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NEW FEDERAL HEALTH CARE REFORM LEGISLATION

What does health care reform mean to employers?

Today's Presenters:

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Federal Health Reform
Legislative Overview and Employer Implications

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Agenda

- Legislative Background
- Short-term Employer Considerations (2010 – 2011)
- Mid- to Long-Term Employer Considerations (2012 and beyond)
- Next Steps for Employers

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Legislative Background

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Federal Health Care Reform Legislative Background

- On March 23 the President signed HR 3590, the Patient Protection and Affordable Care Act (PPACA)
- Both chambers of Congress passed changes to PPACA contained in the budget reconciliation bill (HR 4872) on March 25, clearing the way for the President's signature which occurred on March 30
- The Patient Protection and Affordable Care Act (PPACA) lacks some necessary detail and will require review and further government guidance to ensure all employers are compliant
- The following pages outline the key short-term and mid- to long-term elements of health reform, and their impact on employers. For the purpose of this presentation, we will assume a calendar year plan year (January 1st renewal date).

Federal Health Care Reform
Key Definitions and Considerations

- **"Grandfathered Plans" –** A grandfathered plan is one that was in place before March 23, 2010
  - The effective date for some provisions may be delayed for grandfathered plans
  - The law does not explain how, or when, a plan could lose its grandfathered status. For example, it is unclear whether a plan design change, network change, or introduction of a new plan would affect grandfathered status.
- **Collectively Bargained Coverage –** For coverage maintained under a collective bargaining agreement (CBA) ratified before March 23, 2010, all new coverage and cost-sharing rules apply on the termination date of the last CBA relating to the coverage. Any coverage amendment to a CBA to comply with these rules will not be treated as terminating the CBA.

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Short-term Employer Considerations

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Key Employer Health Care Reform Elements

PPACA Provisions	Comments
2010 Changes	
• National high risk pool created • Insured health plans will develop and file new rates • States approve/reject new rate filings • Federal rate review process to be established	• Effective 90 days from enactment of legislation
• Small business tax credit program to be established	
• Reflect accounting impact of eliminating 2013 tax deduction for retiree medical Part D subsidy	• Headlines making the news on corporate tax hit
• Medicare prescription drug “donut hole” beneficiary rebate	• Beneficiaries receive $250 rebate in 2010
• Temporary retiree reinsurance program is created	• HHS to establish program and specifics ➢ Effective 90 days from enactment of legislation ➢ Applies to providing coverage to retirees and dependents 55-64 years old who are not Medicare eligible ➢ Reimburses employers for 80% of the cost for claims between $15,000 and $90,000 for a covered individual ➢ Program cost is capped at $5 billion ➢ Program ends on January 1, 2014

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Key Employer Health Care Reform Elements

PPACA Provisions	Comments
2011 Changes	
• Minimum medical loss ratio requirements ➢ 85% for plans with more than 100 employees ➢ 80% for plans with less than 100 employees	• Applies to fully-insured health plans
• Dependent coverage to age 26 for individuals lacking access to other employer-based coverage.	• Married or unmarried • No student requirement • No residence or financial dependence requirement • No provision to require covering children of a dependent on a parent's plan • Tax-exempt benefit • Other employer coverage requirement will go away in 2014
• No Lifetime plan maximum benefit limitations	• Insured plans will require the insurer to provide plans with no maximum benefit limitation • Self-insured plans will require the plan's maximum benefit to be eliminated • Employers will need to make sure reinsurance limits are consistent with the plan's unlimited maximum
• Limitations on restricted annual dollar amounts	• Applies to internal plan limits for specified situations; HHS will provide guidance
• No pre-existing conditions exclusions for covered children under age 19	• See 2014 changes for complete elimination of pre-existing conditions provisions

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Key Employer Health Care Reform Elements

PPACA Provisions	Comments
2011 Changes (continued)	
• Reporting of employee coverage on W-2 Form	• Unclear on timing–gather in 2010 for 2011 or gather in 2011 for 2012
• Contract rescission/non-renewal prohibited	• Applicable to fully-insured plans and especially individual contracts
• No health plan or health FSA/HRA/HSA reimbursements for over-the-counter medications	
• Increased penalties for non-qualified HSA distributions	• Penalty increased from 10% to 20% on non-qualified withdrawals • This is an individual tax issue
• Medicare Advantage Plan changes	• CMS to freeze payments to these plans
• Employee-pay-all voluntary long term care program (CLASS Act)	• Employers will need to determine whether to participate

