Agency Guidance Under PPACA and Implications for Employers

Tuesday, October 9, 2012
2:00 pm – 3:00 pm EST
Today’s Speakers

Joe DiBella
- Executive Vice President of the Health & Welfare Practice
- Conner Strong & Buckelew

Phyllis Saraceni
- Senior Vice President and Compliance & Audit Practice Leader
- Conner Strong & Buckelew
This is Conner Strong & Buckelew’s tenth installment in an ongoing series of webinars on key issues dealing with national healthcare reform. The focus of today’s webinar is on what employers still need to know about the various upcoming requirements, including:

- the employer “free rider”/pay-or-play assessment,
- exchange rules, FTE status, 90-day waiting period, and
- reporting, tax and disclosure requirements.

We will also introduce our Healthcare Reform Planner intended to help you determine next steps in plotting your response to the most up-to-date aspects of the law. This Planner will provide you with a framework to identify provisions of Healthcare Reform that will apply specifically to the future of your group health plan.
Healthcare Reform Continues
Future of Healthcare Reform
Continued Uncertainty

- Individual mandate upheld and implementation continues.
- Supreme Court decision did not help answer many outstanding issues surrounding law’s implementation.
- Many questions remain that must be resolved through rulemaking at federal level and through state legislative and regulatory action.
- Uncertain political, legal, regulatory, operational (state and federal) environment continues.
- Continued opportunities for some significant re-thinking of the law in a number of areas.

**Participant Question:**

*Do these changes pertain to Public Sector Agencies?*

Yes. The mandates apply to the group health plans of state and local government employers (and health insurance coverage offered in connection with such plans).
Future of Healthcare Reform
Congressional Action and 2012 Election

- Democrats want law as-is
- Republicans want repeal and replace
- Post-November changes possible?
  - Obama White House and split Congress?
    > Democratic priorities – implementation proceeds; strict or more relaxed approach to implementation, penalties?
    > Republican priorities – push for repeal, defunding, and delay; compromise on cost, coverage and timeline
  - Romney White House and split Congress?
    > Democratic priorities – prevent repeal efforts, fight to maintain reforms, exchanges
    > Republican priorities –repeal efforts, compromises on reforms and timeline
  - Republican sweep?
    > full repeal effort, some popular provisions remain, replacement unclear
States determining pace of implementation. The establishment of “exchanges” is central to expansion of health insurance under law. If law survives the November elections, pressure will be on Administration to delay implementation deadlines.

- Exchanges must be operational by mid-2013 for 2014 open enrollment.
- States to decide whether to establish exchanges or allow “federally-facilitated” exchanges to operate in state.
- Minority of states have taken action to create exchanges; remainder are not in a position to get their exchanges up and running on schedule.
- States face a November 16 deadline to show they can do it, or federal government steps in and takes on job itself.
- HHS has issued guidance regarding federally-facilitated exchanges and discussing federal-state “partnerships,” in an effort to get lagging states on board.
Participant Question:

What is the status of the health insurance exchanges in New Jersey and Connecticut?

New Jersey has not passed legislation to build an Exchange. The state has until November 16 to notify the federal government that it plans to build one - if it wants to obtain funding for it. Governor Christie is likely to wait until after the election to signal his position.

Connecticut established the Connecticut Health Insurance Exchange on July 1, 2011, and legislation altering the composition of the Exchange Board passed in June 2012. The Board has recommended Connecticut should limit the definition of small employers to groups of 50 or fewer employees until it is required to expand the definition to groups of 100 or fewer employees in 2016.
Up to 17 million Americans were expected to gain Medicaid coverage under new law, but now that may fall short. If state opts out of the proposed Medicaid expansion, this may leave some of state’s poorest residents without any way to get coverage in 2014.

