Market Reforms

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Agenda

- 2013 Market Reforms
- 2014 Market Reforms

2013 Market Reforms

- FSA Max $2500. Limit does not include employer contributions
- Medicare Tax. Hospital insurance tax increases .9% for high income earners.
- 3.8% Medicare tax extends to investment income for high income earners.

2014 Market Reforms

- Guarantee Issue. No pre-x
- Effective policy or plan years on or after January 1, 2014, individual and small group will be subject to new rating requirements:
- Community Rating:
  - 3:1 age
  - Geographic area
  - Individual/Family
  - Tobacco 1.5:1
- Health status no longer taken into account.

2014 Market Reforms

- Rating & Pooling:
- Final Rule:
  - Default: one rating area of each MSA in the state and one rating area for all non-MSAs in the state.
- Single Risk Pools:
  - One for individual
  - One for small group
  - State can decide whether to merge the markets.
- Applies to coverage inside and outside the exchange.

2014 Market Reforms

- Nondiscrimination:
- Extends HIPAA rules prohibiting group health plans from establishing rules for eligibility to enroll in coverage based on specified status-related factors (health status, medical condition, claims experience, receipt of health care, medical history, generic information and evidence of insurability) to the individual market.
- Extends current HIPAA rules prohibiting group health plans from charging enrollees higher premiums based on health status (current PHSA § 2702(b)) to the individual market.
- Applies to plans in all markets (but not to grandfathered plans).

2014 Market Reforms

- Guaranteed Renewability:
  - Mandates that health insurance issuers in the individual and group markets renew or continue in force such coverage at the option of the plan sponsor or individual.
  - Allows coverage to be non-renewed in the following circumstances:
    - non-payment of premium;
    - fraud or intentional misrepresentation of material fact;
    - In the case of group health coverage, failure to comply with a material plan provision relating to contribution or participation requirements;
    - movement outside the network service area;
    - the issuer ceases to offer coverage of this type (i.e., forms discontinuance); or
    - the issuer exits the market.

2014 Market Reforms

- Wellness Program:
  - Permits employers to vary premiums by as much as 30% for employee participation in certain health promotion and disease prevention programs. Effective 1/1/14.

Wellness Program:

- Wellness Program:
  - 30% Limit. Rewards for such programs may not exceed 30% of the cost of employee-only coverage, determined based on the total amount of employer and employee contributions
  - Or, if dependents are eligible for the program, 30% of the cost of coverage in which an employee and any dependent are enrolled.
  - Allows HHS to increase this ceiling to 50%.

Wellness Program

- Wellness Program:
  - Programs Not Subject to Requirements:
  - Participation is not based on a health status factor.
  - Do not link rewards to a standard related to a health status factor – so long as participation is made available to all “similarly situated individuals.”
  - Do not provide rewards – so long as participation is made available to all “similarly situated individuals.”

2014 Market Reforms

- Provider Nondiscrimination:
  - Prohibits discrimination against providers acting within the scope of the license or certification with respect to participation under a plan.
  - Is not an “any willing provider” requirement and that the provision does not prohibit reimbursement based on quality or performance
  - Applies to all markets (but not to grandfathered plans). Effective 1/1/14

2014 Market Reforms

- Clinical Trial Coverage:
  - Requires coverage of routine costs for and prohibits discrimination against clinical trial participants. Applies to insured plans in all markets and self-funded plans (but not grandfathered plans).

2014 Market Reforms

- Individual Mandate
  - Penalty $95 year (monthly determination) or 1% of income (whichever is higher), not to exceed 300% ($ 285)
  - 2015: $325 or 2% income
  - 2016: $695 or 2.5% income
  - No more than the lowest cost policy sold through the exchange.
  - Penalty for children is ½ of the adult penalty.

2014 Market Reforms

- Subsidies:
  - 100%-400% FPL
  - Only available in the exchange
  - Can't get subsidy if you are eligible for:
    - Medicaid
    - Tricare
    - CHIP
    - VA
    - Medicare

2014 Market Reforms

- Subsidies:
  - Set up so person doesn't pay more than a fixed amount of his income
  - Cost-sharing subsidies available for expenses such as deductibles and co-pays

2014 Market Reforms

- Employer Shared Responsibility Requirement
- Benefit Levels in Exchange:
  - Bronze, Silver, Gold, Platinum
  - Silver and Gold are a must

2014 Market Reforms

- Essential Health Benefits:
  - 10 categories of coverage
  - Most controversial: pediatric dental & habilitative
  - State has flexibility to choose habilitative services, but if not, carriers will decide.
  - Nebraska EHB Plan: BluePride Opt 5
  - Final Regs issued 2/20/13

2014 Market Reforms

- Any benefit mandate enacted by the legislature after December 31, 2011, falls outside of the EHBs.
- Who pays? Taxpayers?
- State payments made directly to enrollees (individual) or health plans in which individuals are enrolled (small group).