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Mid- to Long-Term Employer Considerations

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Key Employer Health Care Reform Elements

PPACA Provisions	Comments
Issues for 2012 – Presidential Election Year	
• Distribute uniform benefit summaries to participants (March 23, 2012)	• Does not change current SPD and plan document requirements • Unclear whether current SPDs will meet the requirement; likely to require some modifications
2013 Changes	
• $2,500 health FSA contribution cap (indexed for inflation in future years)	• Change may boost dental and vision plans enrollment
• Change in Medicare retiree drug subsidy tax treatment	• Medicare Part D subsidy for plan sponsors will no longer be tax deductible
• Higher Medicare payroll tax on wages for employees exceeding $200,000 single/$250,000 couple	• 2.35% tax on employee earnings exceeding $200,000; $250,000 for couples; Current rate of 1.45% continues for all others
• New Medicare tax on net investment income	• 3.8% on investment income for taxpayers with incomes exceeding $200,000 for individuals or $250,000 for couples
• Provide notice to all employees about the availability of health coverage through the exchange (March 1, 2013)	• Model notice language expected to be developed
• Charge of $1 per participant for plan years ending in 2013; $2 per participant second year, and formula thereafter until 2019	• Unclear if retirees included

Key Employer Health Care Reform Elements

PPACA Provisions	Comments
2014 Changes	
• Health insurance exchanges open in each state	
• Dependent child coverage to age 26 regardless of whether child has access to other employer coverage	• Employers may need to revisit their employee contribution strategy to address potential changes in membership
• Eliminate annual dollar limits for essential services	• Unclear definition of essential services, expect further guidance
• Eliminate pre-existing condition exclusions for all participants	
• Waiting periods may not exceed 90 days	
• Eliminate discrimination in favor of highly compensated individuals under insured plans	• Insured executive medical plans no longer permitted
• Limit annual cost-sharing for non-preventive services to high deductible health plan (HDHP) limits	• Currently $5,950 (Individual) / $11,900 (Family)
• HIPAA wellness incentive limit increased from 20% to 30% of premium	• Potential for increased participation with greater incentives
• Provide coverage for clinical trial participation	
• Implement new reporting requirement	• Whether coverage is offered, lowest cost option, waiting periods, etc.

Key Employer Health Care Reform Elements

PPACA Provisions	Comments
2014 Changes (continued)	
• Comply with Shared Responsibility provisions ("Free Rider" surcharge) to offer affordable coverage to employees working 30+ hours per week ➢ Plans must pay at least 60% of covered cost ➢ Employee's contribution must not exceed 9.5% of household income	• Employers with 50+ full-time employees • Employers offering coverage that is unaffordable or does not meet minimum standards pay annual penalty of $3,000 for each full-time employee receiving income-based assistance for health insurance exchange coverage. Penalties are capped at $2,000 times total number of FTEs. • Employers not offering coverage that have at least one full-time employee receiving income-based premium assistance to buy coverage through an exchange pay an annual penalty of $2,000 per full-time employee (excluding the first 30 full-time employees)
• Offer Free Choice Vouchers to certain employees ➢ Household incomes below 400% of Federal Poverty Level ($88,200 for family of 4) ➢ If contribution would be 8 – 9.8% of income	• Voucher amount equals highest percentage employer contribution to any of its own plans • Used to purchase exchange benefits but employees can keep excess
• Individual coverage mandate with penalty	• Penalty amounts set to lesser of: ➢ National average premium for the year; or • Greater of: ➢ Flat $ amount - $325 in 2015 rising to $695 in 2016, indexed beginning in 2017 ➢ Percentage of income (2.5% in 2016)
• Medicaid expansion	• Up to 133% of FPL (family of 4 in 2009 was approximately $22,000)

Key Employer Health Care Reform Elements

PPACA Provisions	Comments
2018 Changes	
• Excise tax on high cost coverage ("Cadillac Tax")	• 40% excise tax on plans that exceed $10,200 single and $27,500 family ➢ Adjusted for retirees, employees in certain high risk professions and multi-employer plans. Thresholds may be adjusted in some cases to consider age and gender. • Indexed: ➢ 2019: CPI + 1% ➢ 2020+: CPI
Effective date uncertain (2010 – 2013)	
• Auto enrollment of new hires and all full-time employees unless they opt-out of coverage	• Expecting further guidance around the implementation date • Impacts employers with 200+ full time equivalent employees (FTEs)