- Medicaid expansion was the one part of the law that changed significantly with U.S. Supreme Court ruling. The Justices said states can refuse to expand Medicaid to all low-income adults without losing all federal funding for existing Medicaid programs.
- States in process of deciding whether to expand Medicaid eligibility in 2014 to 133% of federal poverty line (FPL) or “opt-out”.
- States that opt in get federal funding covering 100% of costs for first 3 years (90% thereafter).
- States that choose to can expand their Medicaid programs to legal residents under age 65 earning less than $15,302 for an individual and $31,155 for a family of four.
- If a state decides against expansion, very low income residents will have no option to get insurance (if their household income is less than FPL, they cannot get a discount to buy into e exchange), resulting in more uncompensated care than anticipated and continued shifting of costs to those who have coverage.
Still uncertain how health industry will respond

As 32 million previously uninsured people are covered in 2014, expect a deluge of physician visits and long waits for primary care services for your employees

Expect steep rise in emergency room visits as demand outstrips primary care capacity

Employer plan cost pressures will grow

Exchanges and Medicaid expansion will increase provider pressure to shift revenues to private payers

Accounting Care Organizations (ACOs) will increase provider consolidation and potential contracting leverage
Beginning in 2014, a number of prominent healthcare law provisions take effect, including launch of state and federal exchanges, which may impact employer benefit strategies and purchasing decisions.

Employers need to understand the mechanics of the exchanges and individual mandate in order to prepare for decisions regarding “pay or play”. Consider employee options:

- Individual Exchange – resident of state where exchange is based
- Small Business Health Options (SHOP) Program – small business state options
- Private Exchanges – free market for plans to target employers that are interested in defined contribution for their employees
The law does not require employers to offer health insurance to employees.

- Businesses with 50 or more employees that do not offer coverage, or that offer insurance that is too expensive or does not meet minimum standards, may have to pay penalties.

- Only a small percentage of businesses face these potential fines. More than 96% of the nation’s businesses with 50 or more employees already offer health insurance to their workers.

- Companies with fewer than 50 employees won’t face any penalties for not offering coverage to employees.

- These small employers represent about 75% of businesses in the US and employ nearly 34 million people. If a company doesn't offer insurance, its employees can buy insurance on the exchange.
Participant Question:

How beneficial would it be for companies to drop benefits and just pay the penalties?

- McKinsey & Company projects that up to 30% of employers likely will eliminate their employer-sponsored insurance once the state exchanges are in place.

- It's certain that some percentage of employers will drop their group coverage (many in the small employer market).

- While opinions vary wildly on the actual impact, there is no question that in 2014 the law will change the rules, the incentives and the options facing employers.
Healthcare Reform Planner for Employer Group Health Plans
The following Healthcare Reform Planner is intended to be used by employers currently offering group health plan coverage. This Planner provides a framework to identify provisions of Healthcare Reform that will apply specifically to the future of the group health plan. It is intended to help an employer/sponsor determine next steps in plotting its response to the most up-to-date aspects of the law.
Entire healthcare reform law stands as originally passed and changes sponsors have made or are making continue.

- **2011 – Mandates (effective first plan year beginning on or after 9/23/10)**
  - Dependent to age 26
  - Preventive care
  - Annual/lifetime limits
  - Child pre-existing condition

- **2011 – FSAs limit for over-the-counter (OTC) medications**

**Action Taken □  Needs Follow-Up □**
2012 - 2013 Provisions

- 2012 – Medical Loss Ratio (MLR) rebate rules for insured plans
- 2012/2013 – W-2 reporting on value of health coverage
- 2012/2013 – Summary of Benefits and Coverage
- 2012/2013 – Women’s preventive care requirements under non grandfathered plans, including certain contraceptives
- 2013 – FSA contributions limited to $2,500/year

Action Taken □  Needs Follow-Up □
2013 Provisions

- 2013 – Patient Centered Outcomes Research fees (for plan years ending before 10/1/13, pay the fee once each year, by 7/31, for the prior year)
- 2013 - Taxation of Retiree Drug Subsidy (RDS) begins
- 2013 - Reporting/disclosure requirements, including notice to employees regarding Exchange coverage and premium tax credit eligibility

**Action Taken □** **Needs Follow-Up □**

Still waiting on guidance on many upcoming reforms including certain notice requirements, auto enrollment, definition of essential benefits, pay or play, exchanges, etc. Guidance also expected in the coming years on delayed rules (nondiscrimination for insured health benefits, certain claims/appeals standards),
By 2014, individuals will have opportunity to buy insurance via health care exchanges operated by States or federal government.

