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Health Care Reform: What's Next?

On June 28, 2012, the Supreme Court upheld the Affordable Care Act (ACA) with one exception related to Medicaid. It did not support the ACA provision that would withhold existing federal funding for state Medicaid programs should a state fail to implement the Medicaid provisions of the ACA. All other provisions of the ACA were supported including the widely discussed constitutionality of an individual mandate that requires individuals to purchase health care coverage or face penalties.

With the Court's decision, many Plan Sponsors are no longer delaying implementation of the 2012 mandated ACA changes. Plan Sponsors may also want to start thinking about 2013, which is almost certain to be a busy year. However, the 2013 tasks for Plan Sponsors could be different depending on the results of the November Presidential and Congressional elections.

In this Cheiron Advisory, we focus on the To Do Lists and their associated financial impact for Employer-Sponsored Health Plans (Plans). First we provide the 2012 To Do List. We then explore a 2013 To Do List and how it might change with the upcoming November elections and other related factors.

2012 TO DO LIST (FOR THE REMAINDER OF 2012)

Seven items with effective dates between July 1, 2012 and January 31, 2013 that could impact Plans are discussed below. We have included items effective in January 2013 in the 2012 To Do List because of both the implementation time needed and the fact that any official Executive or Legislative branch changes would not take effect until the end of January.

(1) Minimum Loss Ratio (MLR) for Insured Health Products

Effective: Plan/policy year ending on or after December 31, 2011 with first reporting to policy holders or subscribers in July 2012

Provisions: Insurance companies must not have a loss ratio lower than 85% (expenses and profits more than 15% of the premium) in the large group market (50 plus employees) and 80% in the individual and small group market. Special rules apply for mini-med, expatriate plans, and student health plans in 2013. Self-insured, stop-loss, dental and vision plans are all exempt from MLR. The first required reporting to policyholders or subscribers is due July 2012.

Financial Impact: Plans with insured health products may receive money back (rebates) from insurance companies not meeting the MLR. While we have seen some re-categorizations of clinical costs from non-claim expenses to claims, loss ratios lower than 85% are not uncommon. We recommend that administrators and/or consultants request a reporting from their insurer. Also, for Plans covered by ERISA, the administrators and/or consultants should review the Department of Labor's (DOL) Technical Release 2011-04 on Rebates from Group Health Plans Paid Pursuant to Medical Loss Ratio Requirements, as contributory Plans may have to share rebates with participants. In aggregate for the individual and group marketplaces, insurance companies are reported to be refunding/rebating $1.1 billion in July.

(2) Preventive Care for Women

Effective: Later of the plan/policy year beginning on or after August 1, 2012 or date "Grandfathered Status" is lost

Provisions: Plans must cover: i) well-woman visits – includes preventive services that are age and risk factor appropriate, ii) screening for gestational diabetes, iii) human papillomavirus (HPV) testing, iv) counseling for sexually transmitted infections (STIs), v) counseling and screening for HIV, vi) contraceptive methods, sterilization, and counseling using FDA approved methods, vii) breastfeeding support, supplies, and counseling, and viii) screening and counseling for interpersonal and domestic violence.

Financial Impact: Although preventive care is often cost effective – meaning it saves money especially in the long-term for low turnover groups – it is hard to prove that this is the case for all of the above services. This is the first federally mandated requirement for Plans to cover ***all*** FDA approved methods for a covered benefit regardless of best practices. Net costs will vary depending on a Plan's current covered benefits, female population, and health care management practices.

(3) Summary of Benefits and Coverage (SBC)

Effective: On or after September 23, 2012 (see below)

Provisions: Group Health Plans and health insurance issuers must provide an SBC to enrollees, applicants, and policyholders at specified times, free of charge, or face a possible monetary penalty of up to $1,000 per person involved.

Type of Communication *	Effective Date - On or after 9/23/2012
1. Open Enrollment period with an open enrollment communication mailing	1st day of the Open Enrollment
2. Open Enrollment period without an open enrollment communication mailing, e.g., auto-enrollment	30 days prior to the earlier of the beginning of the plan or policy year
3. No Open Enrollment period, i.e., no benefit plan options and cannot opt out	See effective date for other communications
4. Upon request	Seven (7) business days after the earliest of i) open enrollment date ii) beginning of plan year iii) beginning of policy year
5. New Hire Packet	Earlier of beginning of plan or policy year
6. COBRA Packet	90 days after COBRA enrollment following the earlier of the beginning of plan or policy year
7. Summary of Material Modification or Summary of Plan Description	Not required; may include and if so, then must comply with standard location in the packets
8. Group Health Insurance Application	Seven (7) business days after the earlier of application or issuance date
9. Group Health Insurance Renewal	Upon distribution of renewal material
10. Automatic Renewal of Group Health Insurance	30 days prior to policy year
11. Changes to Group Health Insurance	First day of coverage change

* Either paper or electronic

Financial Impact: The cost is administrative and will vary by the complexity of the Plan and current Plan communication materials.