Issues Facing Non Grandfathered Plans

- For 2011
  - Eliminate cost-sharing for preventive services
  - Eliminate requirements for pre-authorization of emergency services
  - Eliminate requirements for pre-authorization or referral for OB-GYN services
  - Allow enrollees to choose, rather than be assigned, a primary care physician (may include a pediatrician)
  - Eliminate discrimination in favor of highly compensated individuals under insured plans (e.g. executive medical plans)
  - Comply with new appeal process requirements, including mandated external appeal process. HHS will provide guidance and has authority to extend deadline

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Next Steps for Employers

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Federal health care reform – What to do now?

- Monitor federal reform efforts while the path forward is refined
- Consider
  - How potential federal mandates would impact your current plan and costs
- Continue and enhance strategies to control cost and improve effectiveness
  - Ensure plans and vendors are operating at optimal levels of efficiency
  - Provide available wellness incentives to
    - Increase participation/self-care compliance
    - Align internal programs and services to support a healthy workforce
- Understand likely areas of risk
  - Potential for inflation, cost shifting and price increases
  - Stop loss implications (unlimited lifetime maximum, plan changes, etc.)
  - Address current cost drivers

Federal health care reform – What to say to employees?

- Set the tone and context for immediate change
  - Tell them what you know – specifics about immediate term benefit enhancements and changes
  - Educate employees about potential cost implications of enhancements
- Address employee fears about
  - Disappearing employer coverage
  - Taxes on high cost coverage
  - Individual coverage mandate
- Assure employees you are following legislative process closely and will update them as you know more
- Begin to plan how to communicate change during annual enrollment

Keep messaging general for now regarding provisions that take effect beyond 2011

For additional follow-up, please contact:

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PATIENT PROTECTION AND AFFORDABLE CARE ACT

TITLE XXXII

C.L.A.S.S. A C T
(COMMUNITY LIVING ASSISTANCE SERVICES AND SUPPORT)

SECTION 3201

Thomas Devine, Legislative Affairs/Executive Vice President

"Is A National Self Funded Voluntary Government Insurance Program To Facilitate Personal Financial Independence, To Provide A Funding Mechanism To Alleviate Burdens of Family Caregivers, Which Allows Personal Choice And Independence Through A New Financing Strategy For Community Living Assistance Services And Support Programs."

PROVISIONS OVERVIEW

- Voluntary coverage for Employee's (EE's) and maybe spouses, 18+ actively at work; are automatically enrolled by Employer (ER) unless they "Opt Out"
- Premiums paid through ER payroll deduction go to "CLASS Fund"
- Self Employed Individuals/Spouses eligible by making direct payments:TBD
- Secretary of DHHS becomes LTCi Program "Czar", the final "say"
- New "CLASS Independence Advisory Council" to advise "Czar" by 10/1/2012 on plan election options, actuarial reporting, plan designs, benefits/features
- New "CLASS Independence Fund Board Of Trustees" to advise/manage funds/assumptions/review/report
- Creates new "CLASS Independence Fund" to hold premiums paid
- Role of Inspector General of DHHS to review: waste, fraud and abuse
- Admin costs capped At 3% of total first 5 years, after cannot exceed 5%

BENEFIT PLAN FEATURES

- Guarantee Issue; Entitlement for all
- Lifetime coverage – no aggregate limit
- CPI and premium increase (decrease) reviewed/set each year
- “Coordination” with supplemental health coverage through the exchange
- Specifics of plan details, in particular premium levels have to be determined by “advisory council” approved by “Czar” by January 1, 2013 expected plan start up date
- Enrollment and disenrollment shall be permitted only during annual open period in manner determined by “Czar”
- Cash benefit for payment of LTC services

PLAN COSTS

- Age rated premiums
- Beginning first year/thereafter, all premiums paid by enrollee's are based on actuarial cost analysis on 75 year projected program
- Those who "Opt Out" after 1 year: Pay more; TBD
- Those who "Opt In" after 5 years lapse: Pay attained age plus 1% penalty
- 65+ No longer Employed, who paid 20+ years, do not pay annual premium Increases or CPI premium increases
- "Nominal" premium for those below poverty line or full time students: TBD- $5/month
- Prohibition of use of Taxpayer Funds to pay claims/program costs
- Minnesota $100 Per Person - $200 Per Couple Tax Credit can be used

