Broader Perspective. Business Solutions.

How Compliant is Your Organization? PPACA Updates and Our New Normal.

Presented by:

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Agenda

- A Brief History
- Employer Shared Responsibility Review
- Determining Full Time Status
- Next Steps
- Questions

The Elements of Reform

Patient Protection and Affordable Care Act (PPACA) & Education Reconciliation Act – a Refresher

- Passed March 23, 2010
- First piece of social legislation strictly to be passed along party lines.
- Bill is over 900 pages in length and is actually 2 pieces of legislation.
- First change requirements of legislation took place for all non grandfathered plans with plan years beginning 6 months following signing of bill (September 23, 2010).
- The Act makes many changes and enhancements to coverage. It allows the health insurance carriers to pass along the increases associated with the increased coverage levels to employers and/or individuals.
- This legislations recently withstood the purview of the Supreme Court (7/2012) which ruled the majority of the bills constitutional. There were some revisions to Medicare.

The 2012 Presidential Election is Over…

- ACA is moving forward
- Rumblings on Capitol Hill post election that there may/will be revision(s) to law.
- Those revisions stem mostly in the Medicare provider payment reductions – not employer penalties and fines.
- President Obama and Democrats did take note that many of the provisions of the law – post implementation – will not get desired results (medical device tax example).
- Recent "Fiscal Cliff" issues with the deferring of raising the debt ceiling and bringing spending under budget sheds concerns on some elements of this reform.
- HHS/DOL/IRS release updated interpretations regularly.

Today 2013 – Unhappy States

- Budget deficits
- Medicaid changes/increased costs to states
- New mandates
- Tight timeframes (i.e., with the state-based exchanges – 17 states have done nothing)
- Lack of timely guidance/regulations
- Refusal of a good number to take ACA funds or implement programs
- Extreme variations in state political climates
- Since the SCOTUS ruling, several states are deciding not to accept the new Medicaid levels.

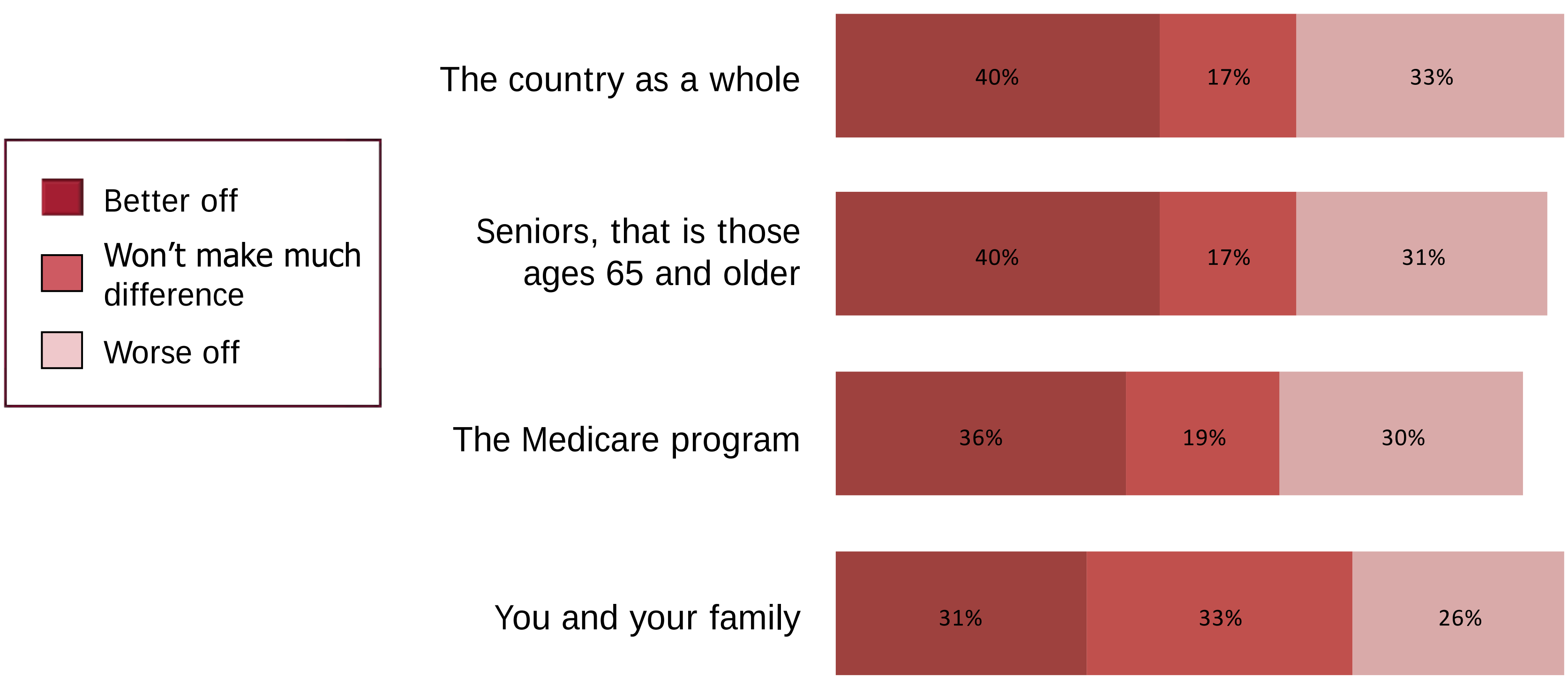
Health and Human Services - HHS

- Department of the US Government responsible for enacting much of this law under the current administration.
- The IRS has partnered with HHS to float trial balloons as it relates to taxation issues of some benefits – 105(h) rules, potential revised definition of full time employee.
- Over 200 additional personnel have been added to this department in the last 23 months.
- Many of the provisions have been delayed due to the huge undertaking of implementing this complete bill.

