THE AFFORDABLE CARE ACT 2014 AND BEYOND
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Patient Protection and Affordable Care Act (PPACA)
Goals

- Enacted March 23, 2010, health reform’s goals were:
  - Provide access for 30+ million uninsured
  - Cost control
  - Quality

- Focusing on all three goals was a challenge

- Health reform is primarily health insurance reform

- It does not address major cost saving opportunities
  - Provider payment
  - Health improvement
  - Harmonization across payer programs
  - Tort reform

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## Key Elements of Health Care Reform for Employers

### 2010
- Change in tax treatment for over-age medical expenses
- Early retiree medical reinsurance
- Medicare prescription drug “donut hole” beneficiary relief
- Break time/private room for nursing moms
- No lifetime dollar limits on essential health benefits
- Restricted annual dollar limits on essential health benefits, phased amounts until 2014
- Dependent coverage to 26 (grandfathered plans may limit to children without access to other employer coverage, other than parent’s coverage)
- No pre-existing condition limitations for enrollees up to age 19 and no rescissions
- No health FSA/HRA/HSA reimbursement for non-prescribed drugs
- Increased penalties for non-qualified HSA distributions
- Additional standards for non-grandfathered health plans, including preventive care on network with no cost-sharing, appeal and external review, provider choice, and non-discrimination rules for insured plans
- Income-based Medicare Part D premiums
- Pharmaceutical importers and manufacturers’ fees start
- Medicare, Medicare Advantage benefit and payment reforms
- Employers subject to medical loss ratio rules
- Phased out employer payments for exclusion of dependent coverage

### 2011
- Medical device manufacturers’ fees start
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- Higher Medicare payroll tax on wages exceeding $200,000/individual; $250,000/couples
- Change in Medicare retiree drug subsidy tax treatment takes effect
- Health Insurance exchanges initial open enrollment period
- 60-day advance notice of mid-year material modifications to SBC content
- Employers notify employees about exchanges
- Medical device manufacturers’ fees start
- Higher Medicare payroll tax on wages exceeding $200,000/individual; $250,000/couples
- Change in Medicare retiree drug subsidy tax treatment takes effect
- Health Insurance exchanges initial open enrollment period

### 2012
- $2,500 per plan year health FSA contribution cap (plan years on or after January 1, 2013)
- Comparative effectiveness group health plan fees first due
- Annual dollar limits on essential health benefits cannot be lower than $2 million
- Medicaid expansion (possibility only some states)
- Employer shared responsibility
- Dependent coverage to age 26 for any covered employee’s child
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### 2019
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### Key Employer Issues and Response

- **2010**: Medicare Part D premiums
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- **2016**: Medicare Part D premiums
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- **2018**: Medicare Part D premiums
- **2019**: Medicare Part D premiums

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*Footnotes:
1. Applies to all plans, including grandfathered plans, effective for plan years beginning on or after Sept. 23, 2010 (Jan. 1, 2011, for calendar year plans).
2. Applies to all plans, including grandfathered plans, effective for plan years beginning on or after Jan. 1, 2014.
3. Applies to non-grandfathered plans, effective for plan years beginning on or after Sept. 23, 2010, except that insured plan discrimination ban is delayed until regulations issued.
4. A temporary exemption applies to certain categories or employers.
5. Applies to nongrandfathered plans, effective for plan years on or after August 1, 2012.*
Key Employer Issues

Overview

• Shared Responsibility (large employers with 50 or more FTEs)
  – Must offer minimum essential coverage to “substantially all” full time employees
  - Or face penalty of $2,000 per FTE (minus first 30 FTEs) if one FTE receives subsidized coverage through public exchange
  - Define full time as 30 or more hours per week (various definitions exist)
  – If offering minimum essential coverage, coverage must be “affordable” and provide “minimum value” in order to fully shield employer from financial penalty
  - If not, penalty of $3,000 per FTE who receives subsidized coverage through public exchange

• Individual Mandate
  – All individuals must have minimum essential coverage or face penalty
  – Will increase employer provided coverage and cost

• Fees and taxes
  – Employers will be directly and indirectly funding many new fees and taxes
  - e.g., impact of 2014-16 Temporary Reinsurance Fee = $63 / member (roughly $140,000 in 2014 for employer with 1,000 employees)

• Public exchanges
  – Will create opportunity for some employees to move off of employer plans
  - No subsidies available for public exchange coverage if individual is eligible for affordable, minimum value minimum essential coverage through employer
  – Will also create potential confusion and challenges

• Medicaid expansion
  – Will create option for some employees to move off of employer plans
  – May decrease likelihood of penalties some employers may face

• Wellness incentives
  – Ability to offer larger incentives for wellness related activities/programs

• Excise Tax
  – Tax of 40% of employer plan cost in excess of allowable limits
Health care reform is driving increased costs for employers

**Anticipated cost increase due to PPACA requirements effective in 2014**

- Don’t know: 29%
- No increase: 14%
- Increase <1%: 10%
- 1% to 2%: 17%
- 3% to 4%: 16%
- 5% or more: 10%
- Increase: 3%

**Plan design**
- No lifetime dollar limits
- Restricted annual dollar limits
- No pre-existing condition limits
- Waiting period <90 days

**Higher plan enrollment**
- Dependents to age 26
- 30-hour eligibility
- Auto enrollment

**Fees**
- Comparative effectiveness research
- Fees on insurers
- Manufacturer’s fees
- Temporary reinsurance programs

**Employer mandate and shared responsibility**
- Minimum 60% actuarial value plan design
- Affordable contribution requirement

**Cost impact of PPACA, by industry**

Expect cost increase of 3% or more due to 2014 PPACA requirements

- Retail and hospitality: 46%
- Health care services: 40%
- Manufacturing: 33%
- Financial services: 32%
- Transportation/Communication/Utility: 31%
- Other services: 29%
- Government: 24%
Despite added cost pressure, employers consistently tell us they will continue to provide health benefits.

**Percent of employers that are likely to terminate plans within the next five years**

<table>
<thead>
<tr>
<th>Year</th>
<th>Small employers (&lt;500 employees)</th>
<th>All large employers</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>20%</td>
<td>6%</td>
</tr>
<tr>
<td>2011</td>
<td>19%</td>
<td>9%</td>
</tr>
<tr>
<td>2012</td>
<td>22%</td>
<td>7%</td>
</tr>
</tbody>
</table>

So what are employers doing? Employers stepping up long-term cost management strategies.

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Likely to implement</th>
<th>Already in place</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee health management</td>
<td>57%</td>
<td>36%</td>
</tr>
<tr>
<td>Consumerism and CDHPs</td>
<td>71%</td>
<td>19%</td>
</tr>
<tr>
<td>Voluntary benefits</td>
<td>29%</td>
<td>18%</td>
</tr>
<tr>
<td>Purchasing collectives</td>
<td>26%</td>
<td>20%</td>
</tr>
<tr>
<td>Outsourcing</td>
<td>8%</td>
<td>10%</td>
</tr>
</tbody>
</table>
Challenges bring opportunities for employers…

- **Drive more aggressive change in employer strategies**
- Providers on board for new care models focused on improved outcomes
- **Broader ways for employers to benefit from group purchasing**
- Leverage public awareness to engage employees in their health
- Development of new venues to purchase insurance – private exchanges
- Potential coverage for pre-65 retirees in public exchange
- Innovation is thriving – creativity in new approaches

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