BENEFIT CLAIMS

- Limited benefit of no less than $50 per day: further TBD
- "Vesting": 5 years-to be claim eligible
- Eligibility determined by State Disability Determination Centers and will be limited to:
  - Individuals who are unable to perform 2/3 or more Activities Of Daily Living (ADL's)
  - Individuals with Cognitive Disability or needing Hands On or other assistance
  - Expect claim to last continually for 90 or more days
- Expected: HIPAA Benefit Triggers – Functional Limitations
- Claims payments are Tax Qualified (T.Q.) Partnership protected: TBD
- Paid daily or weekly – Electronically – into "Independence Accounts"
- The law does not include Waiver of Premium while on claim
- Year end lump sum distributions possible if left in account:"Use It Or Lose It"
- CLASS Program will not provide Comprehensive Coverage afforded under Private Sector LTCi: plans available in market place

IMPACT ON EMPLOYERS – EMPLOYEES

- Knowledge of 4 dates/deadlines:
  - Eligibility Assessments Due: 1-1-12
  - Plan Studies Due To Secretary: 10-1-12
  - Expected Plan Start Up Date: 1-1-13
  - Required First Annual Report: 1-1-14
- Employers will be faced with making a series of decisions:
  - Evaluate Pro-Con of installing new Government Plan
  - Continue/ install new private pay LTCi Employee Benefit Plan
  - Do nothing and hope for best
- Employees will be asking Employers/HR to explain what their options will be
- Employers with plans in place will need to be in position to explain existing Plan Options/Alternatives

CHALLENGES AND CONCLUSIONS

- CLASS messaging is clear: The Government wants to significantly shift spending for LTC expenses to individuals to their taking personal responsibility in their own planning, much like 401(k) education
- Recognize increasing Federal cost factors impacting Medicaid, State financial constraints to make up differences which are passed to Counties, who's lack of funds must be made up with increases to either/both Residential Property Taxes, Commercial Industrial Taxes to cover shortfalls.
- Need for widespread ER education for EE's, because of ease of using the worksite platform
- Review Minnesota Chamber (December 2009) Board Position Statement regarding LTC issues

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COMMENT

- Kennedy final and last Legacy Legislation from 1998 and 2005
- Pre-Tax LTCi: 125, sadly left out
- Need for future ER match for those in the new Government LTCi Plan because of: optimistically low "Opt Out" assumptions, adverse selection issues, "Presumptive Eligibility", cash benefit, limited re-assessment, anticipated inadequate funding
- Significant public awareness needed to address this "Social Issue"
- For additional follow-up, please contact:

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Federal Health Care Reform and the Impact on Minnesota Health Care Reform

Geoff Bartsh, Director, Legislative Affairs, HealthPartners

2008 MN Health Care Reform	Federal Reform
Focus on Cost	Focus on Access
Payment reform as a key to system reform	Payment reform in baby-steps at best
Stakeholder input throughout the process	Little stakeholder input
Implementation well underway	Implementation and interpretation of the law are just beginning
Government in charge of more decisions	Government in charge of more decisions

Bottom Line: Federal reform should have little impact on 2008 state reform activity for now. Moving forward, federal reform may collide with state reform as both define new care delivery models.

MN 2008 Health Care Reform

- Health Care Home (Medical Home)
- Provider quality measures and incentive payments
- Provider peer grouping
- Baskets of care
- Essential benefit set

Federal Reform

- Health Care Home
  - States may develop Medical Home for Medicaid beginning January 1, 2011
  - Will federal criteria match state criteria on Medical Home certification and payment?

- Provider quality measures and incentive payments in Medicare
  - Fraction of what Minnesota will report on
  - Hospital readmission rates
  - Hospital acquired conditions

Federal Reform

- Provider Peer Grouping - Disclosure
  - Hospitals must disclose charges
  - Hospital readmission rates will be published
  - Value modifier will be small part of Medicare payment
- Baskets of Care
  - Bundled payment pilots allowed for Medicare in 2013
- Essential Benefit Set
  - Will be developed
  - Key to “qualified” plans available through the exchange

Accountable Care Organizations

- The next great thing
- Eligible for federal recognition in 2012
- High on the state's priority list for health care reform
- Will state and federal expectations merge or collide?

Questions?