

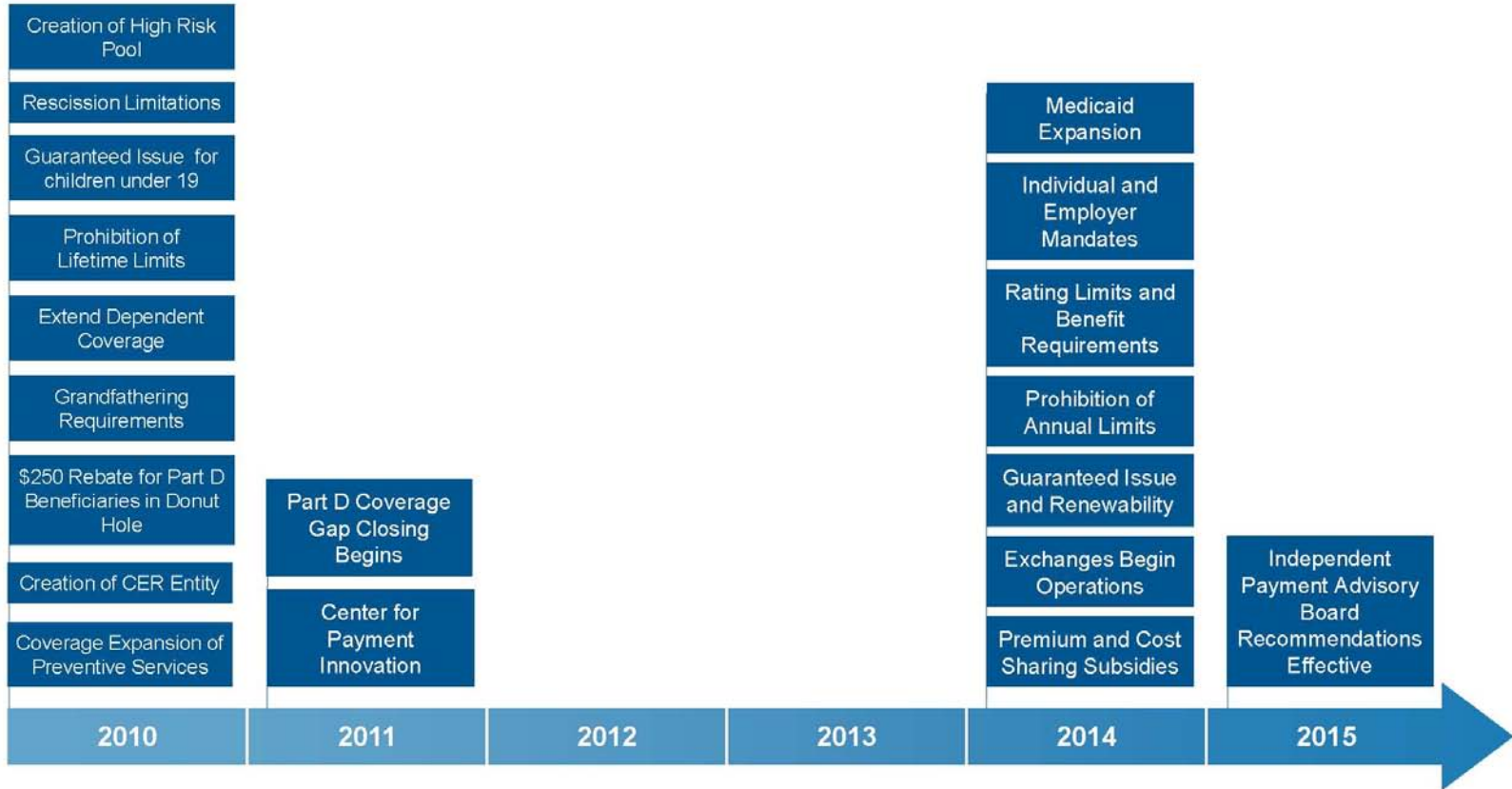
Health Care Reform: What You Need to Know

