



Seminar Series Presents

Health Care Reform 2011 Updates

Presented by:

Joel S. Clark

President, JS Clark Agency

Prepared by:

Jennifer Young

Corporate Compliance Director, JS Clark Agency

www.jsclarkagency.com

Health Care Reform

- Affordable Care Act (ACA)
- Patient Protection and Affordability Care Act of 2010 (PPACA)
- Signed into law on March 23, 2010 by President Obama
 - P.L. 111-148
 - H.R. 3590
- Health Care and Education Reconciliation Act of 2010 (HCERA)
 - Signed into law on March 30, 2010 by President Obama
 - H.R. 4872

Health Care Reform

- Regulatory Challenges
 - Implementation takes place over the next 8 years with multiple election cycles
 - Legislation spans 2010-2018
 - Lawmakers already working on various legislative fixes and technical corrections to bills
 - Complex and challenging to implement
 - 2400 pages plus 153 page reconciliation bill plus managers' amendments
 - HHS, DOL, Dept of Treasury and IRS implementation guidance

Health Care Reform Constitutional?

- Supreme Court slated to determine constitutionality of American Care Act (ACA)
 - New session began October 2011 and runs through June 2012
- 26 –state coalition filed the petition on September 28, 2011
 - Includes Michigan
 - Challenging the federal law, seeking judicial review of a decision by a federal appeals court in Atlanta this summer which ruled a key provision of the law to be unconstitutional

Health Care Reform Constitutional?

- At issue is the "individual mandate" section
 - Requires nearly all Americans to purchase health insurance by 2014 or face financial penalties
 - Is the requirement an improper exercise of federal authority?
 - The states also say if that provision is unconstitutional the entire law with its 450 or so sections must then be scrapped
- Dramatic decision – court to decide what limits are on Congress's Power



Health Care Reform

Review of Current
Enacted Provisions

2010 brought...

- Phase 1 Small Business Tax Credit
 - IRS Guidance issued 4/1/2010
 - Deadline to file was 9/15/2011
 - Deadline for sole proprietors and S-Corps is 10/17/2011
- Early Retiree Reinsurance Program
 - Final Regulations issued 5/10/2010 – 45 CFR Part 149
 - Applications accepted until May 5, 2011
 - As of May 2011 \$2.3 billion paid out
 - Estimated \$3.6 will be paid out by fiscal year end – September 30, 2011
- Medicare Part D Subsidy Donut Hole \$250 Reimbursement
- Medicare Part D Subsidy Tax

2010 brought...

- Extended preventive care coverage with no cost sharing
 - Final regulations issued 7/19/2010 – 26 CFR Part 54 – Reg-120391-10
 - Extension of dependent coverage to adult children to age 26
 - Interim final regulations issued 5/13/2010 – 26 CFR Part 54 – 114494-10
 - Grandfathering guidelines
 - Final regulations issued 11/17/2010 – 26 CFR Part 54 – Reg-118412-10
-

2010 brought...

- Removal of lifetime limits
 - Removal of annual limits (phase out)
 - Emergency services at network cost sharing & no prior authorization
 - No rescission of coverage
 - Patient protections for provider selection HMO plans
 - Removal of pre-existing condition exclusions for children to age 19
 - Final Regulations issued 7/30/2010 – 26 CFR Part 54 – Reg-120399-10
 - New appeals process
 - Final Regulations issued 7/23/2010 – 26 CFR Part 54 – Reg-125592-10
-

2010 brought...

- Insured plans & non-discrimination rules
Postponed until regulatory guidance issued
- Prohibited firearm questions on wellness plans
- 10% tax on indoor tanning
 - Effective 7/1/2010 – IR-2010-73
- Break time for nursing mothers
- Insurance access for individuals with pre-existing conditions (administered by PHP in Michigan)
- Expansion of adoption assistance tax credit
 - From \$12,170 to \$13,170 and annually with inflation

2011 brought...

- Small Employer Wellness Grant Program
 - New W-2 Reporting Requirements
 - Delayed until 2012 – IRS Notice 2011-28 issued 3/29/2011
 - Small Employer Simple Cafeteria Plans without concentration test nondiscrimination requirements
 - Tax penalty increased on HSA distributions for non-eligible expenses to 20%
 - Exclusion of over the counter drugs from FSAs, HSAs, HRAs & Archer MSAs unless prescribed by a physician
 - Extended preventive care coverage with no cost sharing
 - Expanded definition of women's benefits 8/1/2011
 - Rate Review
-

State of Michigan

- 2/10/2011 MI HR 25 2011
 - Michigan appeals to congress to amend PPACA to reinstate use of tax-favored health plans to cover the cost of over-the-counter pharmaceuticals
 - No further action to date
- Public Act No. 142
 - 1% assessment on paid claims under employer group health plans beginning 1/1/2012
 - Medical, prescription drugs, dental and vision claims received in Michigan by Michigan residents
 - Paid by insurers and TPA's up to \$10,000 maximum per individual insured

Medical Loss Ratio (MLR)

- Medical Loss Ratios (MLR)
 - Interim regulations issued 11/22/2010 – 45 CFR Part 158
 - 85% for large groups (50+ employees)
 - 80% for small groups (<50 employees)
- Waiver allowed if the requirement disrupts the state's insurance market
 - Kentucky & Iowa received partial approval
 - Maine, New Hampshire & Nevada received approval
 - Delaware & North Dakota were denied
 - 8 other states have applied as of 9/23/2011 and are pending decisions

Medical Loss Ratio (MLR)

- Michigan applied in July 2011 for MLR waiver approval for the individual insurance market
 - Still waiting for determination from CMS
- 1372 businesses have received waivers from certain requirements under health care reform
 - Waivers for minimum coverage requirements
 - Individual mandates
- It is not public which companies and other entities have been denied waivers and why they were denied
- HHS won't release information, nor will they publicly release the identities of those waiting for a decision



Health Care Reform

2012 Provisions

New Guidelines for Women's Preventive Services

- Expanded guidelines (including frequency of care) to be covered without cost sharing
 - Well-woman visits
 - Gestational diabetes screening
 - HPV DNA testing
 - STI counseling, and HIV screening and counseling
 - Contraception and contraceptive counseling
 - Breastfeeding support, supplies, and counseling
 - Domestic violence screening

W-2 Reporting Provisions Updated!