2014 Market Reforms

- Gun Rights Protections:
  - Prohibits any requirements for disclosure of or collection of information on gun ownership under the bill. Insurers cannot use such information to increase premiums, deny coverage or reduce or withhold rewards for wellness program participation.

2014 Market Reforms

- Cost-sharing limitations:
  - Individual and small group that are required to offer EHBs must meet cost-sharing limits tied to the current HSA limits ($6,400 single; $12,800 family)
  - Small group plans: limit deductibles to $2k single; $4k family.
  - Cost-sharing limits do not apply to out-of-network benefits

2014 Market Reforms

- Insurer Tax
  - Market share
- Transitional Reinsurance Tax

Employer Shared Responsibility

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Overview

- 2014: Employers employing at least a certain number of employees and full-time equivalents will be subject to the ESR provision.
- Don’t offer coverage or unaffordable coverage to full-time employees, could be subject to ESR payment if at least 1 full-time employee receives a premium tax credit for purchasing individual coverage in the exchange.

Certain Number of Employees

- At least 50 full-time employees or a combination of full-time and part-time employees that is equivalent to at least 50 full-time employees.
- Ex: 100 half-time employees=50 full-time employees
- Full-time employee works on average 30 hours per week

Who is Affected?

- Large employer that either:
  - Doesn't offer coverage or offers coverage to less than 95% of its full-time employees (and their dependents) and at least one employee receives a premium tax credit in the hix.
  - Or…
  - The employer offers coverage to at least 95% of its full-time employees (and their dependents) and the employee receives a premium tax credit in the hix which may have occurred because the employer didn't offer coverage to that employee or the coverage was unaffordable or did not provide minimum value.

Penalties

- Only penalized if not offering coverage, have 50 or more full-time employees, including part-timers, and one or more employees receive a subsidy through the exchange
- Could be penalized for offering unaffordable coverage if employee portion is greater than 9.5% of wages and employee receives subsidy

Provisions Go into Effect

- January 1, 2014
- Fiscal year/2014 for fiscal plan years
- Close to 50? Measure during 2013 to determine if employer is subject to 2014 ESR provisions.

No Coverage

- Step 1: Understand the Rules
- If employer has 50 full-time employees (30+ hours/week or 130 hours/month) and offers no coverage, the penalty is $2,000 per employee per year ($166.67 per month) if any employee receives a subsidy in the exchange, minus the first 30 employees.
- Part-time employees calculated by taking the hours worked by part-time employees in a month divided by 120
- Seasonal employees not counted if working less than 120 days a calendar year

Determine Number of Employees

- Step 2: Are you an applicable large employer?
- A large employer is one who employed an average of 50 full-time employees on business days during the preceding calendar year
- Again, takes into account part-time employees as “full-time equivalents”

Calculate Part-time Employees

- Only for purposes of determining if ‘Pay or Play’ applies – do not have to offer coverage to part-time employees
- Hours worked in month ÷ 120 = FTEs
- Example
- A restaurant has 20 part-time employees who all work 24 hours per week or 96 hours per month.
- These 20 part-time employees would be counted as 16 full-time employees.
- 20 part-time employees X 96 hours worked in a month = 1920 ÷ 120 hours = 16 full time equivalents

Determine Full-time Status: Ongoing

- Step 3: Which employees are full-time?
- FTE = 30+ hours a week
- For ongoing employees, IRS proposed 3-12 month standard measurement (“look back”) period selected by employer to determine individual's full-time status
- If determined to be FTE, must offer coverage during a subsequent stability period of at least 6 months but no shorter than standard measurement period

Determine Full-time Status: Example

- For January 1 plans, employer could choose:
- 12-month standard measurement period beginning October 15 and ending October 14
- An administrative period between October 14 and January 1
- 12-month stability period beginning January 1 and ending December 31
- Total hours worked ÷ months = more than 130?
- The administrative period can be used to identify full-time employees, notify them of their eligibility for coverage, and enroll those who elect coverage. Must overlap with stability period.

