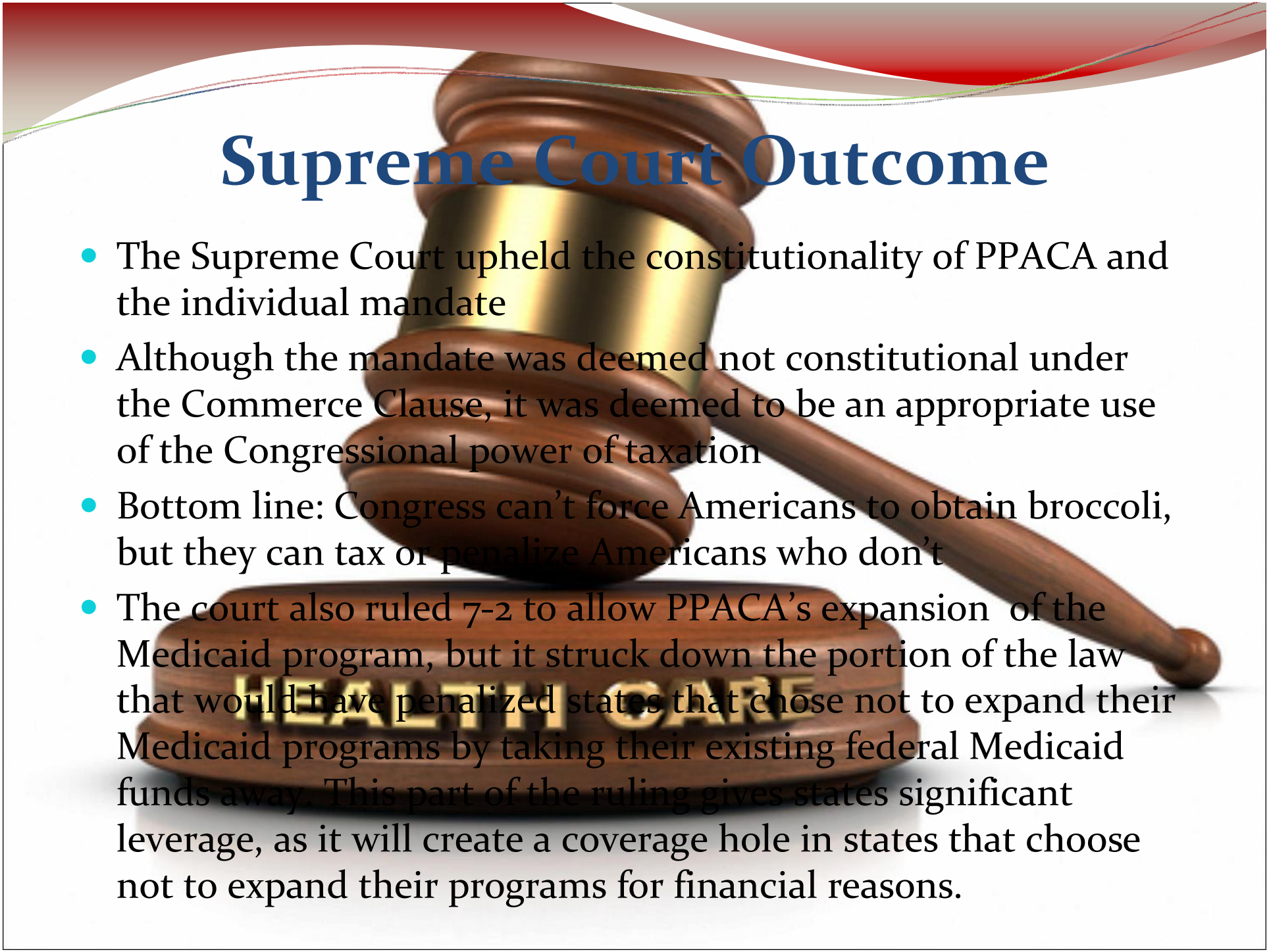
In the States:

