



Health Care Reform Overview of the ACA

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Timeline of Changes and Compliance Measures

A. 2010 – 2015 & Beyond

HEALTH CARE REFORM TIMELINE

2010	2011	2013	2014	2015
Health plans that provide dependent coverage must make coverage available for dependents up to age 26	Medical loss ratio (MLR) rules apply to health insurer premium spending (consumer rebates must be paid by Aug. 1 each year starting in 2012)	Improvements on HIPAA's electronic transaction rules start to be phased in	Individuals must obtain health insurance coverage or pay a penalty (some exemptions apply)	Large employers must offer coverage to FT employees (that is affordable and provides minimum value) or pay a penalty (delayed for one year, until 2015; payments will not apply for 2014)
Uninsured individuals with pre-existing conditions can obtain health insurance through a high-risk health insurance pool program	Employers must report health coverage costs on Form W-2 (optional for 2011; mandatory for later years; delayed for further guidance for small employers)	Employers must provide a notice to employees regarding the insurance exchanges by Oct. 1, 2013	Health insurance Exchanges to be established for individuals and small employers	2018 High-cost plan excise tax established in 2018
HHS established a website for individuals to identify affordable health insurance options in their state (www.healthcare.gov)	OTC medicine and drugs are "qualified medical expenses" for HSAs, FSAs and HRAs only if prescribed (except insulin)	Medicare Part D subsidy deduction eliminated	Health insurance companies will not be able to discriminate against individuals based on health status	
Early retiree reinsurance program provides reimbursement for a portion of the cost of providing health coverage for early retirees. Program was available for claims incurred before Jan. 1, 2012	Simple cafeteria plan provides small businesses with an easier way to sponsor a cafeteria plan	Income threshold for claiming itemized deduction for medical expenses increased	Individual health care tax credits available for certain individuals	Future Automatic enrollment rules for employers with more than 200 FT employees
Lifetime dollar limits on essential health benefits are prohibited. Annual dollar limits are restricted until 2014 when all annual dollar limits on essential health benefits are prohibited	Medicare Part D drug discounts start to be phased in for beneficiaries in the "donut hole" until the coverage gap is filled in 2020	Medicare hospital insurance tax rate for high wage workers increased	Health insurance provider fee and reinsurance fee take effect and increase annually (reinsurance fee effective 2014-2016)	
Pre-existing condition exclusions are eliminated for children under age 19	Penalty tax increases on withdrawals from HSAs (prior to age 65) and Archer MSAs not used for qualified medical expenses	Medical device excise tax established	Health plans cannot impose waiting periods longer than 90 days	
Non-grandfathered health plans must cover certain preventive care services without cost-sharing	Free annual wellness visit for Medicare beneficiaries and elimination of cost sharing for preventive care services	Salary reduction contributions to FSAs are limited to \$2,500	No limits on annual dollar value of essential health benefits	
Rescissions are prohibited in most cases; plan coverage may not be retroactively cancelled without prior notice to the enrollee	2012 Plans must provide SBC with the open enrollment period or plan year beginning on or after Sept. 23, 2012 (depending on type of enrollment)	By Dec. 31, 2013, employers must certify compliance with certain HIPAA electronic transactions	Pre-existing condition exclusions prohibited for adults	
Fully insured group health plans must satisfy nondiscrimination rules regarding participation and benefit eligibility (delayed for future regulations)		For plan years beginning on or after Aug. 1, 2012, plans and issuers must cover additional preventive care services for women without cost-sharing. Exceptions to contraceptive coverage apply to religious employers		Insured plans in the small group and individual market must provide comprehensive benefits coverage (does not apply to grandfathered plans)
Plans and issuers must adopt an improved internal claims and appeals process and comply with external review requirements (some rules were delayed until plan years beginning on or after Jan. 1, 2012)			Reforms related to the allocation of insurance risk through reinsurance, risk corridors and risk adjustment become effective	
First phase of the small business health care tax credit	For plan years ending on or after Oct. 1, 2012, issuers and self-insured health plans must pay PCORI/comparative effectiveness research fees		Some non-grandfathered health plans subject to cost-sharing limits	
Rebates for the Medicare Part D "donut hole" sent to eligible enrollees			Second phase of small business tax credit	

Timeline of Changes and Compliance Measures

Fully Insured

B. PPACA Taxes and Fees Overview

1. PCORI - \$1.00 pmpy (per member per year)
 - *Paid by Carrier for their book of business*
See IRS Form 720
2. Insurer Fee - \$5.25 pmpm (\$63-\$72/yr) per covered life.
 - *Fully Insured Groups - generally paid by Carrier for fully insured groups.*
 - *Self Funded Groups - to be included on Billing for Administration Fees*



Pay or Play

A. Offer of Coverage

1. Classes of Employees
 - a. Full-Time as defined by City
 - b. Part-Time but still have coverage offered
 - c. Full-Time as defined by PPACA
2. Are you a large Employer?
 - a. Number of Employees
 - b. What does Plan look like?
3. To whom must you offer coverage?

B. Penalties for NOT offering coverage

C. Safe Harbor = 95% offer rule



Affordability

A. Affordability of Coverage offered

1. 9.5% of employee W-2 (Line 1)
2. 8% of household income

B. Calculation of hours & pay

1. The “look back” period (measurement period)
2. Administration period
3. Stability (coverage) period

C. Variable Employee vs. Seasonal

What is the City Already Doing to Prepare?

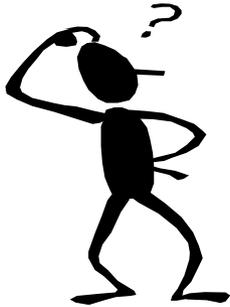
- A. HR and Horton are:
 - 1. Defining size of potential problem
 - a. Offer
 - b. Affordability
 - 2. Strategic Plan
 - a. Lowest Cost plan & premium contribution
 - b. Cost analysis
- B. Actuarial Valuation of Current Plans



Questions For Consideration

- 1) Does our handbook sufficiently describe employee classifications and eligibility?
- 2) Do we have many individuals currently who are not offered coverage, who may become eligible? Do we have a problem and what is the size of the problem (how many individuals)?
- 3) What is our strategy if we do determine we need to offer coverage to those that do not have coverage currently? Will we offer? If we do, what will be the premium contribution? For a single plan vs. family plan? Do we need to change our premium tiers or our plan in total?
- 4) Will we offer spousal coverage? What about a spousal carve-out or surcharge?
- 5) What if employers around us (particularly the private sector) kick spouses off their plan and our current employees and retirees who waive coverage come back on our plan? This is a budgetary consideration at a minimum.
- 6) If we offer a cash-in-lieu or an opt-out, what does this mean and can we pro-rate? Is this a blocking strategy?
- 7) How will we classify employees that we wish to charge differing contribution levels (example full time pays 12.6% of premium, do those working 30 hours (.75) pay 25% plus 12.6% to have the same plan) as our full-time or do we offer them a different plan?
- 8) What do we do now?
- 9) Have we prepared for the taxes and fees that are coming?
- 10) Are we in compliance with the law currently?
- 11) Will we continue to offer coverage at all in the future? When?

Questions?



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