- Exchanges are set to open initially to individuals and small employers with 100 or fewer employees
  - State can opt to limit this to organizations with 50 or fewer employees
  - In 2017, states have the option to expand the exchange to larger employers
- Exchanges must be operational by mid-2013 for 2014 open enrollment (open enrollment is set to begin 10/1/13).
- Pressure will be on Administration to delay implementation deadlines.

*Employers will likely need to supply information to help exchanges determine an employee’s eligibility for federal financial assistance to buy exchange coverage.*
Low and Middle Income Employees

Low to moderately paid employees with incomes above 133% and below 400% of federal poverty level (FPL) may be eligible for subsidized exchange coverage, if:

- Employer plan covers less than 60% of expected plan costs or they must contribute more than 9.5% of their incomes for it

<table>
<thead>
<tr>
<th>Health insurance financing</th>
<th>Single person annual income</th>
<th>Family of four annual income</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid health coverage, if your state decides to offer it</td>
<td>Up to $15,302</td>
<td>Up to $31,155</td>
</tr>
<tr>
<td>Help to pay premium, if buy in state’s exchange</td>
<td>Between $11,505–$46,021</td>
<td>Between $23,425–$93,700</td>
</tr>
<tr>
<td>Subsidies for out-of-pocket costs, if buy in state’s exchange</td>
<td>Up to $28,763</td>
<td>Up to $58,562</td>
</tr>
</tbody>
</table>
To be eligible for exchange coverage, individuals must be lawfully in the US, reside in state where the exchange operates, and generally cannot be incarcerated.

Individuals generally may enroll in exchange coverage even if they are eligible for coverage from other sources, such as employer coverage offered outside of an exchange.

Anyone eligible for Medicaid or the Children’s Health Insurance Program (CHIP) will be enrolled in that coverage rather than exchange coverage.

- Likely low wage employees with incomes below 133% of federal poverty level
Effective in 2014, most people will be required to obtain health insurance coverage or pay a fine if they don't.

Some people are exempt from the mandate tax, including those who:

- have insurance through an employer or purchase individual insurance.
- have insurance through Medicare, Medicaid, Children’s Health Insurance Program (CHIP), Veteran’s Administration and/or Tricare for active duty and retired military, Indian Health Services, or a health-care sharing ministry.
- have to spend more than 8% of household income on the cheapest qualifying health insurance plan, even after tax credits and subsidies.
- have income falling below the threshold for filing federal income tax.
- live outside of the U.S.
The fine (tax) would likely concern only about 7.3 million Americans, or 2% of the population. Most Americans either already have insurance, are exempt under the law, would qualify for Medicaid, or would use tax credits to buy policies in the exchanges.

In 2014, people who can afford to but do not purchase health insurance will pay a tax penalty.

- In 2014, tax starts at $95/yr for an individual, or up to 1% of income, whichever is greater. For family, tax is capped at $285 in 2014.
- By 2016, tax rises to $695/yr for an individual, or 2.5% of income, whichever is greater, and rises to $2,085 for family, or 2.5% of income.

IRS will collect the penalty via tax returns. In 2014, federal returns will include a new form to list source of health insurance.
Employers should prepare for alternatives to employer plan offerings that will be available to your employees and other plan participants.

Specific populations in your plans may prefer exchange coverage (especially if they qualify for a subsidy):

- Spouses/other dependents
- Early Retirees
- COBRA-eligible individuals
- Contract/temp/part-time employees

Some of your FTEs will be comparing your coverage to exchange coverage options:

- Young employees 30 and under
- Other employees
Participant Question:

What impact will it have on the State Health Benefits plan? I am interested in reporting, disclosure and notice requirements since our employee health plan coverage is provided by the State of NJ.