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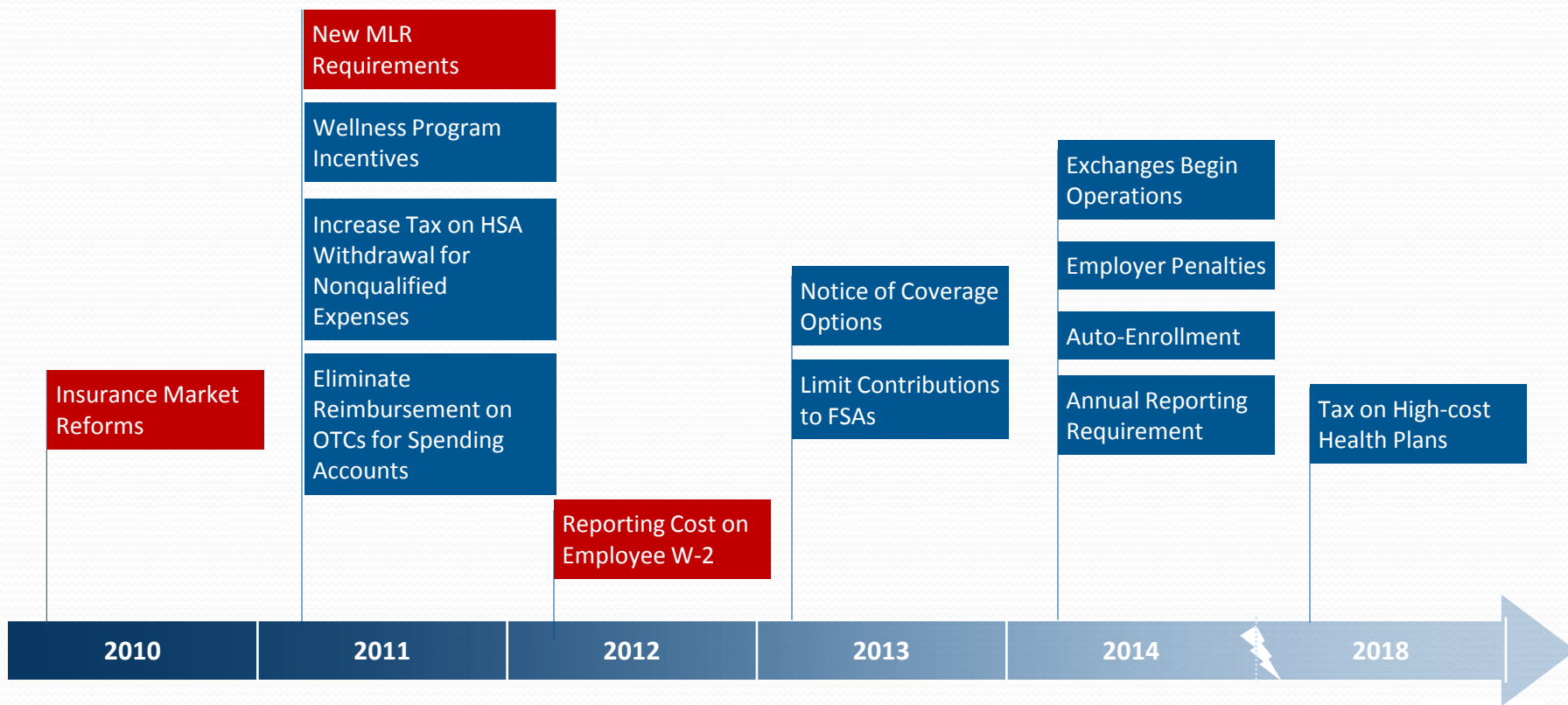
October 2010



Timeline for Implementation



Details Have Been Released on Some of ACA's Requirements for Employers



* Red Flags Indicate New Information Has Been Released
FSA = Flexible spending arrangement
HSA = Health savings accounts
OTC= Over-the-counter (medication)



Health Reform Implementation Timeline

Effective 90 days following enactment

- Temporary Retiree Reinsurance Program begins
- High-Risk Pool

Health Reform Implementation Timeline

Effective Plan Years beginning on or after September 23, 2010

- Adult Children Coverage to age 26
- Restricted Annual Limits on Essential Benefits (to be defined)
- No Lifetime Limits on Essential Benefits
- No Preexisting Condition Exclusions for enrollees under age 19
- No Rescissions (primarily individual and small group coverage)
- First-Dollar Coverage for Preventive Care*
- Revised Appeals Process*
- Emergency Services without prior authorization/treated as in-network*
- Choice of Providers (pediatrician and OB-GYN)*

*Applies to non-grandfathered plans only. Grandfathered plans are exempt until the status is lost.