- Budget deficits
- Refusal to accept PPACA funds/implement programs

- Extreme variation in state political climates

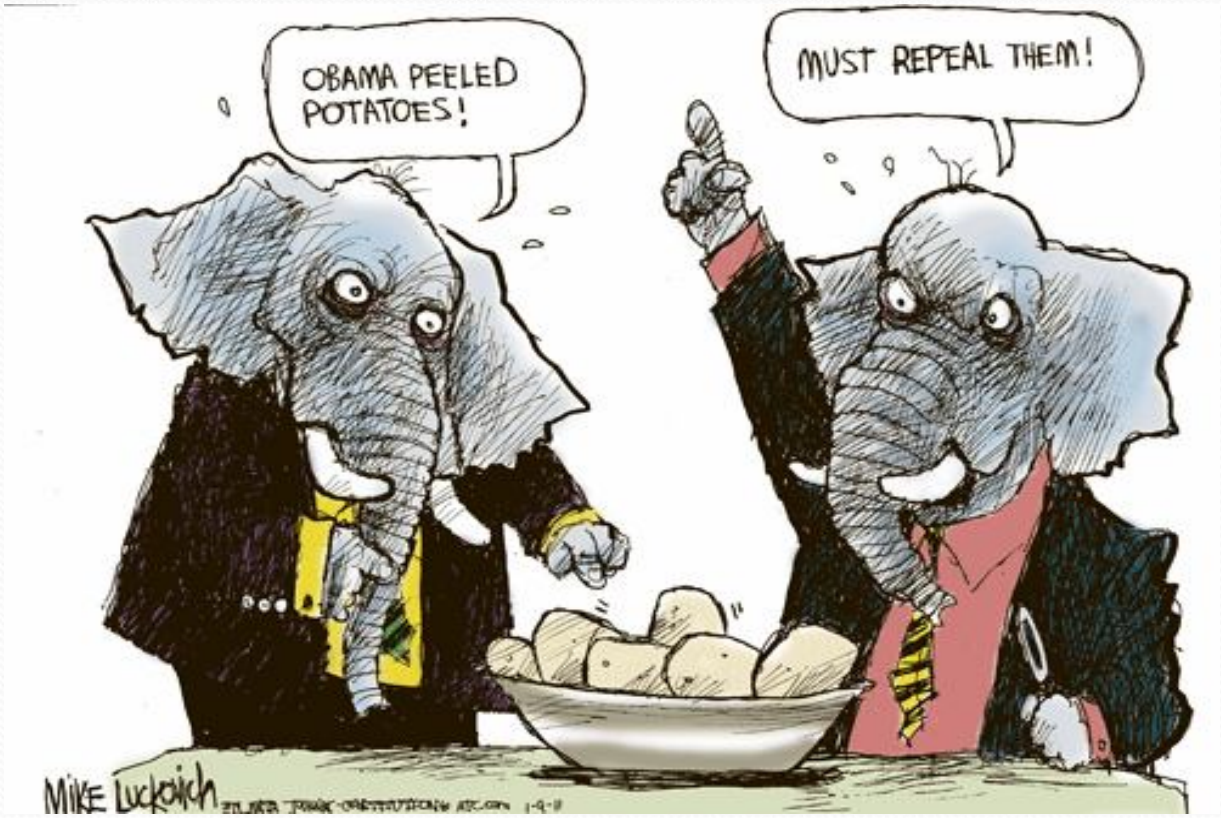
Supreme Court Ruling

Supreme Court Outcome



- The Supreme Court upheld the constitutionality of PPACA and the individual mandate
- Although the mandate was deemed not constitutional under the Commerce Clause, it was deemed to be an appropriate use of the Congressional power of taxation
- Bottom line: Congress can't force Americans to obtain broccoli, but they can tax or penalize Americans who don't
- The court also ruled 7-2 to allow PPACA's expansion of the Medicaid program, but it struck down the portion of the law that would have penalized states that chose not to expand their Medicaid programs by taking their existing federal Medicaid funds away. This part of the ruling gives states significant leverage, as it will create a coverage hole in states that choose not to expand their programs for financial reasons.

Presidential and Congressional Dilemma
Repeal/ Replace vs. Fix It!



