ICCCFO

Making Strategic Decisions Under Health Care Reform

October 10-12, 2012
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New Requirements for 2012-2013

All Plans (grandfathered and non-grandfathered):

- Summary of Benefits and Coverage (final rule published February 14, 2012)
- Comparative Effectiveness Research Fees (proposed rule published April 17, 2012)
- Plans to Certify Compliance with Certain HIPAA Electronic Data Interchange (EDI) Standards (compliance not required until certification process is developed by government)

Non-Grandfathered Plans Only:

- Nondiscrimination Rules for Insured Plans (standards and effective date to be determined in regulations)
- Quality Reporting (awaiting guidance)
New Requirements for 2012-2013 continued

Applicable to Employers:

➢ W-2 Reporting
➢ Employer Exchange-related Notices (awaiting guidance)
New Summary of Benefits and Coverage (SBC)

➢ To provide participants with a summary of benefits and coverage

➢ Template comes with detailed instructions on how to complete it
  • Max of 4-double-sided pages, no smaller than 12-point font
  • Must include coverage examples listing costs for having a baby and managing type 2 diabetes
  • Can be provided as a stand-alone document or included prominently in other summary materials

➢ Effective date:
  • If plan conducts open enrollment, requirement applies on the first day of the first open enrollment period that begins on or after September 23, 2012
  • If plan does not conduct open enrollment, requirement applies on the first day of the first plan year that begins on or after September 23, 2012

➢ Does not replace the plan’s Summary Plan Description (SPD)

Plan sponsors should begin to prepare SBC well in advance of the first applicable plan year.
**Coverage Examples**

### Having a baby (normal delivery)

- **Amount owed to providers:** $7,540  
- **Plan pays:**  
- **Patient pays:**

**Sample care costs:**

<table>
<thead>
<tr>
<th>Service</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital charges (mother)</td>
<td>$2,700</td>
</tr>
<tr>
<td>Routine obstetric care</td>
<td>$2,100</td>
</tr>
<tr>
<td>Hospital charges (baby)</td>
<td>$900</td>
</tr>
<tr>
<td>Anesthesia</td>
<td>$900</td>
</tr>
<tr>
<td>Laboratory tests</td>
<td>$500</td>
</tr>
<tr>
<td>Prescriptions</td>
<td>$200</td>
</tr>
<tr>
<td>Radiology</td>
<td>$200</td>
</tr>
<tr>
<td>Vaccines, other preventive</td>
<td>$40</td>
</tr>
</tbody>
</table>

**Total:** $7,540

**Patient pays:**

- **Deductibles:**  
- **Co-pays:**  
- **Co-insurance:**  
- **Limits or exclusions:**  

**Total:**

### Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400  
- **Plan pays:**  
- **Patient pays:**

**Sample care costs:**

<table>
<thead>
<tr>
<th>Service</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescriptions</td>
<td>$2,900</td>
</tr>
<tr>
<td>Medical Equipment and Supplies</td>
<td>$1,300</td>
</tr>
<tr>
<td>Office Visits and Procedures</td>
<td>$700</td>
</tr>
<tr>
<td>Education</td>
<td>$300</td>
</tr>
<tr>
<td>Laboratory tests</td>
<td>$100</td>
</tr>
<tr>
<td>Vaccines, other preventive</td>
<td>$100</td>
</tr>
</tbody>
</table>

**Total:** $5,400

**Patient pays:**

- **Deductibles:**  
- **Co-pays:**  
- **Co-insurance:**  
- **Limits or exclusions:**  

**Total:**

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**About these Coverage Examples:**

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

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**This is not a cost estimator.**

Don’t use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.
Advanced Notice of Material Modification

- Notice of material modification to terms of plan/coverage reflected in the SBC must be provided at least 60 days *prior* to the date the modification becomes effective.