Public Opinion

Country Divided on Whether ACA Will Help or Hurt

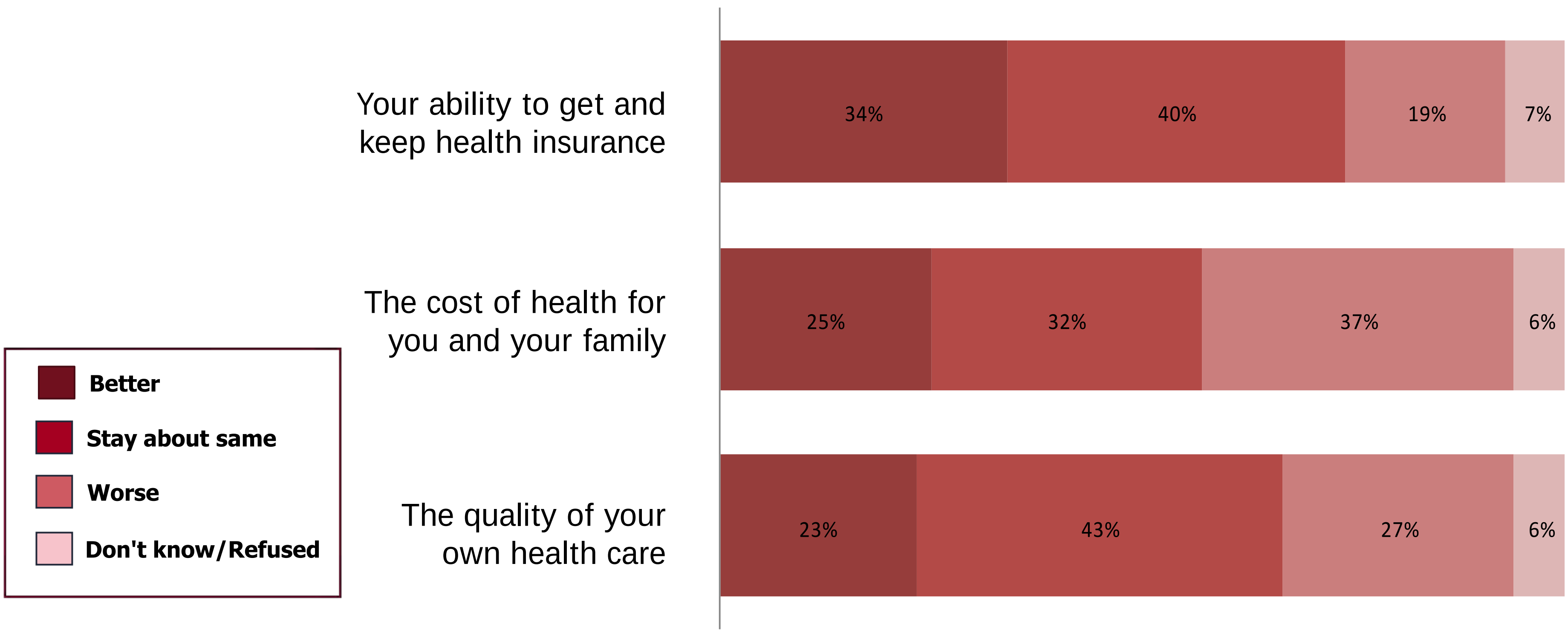
Do you think each of the following will be better off or worse off under the health reform law, or don't you think it will make much difference?



Note: Don't know/Refused answers not shown.
Source: Kaiser Family Foundation *Health Tracking Poll* (conducted September 13-19, 2012)

Impact on Quality, Cost, Access to Coverage

➔ Under the new health reform law, do you think each of the following will get better, worse or will stay about the same?



Source: Kaiser Family Foundation *Health Tracking Poll* (conducted April 9-14, 2010)

