PPACA is Here to Stay: Developing a Strategy for Health Care Implementation in Your Workplace

Panel Discussion March 12, 2013
Moderator: Anne Waidmann, PwC

SHRM Employment Law & Legislative Conference
March 10-13, 2013
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Developing a Strategy for Health Care Implementation in the Workplace

- Now that the Supreme Court has ruled that the Patient Protection and Affordable Care Act (PPACA) is valid and implementation deadlines are approaching, organizations must get serious about their health care implementation strategies.
- The law, regulations and agency guidance raise vexing issues.
- Learn how HR professionals are addressing them at this panel discussion
AGENDA

Introductions
Brief Background on PPACA Issues
Interactive Panel Discussion of Implementation Challenges and Strategies for the Future
Our Panelists

- Eric Oppenheim, chief operating officer, Republic Foods, Inc., Bethesda, Md.
- Pam Werstler, director, Human Resources, National Packaging Co., Inc., Decatur, Ala.
- David Twitchell, director, Human Resources, Rutland Regional Medical Center, Rutland, Vt.

Moderated by:
- Anne Waidmann, director, Human Resource Services, PwC, Washington, D.C.
Background on PPACA

- Patient Protection and Affordable Care Act passed March 23, 2010, effective six months later
  - (amended by reconciliation act passed immediately after)
    - ACA=Affordable Care Act
- Supreme Court upholds challenges to ACA
- Reelection of President Obama
- Significant provisions
  - Individual mandate
  - Employer mandate
  - Exchanges to be established in each State (or by Federal government) to provide an insurance marketplace for affordable minimum coverage beginning 2014
  - Expansion of Medicaid
  - Medicare changes; Financing provisions
Individual mandate

- The **individual mandate** requires all U.S. citizens/residents to have qualifying health coverage or be subject to a penalty.
- Individuals who are not covered will be subject to penalties starting in 2014 ($95 individual/$285 family, or 1% of family income, if greater) and increasing significantly in 2016 ($695 individual/$2,085 family, or 2.5% of family income, if greater).
- This feature of ACA is likely to increase voluntary enrollment in employers’ medical plans.
Employer mandate and shared responsibility penalties beginning in 2014

- Provide access to medical coverage to at least 95% of employees (and their dependent children beginning in 2015*) who work 30 hours or more per week, or face a non-deductible penalty of $2,000 multiplied by all full-time employees (less the first 30).

- Provide medical coverage that is **adequate** (covering more than 60% of medical expenses, “bronze level plan”) and **affordable** (the employee’s required contribution for the lowest cost, single-only coverage option is less than 9.5% of the employee’s income) to employees who work 30 hours or more per week, or face a non-deductible penalty of $3,000 per employee who obtains subsidized coverage in a state health insurance exchange.

- These shared responsibility penalties are separately applied to separate members of a controlled group

* Dependent children currently include: biological children, adopted children, foster children and step children, under age 26. There are no affordability tests applicable to children. The employer may charge participants 100% of cost for dependent children.
How will shared responsibilities be assessed?

– The IRS will contact employers to inform them of their potential liability
  
– Will happen after employees’ individual tax returns are due for that year claiming premium tax credits, and after the due date for employers to file returns identifying full-time employees and describing the coverage offered (if any)

– After initial contact, employer can respond/challenge, then IRS will send notice and demand for payment

– Each subsidiary company that is a member of a controlled group is liable only for its own portion of a penalty
Additional costs

**New fees for insured and self-insured plans**

- Patient-Centered Outcomes Research Institute ("PCORI") fees (all group plans)
  - In the first year it applies, the PCORI fee will be $1 multiplied by the average number of lives covered under the plan (including dependents). In subsequent years, the multiplier is $2 times the average number of covered lives.

- Transitional reinsurance program for health insurance plans offered in the state health insurance exchanges (all group plans)
  - Annual per member fee in the first year is expected to be $63. In the two subsequent years, the annual per member fee is expected to be lower than in the first year.