- Applies only to mid-year changes that affect content of the SBC.
Comparative Effectiveness Research Fees

- All plans (insured and self-insured) must pay a fee to fund comparative effectiveness research
  - Plan sponsor pays if coverage is self-insured; issuer pays if coverage is insured

- First effective for 2012 plan year
  - First year — $1.00 per average number of covered lives
  - 2013 and thereafter — $2.00 per covered life (indexed)
  - Sunsets in 2019

- Paid by July 31 of the calendar year after last day of plan year

Proposed rule provides three ways to calculate average number of covered lives.
Form W-2 Reporting

➢ Informational reporting of aggregate cost of employer-sponsored health care coverage
   • Does not cause employer-sponsored coverage to become taxable

➢ Generally applies to all employers that provide applicable employer-sponsored coverage

➢ Applies for 2012 Form W-2s, which are issued January 2013
Notice/Reporting Requirements

➤ No later than March 1, 2013, employers must provide notice to employees regarding the Exchange

➤ The notice must include the following:
  • The existence of the state-based Exchange
  • Services offered by the Exchange
  • How to enroll/request information
  • If employer’s coverage is unaffordable, the fact that a tax subsidy may be available to purchase exchange coverage
  • The fact that employer contribution may be lost if employee enrolls in exchange
Ban on Waiting Period of More than 90 Days

For All plans (grandfathered and non-grandfathered), beginning with plan year on/after January 1, 2014:

➤ Guidance applicable through 2014 issued August 31, 2012, but more guidance is expected
  • Treasury Notice 2012-59; DOL Technical Release 2012-02

➤ Waiting period is the time period that must pass before coverage for an employee or dependent who is otherwise eligible to enroll becomes effective

➤ Rules don’t require coverage for someone who is not eligible under the terms of the plan
90-Day Waiting Period: General Rules

1. “Variable hour employees”: those who need to work specified number of hours over a period of time to be eligible for coverage, and it cannot reasonably be determined at start date if hours requirement will be met
   - Plan sponsor can take up to one year to determine if eligible for coverage, provided coverage is effective (if eligible) no later than 13 months from employee’s start date, and
   - If plan sponsors uses a shorter measurement period (i.e., less than one year), any waiting period after the measurement period cannot exceed 90 days

2. Part-time employees with regular schedule who must meet cumulative hours of service requirement to be eligible:
   - Coverage must be effective no later than the 91st day after the employee works the required number of hours – AND the hours of service requirement cannot exceed 1,200 hours
Other Group Health Plan Mandates Effective in 2014

For All Plans (grandfathered and non-grandfathered), beginning with plan year on/after January 1, 2014:

- Ban on preexisting condition exclusions (regardless of age)
- No annual dollar limits on essential benefits (no more waivers)
- Payments to temporary (2014 – 2016) reinsurance programs
Payments to Temporary (2014 - 2016) Reinsurance Programs

For All Plans (grandfathered and non-grandfathered), beginning with plan year on/after January 1, 2014:

- TPAs of self-insured plans will have to pay fees to help finance state-established reinsurance programs
- Health insurance issuers will also have to pay fees
- Goal of reinsurance programs is to stabilize the individual insurance market in 2014 – 2016
- Amount of payments due in January 2014 will be calculated based on per capita (i.e., per plan enrollee) contribution rate set by federal government in October 2012
- Nationally, the following amounts will be collected:
  - 2014: $12 billion
  - 2015: $8 billion
  - 2016: $5 billion
Group Health Plan Mandates Effective in 2014

For Non-Grandfathered Plans, beginning with plan year on/after January 1, 2014:

- **Cost-sharing limits**
  - Out-of-pocket maximums cannot exceed amounts for a high deductible health plan combined with Health Savings Account ($6,250 individual/$12,500 family in 2013)
  - Maximum deductibles of $2,000 individual/$4,000 family
    - Application to self-funded plans unclear

- **Additional information reporting relating to transparency in coverage**

- **Coverage relating to clinical trials**

- **Provider nondiscrimination and protection of employees**

Agencies have not released guidance on any of these requirements.
What Lies Ahead?