Immediate Insurance/Benefit Change Timeline for Employers

2010	•Grandfathered Plan Requirements Took Effect •Small Business Tax Credits • Temporary Federal High Risk Pool Program, PCIP, begins •Federal Retirement Reinsurance Program begins • Sept. 23rd Reforms for All Plans-- Dependent Coverage to Age 26, No Preexisting Condition Limitations for Children, Rescission Restrictions, Annual and Lifetime Limit Restrictions •Sept. 23rd Reforms for Non-Grandfathered Plans--Preventive Care, 105h Nondiscrimination rules for all fully-insured group plans (*enforcement delayed)*, New coverage appeals process requirements
2011	•FSAs/HRAs/HSAs — Reimbursement of OTC drugs not allowed without Rx •HSA distribution tax increases •Simple cafeteria plan rules begin •Medical loss ratio requirements begin for all fully insured plans •Federal Rate Review standards begin •Annual DOL studies on the self-funded marketplace begin using form 5500 data

Immediate Insurance/Benefit Change Timeline for Employers

2012

- Newly defined preventive care requirements for non-grandfathered plans begin
- New longer Summary Plan Description requirements
- New quality reporting requirements (to HHS and beneficiaries) for all employer plans and all individual and group carriers – regulations for this have yet to be finalized
- Delayed W2 Reporting begins (requirement is optional for employers who issue less than 250 W2s until further notice)
- Employers whose carrier did not meet MLR standards may receive a rebate.

2013

- FSA contributions capped at $2,500
- New federal premium tax on fully insured and self-insured group health plans to fund comparative effectiveness research program begins. It imposes an annual fee on private insurance plans equal to two dollars for each individual covered.
- Exchange notification requirements for employers
- New Medicare taxes on unearned income and higher income employees and self-employed

The Big Year - 2014

2014

- Individual Mandate
- Health Insurance Exchanges
- Employer Mandate
- Modified community rating for individual and small group markets
- Individual market guaranteed issue
- Elimination of preexisting condition look-back and exclusionary periods
- Subsidies available for qualified individuals purchasing individual coverage through the exchanges
- Medicaid expansion
- New premium taxes on fully-insured plans
- Essential benefit and actuarial value requirements for individual and small group plans
- Quality standards for qualified individual and small group plans
- Minimum value standard for large group plans
- Deductible Limits for Small Businesses

PPACA in 2016-2018

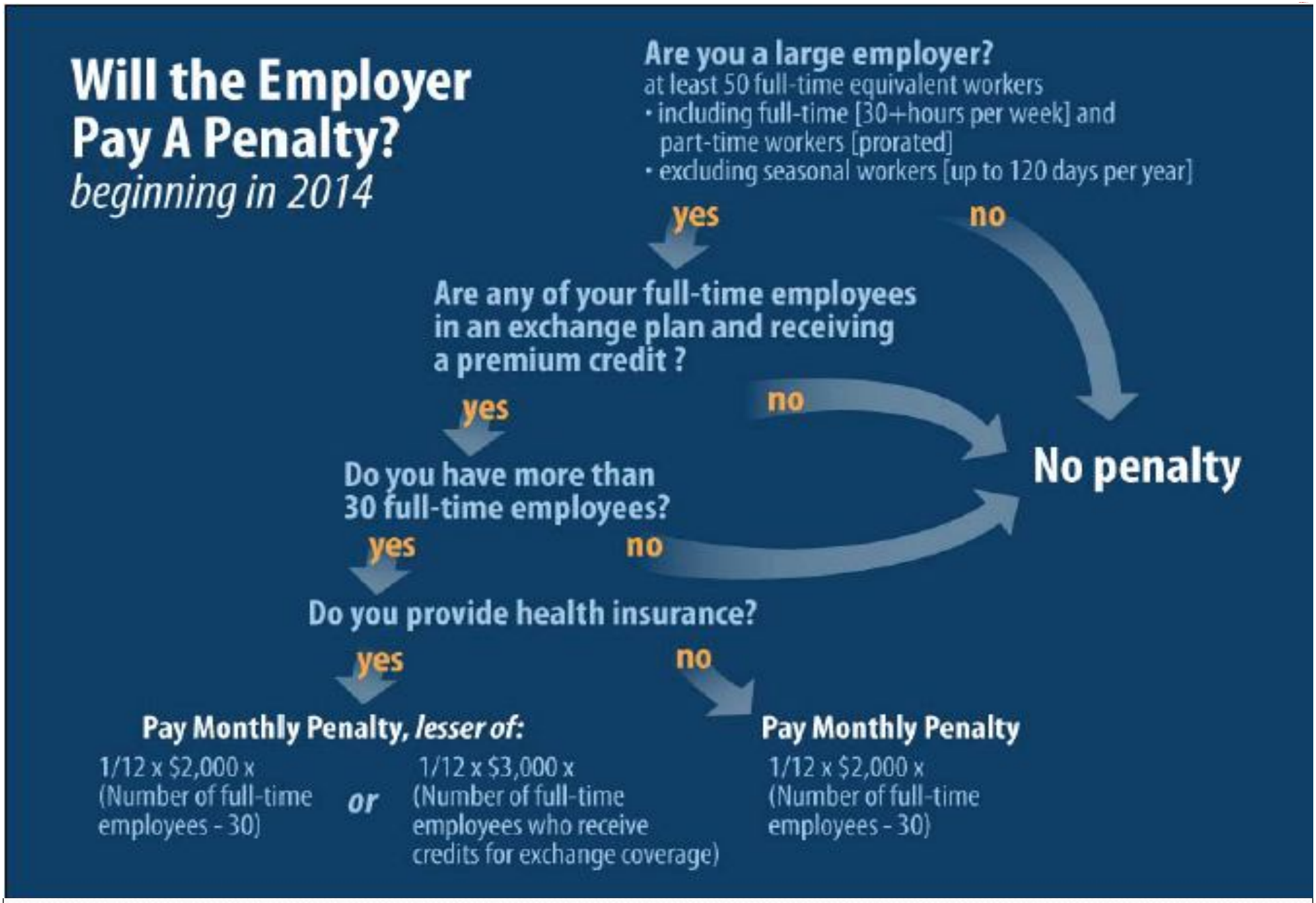
2016	Automatic expansion for state small group markets to 100 employees if the state hasn't taken action to raise the threshold already.
2017	States can allow large group plans to join their exchanges, thereby triggering massive market reform changes for all fully-insured large group plans
2018	"Cadillac tax" or a 40% excise tax goes into effect for all group plans, including self-insured plans. The tax would be paid by the insurer in the case of a fully insured group or the TPA in a self-insured arrangement, but would be passed on directly to the employer.