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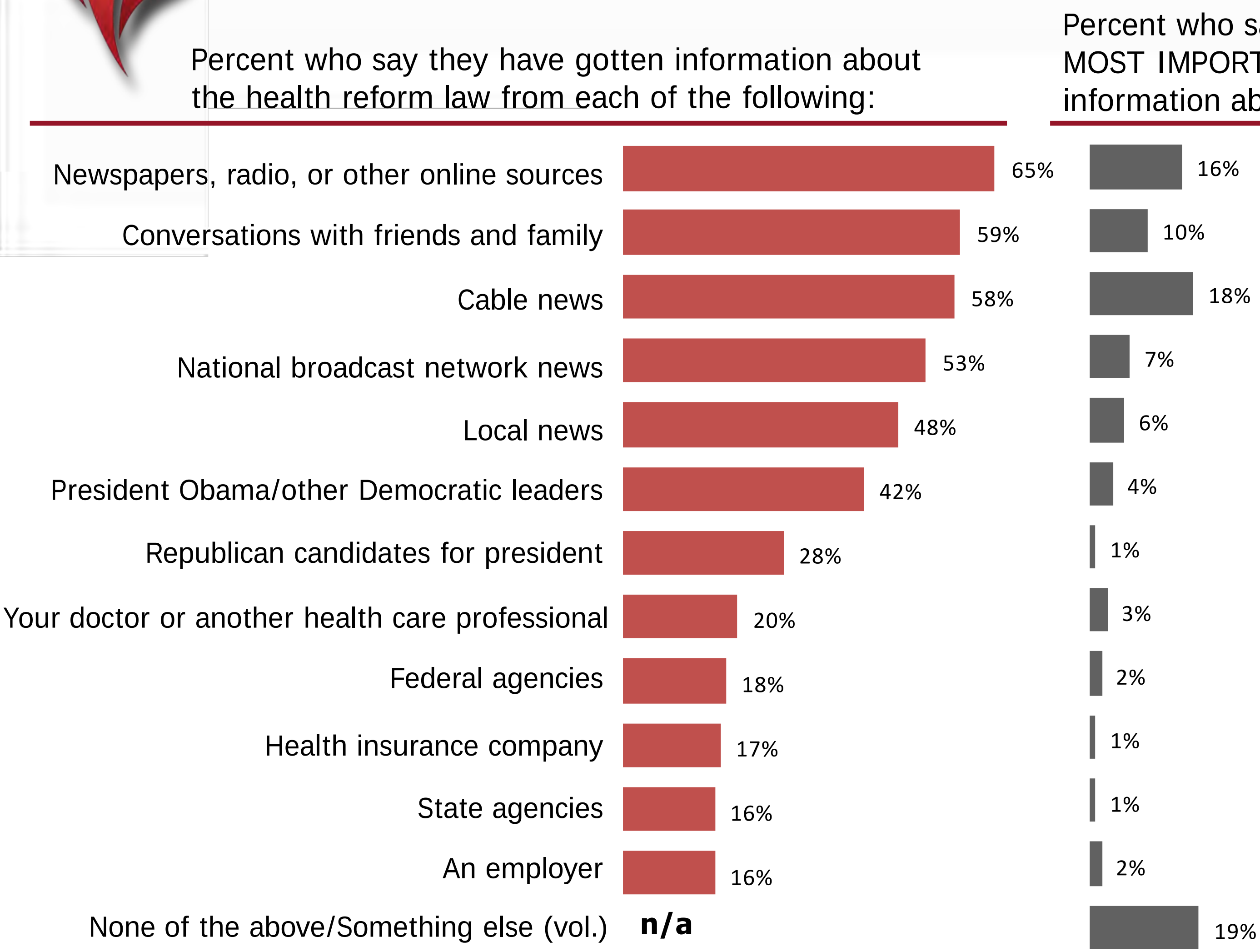
Americans Learning About the Law from a Variety of Sources



Source: Kaiser Family Foundation *Health Tracking Poll* (conducted December 8-13, 2011)

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The “Scary Slide”

HCR – What's Happening When

Effective 2012

- ➔ W2 reporting for employers that produce over 250 W2's the report the aggregate cost of employer health coverage. All size companies must comply in 2014.
- ➔ Summary of Benefits and Coverage notice must be given to employees for plans that renew on or after September 23, 2012. This 4 page document has very specific content. Insurance companies will produce this for fully insured clients. Self funded companies are responsible for producing this document.
- ➔ Plans must pay a $1/ee fee for patient-centered outcomes research trust fund fee. Insurance companies will handle this for fully insured programs.

Effective 2013

- ➔ Health FSA limits will be reduced to $2500.
- ➔ The employee portion of the hospital insurance tax parts of FICA will increase .9% for wages that exceed $200,000. ($250,000 for couples married filing jointly).
- ➔ The deduction for Part D Medicare subsidy to employers will no longer be in effect.
- ➔ Employers must provide employees with notification of insurance exchange options and the potential eligibility of premium credits.

Effective 2014

- ➔ With plan years beginning 2014, employers will be mandated to automatically enroll all employees in the company-sponsored health plan if over 200 full time employees. Employees must ask to be dis-enrolled.
- ➔ Penalty of $2000 per employee per year for employers over 50+ full-time employees that do not offer health insurance coverage – example to follow.
- ➔ Penalty of $3000 per employee that enrolls in a program through the Insurance Exchange.
- ➔ Small adjustments to plans prior to 2014 must be made – "essential benefit adjustment".
- ➔ Employers must file an annual return with the Federal Government that certifies whether full time employees have the opportunity to enroll in minimum essential coverage.
- ➔ Waiting periods of coverage can be no longer than 90 days.
- ➔ Pre-existing condition exclusions will be eliminated.
- ➔ Annual deductibles cannot exceed $2,000 for single coverage and $4,000 for family coverage.
- ➔ Out of pocket maximums cannot exceed those applicable to health savings accounts in 2014 (today those limits are $6050/$12100).
- ➔ Plans can no longer impose annual limits on the dollar value of essential benefits.
- ➔ Wellness rewards cannot exceed 30% of the cost of employee only coverage.
- ➔ Transitional reinsurance fee paid by health insurance carriers or third party administrators to HHS in order to cover high risk individuals in the individual market.