Health Reform Implementation Timeline

January 1, 2011

- No Reimbursement for OTC Drugs unless prescribed
- **Voluntary:** Form W-2 Reporting of Value of Benefits (for W-2 issued in January 2012 with respect to 2011)
- Long-Term Care Program (CLASS)
- Increased Penalty for Non-Medical HSA Withdrawals
- Wellness Program Incentives (Reduce premiums up to 30% for participation)

Health Reform Implementation Timeline

March 23, 2012

- Uniform Explanation of Coverage
- 4-page pre-enrollment coverage document sent outlining benefits and exclusions
- 60-Day Notice in Advance of Material Modifications
- **Mandatory:** Form W-2 Reporting of Value of Benefits (for W-2 issued in January 2013 with respect to 2012)

Health Reform Implementation Timeline

January 1, 2013

- Medicare Tax Increase for High Earners
- No Deduction for Retiree Drug Subsidy
- Cap on Salary Reduction Health FSA Contributions (\$2,500 limit)
- Comparative Effectiveness Fee (policy years ending after November 30, 2012)

March 1, 2013

- Employer Notification Regarding Exchanges

Health Reform Implementation Timeline

January 1, 2014

- State-based exchanges
- No preexisting condition exclusions
- Employer certification of coverage
- Employer notification regarding exchanges
- Individual mandate
- No annual limits
- Required coverage for clinical trials for life-threatening diseases
- 90-day limit on waiting periods
- Retiree reinsurance program ends

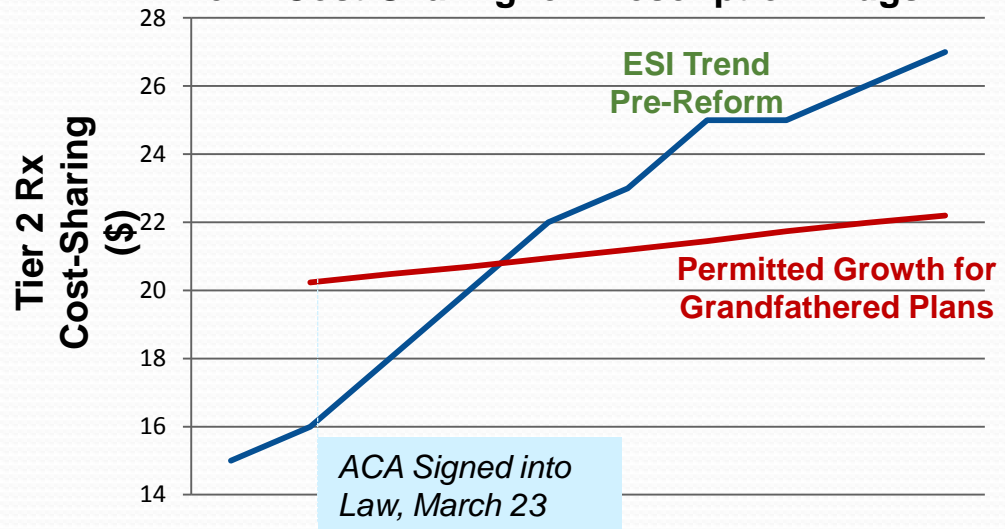
To Maintain Grandfathered Status, Employer Plans Must Deviate from Current Cost-Shifting Trend

- In recent years, employer plans have shifted costs to employees
- However, in order to maintain grandfathered status, employer plans must limit increases in cost-sharing
 - » Permitted increases in cost-sharing are tied to medical inflation
 - » Co-insurance percentages cannot increase

To Maintain Grandfathered Status, Employer Plans Must Deviate from Current Cost-Shifting Trend

Grandfathered status exempts plans from some requirements in the ACA. However, CMS projects that 39-69 percent of all existing employer plans will lose grandfathered status by 2013.

Sample Impact of Grandfather Rules on Tier 2 Cost-Sharing for Prescription Drugs



ESI = Employer-Sponsored Insurance

Sample cost-sharing scenario based on actual average Tier 2 cost-sharing for employer sponsored coverage from 2000-2009 as reported by the KFF and HRET 2009 employer health benefits survey. Grandfathered plan limits based on historical medical inflation for 2001-2009.