Determine Full-time Status: Variable

- What about new variable hour or seasonal employees?
- Use an “initial measurement period” of between 3-12 months to determine average hours worked
- If determined to be full-time, use a stability period that is consistent with ongoing employees and at least 6 months
- Employees become ongoing after the initial measurement period and a full standard measurement period

Calculating the Penalty

- Step 4: Do you owe a penalty?
- (FTEs – 30) X $166.67 month = penalty.
- Penalties calculated on a month-by-month basis
- Employers are only subject to this penalty if not offering coverage and at least one employee receives a subsidy in the exchange.
- Total number of full-time employees is used when calculating this penalty.

Offer Coverage

- Step 1: Is your coverage affordable?
- If employer is offering insurance but it's not affordable, employee can go to the exchange and receive a subsidy
- Unaffordable = employee portion >9.5% of income (W-2 Box 1) or coverage doesn't meet minimum value (60% actuarial value)
- 1/12 of $3,000 ($250) for each full-time employee (not dependent) who receives a subsidy in the Exchange.
- 9.5% affordability test applied only on lowest cost plan, single coverage.

Offer Coverage-Overall Limitation

- The penalty for large employers offering coverage shall not exceed the penalty for those employers NOT offering coverage.
- The absolute highest penalty an employer offering coverage can have is:
- (FTEs – 30) X $166.67 month = penalty.

Measure Hours in 2013

- 50 full-time employees or combo that gets you to 50 full-time employees
- Determine each year, based on current number of employees whether employer is a large employer for next year
- 50 full-time employees in 2013 means employer is large employer for 2014

Measure Hours in 2013

- Average the number of employees across the months in the year to determine if large employer
- Averaging can take fluctuations into account
- Transitional relief: close to 50 but not sure?
  - Can use any consecutive 6 month period in 2013 to measure
  - And 6 months to analyze results

Look Back

- Use look back period to determine hours of service over last year to determine status as a full-time employee for the purpose of the assessment penalty.
- Look back period can be from 3-12 months
- If the employee were determined to be employed on average at least 30 hours of service per week during the measurement period, then the employee would be treated as a full-time employee during a subsequent period (the stability period)

Look Back

- For an employee who has been determined to be employed on average of at least 30 hours of service per week during the measurement period, the stability period would be a period that followed the measurement period, and the duration of which was at least the greater of six consecutive calendar months or the length of the measurement period.
- Measure: 6-12 mos
- Stability: 6+mos

Look Back

- If the employee were employed on average less than 30 hours per week during the measurement period, the employer would be permitted to treat the employee as not a full-time employee during a stability period that followed the measurement period, but the length of the stability period could not exceed the length of the measurement period.
- Measure & Stability Periods must be at least =

Look Forward

- Provides employers the option to use a measurement period of up to 12 months to determine whether new variable-hour employees or seasonal employees are full-time employees
- Variable hour employee: at the start date, it cannot be determined that the employee is reasonably expected to be employed on average at least 30 hours of service per week.

Look Back/Look Forward

- Measurement Period
- Specified administrative periods up to 90 days for ongoing employees and certain new employees
  - To facilitate a transition for new employees from the determination method the employer chose to use for new employees to the determination method the employer chose to use for ongoing employees.
  - Enroll employees in coverage

Look Back

- Look back periods for:
- Ongoing
  - –3 to 12 months measurement period

- Look forward:

  New employee, 30 hours ?

  - –3-6 months to determine if full-time employee
- New variable hours & new seasonal
  - –Up to 12 months/no penalty

Look Back/Hours of Service

- Hourly basis: employers must calculate actual hours of service from records of hours worked and hours for which payment is made or due for vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty or leave of absence

Look Back/Hours of Service

- Non-hourly: employers are permitted to calculate the number of hours of service under any of the following three methods:
  - (1) counting actual hours of service (from records of hours worked and hours for which payment is made or due for vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty or leave of absence;
  - (2) using a days-worked equivalency method whereby the employee is credited with eight hours of service for each day for which the employee would be required to be credited with at least one hour of service under these service crediting rules; or
  - (3) using a weeks-worked equivalency of 40 hours of service per week for each week for which the employee would be required to be credited with at least one hour of service under these service crediting rules.