- Originally effective taxable years beginning 2011
 - Optional for 2011 (IRS Notice 2010-69)
 - Formal delay until 2013 (IRS Notice 2011-28)
 - Employers are not required to report the cost of health care coverage on any W-2 Forms required prior to January 1, 2013
 - Employers must report the aggregate cost of benefits provided for each employee on the employee's Form W-2
 - Amounts continue to be excluded from gross income
 - Aggregate cost is determined under COBRA like rules for self-funded plans


W-2 Reporting Provisions Updated!

- Transition relief for small employers
 - Employers who filed fewer than 250 W-2 Forms for 2011 are not subject to reporting for 2012
 - Future guidance anticipated to require reporting by small employers for W-2 Forms issued on or after January 1, 2014
 - Potential impact of excluding small group data from aggregate cost

W-2 Reporting Provisions Updated!

- Report the aggregate cost of coverage under all group health plans
 - Includes both employer and employee cost
 - Rely on COBRA guidelines to determine ‘group health plan’
 - Includes value of on-site medical clinics

W-2 Reporting Provisions Updated!

a Employee's social security number		Safe, accurate, FAST! Use		 Visit the IRS website at www.irs.gov/efile		
b Employer identification number (EIN)		1 Wages, tips, other compensation		2 Federal income tax withheld		
c Employer's name, address, and ZIP code		3 Social security wages		4 Social security tax withheld		
		5 Medicare wages and tips		6 Medicare tax withheld		
		7 Social security tips		8 Allocated tips		
d Control number		9		10 Dependent care benefits		
e Employee's first name and initial Last name Suff.		11 Nonqualified plans		12a See instructions for box 12		
		13 Statutory employee <input type="checkbox"/> Retirement plan <input type="checkbox"/> Third-party sick pay <input type="checkbox"/>		12b		
		14 Other		12c		
f Employee's address and ZIP code				12d		
15 State	Employer's state ID number	16 State wages, tips, etc.	17 State income tax	18 Local wages, tips, etc.	19 Local income tax	20 Locality name

Form **W-2** Wage and Tax Statement

2011

Department of the Treasury—Internal Revenue Service

Copy B—To Be Filed With Employee's FEDERAL Tax Return.
This information is being furnished to the Internal Revenue Service.

W-2 Reporting Provisions Updated!

- Four methods available to determine cost of coverage
 - COBRA equivalent premium
 - Premium charged
 - Modified COBRA premium
 - For employers who subsidize the cost of COBRA
 - Composite rate
 - Rarely used

W-2 Reporting Provisions Updated!

- Consistency in reporting is key!
 - If reporting active & periods of COBRA coverage
- Calendar year reporting only!
 - Mid-year terminations, enrollments & changes
 - Reported amount must take into account the change in coverage periods
 - Report each coverage period separately
 - Terminated employees requesting a W-2 prior to the end of the calendar year
 - Employer does not have to report the cost of coverage on that employee's W-2 Form for 2012

Summary of Benefits and Coverage and the Uniform Glossary

- All health insurance insurers (including self-insured plans) must provide a summary of benefits and a coverage explanation that meets specified criteria to all enrollees when
 - They apply for coverage
 - They enroll and reenroll in coverage
 - The policy is delivered
 - Any material modification is made to the terms of their coverage
 - They experience a life event
 - They request the information
- Effective March 23, 2012 for new employees enrolling for the first time, during a special enrollment period or following a life event
- Effective first annual enrollment for all employees
- \$1,000 fine per enrollee for willful failure to provide the information
 - Can apply to the group health plan and/or administrator
 - Further guidance to be issued regarding penalties from the DOL

Summary of Benefits and Coverage and the Uniform Glossary

- The summary and explanation
 - Can be provided electronically or in written form
 - Electronic distribution requires the insurance company or employer to
 - Request acknowledgement of receipt
 - Make the information available in an electronic format that is readily usable by the general public
 - Display internet postings in a prominent location that is easily accessible and notify each individual that the information is available and how to access it
 - Promptly provide a paper copy upon request
 - Must include:
 - Uniform definitions of standard insurance terms as well as a description of the coverage, including dollar amount for benefits
 - Exceptions, reductions and limitations on coverage
 - Cost-sharing provisions

Summary of Benefits and Coverage and the Uniform Glossary

- The summary and explanation
 - Must include:
 - Renewability and continuation of coverage provisions
 - Examples of common benefit scenarios
 - Statement whether the plan provides minimum essential benefits
 - Statement that the outline is in summary
 - Contact information where the consumer can get more information and a web link to the individual policy or group certificate of coverage


Summary of Benefits and Coverage and the Uniform Glossary

- Advance Notice of Benefit Changes
 - Group health plan participants must be notified 60 days **before** any material changes in plan terms
 - Material changes include changes to covered services, as well as deductibles and copayments
 - The penalty for a willful failure to comply with this provision can be as high as \$1,000 per day per failure
- NAIC created sample language
 - Language must be replicated using exact wording, format, and layout

Health Plan Name: Insurance Company 1

What This Plan Covers & What it Costs

Policy Period: 9/15/2010 - 9/14/2011
Coverage for: Individual | Plan Type: HMO

 **This is not a policy.** You can get the policy at www.insurancecompany.com/HMO1500 or by calling 1-800-XXX-XXXX. A policy has more detail about how to use the plan and what you and your insurer must do. It also has more detail about your coverage and costs.