Changes to PPACA Requirements for Employers

- Enforcement delayed on 105 (h) non-discrimination rules for all fully insured non-grandfathered plans
  - IRS solicited comments in March 2011
  - No word on when new guidance will be issued/enforcement could begin
  - Enforcement extremely likely to be prospective and with a grace period
- Auto-Enrollment for groups of 200+ delayed
  - Effective date of this provision is unclear in the statute
  - The Administration has notified employers that the guidance on auto-enrollment will not be published before 2014.
  - Auto-enrollment is not effective, until guidance is issued. Consequently, no auto-enrollment before 2014!
- W2 Reporting Requirements Delayed Until 2012 (W2s issued in January 2013)
- 1099 Reporting requirements repealed
- Employee Free Choice Voucher Program eliminated

Employer Responsibility Requirements

- Effective starting January 1, 2014
- Employer must count all full-time employees and part-time employees – on a full-time equivalent basis – in determining if they have 50 or more employees
  - Certain seasonal workers are not counted in determining if employer has 50 workers
  - Full-time = 30 or more hours per week, determined on a monthly basis
- Penalties assessed for "no coverage" or coverage that doesn't meet a "minimum value" standard or is "not affordable"
- Minimum value standard will determine adequacy of coverage
  - Obama Administration released preliminary bulletin outlining thoughts on how this standard might work in May 2011
  - While final details are still unknown, it can be assumed market will respond so that group coverage will qualify
- Affordable coverage is coverage where the employee's share is less than 9.5% of household income. However, employers don't need to use that standard to determine if their plan is adequate. The premium employers use to calculate affordability is the single employee rate for the lowest tier plan, regardless of how many dependents employee has covered on the employer plan or what plan the employee elects. The employer uses the employee's W2 wage to calculate income, not the household income.



Summary of Potential Employer Penalties under PPACA, Congressional Research Service, May 14, 2010

Does Group Coverage Meet the Affordability Test?

