THE McCART GROUP
RISK MANAGEMENT & INSURANCE

Wednesday's News You Can Use

Healthcare Reform

For The Government Finance Professional

CARL VINSON INSTITUTE OF GOVERNMENT
The University of Georgia

GGFOA
GEORGIA GOVERNMENT FINANCE OFFICERS ASSOCIATION

Call It What You Like …

PPACA

ACA

Obamacare

HCR

…

We have a few things to cover…

Photo:
J. Scott Applewhite

A Senate aide delivers a stack of documents bound in red tape being used as a prop during debate on the budget in the Senate, at the Capitol in Washington, Friday, March 22, 2013. The paperwork was described as the federal regulations dealing with the Affordable Care Act, often called "Obamacare."

Topic Overview

- W-2 Reporting – January 2013
- Full-Time Employee Determination
- Shared Responsibility Rule
- Reducing My Hours – Section 510 ERISA
- 90-Day Rule
- Cost Sharing Limits
- PCORIF, TRF, IF, and RAF

- Community Rating
- Health Insurance Exchanges
- Estimating Number of Full-Time Employees
- Employer Fair Share Penalties
- Adequate and Affordable Coverage
- Impact Analysis
- How Prepared are You?
- What are Other Employers Doing?

Poll

Do you consider yourself current on the requirements of the Affordable Care Act?

Yes or No

W-2 Reporting

- Employers Not Required To Report
  - Less Than 250 W-2s
- Must Report Total Cost Of All Group Health Plans
  - Use COBRA Definition

Poll

Does your government have more than 50 full-time employees?

Yes or No

How To Calculate FTEEs to Determine Small or Large Employer Status

Determine how many full-time employees (FTEs) and how many part-time employees (PTEs) you have on staff:

 # Full-Time Employees (FTEs)
{avg 30+ hours / week}

Monthly Hours worked for Part-Time Employees (PTEs)
{avg < 30 hours / week}

Example: You determine you have 45 FTEs and 10 PTEs, then:

45 FTEs

+

600 hours worked by PTEs
÷ 120
= 5 Full-Time Equivalents (FTEEs)

= 50 Full-Time Employees under the Shared Responsibility Rules

Health Insurance Exchanges

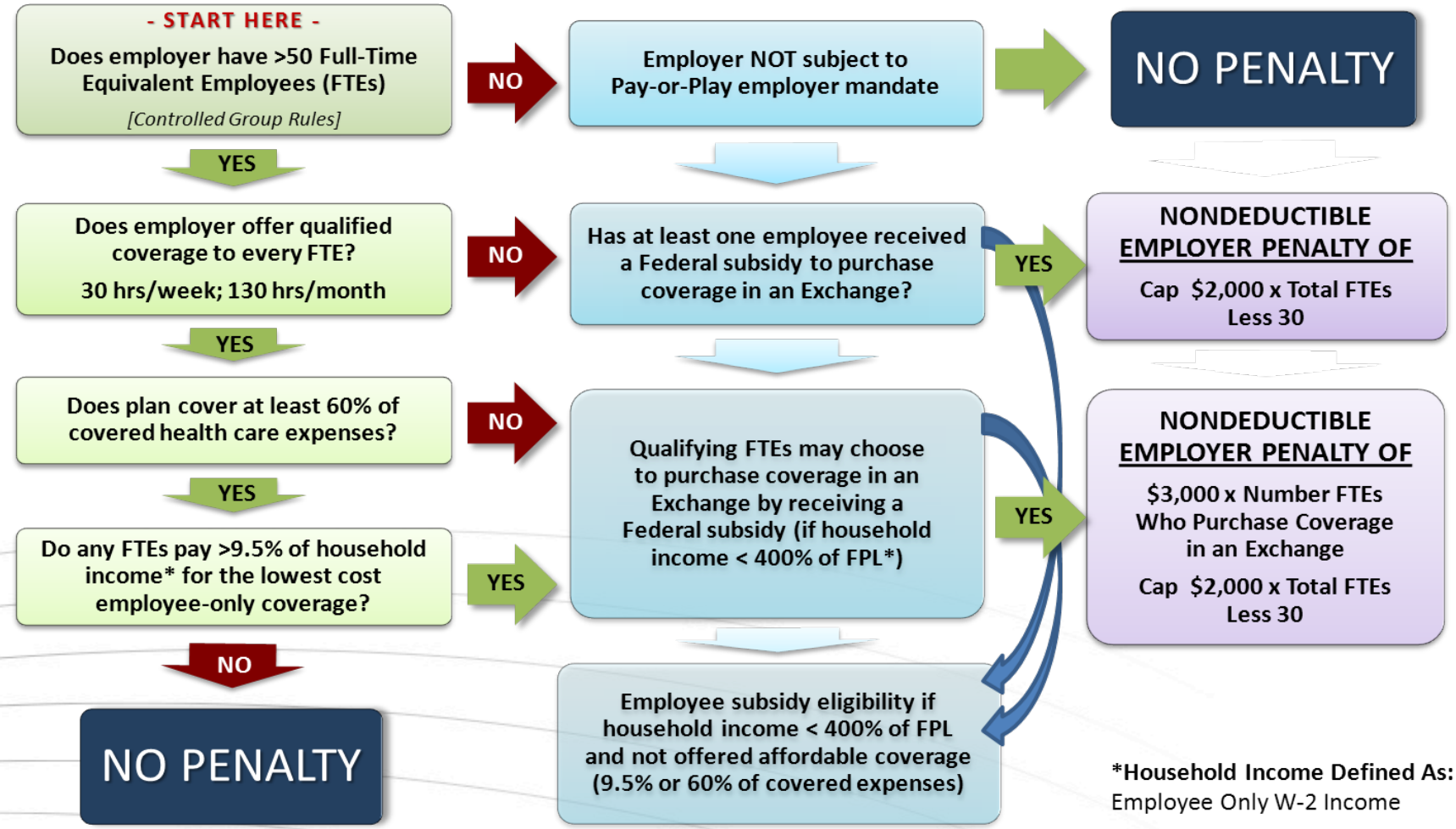
- Exchanges designed as marketplace where individuals and small employers will be able to shop for insurance coverage.
  - Promote availability of these options to categories of employees (such as part-time or seasonal employees) who are not eligible for your plan.
- All states have the option of setting up their own exchanges, partnering with the federal government to run an exchange or opting out. In that case, the federal government will run the exchanges for their residents.
- Exchange plans will be guarantee issue with no pre-existing condition restrictions.