Important Questions	Answers	Why This Matters:
What is the premium ?	\$280 monthly	The premium is the amount paid for health insurance. This is only an estimate based on information you've provided. After the insurer reviews your application, your actual premium may be higher or your application may be denied.
What is the overall deductible ?	\$1,500 Doesn't apply to office visits, preventive care, and generic drugs.	You must pay all the costs up to the deductible amount before this health insurance plan begins to pay for covered services you use. Check your policy to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible .
Are there other deductibles for specific services?	Yes; \$500 for pharmacy expenses.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
Is there an out-of-pocket limit on my expenses?	Yes. \$5,000	The out-of-pocket limit is the most you could pay during a policy period for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit ?	Copayments, premium, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit . So, a longer list of expenses means you have less coverage.
Is there an overall annual limit on what the insurer pays?	No. There is no <i>overall</i> annual limit, but see page 2 for <i>specific</i> limits on covered services.	The chart starting on page 2 describes any limits on what the insurer will pay for specific covered services, such as office visits.
Does this plan use a network of providers?	Yes. See insurancecompany.com for a list of participating doctors and hospitals.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Plans use the term in-network , preferred , or participating for providers in their network.
Do I need a referral to see a specialist ?	Yes. You need a referral to see a specialist.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have the plan's permission before you see the specialist.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 3.

Questions: Call 1-800-XXX-XXXX or visit us at www.insurancecompany.com

If you aren't clear about any of the terms used in this form, see the Glossary at www.insuranceterms.gov.

Covered Services, Cost Sharing, Limitations and Exception



- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. You pay this plus any deductible amounts you owe under this health insurance plan. For example, if the health plan's allowed amount for an overnight hospital stay is \$1,000 and you've met your deductible, your coinsurance payment of 20% would be \$200. If you haven't met any of the deductible and it's at least \$1,000, you would pay the full cost of the hospital stay.
- The plan's payment for covered services is based on the **allowed amount**. If an **out-of-network provider** charges more than the allowed amount, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the allowed amount is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower deductibles, copayments and coinsurance amounts.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$35 copay/visit	Not Covered	_____ none _____
	Specialist visit	\$50 copay/visit	Not Covered	_____ none _____
	Other practitioner office visit	30% coinsurance for chiropractor and 20% coinsurance for acupuncture	Not Covered	_____ none _____
	Preventive care/screening/immunization	\$35 copay/visit	Not Covered	No charge for mammograms at a participating provider
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance	Not Covered	_____ none _____
	Imaging (CT/PET scans, MRIs)	30% coinsurance	Not Covered	_____ none _____

Questions: Call 1-800-XXX-XXXX or visit us at www.insurancecompany.com

If you aren't clear about any of the terms used in this form, see the Glossary at www.insuranceterms.gov.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you need drugs to treat your illness or condition More information about drug coverage is at www.insurancecompany.com/prescriptions	Generic drugs	\$15 copay (retail); \$30 copay (mail order)	Not Covered	Covers up to a 30-day supply (retail prescription); 31-60 day supply (mail order prescription)
	Preferred brand drugs	\$40 copay (retail); \$80 copay (mail order)	Not Covered	
	Non-preferred brand drugs	\$60 copay (retail); \$120 copay (mail order)	Not Covered	
	Specialty drugs (e.g., chemotherapy)	Covered	Not Covered	
If you have outpatient surgery	Facility fee (example, ambulatory surgery center)	30% coinsurance	Not Covered	_____ none _____
	Physician/surgeon fees	30% coinsurance	Not Covered	_____ none _____
If you need immediate medical attention	Emergency room services	30% coinsurance	30% coinsurance	_____ none _____
	Emergency medical transportation	30% coinsurance	Not Covered	_____ none _____
	Urgent care	\$50 copay/visit	Not Covered	_____ none _____
If you have a hospital stay	Facility fee (example: hospital room)	30% coinsurance	Not Covered	_____ none _____
	Physician/surgeon fee	30% coinsurance	Not Covered	_____ none _____
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$50 copay/visit	Not Covered	_____ none _____
	Mental/Behavioral health inpatient services	30% coinsurance	Not Covered	_____ none _____
	Substance use disorder outpatient services	\$50 copay/visit	Not Covered	_____ none _____
	Substance use disorder inpatient services	30% coinsurance	Not Covered	_____ none _____
If you become pregnant	Prenatal and postnatal care	30% coinsurance	Not Covered	_____ none _____
	Delivery and all inpatient services	30% coinsurance	Not Covered	_____ none _____

Questions: Call 1-800-XXX-XXXX or visit us at www.insurancecompany.com

If you aren't clear about any of the terms used in this form, see the Glossary at www.insuranceterms.gov.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you have a recovery or other special health need	Home health care	30% coinsurance	Not Covered	60 visits per calendar year
	Rehabilitation services	30% coinsurance	Not Covered	60 consecutive day period per instance of illness or injury
	Habilitation services	30% coinsurance	Not Covered	———— none ————
	Skilled nursing care	30% coinsurance	Not Covered	60 days per calendar year
	Durable medical equipment	30% coinsurance	Not Covered	Covered up to \$1,000 per calendar year
	Hospice service	30% coinsurance	Not Covered	———— none ————
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	———— none ————
	Glasses	Not Covered	Not Covered	———— none ————
	Dental check-up	Not Covered	Not Covered	———— none ————

Excluded Services & Other Covered Services:

Services Your Plan Does **NOT** Cover (This isn't a complete list. Check your policy for others.)