The rules apply to governmental (federal, state or local) employers, whether or not they offer health coverage to employees.

- Shared-responsibility obligations come with related reporting and disclosure requirements for all employers (including governmental agencies).
  - Beginning 3/1/13, employers must give new hires written information on health insurance exchanges and how to access information about premium credits and cost-sharing subsidies for exchange coverage.
  - In 2014, employers must notify employees about whether the plan meets minimum coverage requirements.
  - And employers must report plan specifics to HHS (length of waiting period, FTE certification, period and premium for coverage, employer’s share of cost of coverage).
Key term is “essential health benefits” (EHB)

Required EHBs include: (1) ambulatory patient services, (2) emergency services, (3) hospitalization, (4) maternity and newborn care, (5) mental health and substance use disorder services, including behavioral health treatment, (6) prescription drugs, (7) rehabilitative and habilitative services and devices, (8) laboratory services, (9) preventive and wellness services and chronic disease management, and (10) pediatric services, including oral and vision care.

Non-grandfathered individual and small group plans (inside and outside Exchanges) must cover EHBs beginning in 2014

Participant Question:

How are self funded employers affected by reform?

• Self funded employer is group health plan subject to the rules.
• No lifetime dollar limits on EHB (if covered) for plan years beginning on or after 9/23/2010
• Self-insured plans do not have to cover EHBs but if covered, must phase out annual dollar limits on EHB by plan years beginning on or after 1/1/2014
Prepare for “Free Rider”/Pay or Play Assessment

- Larger employers (over 50 FTEs) that don't offer coverage or offer “substandard” coverage face penalties if their workers get subsidized coverage through the exchange. "Substandard" coverage - a policy that doesn't cover at least 60% of an employee's total medical costs or whose premiums cost more than 9.5% of the worker's income.
  - Determine actuarial value of your plans (how much the plan is expected to pay in benefits for average population)
  - Estimate percentage of household income that your employees pay in contributions or safe harbor based on percentage of what you pay employees

- Assumes final regulations are issued
- Requires “exchange” be available
Participant Question:

Will the employer face a penalty for not offering affordable dependent coverage?

Open issue, but it appears regulators are of the view that –

- Applicable large employers must make qualifying minimum essential coverage available to FTEs and their dependents,
- BUT affordability will be based on self-only coverage.

Clarification on this issue is needed.
Small Employers

Are you a small employer sponsoring a group health plan? Yes □  No □

➢ If you answered “No” and you are a large employer then go on to the next slide.

➢ If you answered “Yes” then:

   ▪ In 2014, employers with generally fewer than 100 employees can shop in an Exchange.

   ▪ If you have up to 25 employees, pay average annual wages below $50,000, and provide health insurance, you may qualify for a small business tax credit of up to 35% (up to 25% for non-profits). Credit increases in 2014 (50%, 35% for non-profits).

   ▪ Employers with fewer than 50 employees are exempt from penalties (no assessment if employees get tax credits through an Exchange).

   ▪ If file fewer than 250 W-2s, will not be required to report the cost of health coverage on a W-2 until at least January 2014 (reporting date will be further extended provided no subsequent guidance is issued).
Large Employers

For larger employers sponsoring a group health plan:

- In 2014, employers with more than 100 employees cannot shop in an Exchange.
- Exchanges for small businesses and individuals are offered initially to individuals and small employers with 100 or fewer employees, unless the state opts to limit this to organizations with 50 or fewer employees.
- Beginning in 2017, states would have the option to expand the exchange to larger employers.
- Employers with 50 or more FTEs are subject to the shared responsibility penalties.
  - Employer must include FTEs and a full-time equivalent for employees who work part-time (add up all the hours of service in a month for employees who are not full-time and divide that aggregate number by 120). Add result to number of FTEs during month. If average number of employees for year is 50 or more, employer is applicable large employer (the 30 FTE reduction rule does not apply). Employer employing seasonal workers may be exempt from definition of applicable employer if certain conditions are met.
Employers generally do not have to pay an assessment for:

- First 30 FTEs.
- Employees working less than 30 hours/week.
- Employees hired for less than 120 days, “seasonal employees”, and retail workers employed exclusively during the holiday season.