Employer Coverage Mandate & Auto-Enrollment Requirements - 2014

Provision	Details	Impact
Employer Mandate	<ul style="list-style-type: none"> ▪ Sets penalties, effective December 31, 2013, as follows: <ul style="list-style-type: none"> » For employers that offer coverage, fee will be lesser of \$3,000/employee receiving tax credit or \$2,000/full-time worker » For employers that do not offer coverage, fee will be \$2,000/full-time worker » For purposes of calculating total penalty, number of full-time employees is reduced by 30 	<ul style="list-style-type: none"> ▪ Could face new fees if low-wage workers receive tax credits via the exchange
Auto-Enrollment	<ul style="list-style-type: none"> ▪ Requires employers with 200 employees or more to auto-enroll employees in employer coverage, but allows employees to opt out if they can show proof of other coverage 	<ul style="list-style-type: none"> ▪ New procedural requirement

Employer Mandate Penalties By Who Does/Does Not Offer Coverage – 2014

If at least one employee purchases health insurance through an exchange with a subsidy, the employer must pay:	
For a 50+ employer that <u>does not</u> offer coverage	<ul style="list-style-type: none">▪ A penalty (non-deductible) each month equal to the number of full-time employees over a 30-employee threshold during the month multiplied by one-twelfth of \$2,000 (the amount will be indexed to premium cost growth)▪ For example, an employer with 50 FTEs that does not offer coverage for an entire year and that employs one or more employees who buys coverage through an exchange with the help of a subsidy will owe the IRS: (50-30) times \$2000, or \$40,000
For a 50+ employer that <u>does</u> offer coverage	<ul style="list-style-type: none">▪ The lesser of:<ul style="list-style-type: none">» \$2,000 per year times the number of FTEs minus 30, or» \$3,000 per year for each FTE who buys coverage through an exchange with a subsidy because the employer-offered coverage is unaffordable or unacceptable▪ For example, an employer with 50 FTEs that offers coverage that is unaffordable for 10 employees who then buy coverage through an exchange with a subsidy will owe the IRS \$30,000: the lesser of [(50-30) times \$2000] and [10 times \$3000]

Employer Mandate – Additional Details

- Non-profit organizations are not exempt from the employer mandate
- An employer is not required to pay a penalty for any employees enrolled in Medicaid
- There is no mandate to cover part-time employees or penalty for not offering them coverage
- The Secretary of HHS and the Secretary of Labor will issue regulations and guidance on details of implementation and interstitial issues, such as how to treat employees with more than one 30 hour per week job

Annual Reporting of Employee Benefits - 2014

Provision	Details	Impact
Annual Reporting Requirement	<ul style="list-style-type: none">▪ Effective 2014, requires employers of 50 or more FTEs to file an information return (in a form to be established by the Secretary of the Treasury) containing:<ul style="list-style-type: none">» Employer's name and ID number» Certification as to whether employer offers to its FTEs an opportunity to enroll in employer-sponsored plan» The number of FTEs for each month during the calendar year» The name, address, and TIN of each FTE during the calendar year and the months during which such employee was covered▪ Requires employer to provide a written report to each employee listed in the report▪ Report due to employee by January 31 of the year following the year for which the return is required to be submitted	<ul style="list-style-type: none">▪ New reporting requirement

Self-funded Plans Have Somewhat More Flexibility in Terms of Plan Design

Provision	Employer Plans		
	Fully Insured 1-100	Fully Insured 100+	Self-funded
Requires modified community rating allowing insurers to vary premiums only under limited circumstances	✓	✓	
Prohibits individual and group plans from placing annual limits on the dollar value of coverage	✓	✓	✓
Prohibits pre-existing condition exclusions for children under 19 years old	✓	✓	✓
Prohibits individual and group health plans from placing lifetime limits on the dollar value of coverage	✓	✓	✓
Prior to 2014, allows plans to only impose annual limits on the dollar value of coverage as determined by the Secretary	✓	✓	✓
Requires all plans to issue coverage to those seeking it, regardless of pre-existing conditions	✓	✓	✓

Self-funded Plans Are Exempt from MLR Requirements Effective in 2011

Provision	Fully Insured	Self-funded
Requires all plans, excluding self-insured, to report the proportion of premium dollars spent on non-claims costs	✓	
Requires 85% MLR in large group market and 80% MLR in the small group and non-group market	✓	
Requires plans to give rebates to enrollees for the amount in which the proportion of premium dollars spent on claims costs (minus reimbursement for clinical services; activities that improve quality; and, other non-claims cost) is less than 85% for group plans and 80% for small group and individual plans	✓	