- Auto Enrollment
- Individual Mandate/Penalty
- Health Insurance Exchanges
- Individual Subsidies
- Medicaid Expansion
- Employer Free-Rider Penalty
- Excise Tax
Automatic Enrollment

- Applies to employers with more than 200 full-time employees and that offer health coverage
- Must automatically enroll employees in the plan and provide notice to employees
- Employees may opt out
- Compliance will not be required before regulations are issued
  - FAQ issued February 9, 2012 states that regulations will not be ready to take effect by 2014 as initially contemplated
Individual Mandate

- Individuals must have *minimum essential coverage* (including employer-sponsored coverage) or pay a monthly penalty.
- Individual penalty accounted for as an additional amount of federal tax owed.
- Supreme Court upheld the constitutionality of the individual mandate on June 28, 2012.
State Health Insurance Exchanges—the New Marketplace

- **2014**: State Health Insurance Exchanges will allow individuals and small employers to choose from a menu of insurance products.

- **2017**: States may allow large employers to buy through Exchanges.

- Federal subsidies will be available to help people buy coverage.
Key Dates for Exchanges

States seeking to operate a State Exchange or a State Partnership Exchanges must submit an Exchange Blueprint (Declaration letter signed by Governor and Application) to HHS no later than November 16, 2012.

Employers must notify employees of the new Exchanges by March 2013.

The initial open enrollment period will run from October 1, 2013 through March 31, 2014.

HHS will approve or conditionally approve State Exchanges no later than January 1, 2013.

Annual open enrollment periods will run from October 15 through December 7, with coverage effective on January 1 of the following year.
Essential Health Benefits

- Essential benefits must be offered by Exchange plans

- Government has proposed that each state determine the essential benefits package by selecting among certain benchmark plans

- Self-insured group health plans do not have to offer essential benefits, but if they do, then in 2014 they cannot have an annual maximum on those benefits
  - lifetime maximums were prohibited effective for plan years beginning on or after 9-23-10
Exchange Benefit Levels

- Bronze: benefits actuarially equivalent to 60% of the full actuarial value of the benefits provided under the plan
- Silver: 70% of the full actuarial value
- Gold: 80% of the full actuarial value
- Platinum: 90% of the full actuarial value
- Young Invincible (catastrophic plan under 30)
Medicaid Expansion/Exchange Subsidies

➤ Expansion of Medicaid to 133% of the Federal Poverty Level (FPL)
  • More federal money toward Medicaid expansion to ease burden on states

➤ Subsidies to individuals up to 400% of FPL to purchase Exchange coverage
  • In 2012: 400% FPL = $92,200 for family of 4
  • Subsidies on a sliding scale based on income
  • Premium assistance tax credit
    – Refundable and advanceable
    – Measured by cost of purchasing silver-level plan
  • Cost sharing assistance also available
Premium Assistance Tax Credit Eligibility

Individuals must:

➤ Not be eligible for minimum essential coverage except in the individual market (including employer-sponsored coverage, Medicare, Medicaid, CHIP, TRICARE, certain veteran’s health programs or any other coverage named by HHS)
  • If eligible for employer-sponsored coverage, coverage is unaffordable (9.5% test) or not minimum value (60% test)

➤ Be a resident of the state where the Exchange is established

➤ Not be incarcerated at the time of enrollment

➤ Be a citizen or legally documented immigrant currently residing in the United States

➤ Have household income between 133% and 400% of Federal Poverty Level (FPL)

➤ Not be claimed as a dependent on anyone’s tax return

➤ If married, file joint tax return
Premium Assistance Tax Credit Calculation

The premium assistance tax credit is calculated based on:

- The premium cost of the second-lowest-cost silver plan offered through a state health benefit exchange, and
- The household income level of the applicant

<table>
<thead>
<tr>
<th>Household Income Level (% above FPL)</th>
<th>Maximum Premium as Percentage of Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>Up to 133%</td>
<td>2.0%</td>
</tr>
<tr>
<td>133% – 150%</td>
<td>3.0% – 4.0%</td>
</tr>
<tr>
<td>150% – 200%</td>
<td>4.0% – 6.3%</td>
</tr>
<tr>
<td>200% – 250%</td>
<td>6.3% – 8.05%</td>
</tr>
<tr>
<td>250% – 300%</td>
<td>8.05% – 9.5%</td>
</tr>
<tr>
<td>300% – 400%</td>
<td>9.5%</td>
</tr>
</tbody>
</table>
2014 ESTIMATED* POVERTY GUIDELINES FOR THE 48 CONTIGUOUS STATES AND THE DISTRICT OF COLUMBIA