Exchange Coverage Notification

- Employee Notice to Include Information On:
  - Health Insurance Exchanges
  - Premium Subsidies
  - Employer's Plan Meeting Minimum Coverage Requirements
- Requirement for Employee Notification by October 1, 2013
  - Many to distribute sooner - employees already asking questions regarding availability of coverage and subsidies through exchanges.
- HHS Has Released Model Notice: www.dol.gov/ebsa/healthreform

Employer Shared Responsibility – 2014

Penalties for not offering affordable coverage under the ACA



***Household Income Defined As:**
Employee Only W-2 Income

The “Unaffordable Care Act”

How do they expect us to absorb all these extra costs and still stay within budget?

- Employers seeking to limit their costs under the law will need to tread carefully.
- Avoid running afoul of section 510 of the Employee Retirement Income Security Act (ERISA), which prohibits organizations from making employment decisions specifically to prevent an employee from obtaining or keeping benefits coverage.

Proposed Rule on 90-Day Waiting Period

Waiting Period Defined:

The Affordable Care Act prohibits insured and self-insured group health plans from imposing a waiting period that exceeds 90 days before coverage can begin for an otherwise eligible person.

NOTE: 3 months, or 1st of month after 90 days is not acceptable.

Cost-Sharing Limits

- **Deductible Limitations**

  Until future guidance is issued, the rules regarding limitations on deductibles will *only* apply to small group health plans (generally those maintained by employers with 100 or less employees). Under these rules, deductibles cannot exceed $2,000 for employee coverage or $4,000 for family coverage in 2014. These amounts are indexed and will likely increase in 2015.

- **Annual Limitations on Out-of-Pocket Maximums**

  All non-grandfathered group health plans, *including* self-insured and large group health plans, are required to comply with the HCRA annual limitation on out-of-pocket maximums. Starting in 2014, these plans may not impose out-of-pocket limits in excess of a certain indexed dollar amount. This dollar amount is generally equal to the limits that would apply to a high-deductible health plan in 2014 (in 2013, the limits are $6,250 for self-only coverage and $12,500 for family coverage). After 2014, this amount will be indexed separately.

Patient-Centered Outcomes Research Institute (PCORI) Fee

PCORI affects fully-insured and self-funded plans. The fee funds research that evaluates and compares health outcomes, clinical effectiveness, risks and benefits of medical treatments and services.

- Effective 2012-2019, health insurance issuers and employers sponsoring self-funded group health plans must pay $1 per member per year. The fee increases to $2 per member per year in the second year. Then, the fee adjusts based on the percentage increase in the projected per capita amount of national health expenditures.
- Fully-insured coverage - carrier must file and pay the fee. The nominal fee is rolled into the premium and not called out separately on the invoice.
- As plan sponsor, self-funded employers must file **Form 720** and pay the fee directly to the IRS. Third parties may not pay the fee or file the form on behalf of self-funded plans. The fee is due by July 31 of the calendar year immediately following the last day of the plan year. The 2012 fee must be paid by July 31, 2013.