Look Back/Averaging Method

- Determine the average hours of service per week for the employee during the measurement period excluding special unpaid leave period
- Use that average as the average for the entire measurement period
- Alternatively, the employer may choose to treat employees as credited with hours of service for special unpaid leave at a rate equal to the average weekly rate at which the employee was credited with hours of service during the weeks in the measurement period that are not special unpaid leave

Look Back

- Non-hourly:
  - Employer must use 1 of 3 options presented
    - Count hours
    - Days-worked equivalency
    - Weeks-worked equivalency
  - Doesn't have to use same method for all non-hourly employees
  - Reasonable and consistently applied

Minimum Value Requirement

- To determine if the employer is offering coverage that meets minimum value, use HHS' minimum value calculator.
- Employer can input figures such as deductibles and co-pays and determine if the plan meets minimum value (60% AF of total allowed cost of benefits that are expected to be incurred under the plan).

Affordability Safe Harbors

- W-2
- Rate of Pay
- FPL

Does Employer Owe Money?

- Initial IRS Contact
- Employer Responds
- IRS sends notice and demand for payment
- Payment calculated monthly but presented to employer at end of year.
- IRS first looks at employees' individual tax returns claiming premium tax credit.
- Large employer files information return.
- Employer payment NOT made on tax return.

Employee Eligibility for Tax Credit

- Employees who are between 100-400% FPL
- Enroll in individual exchange
- Not eligible for Medicaid, CHIP
- Not eligible for employer-sponsored coverage
  - Unaffordable
  - Doesn't meet minimum value

Reliance on Proposed Regs

- Rely on these until final regulations are issued
- Employers will be given sufficient time to comply with final regs

90 Day Waiting Period

- Temporary guidance in effect until 2014
- Group health plan or health insurance issuer offering group health insurance coverage shall not apply any waiting period that exceeds 90 days
- Prevents an otherwise eligible employee (or dependent) from having to wait more than 90 days before coverage becomes effective.

Auto-enrollment

- Automatically enroll new full-time employees in the employer's health benefits plans and continue enrollment of current employees.
- Applies to employers with more than 200 full-time employees
- 2014

The True Cost of PPACA

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Topics

- Overview of Key Provisions with Direct Financial Impact on Employers, Individuals, and Carriers

- True Cost of PPACA

Preventive Services

In the first wave of health care reform provisions, PPACA required certain services to be covered without cost-sharing

- Preventive services that receive top marks from the U.S. Preventive Services Task Force.
- Immunizations recommended by the U.S. Centers for Disease Control and Prevention immunization practices advisory council.
- The preventive care and screenings recommended for babies, children and adolescents by the federal Health Resources Services Administration (HRSA).

Women's Preventive Services

In 2012, HHS amended the Preventive Services requirements to include certain additional services for women that must be covered without cost-sharing:

- Well-woman visits
- Gestational diabetes screening
- Domestic and interpersonal violence screening and counseling
- FDA-approved contraceptive methods, and contraceptive education and counseling
- Breastfeeding support, supplies, and counseling
- HPV DNA testing, for women 30 or older
- Sexually transmitted infections counseling for sexually-active women
- HIV screening and counseling for sexually-active women

Essential Health Benefits

- Beginning on January 1, 2014, PPACA requires that all non-grandfathered individual and small group health insurance plans sold in a state, including those offered through an Exchange, cover certain essential health benefits (EHBs).

- The categories of EHBs are:
  - Ambulatory patient services
  - Emergency services
  - Hospitalization
  - Maternity and newborn care
  - Mental health and substance use disorder services, including behavioral health treatment
  - Prescription drugs
  - Rehabilitative and habilitative services and devices
  - Laboratory services
  - Preventive and wellness services and chronic disease management
  - Pediatric services, including oral and vision care

Taxes

- Beginning in 2014, PPACA imposes a tax of at least $73 billion through 2019 on many Americans in the form of what is essentially a sales tax on health insurance.
  - Businesses that purchase insurance
  - All individuals and families who purchase coverage in the individual market or through an Exchange
  - Medicare beneficiaries who enroll in Medicare Advantage health plans
  - States that contract with managed care organizations under Medicaid
- The tax begins at $8 billion in 2014 and rises to $14.3 billion in 2018. It increases thereafter annually based on premium growth.
- While the tax is assessed on health plans, the cost will be transferred to customers.

Fees

- In order to offset expected large claims which will be absorbed by the exchanges for individual coverage, a **Reinsurance Fee**, assessed on a per-capita basis, will apply from 2014 to 2016 on insurers and self-funded plans. The total fees are estimated at $12 billion in 2014, $8 billion in 2015 and $5 billion in 2016. They will increase total plan costs by approximately 3% to 4%.