**Participant Question:**

*Detail the inner working of measuring transitional employees and seasonal employees under new guidance.*

- Many and detailed example scenarios provided depending on types of employees.
- Provides greater flexibility for employers to determine FTE status for current or new variable hour or seasonal employees.
- Many shared-responsibility questions remain unanswered, particularly for employers with many part-time or seasonal employees (regulators don’t seem inclined to delay the 2014 effective date).
Guidance issued on determining FTEs (IRS Notice 2012-58)

• 30+ hours of service/week on average (or 130+ hours/month)

• Addresses “measurement periods” (lookback periods for counting hours) and “stability periods” (periods when workers must be treated as FT if they met requisite hours in the measurement period).

• Look-back measurement period (of 3 to 12 months) to determine whether new variable-hour or seasonal employees are FTEs.

• Define “seasonal employees” using a reasonable, good faith interpretation, and treat them under the same rules that apply to variable hour employees.
FTEs Defined

• Optional safe havens for determining FTE status:
  - Ongoing employees
  - New employees (variable hour and seasonal)

• Must make FTE determination on uniform and consistent basis for all employees in same category.

• Can rely on guidance at least through 2014 and do not have to comply with more restrictive guidance at least until 1/1/2015

Employers can use W-2 wages to determine if employee group health contributions are “affordable” under the shared-responsibility rules and can apply a three-month waiting period to new employees expected to work full time without incurring a shared-responsibility assessment.
Guidance issued on waiting periods rule (IRS Notice 2012-59)

- In plan years beginning on or after 1/1/14, a group health plan cannot apply any waiting period that exceeds 90 days.
- Does not distinguish between full-time and part-time employees.
- Employers may still impose a waiting period for coverage without being subject to a penalty, but this waiting period may not exceed 90 calendar days.
- Guidance defines the term “waiting period.”
- Addresses implementation with respect to variable-hour employees where a specified number of hours of service per period is a plan eligibility condition.
- Provides example implementation scenarios.

Full regulatory picture isn’t yet complete, so should stay tuned for further guidance.
Calculating Penalties

Employers with fewer than 50 employees are exempt from the shared responsibility penalties (no assessment if their employees get tax credits through an Exchange).

Do you average 50+ FTEs on business days in prior year?

Yes ☐  No ☐

- If you answered “No” then you are not subject to a penalty (no assessable payments).

- If you answered “Yes” and you are a large employer then go on to the next slide.
Calculating Penalties

Does at least one of your FTEs get premium tax credit or cost sharing reduction for exchange coverage?

Yes □  No □

- If you answered “No” then you are not subject to a penalty (no assessable payments). Employer pays penalty only if 50+ FTEs and at least one FTE gets premium tax credit or cost sharing reduction for exchange coverage.

- If you answered “Yes”, at least one of your FTEs will get premium tax credit or cost sharing reduction for exchange coverage, then go on to the next slide.
Calculating Penalties

Larger employers (over 50 FTEs) that don't offer coverage or offer “substandard” coverage face possible penalties if their workers get subsidized coverage through the exchange. "Substandard" coverage - a policy that doesn't cover at least 60% of an employee's total medical costs or whose premiums cost more than 9.5% of the worker's income.

Employer pays ONLY if 50+ FTEs AND at least one FTE gets premium tax credit or cost sharing reduction for exchange coverage.