- Bariatric surgery
- Non-emergency care when traveling outside the U.S.
- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Routine hearing tests
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy for other covered services and your costs for these services.)

- Acupuncture
- Chiropractic care
- Hearing aids

Coverage Facts:

Your Rights to Continue Coverage:

You can keep this insurance as long as you pay your premium unless one or more of the following happens:

- you commit fraud
- the insurer stops offering services in the state
- you move outside the coverage area

Your Grievance and Appeals Rights:

- A **grievance** is a complaint you have about your health insurer or plan. You have the right to file a written complaint to express your dissatisfaction or denial of coverage for claims under this health insurance. Call 1-800-XXX-XXXX or visit www.XXXXXXXXXXXXXX.com.
- An **appeal** is a request for your health insurer or plan to review a decision or a grievance again. For more information on the appeals process, call your state office of health insurance customer assistance at: 1-800-XXX-XXXX or visit www.XXXXXXXXXXXXXX.gov.

Glossary of Health Insurance and Medical Terms

- This glossary has many commonly used terms, but it isn't a full list. These are not contract terms. Those can be found in your insurance policy or certificate. You can get a copy of the policy at [www.insurancecompany.com] or you may call [1-800-xxx-xxxx].
- **Bold** text indicates a term defined in this Glossary.
- See page 4 for an example showing how deductibles, co-insurance and out-of-pocket limits work together in a real life situation.

Allowed Amount

Maximum amount on which payment is based for covered health care services. This may be called "eligible expense," "payment allowance" or "negotiated rate." If your **provider** charges more than the allowed amount, you may have to pay the difference. (See **Balance Billing**.)

Appeal

A request for your health insurer or **plan** to review a decision or a **grievance** again.

Balance Billing

When a **provider** bills you for the difference between the provider's charge and the **allowed amount**. For example, if the provider's charge is \$100 and the allowed amount is \$70, the provider may bill you for the remaining \$30. A **preferred provider** may **not** balance bill you.

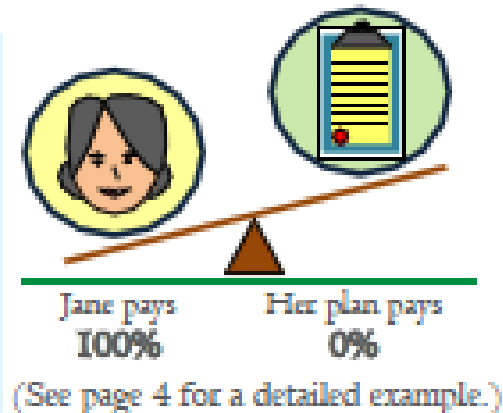
Co-insurance

Co-payment

A fixed amount (for example, \$15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Deductible

The amount you owe for health care services your **health insurance** or **plan** covers before your health insurance or plan begins to pay. For example, if your deductible is \$1000, your plan won't pay anything until you've met your \$1000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services.



Class Act

- NEW employee-funded long-term care benefit
 - Community Living Assistance Services and Supports Act – Class Act
 - Employer involvement is voluntary
 - 5 year investment period
 - Benefits available for assisted living after 5 years of payroll deducted premium
 - Employers participating must automatically enroll employees unless they opt-out
- Originally scheduled for a 1/1/2011 effective date
 - Most recent releases from HHS indicate no later than 10/01/2012
- **\$1.2 million in funding repealed for 2012 – no further guidance available at this time**
- **Many speculations Congress may repeal based on fiscal soundness**



Health Care Reform

Provisions Effective

January 1, 2013

Benefit Plan Requirements

- Section 125 Limits – Flexible Spending Account Limits
 - Contributions are limited to \$2,500 per year
 - Couples may make separate elections
 - Indexed by CPI annually beginning 2014

Tax Deduction Reduction

- Itemized deductions for unreimbursed medical expenses threshold increases from 7.5% of adjusted gross income to 10%
 - Waived for individuals age 65 and older for tax years 2013 through 2016

Medicare Part D Subsidy Tax

- Medicare Part D retiree prescription drug subsidy payments are no longer tax deductible



Health Care Reform

Provisions Effective

January 1, 2014

Waiting Period Requirements

- All Plans
 - Waiting period for coverage cannot exceed 90 days
- Large Employer Plans (50+ employees)
 - \$600 tax assessment for each employee with a waiting period exceeding 60 days

Health Insurance Exchanges

- An exchange is an insurance marketplace mandated by the federal government
- State based marketplace for buyers and sellers of health insurance
 - Each state must establish an American Health Benefit Exchange or use the federal government exchange
 - Each exchange must create a Small Business Health Options program (SHOP Exchange) for small employers to enroll employees in small group qualified health plans
- Exchanges in each State for individuals and small employers
 - Facilitates enrollment and administers subsidies

Health Insurance Exchanges

- Exchanges must
 - Offer only qualified health plans
 - To all qualified individuals
 - To all qualified employers
- Insurers can offer policies both inside and outside the exchange
- If an employer provides coverage through an exchange it must make all full-time employees eligible for one or more of the qualified health plans offered
- Subsidized by government

Health Insurance Exchanges

- Exchanges must have
 - An initial open enrollment period
 - An annual open enrollment period
 - And certain special open enrollment periods
- Cost sharing for qualified plans may not exceed current out of pocket maximums for HDHPs
 - \$5,950 for Individuals
 - \$11,900 for Families