- Health insurance premium “fee” on (insured plans only)
  - Fee will be paid by insurers, effectively as an excise tax (fees paid are not tax deductible), so insurers will most likely gross up fee on premiums to cover costs
  - A report commissioned by AHIP estimates this fee will increase employer premiums by ~2% in 2014, increasing to over 3% by 2023

- Excise tax on high cost ("Cadillac") plans beginning in 2018
Significant reach for many employers to comply with ACA in first years

2010
- Change allowing tax-free coverage for certain children
- Accounting impact of change in Medicare retiree drug subsidy tax treatment
- Early retiree medical reinsurance
- Medicare prescription drug “donut hole” beneficiary rebate
- Break time/private room for nursing moms

2011
- Dependent coverage to 26
- No lifetime dollar limits on essential health benefits
- Restricted annual dollar limits, on essential health benefits (phased amounts until 2014)
- No pre-existing condition limitations for enrollees up to age 19 and no rescissions
- No health FSA/HRA/HSA reimbursement for non-prescribed drugs
- Additional standards for new or “non-grandfathered” health plans, including preventive care in network with no cost-sharing, appeal and external review, provider choice, and non-discrimination rules for insured plans
- Insurers subject to medical loss ratio rules; employers to shared rebates with employees in some cases

2012
- Uniform summary of benefits and coverage (SBC) must be distributed to participants (deadlines vary with group of recipients)
- Form W-2 reporting for health coverage (track in 2012 for W-2 form provided in early 2013)
- Additional women’s preventive care services must be covered with no cost-sharing (plan years on or after August 1, 2012)
- 60-day advance notice of mid-year material modifications to SBC content
ACA Implementation will reach its stride in 2014, when additional key provisions take effect

- Issue W-2 forms to employees (by 1/31)
- New Medicare taxes on high earners
- $2500 cap on health FSAs
- Women’s preventive services
- Notices of exchanges – delayed past March
- PCORI fees
- Annual dollar limits on essential health benefits cannot be lower than $2 million (unless plan has waiver)
- Exchange open enrollments start in October
- Medicare retiree drug subsidy tax change

2013

2014

- Individual mandate
- Employer shared responsibility (Pay or play)
- Income-based subsidies for exchange coverage
- Health insurance exchanges
- Medicaid expansion (states’ option)
- Enhanced wellness incentives
- Additional reporting
- New health plan mandates: no pre-existing condition exclusions, no annual dollar limits on essential health benefits, no waiting period over 90 days, and for nongrandfathered plans - caps on out-of-pocket maximums, coverage for certain clinical trial patient expenses, and provider nondiscrimination

2015

- Employer reporting to IRS and employees
- First shared responsibility penalties assessed
- Auto-enrollment may begin

2018

- Excise tax on high cost “Cadillac” plans
Panelists’ current healthcare plans and employee populations

- Company structure
- Numbers and types of employees
- Healthcare currently offered
  - Insured? Self-insured? TPA?
  - Consumer-directed?
    - HSAs, HRAs?
  - Grandfathered plans?
  - Retiree plans?
  - Union plans?
Implementation challenges to date

- Grandfather status of original plans
- Age 26—
  - payroll issues?
  - conclusions regarding cost implications after 2+ years?
- Annual/lifetime limits—minimed plans
- Insurance company/TPA issues
- Summaries of Benefits and Coverage (SBCs)!
- Cost increases
Planning for 2014 and beyond
Counting Full-time Employees
Pay or Play
## Panelist Example

### Status Quo

<table>
<thead>
<tr>
<th>Annualized Health Plan Costs at Current Enrollment</th>
<th>2012</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estimated Total Enrollment</td>
<td>34</td>
<td>34</td>
</tr>
<tr>
<td>Total health plan costs (assumed annual cost increase of 10%)</td>
<td>$205,385</td>
<td>$248,515</td>
</tr>
<tr>
<td>Employee contributions</td>
<td>($127,226)</td>
<td>($153,944)</td>
</tr>
<tr>
<td>Estimated tax deduction benefit</td>
<td>($26,574)</td>
<td>($32,154)</td>
</tr>
<tr>
<td>Total Net Health Plan Costs</td>
<td>$51,584</td>
<td>$62,417</td>
</tr>
</tbody>
</table>
## 2014 “Pay” Scenarios

<table>
<thead>
<tr>
<th>Health Plan Not Offered to Employees in 2014</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Average number of full-time employees in 2014</td>
<td>542</td>
</tr>
<tr>
<td>Number of employees subject to the penalty (total less first 30)</td>
<td>512</td>
</tr>
<tr>
<td>Annual penalty per employee</td>
<td>$2,000</td>
</tr>
<tr>
<td>Total costs if health plan is not offered</td>
<td>$1,024,000</td>
</tr>
</tbody>
</table>
## 2014 “Play” Scenarios