- If NO COVERAGE offered to FTEs, penalty = $2,000 per FTE minus first 30 FTEs (will be used to help offset the cost of health insurance for employees receiving help from the federal government to purchase insurance)

- If SUBSTANDARD COVERAGE OFFERED to FTEs, penalty = lesser of:
  o $3,000 per FTE on exchange plan receiving credits/subsidies, or
  o $2,000 per FTE minus first 30 FTEs
# Shared Responsibility “Play”

<table>
<thead>
<tr>
<th>The Current Way</th>
<th>Options</th>
<th>Shared Responsibility “Play”</th>
</tr>
</thead>
</table>
| • Offer comprehensive benefit package with choice.  
• Payroll deductions.  
• Number of plan choices.  
• Charge to EEs. | Anything in between | **Play**: Offer employees a base plan that covers:  
• Essential benefits  
• 60% actuarial value of coverage  
**and**  
• Charge no more than 9.5% of W-2 wages (for employee only coverage) |
| Annual Plan Costs: $_________  
Less EE Costs: ($______)  
Net Costs: $_________________ | Annual Cost to Play: $_________  
Less EE Costs: ($______)  
Net Costs: $_________________ |

*
## Shared Responsibility “Pay”

<table>
<thead>
<tr>
<th>The Current Way</th>
<th>Options</th>
<th>Shared Responsibilities “Pay”</th>
</tr>
</thead>
</table>
| • Offer comprehensive benefit package with choice.  
  • Payroll deductions.  
  • Number of plan choices.  
  • Charge to EEs. | Anything in between | **Pay:** $2,000 penalty per F/T employee less first 30 F/T employees |

Annual Plan Costs: $__________  
Less EE Costs: ($_______)  
Net Costs: $__________  

$2,000 x (_______ - 30)  
Annual Costs to Pay: $__________
Key Questions

1. Are benefits a differentiating value proposition?

- Do employees / recruits “expect” comprehensive benefits?
- Do employees / recruits “value” the benefit package?

2. Are you committed to providing a competitive benefit package?

If yes,
- What level of plan design?
- What level of cost sharing (payroll deductions, etc.)?
- What plan design and cost sharing is sustainable?

If no,
- Will you play (essential benefits, 60% actuarial value, 9.5% of payroll)?
- Will you pay ($2,000 per F/T employee)?
If “Yes” - Next Generation Benefits

Issue 1

- Establish an absolute commitment to health, wellness and productivity in the workplace with C-suite “buy-in”

Issue 2

- Determine the right plan design strategy: defined benefit or defined contribution

Issue 3

- Share the strategy with management around cost and quality

Issue 4

- Communicate and engage (internally with employees and management team) and “expect” support

Issue 5

- Measure and benchmark
Planning for 2018

Prepare for “Cadillac” Tax

- Project the COBRA premiums for your health plans in 2018 and beyond
  - Dental and vision is excluded, but other coverage is aggregated, including PPO, HMO, HDHP, HSA, FSA, HRA, etc.

- To be implemented in 2018:
  - 40% excise tax on “Cadillac” benefit plans (value, or premium equivalents of $10,200 / $27,500 per year)
  - Tax applies to amount of the premium in excess of the threshold, so the first $27,500/family and $10,200/individual is exempt from tax
  - Tax is imposed on coverage provider

- 2018 Tax for “Single” = $1,120 and for “Family” = $3,800

- Some plans will qualify for higher thresholds (certain high risk occupations, retirees, etc.)
Resources
Agency Healthcare Reform Sites:

Health and Human Services (HHS):
http://healthcare.gov/

Department of Labor (DOL):
http://www.dol.gov/ebsa/healthreform/

Internal Revenue Service (IRS):
Conner Strong & Buckelew
Healthcare Reform website page at:

http://www.connerstrong.com/healthcare_reform

» News updates
» Online library of client updates and alerts
» Summary of major provisions of the new law
» Detailed Year-by-Year timeline of changes
» Outline of all aspects of the new law

Check back for updates, news and analysis, and updated tools to help you navigate this complex process

Call Conner Strong & Buckelew at 877-861-3220
Other Resources from Conner Strong

Periodic Webinars
- Web-based presentations on health care legislation, regulations and innovative ideas

Email Alerts and Updates
- High level, quickly produced articles about emerging issues intended to alert clients to legislative and regulatory developments
- Historic library available online

Perspectives
- Thought pieces intended to identify trends and issues, helping clients anticipate challenges
Thank you for your participation!