Health Insurance Exchanges

- Coverage levels are not defined using specific deductibles, coinsurance and copayments
- Coverage levels based on actuarial value
 - The HHS has not yet issued guidance on how actuarial values will be assessed
 - Generally actuarial value of health insurance indicates the average share of medical spending paid by the plan vs. that paid by the participant
 - A plan with an actuarial value of 60% would mean in a standard population the plan pays 60% and participant pays 40% of health care expenses in any form or combination of:
 - Deductibles
 - Coinsurance
 - Copayments

Health Insurance Exchanges

- 5 coverage levels
 - Catastrophic (Individual only)
 - Up to age 30 – exempt from individual penalties – not available to groups
 - Bronze – 60%
 - Silver – 70%
 - Gold – 80%
 - Platinum – 90%

Health Insurance Exchanges

- Benefit plans inside the exchange must include:
 - Cost sharing maximum set at 60% of the actuarial value
 - Essential health benefits
 - Fully insured plans only
 - Accreditation on clinical quality measures
 - No pre-existing conditions for all ages & no medical underwriting
 - No annual limits on essential health benefits
 - No lifetime dollar limits on essential health benefits
 - Minimum of five levels of coverage
 - At least one offering in the gold and silver categories to participate on the exchange
 - Subsidies are based on the second lowest cost silver plan available

Health Insurance Exchanges

- Essential Health Benefits
 - Yet to be defined but most likely to include (expected release date 10/7/2011):
 - Ambulatory patient services
 - Emergency services
 - Hospitalization
 - Laboratory services
 - Maternity and newborn care
 - Mental health and substance use disorder services, including behavioral health treatment
 - Prescription drugs
 - Rehabilitative and habilitative services
 - Preventive and wellness services and chronic disease management
 - Pediatric services, including oral and vision care

Health Care Exchanges

- Health insurance premium & cost sharing subsidies
 - Refundable
 - Advanceable
 - Methods yet to be determined
 - Available for those with incomes between 133-400% of the federal poverty level
 - Individuals earnings less than 133% of federal poverty level generally eligible for Medicaid

Health Care Exchanges

Premium Subsidy Thresholds & % of Income Cap Amounts

# in Household	1	2	3	4	5	Premium Cap as % of Income
133%	\$14,404	\$19,378	\$24,352	\$29,327	\$34,301	3%
150%	\$16,245	\$21,855	\$27,465	\$33,075	\$38,685	4%
200%	\$21,660	\$29,140	\$36,620	\$44,100	\$51,580	6.3%
250%	\$27,075	\$36,425	\$45,775	\$55,125	\$64,475	8.05%
300%	\$32,490	\$43,710	\$54,930	\$66,150	\$77,370	9.5%
350%	\$37,905	\$50,995	\$64,085	\$77,175	\$90,265	9.5%
400%	\$43,320	\$58,280	\$73,240	\$88,200	\$103,160	9.5%

Source: healthreform.kff.org – Table by Incomes as Percent of the Poverty Level and Age, 2014

Health Care Exchanges

What a Family Pays

Age/Percentage	20	30	40	50	60
100%	Medicaid	Medicaid	Medicaid	Medicaid	Medicaid
125%	Medicaid	Medicaid	Medicaid	Medicaid	Medicaid
150%	\$1,405	\$1,405	\$1,405	\$1,405	\$1,405
175%	\$2,111	\$2,111	\$2,111	\$2,111	\$2,111
200%	\$2,952	\$2,952	\$2,952	\$2,952	\$2,952
225%	\$3,782	\$3,782	\$3,782	\$3,782	\$3,782
250%	\$4,714	\$4,714	\$4,714	\$4,714	\$4,714
275%	\$5,653	\$5,653	\$5,653	\$5,653	\$5,653
300%	\$6,676	\$6,676	\$6,676	\$6,676	\$6,676
325%	\$7,232	\$7,232	\$7,232	\$7,232	\$7,232
350%	\$7,789	\$7,789	\$7,789	\$7,789	\$7,789
375%	\$8,345	\$8,345	\$8,345	\$8,345	\$8,345
400%	\$8,901	\$8,901	\$8,901	\$8,901	\$8,901
425%	\$9,139	\$10,108	\$12,130	\$16,858	\$24,042

Source: healthreform.kff.org – Table by Incomes as Percent of the Poverty Level and Age, 2014

Health Care Exchanges

Subsidy Amounts

Age/Percentage	20	30	40	50	60
100%	Medicaid	Medicaid	Medicaid	Medicaid	Medicaid
125%	Medicaid	Medicaid	Medicaid	Medicaid	Medicaid
150%	\$7,734	\$8,703	\$10,725	\$15,452	\$22,637
175%	\$7,028	\$7,977	\$10,019	\$14,747	\$21,931
200%	\$6,188	\$7,157	\$9,179	\$13,906	\$21,091
225%	\$5,358	\$6,327	\$8,348	\$13,076	\$20,261
250%	\$4,425	\$5,394	\$7,416	\$12,143	\$19,328
275%	\$3,487	\$4,456	\$6,477	\$11,205	\$18,390
300%	\$2,463	\$3,432	\$5,454	\$10,182	\$17,366
325%	\$1,907	\$2,876	\$4,898	\$9,625	\$16,810
350%	\$1,351	\$2,320	\$4,341	\$9,069	\$16,254
375%	\$794	\$1,763	\$3,785	\$8,513	\$15,697
400%	\$238	\$1,207	\$3,229	\$7,956	\$15,141
425%	\$0	\$0	\$0	\$0	\$0