Updated 1-13-13

New Taxes and Fees

First Element – New Taxes and Fees

Effective 2010

- Annual tanning tax – applied to indoor tanning service businesses. 10% tax

Effective 2011

- Pharmaceutical industry fee
- Excise tax for non qualified HSA withdrawals increased from 10% to 20%

First Element – New Taxes and Fees

Effective 2014

- Medical device manufacturer fee – excise tax of 2.3% on any sale of taxable medical device. The House has currently passed a repeal of this tax. Senate refuses to hear.
- **Potential Impact** - tax is on gross sales. Will put many smaller device manufacturers out of business or move business outside of US. Will reduce advancements in this industry.
- Medicare payroll tax increased from 1.45% to 2.35% for filers earning above $200,000 individually, $250,000 married filing jointly or $125,000 married filing separately.
- Annual insurer fee – this cost passed onto employers who do not cover full time employees under a health plan.
- **Potential Impact** – reviewed later in presentation. Projections are an increase in fee income of $60.1 B to government.

First Element – New Taxes and Fees

Effective 2018

- Annual high cost insurance tax – referred to as "Cadillac Tax". Will be assessed against healthplans that offer coverage that exceeds a certain cost.

- **Potential Impact** – insurance carriers will not offer rich benefit plans that exceed the limits. Will reduce an employer's ability to design health plans that they want to offer. Anticipate rich plans coming off the market in 2014-2015.

Patient Centered Outcomes Research Fee - PCORI

- **Effective:** Applies to plan and policy years ending on or after October 1, 2012
- Who pays? Insurer or plan sponsor, depending on whether fully insured or self-funded
- Applies to covered lives (include dependents)
- How much?
  - $1 per covered life for 2012
  - $2 per covered life for 2013
- **Action Item:** For self-insured calendar year plans, payment on IRS Form 720, due 7/31/13

Transitional Reinsurance Fee

- **Effective:** January 1, 2014
- Who pays? Insurer or plan sponsor, depending on whether fully insured or self-funded
- What is it? A fee to offset a portion of the high cost medical claims that arise in the individual market in the first three years of the mandate's operation.
- Applies to covered lives (includes dependents)
- How much? – Good Question
  - HHS estimates that the transitional reinsurance fee will be $5.25 PMPM (or approximately $63.00 annually)
- **Action Item:** For self-insured calendar year plans, payment to HHS (form to be determined) by January 15 for calendar years 2014, 2015, 2016.

Individual Mandate

Second Element – Individual Mandate

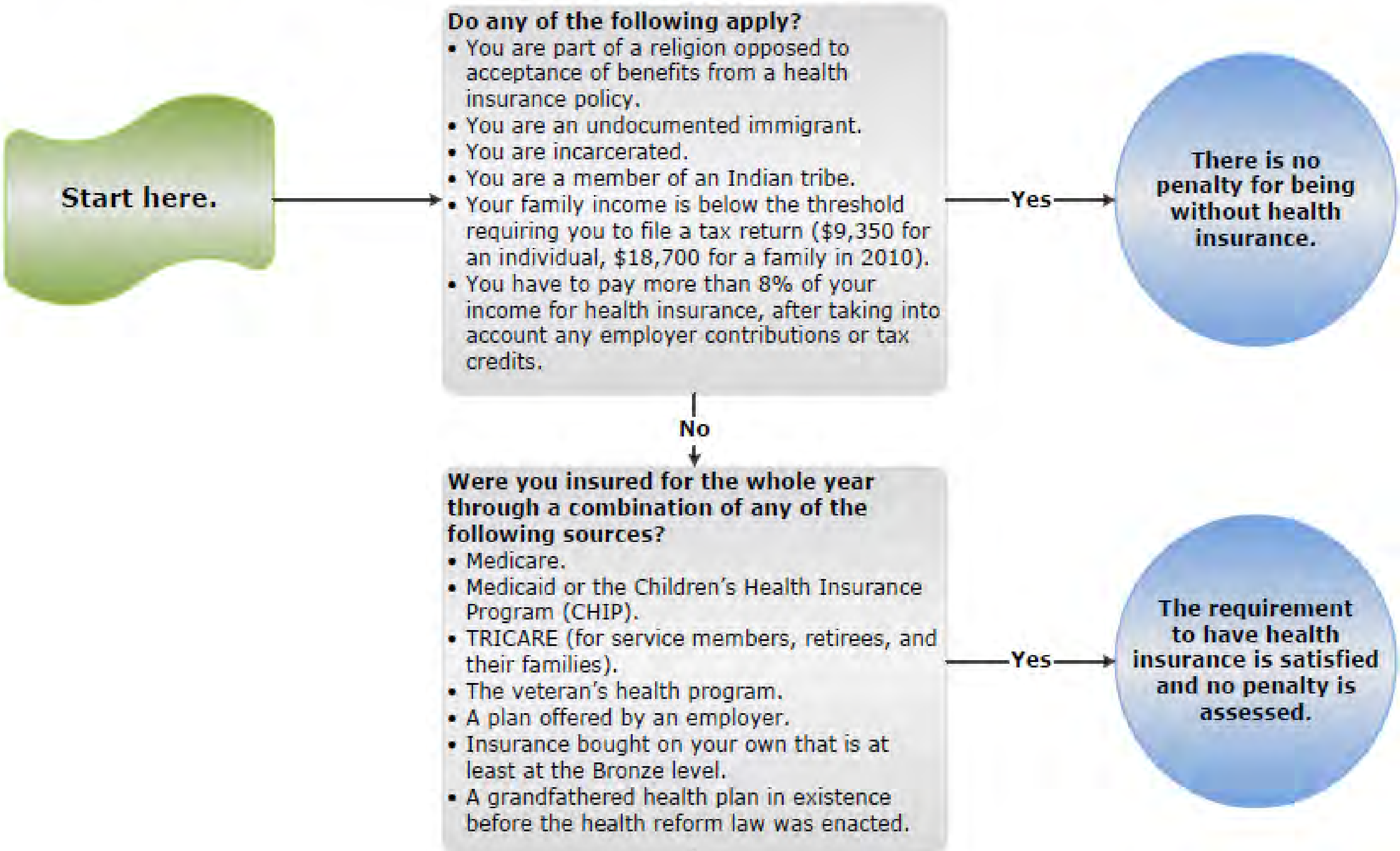
- **Effective 1/1/14**, individuals (US Citizens and legal residents) must have “minimum essential coverage” for themselves and their dependents or pay a penalty (some exceptions apply).