(4) Flexible Spending Accounts Limited

Effective: Plan/policy year beginning on or after January 1, 2013

Provisions: Maximum salary reduction amount is $2,500.

Financial Impact: Employers will have reduced FICA savings, reduced forfeitures, and increased communication costs which will be slightly offset by reduced claims processing. Individuals who would have contributed more than $2,500 will have an additional tax burden.

(5) W-2 Reporting of Employer-Sponsored Health Coverage

Effective: January 31, 2013

Provisions: The value of the health benefits (net of employee contributions) must be reported on the employee's 2012 W-2 Form due by January 31, 2013.

Financial Impact: Administrative cost of calculating the value and producing the new W-2 forms.

(6) Added Medicare Tax

Effective: January 1, 2013

Provisions: Employers must withhold an additional 0.9% Medicare tax for employees with adjusted gross income over $200,000 ($250,000 for joint filers), increasing the total Medicare tax to 3.8%. These thresholds are not indexed. In addition, these same high earnings individuals will see their investment income taxed an additional 3.8%.

Financial Impact: Administrative costs plus possibly all or part of the 0.9% extra Medicare tax since either the employer or the individual may be picking up the burden via a wage adjustment.

(7) Tax on Retiree Drug Subsidies (RDS) and Gradual Closing of the "Donut Hole" for Medicare Rx coverage

Effective: Tax Years beginning after December 31, 2012

Provisions: Plans that are taxable entities will be taxed on the amount that they receive from the RDS program beginning in 2013. However, Plans can achieve an even greater savings than provided by RDS by using a Medicare Part D product since the infamous "donut hole" will continue to shrink through 2020 via pharmaceutical industry discounts and increasing federal subsidies. Below we list three Medicare Part D options available for Plans to consider:

1) Employer Group Waiver Program (EGWP) – This solution is the easiest to implement. It is a one pharmacy card solution. The disadvantage is that all the products we have seen only offer a single formulary that is subject to the Centers for Medicare and Medicaid Services (CMS) approval (i.e., the "Medicare Part D formulary"). Adding drugs to the formulary is often possible but removing covered drugs typically is not. The cost is typically based on the Plan's actual experience.

2) EGWP or Group Enrolled Part D Plan (PDP) with a Wrap Around Plan – This solution is a bit more difficult as two cards are usually required, hence additional retiree communication is needed. It consists of tacking a wrap around plan onto basic Medicare Part D benefits (EGWP or PDP) to replicate the current benefit design. The advantage is the current Plan's formulary can remain for the wrap around coverage which can result in lower costs. However, any Medicare Part D drugs excluded from the Plan's formulary must be covered under the EGWP or PDP part of the benefit. Furthermore, the Plan may incur additional administration fees as a claim will have to be processed twice: once under the EGWP and once under the wrap around provisions. The cost is typically based on the Plan's actual experience.

3) Individual Enrolled PDP with a Wrap Around Plan – This two-card solution is the most difficult to implement, but for many Plans it would provide the greatest savings. This option maintains the advantage of the current Plan's formulary for the wrap around coverage and adds the savings of the individual Medicare Part D marketplace. The individual Medicare Part D marketplace typically has substantially lower costs than the employer-sponsored market because of the very strong generic drug utilization incentives. The PDP costs are based on the individual PDP marketplace with the wrap around costs based on the Plan's actual experience. Paying for the Medicare Part D premium presents several challenges as retirees can select various PDPs with various costs and levels of benefits. Some of the PDP reimbursement could be alleviated by having the employer contribute a fixed amount towards retiree PDP premium or limiting the wrap around to one PBM's PDP. There could also be some tax consequences for "dropping coverage" when using this strategy.