Source: healthreform.kff.org – Table by Incomes as Percent of the Poverty Level and Age, 2014

Health Care Exchanges

Percent of Premium Paid for a Family

Age/Percentage	20	30	40	50	60
100%	Medicaid	Medicaid	Medicaid	Medicaid	Medicaid
125%	Medicaid	Medicaid	Medicaid	Medicaid	Medicaid
150%	15%	14%	12%	8%	6%
175%	23%	21%	17%	13%	9%
200%	32%	29%	24%	18%	12%
225%	41%	37%	31%	22%	16%
250%	52%	47%	39%	28%	20%
275%	62%	56%	47%	34%	24%
300%	73%	66%	55%	40%	28%
325%	79%	72%	60%	43%	30%
350%	85%	77%	64%	46%	32%
375%	91%	83%	69%	50%	35%
400%	97%	88%	73%	52%	37%
425%	100%	100%	100%	100%	100%

Source: healthreform.kff.org – Table by Incomes as Percent of the Poverty Level and Age, 2014

Health Insurance Exchanges

- Cost sharing subsidies reduce out of pocket expenses (deductibles/coinsurance)
- Actuarial value of basic benefit plan increases based on federal poverty level as reflected in the table below for non-bolded options

Table 1: Actuarial Value and Plan Requirements in the ACA

	Actuarial Value	Out-of-Pocket Maximum	Who it Applies to
A	60%	HSA Level	Bronze plan, available to all individuals and small businesses
B	70%	HSA Level	Silver plan, available to all individuals and small businesses
C	70%	2/3 of HSA Level	Silver plan for people with income 300-400% of poverty
D	70%	1/2 of HSA Level	Silver plan for people with income 250-300% of poverty
E	73%	1/2 of HSA Level	Plan with cost-sharing subsidies for people with income 200-250% of poverty
F	80%	HSA Level	Gold plan available to all individuals and small businesses
G	87%	1/3 of HSA Level	Plan with cost-sharing subsidies for people with income 150-200% of poverty
H	90%	HSA Level	Platinum plan available to all individuals and small businesses
I	94%	1/3 of HSA Level	Plan with cost-sharing subsidies for people with income 100-150% of poverty

Note: Bolded rows reflect coverage that is available to all participants in the individual or small group market. Other levels of coverage are available only to individuals eligible for subsidies in Exchanges based on family income. "HSA Level" refers to the maximum out-of-pocket costs in a high deductible plan paired with a Health Savings Account.

The current limits are \$5,950 for an individual and \$11,900 for a family and will be adjusted over time.

Source: healthreform.kff.org

Health Insurance Exchanges

Table 2: Estimates of Plan Designs Meeting Selected ACA Actuarial Value Thresholds, 2014

			Actuarial Research Corporation		Aon Hewitt		Towers Watson	
	Actuarial Value	Out-of-Pocket Maximum	Deductible	Coinsurance	Deductible	Coinsurance	Deductible	Coinsurance
A	60%	\$6,350	\$6,350*	0%	\$4,350	20%	\$2,750	30%
B	70%	\$6,350	\$4,200	20%	\$2,050	20%	\$1,850	20%
C	70%	\$4,200	\$4,200*	0%	\$2,650	20%	\$1,550	30%
D	70%	\$3,200	\$3,200*	0%	\$3,200*	0%	\$2,050	30%
E	73%	\$3,200	\$3,200*	0%	\$3,200	0%	\$1,750	25%
G	87%	\$2,100	\$1,050	20%	\$250	20%	\$150	20%
I	94%	\$2,100	\$60	10%	\$200	5%	\$0	8%

Note: Amounts shown for the out-of-pocket maximum and deductibles are per person; figures for families would be double these amounts. Where an asterisk appears, the firm was unable to construct a plan design within the constraints of the actuarial value and out-of-pocket maximum. The deductible shown in these cases is equal to the out-of-pocket maximum, which is the highest it can be. The out-of-pocket maximum amounts are based on those for high-deductible plans that qualify to be paired with a Health Savings Account, inflated forward to 2014.

Source: healthreform.kff.org

Health Insurance Exchanges

- Large employers
 - 50 or more full time employees during preceding calendar year
 - Exception: employer not considered to employ more than 50 full time employees if
 - Its workforce exceeds 50 full time employees for 120 days or fewer during the year AND
 - The employees in excess of 50 employed during the 120 day period were seasonal workers
 - Full time employees work an average of at least 30 hours per week
 - Part time employees are counted as full time equivalent employees
 - Add total # full time employees PLUS a number equal to the total number of hours worked in a month by part time employees divided by 120
 - IRS requests public comment – Notice 2011-36 to determine approaches to determine full time employee definition
-

Health Insurance Exchanges

- SHOP program operational in 2014 for uninsured individuals and employers with less than 50 employees
 - Operational in 2016 for employers with less than 100 employees
- No penalty to small employers (less than 50 employees) not providing coverage
- Yet to be determined
 - Participation and contribution requirements both inside and outside of the exchange

Health Insurance Exchanges

- Large Employer Mandate
 - Requires most employers to provide a qualified health plan or “play or pay provisions” apply (or shared responsibility provisions)
 - If any employees’ cost of coverage exceeds 9.5% of household income AND at least one employee purchases coverage through the exchange penalties apply

Health Insurance Exchanges

- Penalties

- Large employers not offering a qualified health plan to employees pay \$2,000 annually (1/12 per month) for each full time employee over the first 30 employees

- Indexed annually beginning 2014

- Example: Company A does not provide access to a qualified health plan for 150 employees, and even 1 employee is enrolled for and receives premium subsidy to purchase coverage through the exchange