- The penalty is **the greater of**
  - $95 in 2014, $325 in 2015, and $695 in 2016 (capped at 3x the annual flat dollar amount per year) **or**
  - 1% of income for 2014, 2% for 2015, and 2.5% by 2016

- “Minimum essential coverage” includes
  - An eligible employer-sponsored plan
  - A grandfathered health plan
  - An individual health plan
  - Medicare Part A, Medicaid, or CHIP

Individual Mandate – a Flow Chart

The Requirement to Buy Coverage Under the Affordable Care Act Beginning in 2014



Individual Mandate – a Flow Chart

No

There is a penalty for being without health insurance.

2014	**2015**	**2016 and Beyond**
Penalty is $95 per adult and $47.50 per child (up to $285 for a family) or 1.0% of family income, whichever is greater.	Penalty is $325 per adult and $162.50 per child (up to $975 for a family) or 2.0% of family income, whichever is greater.	Penalty is $695 per adult and $347.50 per child (up to $2,085 for a family) or 2.5% of family income, whichever is greater.

The penalty is pro-rated by the number of months without coverage, though 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 Bronze level coverage in an Exchange. After 2016, penalty amounts are increased annually by the cost of living.

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healthreform.kff.org

Key Facts:

- **Premiums for health insurance bought through Exchanges would vary by age. The Congressional Budget Office estimates that the national average annual premium in an Exchange in 2016 would be $4,500-5,000 for an individual and $12,000-12,500 for a family for Bronze coverage (the lowest of the four tiers of coverage that will be available).**
- **In 2010 employees paid $899 on average towards the cost of individual coverage in an employer plan and $3,997 for a family of four.**
- **A Kaiser Family Foundation subsidy calculator illustrating premiums and tax credits for people in different circumstances is available at http://healthreform.kff.org/subsidycalculator.aspx.**

Employer Mandate
"Shared Responsibility"

Employer Mandates

Effective 2012

- W2 reporting for employers that produce over 250 W2's that report the aggregate cost of employer health coverage. All size companies must comply in 2014. **- DELAYED**

- Summary of Benefits and Coverage notice must be given to employees for plans that renew on or after September 23, 2012. This 4 page document has very specific content. Insurance companies will produce this for fully insured clients. Self funded companies are responsible for producing this document.

- Plans must pay a $1/ee fee for patient-centered outcomes research trust fund fee for 2012. It will be increased to $2/ee in 2013. Insurance companies will handle this for fully insured programs.

Employer Mandates –
a Word About the SBC's

"I need you to write a manual to interpret the brochure that we created to clarify the pamphlet that we printed to define the handout that we sent to explain the memo."

Employer Mandates – a Word About the SBC's

- **Effective:** Compliance periods begin on or after September 23, 2012
- Applies to grandfathered and non-grandfathered plans
- Applies to fully insured and self-funded plans
- Uniform Summary of Benefits and Coverage (SBC):
  - A standardized summary of medical benefits & coverage (4 pages, front and back)
  - Model forms available (http://www.dol.gov/ebsa/healthreform/)
- A uniform glossary of common terms also must be provided upon request
- **Fully Insured Plans**
  - Carriers will provide to employer
  - Carriers and employer responsible for distribution
- **Self Funded Plans**
  - Employer must draft (will take time and a budget)
  - Employer must distribute

Employer Mandates

Effective 2013

- Health FSA limits will be reduced to $2500 effective 1/1/2013.
- The employee portion of the hospital insurance tax parts of FICA will increase .9% for wages that exceed $200,000. ($250,000 for couples married filing jointly)
- The deduction for Part D Medicare subsidy to employers will no longer be in effect.
- Employers must provide employees with notification of insurance exchange options and the potential eligibility of premium credits – pending model notice.

Employer Mandates

Effective 2014

- Penalty of $2000 per employee per year for employers over 50+ full-time employees that do not offer health insurance coverage – example to follow.
- Employers must file an annual return with the Federal Government that certifies whether full time employees have the opportunity to enroll in minimum essential coverage.
- Penalty of $3000 per employee that qualifies and enrolls in a program through the Insurance Exchange.
- Small adjustments to plans prior to 2014 must be made – "essential benefit adjustment".

Employer Mandates

Effective 2014

- Waiting periods of coverage can be no longer than 90 days.
- Pre-existing condition exclusions will be eliminated.
- Annual deductibles cannot exceed $2,000 for single coverage and $4,000 for family coverage.
- Out of pocket maximums cannot exceed those applicable to health savings accounts in 2014 (today those limits are $6050/$12100).
- Plans can no longer impose annual limits on the dollar value of essential benefits.
- Wellness rewards cannot exceed 30% of the cost of employee only coverage.
- Transitional reinsurance fee paid by health insurance carriers or third party administrators to HHS in order to cover high risk individuals in the individual market.