Transitional Reinsurance Fee

This fee impacts both fully insured and self-funded plans. The fees are distributed to health insurance issuers in the non-grandfathered individual market that disproportionately attract individuals at risk for high medical costs. The intent is to spread the financial risk across all issuers to provide greater financial stability.

- The fee is temporary and is collected from 2014-2016.
- The Transitional Reinsurance Fee is assessed on a per capita basis for both fully-insured and self-funded plans. ***For fully-insured plans***, the carrier will collect the Reinsurance Fee through premium rates, when approved by the state. ***For self- funded plans***, because the federal rules are still subject to change, The McCart Group is monitoring the rulemaking process to determine how we can assist our clients in meeting this obligation.
- Fee is effective Jan. 1, 2014; first payment anticipated due date: Jan. 15, 2015
- The health reform law specifies the total amounts of the Reinsurance Fee that must be collected: $12 billion in 2014, $8 billion in 2015 and $5 billion in 2016, totaling $25 billion.

Insurer Fee

This fee applies to health insurance issuers and impacts fully insured plan sponsors only. The Insurer Fee will fund premium tax subsidies for low-income individuals and families who purchase health insurance through Health Benefit Exchanges.

- The Insurer Fee is an annual, permanent fee beginning in 2014.
- The amount is determined by the market share of the health insurance issuer.
- The fee is due no later than September 30 of the following calendar year.
- Industry sources have estimated the impact of the fee during the first year to be about 2.3 percent of the total premium.

Risk Adjustment Fee

This fee is assessed on issuers of risk-adjusted plans in the non- grandfathered individual and small group markets, whether in or out of the Exchanges, to help fund the administrative costs of running the Risk Adjustment Program. The Risk Adjustment Program is intended to protect health insurance issuers of risk-adjusted plans against adverse selection by redistributing premiums from plans with low- risk populations to plans with high-risk populations. In other words, it helps level the playing field.

- The Risk Adjustment Fee is estimated to be about $1 per member per year.
- The modest fee will be rolled into the premium and not called out separately on invoices.
- The Risk Adjustment Fee is permanent and begins in 2014.

New Community Rating Rules

Small Group Only 2-50

- Health plans will be allowed to adjust premiums only for the following factors:
  - Self-only or family enrollment
  - Geographic area
  - Age (except the rate cannot vary by more than 3 to 1 for adults)
  - Tobacco use (except the rate cannot vary by more than 1.5 to 1)
- Other factors traditionally used by plans to charge higher rates, such as health status and gender, will no longer be allowed.

Estimating Number of Full-Time Employees

Look-Back Period

Employers May Use a Look-Back "Measurement Period" to estimate number of full-time employees to determine potential coverage/tax exposure.

- **The Measurement Period:** The 3-12 month look-back period used to track employee hours to determine if an employee is to be classified as full-time. If an employee worked 1,560 hours or more during a 12-month measurement period, they are deemed a full-time employee for tax/coverage purposes.
- **The Administrative Period**: A period of time (up to 90 days) after or coinciding with the end of the measurement period. Used to compile data on employees that worked during the measurement period and identify them.
- **The Stability Period:** The 6-12 month period after the administrative and measurement periods end for employees. A variable hour employee deemed full-time during a previous 12-month measurement period will be considered a full-time employee for the next 12-month stability period REGARDLESS of # of hours worked during that time frame, as long as he/she is employed.

Note: Stability periods can be no shorter than 6 months in any case and must coincide in length of measurement period. (e.g., 3mo.-6mo. OK; 12mo.-12mo. OK; 3mo.-3mo. Not OK; 9mo.-6mo. Not OK

Poll

Does your government offer health insurance to employees?

Yes or No

Employer Fair Share Penalties

- Penalty For Not Offering Qualifying Coverage To Essentially All Full-Time Employees
  - Penalty Is $2,000 Per Year Times Number Of Full-Time Employees
    - Does not apply if under 50 FTEEs
    - Do not count first 30 employees
  - “Essentially All” Defined at 95% of its full-time employees.

Employer Fair Share Penalties

- Penalty For Unaffordable Coverage
  - If Employer Offers Minimum Essential Coverage To All Full-Time Employees
  - May Still Pay A Penalty Of $3000/Year Per Employee Who:
    - Has A Household Income < 400% Of Federal Poverty Level
    - Employee Contribution Equals More Than 9.5% Of Household Income
    - The Individual ***Purchases Subsidized Coverage*** On The Exchange
    - Penalty not tax deductible
- Employer Safe Harbor
  - If Cost Of Single Coverage < 9.5% Of Employee's Wages, No Employer Penalty Regardless of Household Income