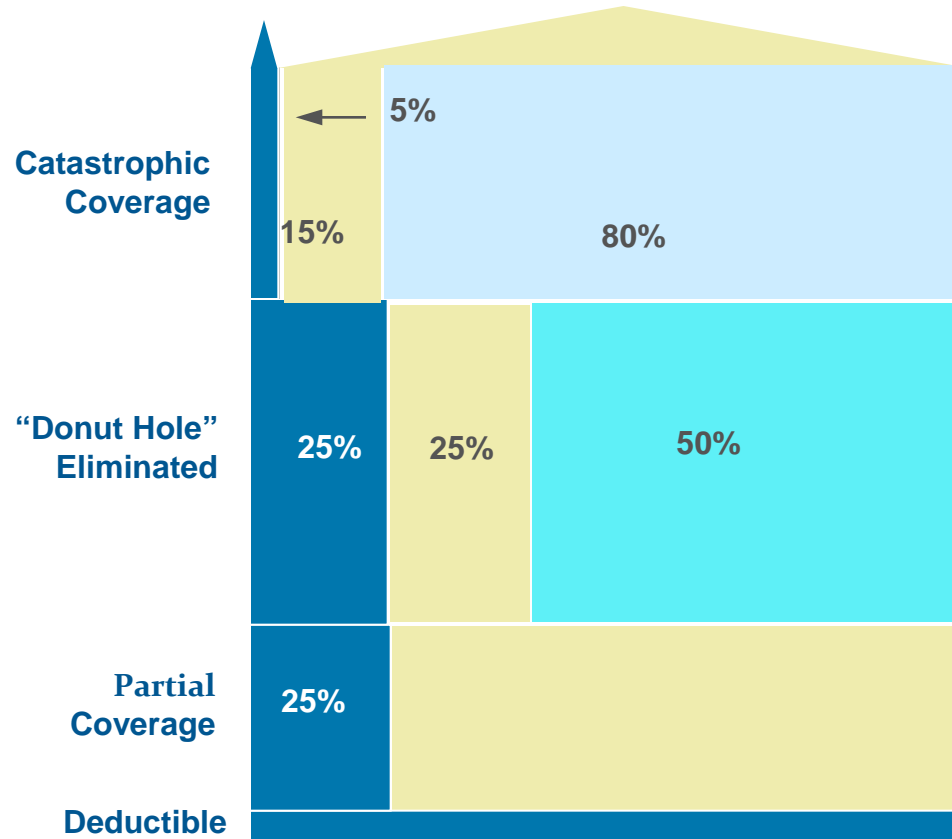
The NAIC delivered its recommendations to HHS Secretary Sebelius on October 21, 2010. Secretary Sebelius said, “The next step is for the Department of Health and Human Services to issue a medical loss ratio regulation that will provide clear guidance to stakeholders in the coming weeks. We will work quickly to promulgate this regulation, using the NAIC recommendations as a basis.”

MLR = medical loss ratio
 NAIC = National Association of Insurance Commissioners
 HHS = The Department of Health and Human Services

Excise Tax on High-Cost Health Care Plans - 2018

Provision	Details	Impact
Tax on High Cost Health Plans	<ul style="list-style-type: none">■ Imposes an excise tax on employer health insurance plans that offer policies with generous levels of coverage<ul style="list-style-type: none">» The tax would be levied on group health insurance plans as well as plan administrators for self-insured companies■ Tax is equal to 40% of the plan's value that exceeds \$10,200 for an individual and \$27,000 for family coverage, beginning in 2018<ul style="list-style-type: none">» For example, if a given plan is worth \$15,000 for an individual in 2018, the difference between the plan cost (\$15,000) and the threshold amount (\$10,200) is \$4,800» The insurer would pay a tax equal to 40 percent of the difference, or \$1,920■ Threshold will increase beginning in 2019 by the cost-of-living adjustment plus 1%■ Imposes a penalty for employers that under-report excise tax liability to insurers<ul style="list-style-type: none">» The penalty is equal to the difference between the actual and reported liability amount, plus interest from the date the tax was due to the date paid by the employer	<ul style="list-style-type: none">■ May want to reduce coverage below taxable thresholds beginning in 2018

Areas of Focus: Medicare Part D by 2020



Beneficiary Cost-Share
 Plan
 Manufacturer Discount
 Government Payment



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