Financial Impact: Plans that switch from RDS to one of the above options can typically save up to $60 per Medicare eligible covered person per month depending on their current coverage, generic utilization, and administrative costs. However, taxable organizations that continue with the RDS program will lose their tax rates times the RDS amount that they receive.

PREPARING FOR 2013

The 2013 To Do List could be different, depending on the outcome of the November elections. We start first with a list if the ACA is implemented as is and then provide a possible list if the ACA is repealed or modified.

A. 2013 To Do List - If the ACA is implemented as is

The chart below shows an overview of key Plan related ACA provisions taking effect after January 2013.

	Effective Date:	Key Program Impact:	
1.	3/1/13	Reporting	**Notice to employees about Exchanges** including (for **families under 400% of FPL,** currently $92,200 for a family of four) that they have access to **subsidies** if their **employer does not offer affordable health care - 60% benefit ratio for less than 9.5% of the household income**
2.	7/31/13	Tax	**Patient-Centered Outcome Research fees of $1** per covered person are due for 2012 plan/policy years ending before October 1, 2013. The fee increases to $2 for the 2013 plan year and is then indexed by the Per Capita National Health Expenditure each year through 2019. After the 2019 plan year, no fees are required. Fees apply to both insured and self-insured plans with Plans that have both components paying twice. Stop-loss, stand alone dental/vision, HSAs, and most FSAs are exempt. HRAs and retiree-only Plans must pay the fees.
3.	1/1/14	Exchanges	**Exchanges** available for individuals and for employers with less than 50 employees (states may choose to allow employers up to 100 employees)
4.	PYB 1/1/14	Benefits	**Wellness Incentive Cap** increased from 20% to 30% of cost of health care
5.	PYB 1/1/14	Benefits	Removes **Annual Maximum** on Essential Health Benefits[2] (phased in)
6.	PYB 1/1/14	Benefits	Prohibits **Pre-existing Limitation** for all enrollees
7.	PYB 1/1/14 [1]	Benefits	Applies **Maximum Caps on Cost-Sharing** (e.g., Ded.: $2,000/$4,000 single/family indexed starting in 2015; OOP Max: $6,050/$12,100 indexed from 2012)
8.	PYB 1/1/14	Eligibility	Requires **Auto-Enrollment** for employers of 200 or more employees and allows for opt-outs
9.	PYB 1/1/14	Eligibility	Requires **New Employee Waiting Period** not to exceed 90 days
10.	PYB 1/1/14 [1]	Eligibility	Prohibits **excluding from coverage** because of **Health Status**
11.	PYB 1/1/14 [1]	Eligibility	Prohibits **excluding from coverage** because of **Clinical Trial** participation
12.	PYB 1/1/14 [1]	Eligibility	Fully insured plans must provide **Guaranteed Availability and Renewability**
13.	PYB 1/1/14 [1]	Premiums	Fully insured plans have **rating restrictions** on age of 3 to 1; on tobacco use of 1.5 to 1
14.	PYB 1/1/14	Tax LPS[3]	**If No Coverage** *and* 1 FTE qualifies[4], then pay **No Coverage Tax = (#FTE - 30) x $2,000**
15.	PYB 1/1/14	Tax LPS[3]	**If Limited Coverage**[5] *and* 1 FTE qualifies, then Plan Sponsor must pay **Assisted Coverage Tax (assisted #FTE x $3,000)**, but not greater than No Coverage Tax
16.	PYB 1/1/14	Subsidy	Certain small employers may be eligible for **subsidies** of up to 50% of premium for up to 2 years if coverage is purchased from exchanges
17.	1/31/15	Reporting	Special IRS Report required by Plan Sponsor on **Minimum Essential Coverage**
18.	1/31/15	Reporting	Special **IRS Report** from Large Plan Sponsor[3] to IRS and FTE
19.	1/1/16	Exchanges	**Exchanges** available for employers with up to 100 employees in all states
20.	1/1/17	Exchanges	States may expand **exchanges** for employers of more than 100 employees
21.	PYB 1/1/18	Tax	**Excise Tax** on cost of more than $10,200 single / $27,500 family; industry and retiree adjusted

PYB means Plan Year Beginning on or after. **FTE** means Full-time Employees

[1] Grandfathered plans are exempt from this requirement.

[2] HHS has until 1/1/2014 to issue regulations on what can be covered under the annual limits.

[3] Large Plan Sponsor (LPS) is defined as having 50 or more FTEs on average during the Plan Year. An FTE works 30 or more hours a week.