Penalty = 150 employees – 30 employees = 120 employees

120 employees * \$2,000 annually = **\$240,000 annually**

Health Insurance Exchanges

- Penalties
 - Large employers who offer a qualified health plan but have employees receiving premium subsidy pay the lesser of \$3,000 for each worker receiving a premium subsidy up to an aggregate cap of \$2,000 per full time employee
 - Penalty applies if the plan is not affordable
 - If any employees' cost of coverage exceeds 9.5% of household income AND at least one employee purchases coverage through the exchange penalties apply

Health Insurance Exchanges

- Example: Company A provides access to a qualified health plan for 150 employees, 20 employees are enrolled for and receive premium subsidy to purchase coverage through the exchange

Penalty = 150 employees – 30 employees = 120 employees

120 employees * \$2,000 annually = \$240,000 annually

20 employees eligible for premium subsidy * \$3,000 =

\$60,000 PENALTY

- ***This is a PENALTY and not TAX DEDUCTIBLE***

Will the Employer Pay A Penalty? *beginning in 2014*

Are you a large employer?

- at least 50 full-time equivalent workers
 - including full-time [30+hours per week] and part-time workers [prorated]
 - excluding seasonal workers [up to 120 days per year]

yes

no

Are any of your full-time employees in an exchange plan and receiving a premium credit?

yes

no

Do you have more than 30 full-time employees?

yes

no

Do you provide health insurance?

yes

no

No penalty

Pay Monthly Penalty, *lesser of:*

$\frac{1}{12} \times \$2,000 \times$
(Number of full-time employees - 30)

or

$\frac{1}{12} \times \$3,000 \times$
(Number of full-time employees who receive credits for exchange coverage)

Pay Monthly Penalty

$\frac{1}{12} \times \$2,000 \times$
(Number of full-time employees - 30)

Summary of Potential Employer Penalties under PPACA, Congressional Research

Service, May 14, 2010

Health Insurance Exchanges

- Employer compliance strategies
 - No Action
 - Little or no fines
 - High income group
 - Rich benefit levels
 - Low contributions
 - Amend Plans to Avoid Fines
 - Reduce contributions as a percentage of plan cost
 - Increase benefits
 - Increase wages
 - Pay Fines
 - Cost of providing coverage substantially greater than fines

Health Insurance Exchanges

- Careful evaluation of current plan design
 - Income evaluations
 - Benefit testing
 - Contribution testing

Health Insurance Exchanges

- Individual Mandate
 - Requirement to have coverage
- Tax penalty for those without coverage
 - The greater of \$695 annually to maximum of \$2,085 per family or 2.5% of household income
 - Phase In:
 - 2014 - \$95 or 1% of household income
 - 2015 - \$325 or 2% of household income
 - 2016 - \$695 or 2.5% of household income
 - Will increase annually with cost of living

Health Insurance Exchanges

- Challenges
 - Reforms such as guarantee issue, guaranteed renewal, 3:1 age rating variation, 1.5:1 smoking rating variation & insurance market reforms will drive premiums higher
 - Weak individual mandate with modest penalties for not purchasing health insurance
 - Use of traditional health plans such as PPOs and HMOs will not result in lower costs under the Exchange
 - Only insured medical products - self funding not permitted

Michigan Health Insurance Exchange

- Proposed Legislation - MI Health Marketplace
 - Non-profit corporation
 - Governed by a board of seven voting members and the Insurance Commissioner
 - Limited to no more than 2 consecutive terms of office
 - Without conflicts of interest
 - Board to establish committees for guidance for operation and implementation of the marketplace
 - Board to establish criteria for rating health plans offered based on relative value and quality
-

Michigan Health Insurance Exchange

- Proposed Legislation - MI Health Marketplace
 - Contracts with public and/or private entities for management and operations
 - Health plans to be available via web for review, purchase or enrollment by January 1, 2014
 - Only qualified health plans allowed
 - Those eligible for subsidy will receive additional information
 - Small employers = <100 employees
 - Includes part-time employees
 - Growth over 100 still eligible provided continuous enrollment is available through the SHOP

Michigan Health Insurance Exchange

- Proposed Legislation - MI Health Marketplace
 - Board to develop rating criteria for health plans
 - Justification for premium rate increases must be submitted in advance
 - Board will review justification and determine if plans will be allowed to continue in the MI Health Marketplace

Automatic Enrollment

- Employers with more than 200 full time employees offering enrollment in one or more health benefit plans must automatically enroll new full time employees in one of the offered plans
- Adequate notice must be provided
- Option to waive coverage mandatory

Automatic Enrollment

- Supersedes state laws that would otherwise prevent automatic enrollment
- Includes “evergreen” approach to existing elections during annual enrollment period for current participants
- Secretary of Labor to issue regulations
 - Effective date is March 23, 2010, but subject to issuance of regulations which could delay this provision to as late as 2014

Small Business Tax Credit (Phase 2)

- Tax credit equal to 50% of health insurance costs
- To qualify for the full credit the business must have:
 - 10 or fewer full-time equivalent employees
 - Average annual wages of less than \$25,000
 - Employer must pay 50% or more of the premium
 - Must purchase coverage through the state based exchange
- Companies with between 11 and 25 workers and an average wage of less than \$50,000 are eligible for partial credits

Wellness Incentives

- Plans may condition wellness rewards upon satisfaction of a standard that is related to a health status factor
 - Rewards may not exceed 30% of cost of employee-only coverage
 - If spouse/dependents participate the reward cannot exceed 30% of cost of couple/family coverage
 - Reward may include
 - Rebate of premium
 - Contributions
 - Waiver of cost-sharing (deductibles, copays, etc.)
 - Potential for an increase of up to 50% of the cost of coverage
-