Federal Poverty Limit - FPL	2011 FPL	Hourly Rate (40 hr week) W2 Wage		Employee Share of Single Premiums per Mo @ 9.5% income Standard
100% (Possibly Medicaid Eligible)	$10,890	$5.24/hr	9.5%	$86/mo
133%(Possibly Medicaid Eligible)	$14.484	$6.96/hr	9.5%	$114/mo
150% (Minimum Wage)	*$16,335*	*$7.85/hr*	*9.5%*	*$130/mo*
200%	$21,780	$10.47/hr	9.5%	$172/mo
250%	$27,225	$13.09/hr	9.5%	$216/mo
300%	$32,670	$15.71/hr	9.5%	$259/mo
350%	$38,115	$18.32/hr	9.5%	$302/mo
400%	$43,560	$20.94/hr	9.5%	$345/mo
400% family of 4	*$89,400*	*$20.94/hr*	*9.5%*	*$345/mo since employer only has to use the single rate for lowest tier plan to calculate affordability*

Why Offer Employer-Sponsored Coverage?

- Employers can provide substantial economic value and financial peace of mind to employees by offering group health insurance coverage. This gives employers an advantage when competing in the labor market.
  - A healthy workforce is directly linked to productivity
  - Offering benefits can allow employers to attract the best workers and remain competitive.
  - Employers have great flexibility and can pick and choose among new benefit, payment, and organization innovations and can implement new programs and halt unsuccessful ones relatively quickly
  - The federal government supports employer-sponsored coverage through the tax code by recognizing firms' insurance premiums paid on behalf of their workers as a business cost, which are generally deductible for tax purposes.
- For workers, there are a multitude of advantages to employer-sponsored coverage, including:
  - The significant contribution most employers make towards the cost of coverage for both the employee and their dependents
  - Individuals with employer-sponsored coverage also have the ease of purchasing coverage through workplace enrollment that comes with group coverage
  - Administrative costs are also lower since coverage is provided to many individuals through a single transaction with one employer.

Facts about the Employer Penalty and Subsidies

- If an employer drops coverage and sends employees to the exchange, employees do not see one dime of the penalty money the employer pays. The entire fine amount goes straight the federal treasury and employees reap no coverage assistance from it.
- Many employers think that if they drop coverage and send people to the exchange, their employees will get free or drastically reduced coverage there, but for many employees, particularly those without dependents, the subsidy benefit will not be that great.

Individual Coverage Subsidies

- PPACA's premium tax credit (subsidies) only are available to qualified individuals purchasing coverage through health insurance exchanges after January 1, 2014.
- Individuals with family incomes between 100-400% of the federal poverty level are eligible for a premium tax credit. Individuals with family incomes at or below 250% of the FPL also qualify for reduced cost-sharing.
- Individuals and their dependents who have been offered coverage through an employer that meets an affordability and minimum value test ***are not eligible to purchase coverage through an exchange or get a subsidy***.
- The premium subsidy will come in the form of a refundable and advanceable tax credit paid directly to the individual's insurer.
- The amount of the refundable premium tax credit received is based on the premium for the second lowest cost qualified health plan in the exchange (the silver plan) and in the rating area where the individual is eligible to purchase coverage.

The PPACA Premium Tax Credit's Varying Impact

Individual	Family Status	Income	Percentage of income that may be spent on health insurance	Estimated value of the employee's annual tax credit in 2014
30 year old with qualified employer coverage	Married, two children	$35,000	9.5% of household income	No one in the family qualified to buy coverage in the exchange or get a subsidy
30 year old with no employer coverage	Single	$35,000	9.5% of household income	$155 (based on Kaiser Family Foundation's projection of a $3440 annual single premium in 2014) **Individual's annual premium costs would be $3325**
30 year old with no employer coverage	Married, two children	$35,000	3.97% of household income	$8,720 (based on Kaiser Family Foundation's projection of a $10,108 annual family premium in 2014) **Family's annual premium costs would be $1,388**
45 Year old with qualified employer coverage	Married, three children	$55,000	9.5% of household income	$0 -- No one in the family is qualified to buy coverage in the exchange or get a subsidy
45 year old with no employer coverage	Single	$55,000	N/A	$0 – Individual may buy coverage in the exchange but would not qualify for subsidy **Individual's annual premium payments would be $5,609 based on Kaiser Family Foundation's projection of 2014 single premium**
45 year old with no employer coverage	Married, two children	$55,000	7.52% of household income	$10, 100 (based on Kaiser Family Foundation's projection of a $14, 250 annual family premium in 2014) **Family's annual premium costs would be $4,135**

What employers need to be thinking about right now:

- Reporting on W-2s the value of employer provided health insurance is required for 2012
- Preventive care requirements for women that begin on plan years starting on or after August 1, 2012
- MLR Rebates being issued byAugust 2012
- Summary of benefit requirements begin on plan years beginning on or after September 23, 2012

- **What they don't:**
  - FSA Account cap that begins in 2013 if you have a non-calendar year plan

W-2 Reporting

- Employers will be required to include the value of group health plan coverage on W-2s issued after 1/1/2013.
- Reporting for 2011 is voluntary.
- The new reporting requirements do not change the tax treatment of employer-provided health coverage. The reporting is for informational purposes only.
- Small Employer Exception
  - Employers issuing fewer than 250 Forms W-2 in the preceding calendar year are exempt from the reporting requirement.
  - May be on an entity rather than control group basis
  - Note- this is not the total number of employees, but the total number for Forms W-2
  - Applies to all employers who provide applicable employer sponsored coverage

What to Report

- Employers are required to report the value of all "applicable employer-sponsored coverage". Generally, group health plans, including:
  - Major medical
  - Mini-meds
  - On-site medical clinics
  - Medicare supplemental coverage
  - Health FSA contributions (employer)
  - Employee assistance & wellness programs (with separate COBRA rates)
- Optional Reporting
  - IRS guidance permits employers to report the cost of coverage that is not required to be reported (e.g. multiemployer, HRA) if reported coverage is otherwise applicable employer sponsored coverage

How to Report: Determining the "Aggregate Cost"

- Must report the "aggregate cost"
- Include pre-tax and post-tax coverage
- Include employer and employee contributions (e.g. employer premium contribution or employee cafeteria plan contributions)
- Multiple methodologies for determining aggregate cost.

- ***General Rule: Use cost of COBRA premium***

Women's Preventive Care

- Based upon Institute of Medicine Recommendations to HHS
- Effective for the first plan year on or after August 1, 2012
  - Screening for gestational diabetes
  - Human Papillomavirus (HPV) testing
  - Annual counseling and screening on STDs & HIV
  - All FDA approved contraceptives, sterilization procedures, and counseling
  - Lactation support and equipment rental
  - Screening and counseling for domestic violence
  - At least one well-woman preventive visit annually
- Per HHS:
  - Religious based, non profits, have until August 1, 2013 to comply
  - New accommodation "Insurance Carriers must provide, not Employer"
- Grandfathered plans will need not comply unless they adopted initial set preventive rules

Medical Loss Ratio Rebates

- Applies to fully insured medical plans only
- Carrier calculation based on calendar year
- First applicable CY 2011
- First checks to be issued by August 1, 2012
  - Look for them to arrive in July
  - Carrier to send participants and group policyholder notification
  - Group policyholder to be issued rebate
  - May be in the form of a future premium credit

Medical Loss Ratio – Rebate checks

- Rebates must distributed proportionate to CY 2011 employer contribution structure
  - Chasing down former participants is *not required*
- In ERISA plans the group policyholder must consider the portion of the rebate attributable to what the employees paid "plan assets."
- Plan assets distributed for the exclusive benefit of participants and beneficiaries in the following three ways.
  - The rebate can be paid to the participants, under a fair and equitable allocation method.
  - The employer can apply the rebate toward future participant premium payments.
  - The employer could use the rebate to provide enhanced benefits for the participants.
- The DOL ***suggests*** that the second and third options should be used only if distributing payments to participants is not cost effective
- To avoid being forced to establish a trust to hold the rebate, the employer should distribute the rebate within three months of receipt.
- Rebates are taxable to employees that paid their share of the

Summary of Benefits Requirements

- All insurers and self-funded employers will have to give people who apply for or enroll in individual or employer-sponsored coverage a standardized summary of benefits and coverage that includes:
  - Four page coverage summary
  - Coverage terms glossary
  - Coverage examples of two set medical scenarios
  - Customer service and website information
- Intent is to give consumers standardized information for comparative purposes
- Effective date has been delayed to on or after the plan year that begins on or after September 23, 2012
- Applies to all plans, including grandfathered plans and self-funded plans.
- HIPAA excepted benefit plans (e.g., stand-alone dental, specific diseases, etc.) do not have to comply

Enid was finally ready to admit that compliance was a bit more complicated than she first thought.

Thank You!

Insert Presenter Contact Information