<table>
<thead>
<tr>
<th>Health Plan Offered to Employees in 2014: Current Benefits Maintained</th>
<th>Highest</th>
<th>Mid</th>
<th>Lowest</th>
</tr>
</thead>
<tbody>
<tr>
<td>Est. number of employees with “unaffordable” contribution</td>
<td>226</td>
<td>117</td>
<td>63</td>
</tr>
<tr>
<td>Annual “unaffordable” penalty per employee</td>
<td>$3,000</td>
<td>$3,000</td>
<td>$3,000</td>
</tr>
<tr>
<td><strong>Subtotal: annual “unaffordable” penalty</strong></td>
<td><strong>$678,000</strong></td>
<td><strong>$351,000</strong></td>
<td><strong>$189,000</strong></td>
</tr>
<tr>
<td>Estimated number of employees enrolled in health plan</td>
<td>316</td>
<td>171</td>
<td>98</td>
</tr>
<tr>
<td>Total projected health plan costs (2014 prems x enroll)</td>
<td>$1,963,274</td>
<td>$1,070,096</td>
<td>$623,733</td>
</tr>
<tr>
<td>Employee contributions (based on current contrib. %’s)</td>
<td>($1,161,295)</td>
<td>($633,047)</td>
<td>($370,406)</td>
</tr>
<tr>
<td>Estimated tax deduction benefit</td>
<td>($272,673)</td>
<td>($148,597)</td>
<td>($86,131)</td>
</tr>
<tr>
<td>Subtotal health plan costs</td>
<td>$529,306</td>
<td>$288,453</td>
<td>$167,196</td>
</tr>
<tr>
<td><strong>Total Estimated Costs at Current Benefits</strong></td>
<td><strong>$1,207,306</strong></td>
<td><strong>$639,453</strong></td>
<td><strong>$356,196</strong></td>
</tr>
</tbody>
</table>
Planning for future costs
Wellness
Other issues
COMPLIANCE RED FLAGS

- Employer believes plan is grandfathered
- Employer relied completely on broker to implement ACA
- Retiree-only plan has active employees (e.g., returned to active status, long-term disability)
- Plan has dollar caps on benefits
- Plan has not established an external review program
- Employer has not conducted oversight of vendors implementing ACA
- Employer received a medical loss ratio (MLR) rebate from insurer
- Employer in retail, hospitality, fast-food, health care, call centers, security, janitorial (low-wage earners/part-time)
- Employer with seasonal workers: resorts, retail, amusement and recreation
- Employee contributions for single coverage exceed 9.5% of lowest wage earner’s rate of pay
- Executive health benefits under separate insured plan
- Low plan participation/high opt-out rate
- No dependent coverage (or waiting period to obtain)
Ongoing healthcare strategy-questions for employers

- What role should we play in providing health care coverage to our employees and their dependents?
  - Do we want to continue to sponsor coverage (“pay” or “play”)?
  - What level of subsidy do we want to provide?
- Can we move to a more sustainable approach to health care benefits?
  - What are our options today and how can we drive the market?
  - How will this impact employee attraction, retention and engagement strategies?
  - What will our competitors be doing?
- Are there lessons to be learned from prior experiences?
  - DB conversion to DC for retirement programs
  - Implementation of private exchanges for retirees
- Is there a new window of opportunity to transform our approach?

Three Key Populations
- Active Employees
- Pre-65 Retirees
- Post-65 Retirees
Next steps

• Challenge current thinking on health benefits strategy
  1. Reassess role in health benefits
  2. Evaluate “how to play and when to pay”
  3. Bend the cost curve
     – Reevaluate financing approach (e.g., self-insurance)
     – Accelerate consumerism
     – Improve clinical care coordination
     – Integrate delivery based strategies
  4. Consider “defined contribution” approach
     – For Actives and/or Retirees
     – Assess private exchanges
     – Introduce more efficient options
• Understand and implement compliance requirements

ACA establishes a new landscape in which employer healthcare strategy should be assessed and revisited from the ground up.
- **Moderator:** Anne Waidmann, director, Human Resource Services, PricewaterhouseCoopers LLP
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  - Eric Oppenheim, chief operating officer, Republic Foods, Inc., Bethesda, Md.
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