[4] No Coverage FTE qualifies if their Household Income (HHI) is at least equal to 100%/133% FPL (depending on that State's Medicaid limit) and is below 400% of the Federal Poverty Level (FPL) AND goes to an Exchange.

[5] Limited Covered FTE qualifies for either a Tax Credit if HHI >=100%/133% FPL and <400% FPL AND goes to an Exchange AND A or B.

A) Benefit Ratio on Essential Benefits < 60%; or

B) FTE contribution > 9.5% HHI

Plans could start considering how the following key items will impact them:

1) How should the Plan address/use the new 2014 marketplace with exchanges operational in at least some or all states?
2) How can the Plan prepare for the auto-enrollment requirements?
3) Will the maximum three month waiting period for full-time new employees impact the Plan?
4) What is the impact of covering dependents until age 26 with other group insurance available (for Plans that are Grandfathered and exclude those dependents currently)?
5) How much are the new subsidies and how will they impact Plan offerings and finances, i.e., quantify the amount of subsidies the Plan can access and potential taxes by enrolling lower income employees in the exchanges?
6) What benefit changes and/or changes in contributions need to be made?
7) Should the 2018 Excise Tax be considered now in planning?

B. 2013 To Do List - If the ACA is modified or (partially) repealed

Trying to map out this scenario involves numerous assumptions, as some sort of replacement to the ACA might be developed since completely returning to the pre–ACA would be difficult as a result of the many implemented ACA provisions. In a scenario where the ACA no longer exists or is substantially modified, Plans would need to decide whether or not to maintain or remove the Plan changes that they have already implemented, to the extent allowed. Issues to consider include:

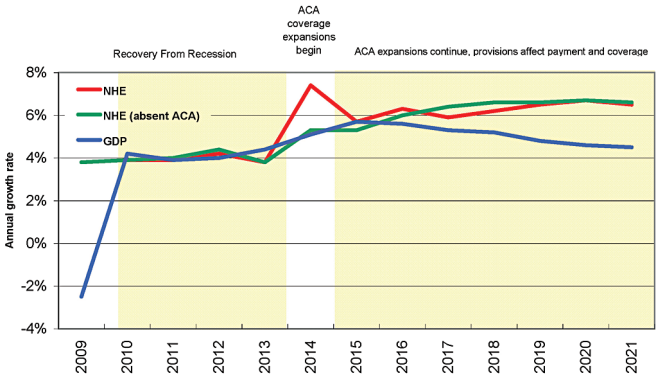
1) Coverage for dependent children up to age 26
2) Removal of dollar maximums on essential benefits
3) Maintenance of 100% Preventive Care coverage for those that lost Grandfathered status
4) Maintenance of External Claims Review Process
5) Maintenance of Summary of Benefits and Coverage communication packages
6) Handling of options for Medicare Eligible retirees and dependents for prescription drugs (One scenario might be that certain ACA provisions would be retained as Medicare changes could be an area that is more difficult to repeal or modify back to pre-ACA days.)
7) Benefit changes for Flexible Spending Accounts
8) Other provisions, such as Pre-existing Conditions, Rescission, and Discrimination

CONCLUSION

Implementation of the above eight items is sure to keep most Plans busy for the remainder of 2012. As for 2013, it is almost certain to be the busiest year for health care reform, either as a result of regulations that give guidance on implementation of the ACA or legislation that modifies or repeals portions of the ACA.

Interestingly, according to Health Affairs, while there might be higher costs in 2013 and 2014, by 2015 health care costs are expected to return to the same trend levels as though the ACA had not been implemented. However, the national health care spending is projected to be about 1.5% higher by 2020 as a result of the ACA.

Annual Growth Rates, Gross Domestic Product (GDP) And National Health Expenditures (NHE), Calendar Years 2009-21



SOURCES Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group; and Department of Commerce, Bureau of Economic Analysis. NOTES Data for 2011-21 are projections. Years 2010-13 are based on recovery from recession and include the impact of some Affordable Care Act (ACA) provisions and the 2013 Medicare physician payment cut. Year 2014 reflects the beginning of major Affordable Care Act coverage expansions. Years 2015-21 reflect the continuation of Affordable Care Act coverage expansions through 2017 and the effects of other provisions of the act on payment and coverage. Elevated Medicare enrollment growth is due to baby boomers. (http://content.healthaffairs.org/content/early/2012/06/11/hlthaff.2012.0404.full.html)

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