Employer Mandates

Other things to know:

- Full time employees now will be 30 hours per week. Look back window has been favorably determined by the IRS to be allowed by employers. Employers can choose a 3, 6, 9 or 12 months look back window to determine whether or not an employee can be defined as full time.

- Employers **MAY** continue to discriminate in favor of highly compensated employees in either plan design or cost until 105(h) ruling has been decided upon. **Still pending with HHS.**

- Plans under 100 employees will be community rated.

- Carriers will be required to inform all clients of MLR – medical loss ratio effective in 2012 for 2011 plans. Carriers must report by June and Carriers must refund appropriate dollars – if any – by August. Carriers did refund millions of dollars in 2012 to plan sponsors and individual insureds.

A Word About MLR

- Paid each August
- Only applies to fully insured plans, not self-funded
- Insurers must report costs that exceed certain ratios beginning for calendar year 2011
  - 85% for large groups
  - 80% for small groups
- If costs exceed limits, insurers must rebate the difference
- If they are "plan assets," there are restrictions on how the rebates may be used
- **Action Item:** Employers need to plan how the rebates will be used or distributed

Employer Mandates

Pay or Play – Employer Shared Responsibility Rules Updated per IRS 12.28.12

- Employers must offer coverage to 95% of full time employees and dependents will meet coverage requirement of ACA.
- Term dependents refers only to employee’s children under the age of 26 and not spouses.
- Regulation establishes a transition period during 2013 for those employers that only offer coverage to employees and not dependents.
- Regulation offers relief to non-calendar year plans that are currently in place so that requirements are effective the first day of the plan year commencing after January 1, 2014.
- Allowing for a one time election change in cafeteria plans for employees opting exchange coverage in 2014.
- Clarification on controlled group rules for purposes of determining whether an employer is a large employer (over 50 full time equivalent employees)
- Language that allows employers to look at the pay or play mandate on a controlled group basis but penalties apply on a member-by-member basis.

Employer Mandates – Shared Responsibility Examples

Example Client #1 – Employees Qualifying for Subsidies and Being Covered Through Exchange Plan

120 person manufacturing firm

40 part time employees. 80 full time employees.

61 of the 80 are enrolled in the employer sponsored health plan. 19 are not covered for a variety of reasons.

Due to income and contribution calculation , 8 employees will qualify for vouchers. 4 employees become insured through the exchange.

Penalty = 4 X $3,000 = $12,000

Example Client #2 – Company Not Offering Health Care Coverage

200 person janitorial firm.

100 part time employees.

Employer does not offer a health insurance plan at all.

One employee qualifies for subsidy and becomes covered through Exchange plan.

Penalty = 100 - 30 = 70 X $2,000 = $140,000

Note – Part-time employees working less than 30 hours per week are excluded from calculations.

Employer Mandates – Shared Responsibility Examples

Example Client #3 –

Employees Qualifying for Subsidies and Being Covered Through Exchange Plan

Company has 43 full time employees and 20 part time employees.

Part time employees total annual hours are 12,480 hours.

Total hours equal 8 full time equivalent employees.

For ACA purposes – Company has 51 full time equivalent employees

Company is subject to fines under shared responsibility rules

Full Time? Part Time?

Determining Full Time Status

- IRS Notice 2012-58 Safe Harbor Approach
  - If an employee is not expected to work full-time when hired, employee's status will be determined by a look-back period.
  - Look –back period can be between 3 months to 12 months
  - Employers also permitted to use an administrative period of no more than 90 days which provides time to perform administrative functions such as distributing enrollment materials.
  - This calculation must be performed in 2013 to be effective in 2014.

Determining Full Time Status

3 periods of time that need to be addressed:

- **Measurement Period** – period of time used to determine 30 hrs per week. (3-12 months)
- **Stability Period** – period of time that employee is covered under the plan
- **Administrative Period** (no longer than 90 days)

If plan year is calendar year, all or most of 2013 will be used as a measurement period.

Determining Full Time Status

- If new employee hired without clear understanding of hours, then ee will not be offered benefits and for 3,6, or 12 months, and will be put into company measurement period.
- If new ee is determined to be 30 hrs per week, then new ee will be offered benefits under next stability period or end of waiting period.
- An administrative period can be applied to allow for time for enrollment, proper form distribution, etc. That period can be 90 days. However, if a client has a 12 month measurement period, they can only have a 30 day administrative period due to the fact that the ee must be offered coverage within 13 months of start date.

Determining Full Time Status – An Example

Employee Anna Smith

Working for ABC Upholstery, Inc. (plan year calendar year)

Start date 2/1/2014 – unsure about amount of hours.

Employer does not offer benefits but puts her in an initial measurement period. The company chooses a 12 month period.

After 12 months (1/31/15), it is determined that Ana is a 30 hr per week ee and must be offered benefits under the plan no later than 3/1/15 (12 months plus 1 month administrative period).

During the 2015 stability period for ABC Upholstery, Inc. it is determined that Ana is not averaging 30 hours per week.