<table>
<thead>
<tr>
<th>Persons in Family</th>
<th>100% FPL</th>
<th>133% FPL</th>
<th>400% FPL</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$11,735</td>
<td>$15,608</td>
<td>$46,940</td>
</tr>
<tr>
<td>2</td>
<td>$15,896</td>
<td>$21,142</td>
<td>$63,584</td>
</tr>
<tr>
<td>3</td>
<td>$20,056</td>
<td>$26,674</td>
<td>$80,224</td>
</tr>
<tr>
<td>4</td>
<td>$24,217</td>
<td>$32,209</td>
<td>$96,868</td>
</tr>
<tr>
<td>5</td>
<td>$28,377</td>
<td>$37,741</td>
<td>$113,508</td>
</tr>
<tr>
<td>6</td>
<td>$32,538</td>
<td>$43,276</td>
<td>$130,152</td>
</tr>
<tr>
<td>7</td>
<td>$36,698</td>
<td>$48,808</td>
<td>$146,792</td>
</tr>
<tr>
<td>8</td>
<td>$40,859</td>
<td>$54,342</td>
<td>$163,436</td>
</tr>
</tbody>
</table>

* 2014 estimate based on 2012 levels increased by 2.5% per year.
## Low Income Cost-Sharing Subsidy for Silver Plan Enrollees

<table>
<thead>
<tr>
<th>Household Income Level (FPL%)</th>
<th>Reduction in Out-of-Pocket Max</th>
<th>Extra Cost-sharing Reductions to Achieve Higher Actuarial Value of:</th>
</tr>
</thead>
<tbody>
<tr>
<td>100% – 150%</td>
<td>2/3 reduction</td>
<td>94%</td>
</tr>
<tr>
<td>151% – 200%</td>
<td>2/3 reduction</td>
<td>87%</td>
</tr>
<tr>
<td>201% – 250%</td>
<td>1/2 reduction</td>
<td>73%</td>
</tr>
<tr>
<td>251% – 300%</td>
<td>1/2 reduction</td>
<td>None – stays at 70% (silver)</td>
</tr>
<tr>
<td>301% – 400%</td>
<td>1/3 reduction</td>
<td>None – stays at 70% (silver)</td>
</tr>
</tbody>
</table>
Employer Free-Rider Penalty

- Applies to employers with 50 or more full-time employees
  - Must aggregate hours of part-time employees to create total number of full-time employees
  - Full-time = works on average at least 30 hours per week
  - Treasury Notice 2012-58 addresses how to determine if employees are full-time employees

- If the employer **does not** offer coverage (and one full-time employee receives a tax credit in the Exchange)
  - Penalty is $2,000 (annualized) times the **total #** of full-time employees (minus first 30 workers)

- If the employer **does** offer coverage (and one full-time employee receives a tax credit in the Exchange)
  - Penalty is $3,000 (annualized) times **# of full-time employees getting tax credit** in Exchange (penalty max)
  - Tax credit would only be available if group coverage is unaffordable or actuarial value is less than 60%
Notice/Reporting Requirements Applicable to Large Employers

- Report to IRS beginning in 2014 regarding coverage options offered to all full-time employees:
  - Employer information
  - Whether minimum essential coverage is offered
  - The length of the waiting period
  - The months during the year that it was offered
  - Monthly premium for the lowest cost option in each enrollment category
  - Employer’s share of the total allowed costs of benefits
  - The number of full-time employees each month
  - Name, address, and TIN of each full-time employee during the year and the months during year covered under plan

- Notices also provided to full-time employees by January 31 of the year following the year in which employer files the IRS return
Excise Tax—2018

40% Excise Tax on Health Plans that Cost Above a Certain Threshold

➢ Threshold $10,200/$27,500 indexed to the CPI-U
➢ Adjustments due to age/gender; increased thresholds for high-risk professions and retirees
➢ Thresholds increased in 2018 if CBO projections incorrect
➢ Excludes dental and vision; includes health FSAs and HRAs
Resources

www.dol.gov/ebsa
www.hhs.gov/ociio
Questions?