Adequate and Affordable Coverage

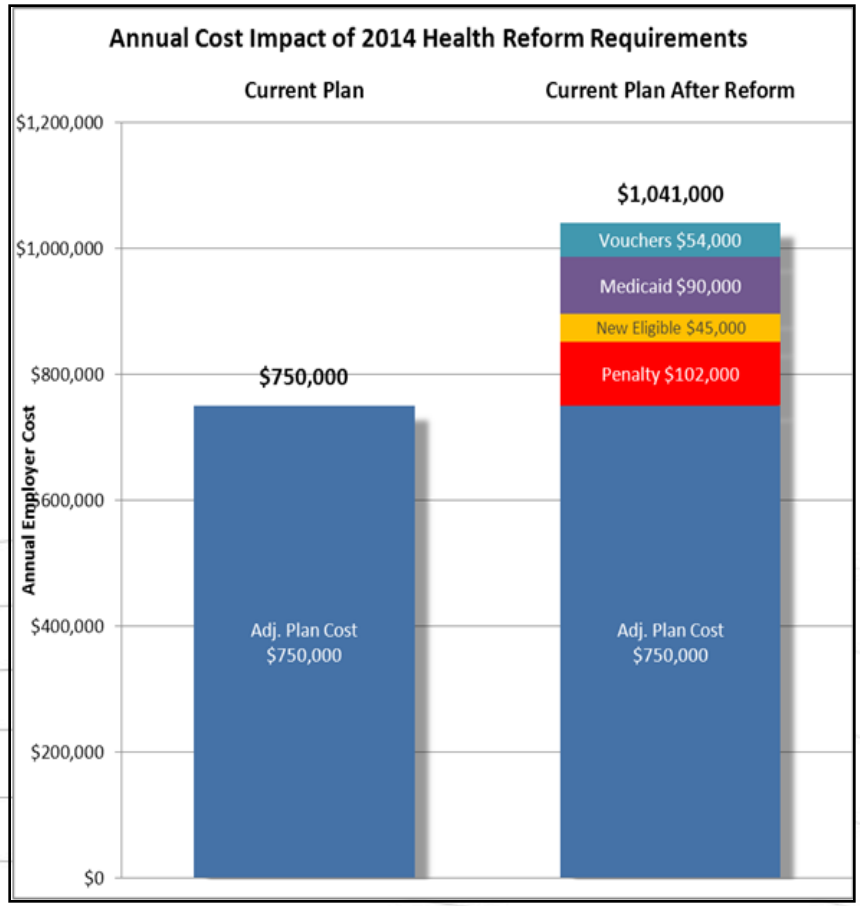
- Essential Health Benefits vs. Minimum Essential Coverage
  - Essential Health Benefits
    - Requirements Which Apply To Individual Or Small Group Plans That Must Include Coverage In A Variety Of Categories
  - Minimum Essential Coverage (MEC)
    - Minimum Actuarial Value Employer Plan Must Offer To Avoid Penalty Under Shared Responsibility Rules
      - Plan Must Cover 60% Of The Total Costs Incurred By Participant, on average
      - Equivalent To A “Bronze Plan” On An Exchange

Adequate and Affordable Coverage

- Kaiser Study: Model “Bronze” Plan Total Out Of Pocket = $6,350
  - $4,375 Individual Deductible With 80/20 Coinsurance
  - $3,475 Individual Deductible With 60/40 Coinsurance
- Who Will Determine MEC?
  - Will Health Insurance Carriers Determine Actuarial Value For Fully Insured Plans?
  - IRS/HHS To Release Valuation Tool

Impact Analysis Results Summary

This chart illustrates the combined impact of the 2014 health reform changes considered by this report. This summary assumes the employer will provide minimum essential coverage to all full-time employees.



Compliance Management

Impact Analysis – Health Care Reform Risk Projection

- Penalty Calculation
- Subsidy Eligibility
- Medicaid Eligibility
- Alternative Modeling

Healthcare Reform Audit Checklist

- Have you enforced the new, lower maximum ($2,500) for FSA plans?
- Have you adjusted your waiting period to comply with the new law?
- Have you properly determined if you are considered a large employer and defined which employees impact (and are impacted) by the various set of new rules?
- Have you adjusted tax rates for higher earning employees? (Medicare HI Tax)

What are Employers Doing?

Options and Opportunities

- Press your HR staff and/or advisor to look for new ideas and alternative risk arrangements to consider.

  Examples:
  - Defined contribution plans
  - Private exchanges
  - Multiple Employer Welfare Arrangements (MEWAs)
  - Creativity in plan and contribution strategies
  - Strongly consider self-insuring if you are fully-insured
  - Consider onsite clinics if you have over 500 FTEs in a location
  - Consumer-directed plans (HDHP)
  - Outcome-based wellness plans
  - Look for cost/quality transparency tools for employees
  - Learn where an ACO (Accountable Care Organization) can benefit you

Questions?

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