- PPACA also imposes a **Patient-Centered Outcomes Research Institute Fee** on commercial health insurers and self-funded plans. The fee, which is one dollar per covered life for the first year, increasing to two dollars per covered life for the second year and indexed to medical inflation thereafter, is used to pay for research on comparative effectiveness by the new Patient-Centered Outcomes Research Institute.

Administrative Simplification

- PPACA requires HHS to issue rules to implement new and amended standards and operating rules for electronic administrative and financial transactions.
  - Adopts Operating Rules for each individual standard transaction
  - Establishes a unique health plan identifier
  - Establishes a standard and associated operating rules for health claims attachments
  - Establishes a standard for electronic funds transfers
- The exact cost of implementing these new standards is unknown since final rules have yet to be issued, but the requirements could be significant.

Health Insurance Marketplace

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Agenda

- Exchange
- Health Insurance Marketplace
- Nebraska's Plan
- State Options/Decisions
- National Update
- User Fees

Exchange

- Individual Exchange
- SHOP Exchange
- Term “exchange” includes both
- Need to set up both in the state (can be various models)

Exchange

- Online portals for purchasing insurance
- To the consumer, seamless purchasing experience
- Back end, highly complex
- Run by government entity or non-profit organization

Exchange Choices:

- FFE-January 1, 2013, choose or default
- Partnership-February 15, 2013 drop dead date
- State-based-December 15, 2012 drop dead date
- Regional-Never really a choice in NE

Individual Exchange

- Single or families
- Only place to get subsidies
- Paper apps/bricks & mortar locations
- Online app-”real time” eligibility determination
- Will interact with carriers’ websites
- Products sold in the exchange must be the same price outside of the exchange
- Today’s marketplace will still exist

SHOP Exchange

- Small groups will be able to purchase insurance coverage through exchange.
- 2-50 until 2016
- Up to state to determine small group size
- 2016: 1-100 federal definition of “small employer”
- 2017-Nebraska has option of adding large group employers (101+)
- Can get small group tax credit if you qualify
  - IRS.gov
  - 2 consecutive years

Initial Open Enrollment

- October 1, 2013 through March 31, 2014
- Annual OE periods thereafter
- Special enrollment periods
- Coordination with Medicaid and CHIP
- Brokers/agents available to help you
- Navigators for hard-to-reach populations
  - Public education; not insurance advice

Plan Levels in the Exchange

- Bronze
- Silver-*must
- Gold-*must
- Platinum
- Catastrophic-under 30/hardship waiver

Products

- Must be QHP certified
- Must offer MEC (60% AV)
- Must have EHBs in each offering
- Must have child-only offerings as well (1:1)
- Same premium for same plan
  - Inside & outside the exchange

Health Insurance Marketplace

- Now referred to as Health Insurance Marketplace
- 1/17/13
- Rebranding effort
- Consumer-friendly

Nebraska's Plan

- On Nov. 15, Governor Heineman chose a federal health insurance exchange (FFE), citing increased costs on Nebraska taxpayers.
- State exchange = $646 million over the rest of this decade
- Federal exchange = $176 million

Nebraska's Plan

- Nebraska Department of Insurance:
  - Plan management
    - Retain sovereignty/authority
    - Nebraska certified for plan management 3/11/13
  - Dialogue with Feds
  - Wait on further guidance

State Options/Decisions

- States have until February 15 to choose a federal-state partnership exchange.
- 17 states+ D.C. chose a state-run exchange.
- 26 states chose a FFE
- 7 state chose partnership

National Update

- CMS is hosting a month long series of calls with carriers to nail down the technical requirements of building the exchange.
- Conditional Approvals: 1/17/13-HHS announced that $1.5 billion in new Exchange Establishment Grants have been awarded to the following states: California, Delaware, Iowa, Kentucky, Massachusetts, Michigan, Minnesota, New York, North Carolina, Oregon, and Vermont.

User Fees

- To fund the full cost of the federal exchange, participating issuers will be charged user fees.
- For 2014, issuers will pay a monthly user fee to HHS at 3.5 percent of the monthly premium charged by the issuer for a policy under the plan.
- This rate might be adjusted to conform with state exchanges.
- States can still accept establishment grants to build Medicaid interfaces with FFEs.

Sample Exchange

- https://www.mahealthconnector.org/portal/site/connector

Questions?