At the end of the stability period, ABC Upholstery, Inc. no longer must offer coverage to Anna (12/31/2015)

Insurance Exchanges

Insurance Exchanges

- Requires States to establish insurance exchanges for individuals and small employers (SHOPS – Small Business Health Option Plans) .
- Government subsidies will be available for individuals up to 400% of poverty level based on sliding scale. Current poverty level is $10,830 single.
- These exchanges will operate like purchasing pools. Individuals that do not have group health coverage or qualify in some other way, will purchase insurance through this exchange.
- Each State will have their own exchange but plan designs will be the same across the country. 33 States currently setting up exchanges, 17 are not.
- There will be four to five plan designs available. A catastrophic plan and then 4 other plans that the legislation calls, Bronze, Silver, Gold and Platinum. The plans will have different costs based upon coverage.

Insurance Exchanges

- The ACA provides that individual and group health insurance markets are to exist outside of the exchanges.
- The law specifies that “grandfathered” plans will continue to exist outside the exchange.
- Other plans are also permitted to exist outside of the exchange, and from experience in Massachusetts and Utah some individuals and businesses will continue to purchase coverage there.
- Subsidies are currently only available through the public exchanges. Fixing that will literally require an "act of Congress".
- Many “private exchange” platforms are being developed. The idea of new “marketplaces” for the purchase of insurance could be a good thing for consumers.
- The exchanges will look different from State to State. The idea of similar programs across State lines appears to be a fleeting notion.
- Much more information about the exchanges and the plans will be forthcoming in the next year and must be disclosed to employees in 2013 (still pending guidance).

Covered California

- Name of the California exchange is "Covered California".
- It must be ready to accept enrollees in October 2013 for coverage beginning January 1, 2014.
- Plan designs have been released. Some nuances between individual plans and small business plans. HSA plan is available.
- Participating carriers are being currently selected.
- Pricing is unknown at this time – anticipated May 2013

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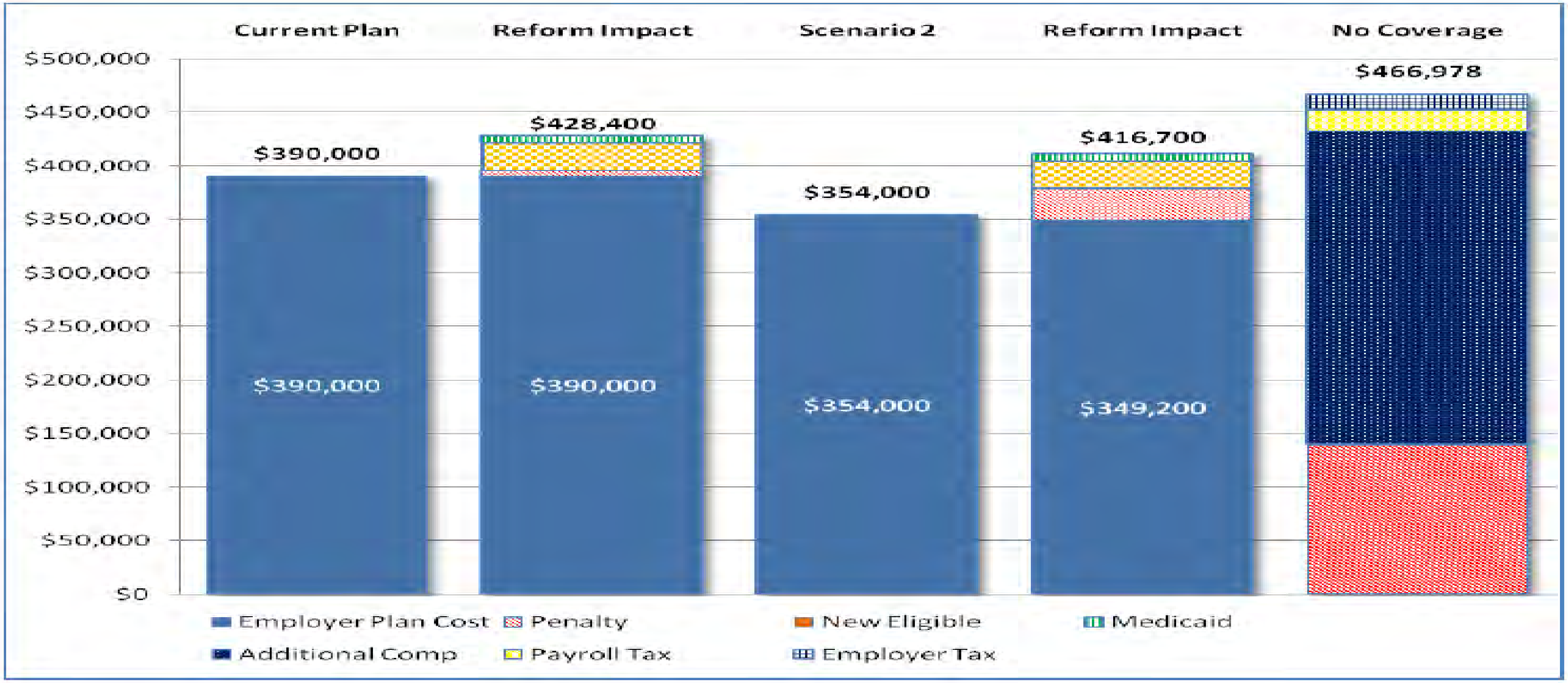
The Cost of the Exchange Plans

- Massachusetts "Connector" Plans – example below shows cost of a 47 years old with a family of 4. HMO Network type plans only.