Tax Changes

- Premium Tax
 - Federal premium tax on health plans funding comparative effectiveness research program begins
- For insured plans, the health insurance issuer pays the fee
- For self-funded plans, the plan sponsor (usually the employer) pays the fee

Tax Changes

- The dollar amount of the fee will vary depending on the fiscal year in which a plan or policy year ends
 - For plan or policy years ending in fiscal 2013, the fee will be equal to \$1 multiplied by the average number of covered lives
 - For plan or policy years ending in fiscal 2014, the fee will be \$2 per average number of covered lives
 - For fiscal years 2015 through 2019, the \$2 fee is indexed to the growth in national health spending as measured by the Centers for Medicare and Medicaid Services' per-capita National Health Expenditure data.
 - Fee terminates at the end of fiscal 2019
-

Tax Changes

- Employee Portion of Medicare Hospital Insurance Tax
 - For individuals who earn \$200,000+ (\$250,000+ for joint filers) the Medicare tax rate will increase by .9% (1.45% - 2.35%) – for employee share only
 - Additional tax is imposed on combined wages of employee and spouse in the case of a joint return
 - Withhold the increased amount from all workers with wages exceeding \$200,000 regardless of marital status claimed on Form W-4
 - Standard employer penalties for failure to withhold the tax apply
 - Applies to self-employment income exceeding threshold

Tax Changes

- Medicare Tax Rate
 - 3.8% tax on investment income for individuals, estates, and trusts
 - Imposed on modified AGI exceeding \$250,000 (joint filers), \$125,000 (individual filers)
 - Distributions from qualified retirement plans are not treated as investment income

Mandates for All Plans

- Coverage of essential benefits for individual and small group plans
- No annual dollar limits on essential health care benefits
- Guaranteed issue
 - Insurers will no longer be able to set rates or exclude coverage based on pre-existing conditions, and can vary premiums only by geographic location, age, and tobacco use
 - Insurance carriers may no longer deny coverage based on health factors
- Guaranteed renewals
- No pre-existing condition exclusions for all enrollees



Health Care Reform

Provisions Effective
January 1, 2015 & Beyond

2015 & Beyond

- 2015
 - Individual mandates increase to \$325 (from \$95) or 2% of household income over filing threshold
 - Large employer reporting of health insurance coverage
 - Average of at least 50 full-time employees on business days for preceding calendar year
 - Exemption applies for employers exceeding 50 employees for fewer than 120 or fewer days during preceding calendar year provided they are seasonal workers
 - 2016
 - Individual mandates increase to \$695 or 2.5% of household income over filing threshold
-

2015 & Beyond

- 2017
 - Large employers permitted to purchase coverage through state exchanges
- 2018
 - Tax on high cost (Cadillac) plans
 - 40% excise tax on employer-sponsored health benefits in excess of \$10,200 for individuals and \$27,500 for families
 - Employers will be required to provide information to the IRS and insurers for the amounts subject to excise tax

Some Statistics

- 88 Million
 - The number of people predicted to lose their employer plan (Lewin Group)
 - Congressional Budget Office (CBO) estimates 8 million to 9 million individuals, mostly lower-wage workers and people who work for smaller employers, could lose their employer-sponsored coverage as a result of the legislation
- 7.4 Million
 - The number of seniors and disabled people at risk of losing their Medicare Advantage Plan (Medicare Chief Actuary)
- \$100 Million
 - The cost of Healthcare Reform mandates for Caterpillar, Inc in the first quarter of 2011 (Caterpillar, Inc)
- 1 in 7
 - Hospitals & facilities that would become unprofitable after Medicare spending cuts (Medicare Chief Actuary)
- \$460 Annually Per Person
 - Estimated cost of private insurance increases as a result of cost-shifting (Lewin Group)

End Results...

- Higher costs for health insurance
- Expansion of health care in the US at a HUGE cost!

Medicare Part D Procedure Change

- Updated creditable coverage notices are due October 15th this year!
- CMS has released updated Creditable and Non-Creditable model notices
- The CMS requires employers providing prescription drug coverage to notify their Medicare eligible participants of the creditability status of the prescription drug plan
- Due to Health Care Reform the annual enrollment period has changed and notification is due prior to the annual Part D enrollment period
 - Was November 15th through December 31st of each year
 - Now October 15th through December 7th
 - JS Clark released to clients September 15th

IRS Announces 2012 HSA Maximums

- 2012 cost-of-living adjustments affecting HSAs
 - Contribution Limits
 - Individuals with self-only HDHP coverage is \$3,100
 - \$50 increase from 2011
 - Family with HDHP coverage is \$6,250
 - \$100 increase from 2011
 - Minimum Required Deductibles
 - Individuals with self-only HDHP coverage remains \$1,200
 - Family with HDHP coverage remains \$2,400
 - Out-of-Pocket Maximum
 - Individuals with self-only HDHP coverage is \$6,050
 - \$100 increase from 2011
 - Family with HDHP coverage is \$12,100
 - \$200 increase from 2011

Our Role

- We will continue to monitor developments as regulations are released
- Provide updates and communication guidance
- Provide technical support
- Continue to seek and secure cost containment opportunities



Q & A

Jennifer Young
Corporate Compliance Director
J.S. Clark Agency, Inc.
248-355-9600
jennifer@jsclarkagency.com
www.jsclarkagency.com

Joel Clark
President
J.S. Clark Agency, Inc.
248-355-9600
joel@jsclarkagency.com
www.jsclarkagency.com