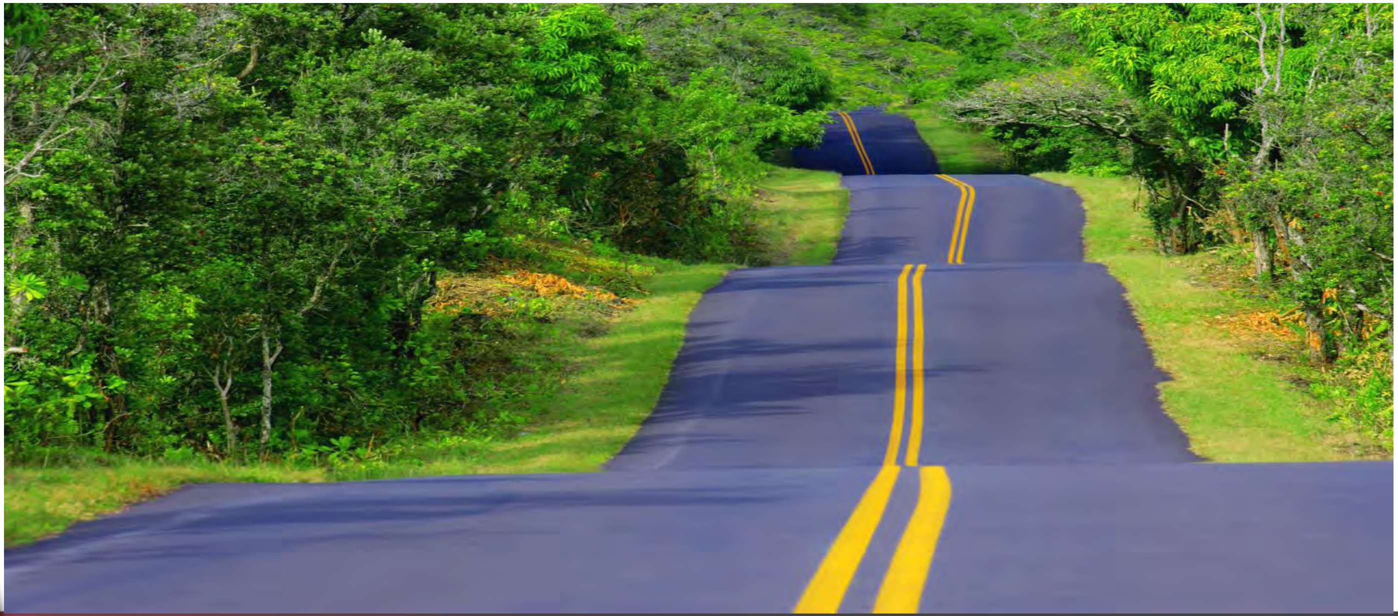
	Bronze	Silver	Gold
Deductible	$2,000/$4,000	$1,000/$2,000	$0
Coinsurance	80%	90%	100%
Out of Pocket Max	$5,000/$10,000	$2,000/$4,000	$0
Office Copay	Deductible, then $25	$20	$20/$30
RX Copay	Deductible, then $15/50%	$15/$30/$50	$15/$30/$50
Annual Cost	$13,324	$15,960	$26,316

Exchange Analytics

Section 4 - Employer Summary



Summary Table		
Current plans	Current Plans	Scenario 2
Employer cost midpoint estimate of Medicaid eligibles	$ 7,200	$ 7,500.00
Cost of newly eligible individuals	$ 25,200	$ 25,200.00
Cost impact of employer shared responsibility penalty	$ 6,000	$ 6,000.00
Employer Plan Cost	$ 390,000	$ 390,000
Cost Impact of Dropping Coverage		
Employer Penalty	$ 140,003	
Additional Compensation	$ 292,500	
Employer payroll tax on additional compensation	$ 20,475	
Tax impact of penalty not being tax deductible	$ 14,000	



Federal Reform – Issues on Horizon

Federal Reform…What Now?

- Review Your Compliance Issues
  - Determine who within the organization will be responsible for implementation
  - Coordinate with other departments (payroll, IT, CFO, legal)
  - Establish budget
  - Set timelines
  - Coordinate with outside vendors
  - Establish a communication strategy

Federal Reform…What Now?

- Prepare for W2 reporting (if not already mandated). Work with your payroll administrator to understand what reporting requirements you will need to provide so that this part of the law can be complied with.
- Begin looking at your workforce to determine full time status and impacted employees.
- Work with your healthcare consultant/broker to understand how the exchanges and penalties and fines could impact your business.
- Begin thinking about a strategy for your organization. Does it make sense to have your employees only purchase healthcare from an exchange program or will you continue to offer benefits in an attractive/cost effective way?
- Begin looking at alternative plan designs and financing opportunities for benefits.
- Be aware of market place changes and new plans and programs available.

Federal Reform…What Now?

- Department of Labor PPACA Resource Page (links to FAQs, regulations, and guidance):

http://www.dol.gov/ebsa/healthreform/

- The Center for Consumer Information and Insurance Oversight (within CMS): http://cciio.cms.gov/

- IRS: Affordable Care Act Tax Provisions:

http://www.irs.gov/newsroom/article/0,,id=220809,00.html?portlet=6

- Consumer Information on PPACA: www.healthcare.gov

- California Exchange: www.healthexchange.ca.gov

- Kaiser Family Foundation: www.kff.org

Questions