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HEALTHCARE REFORM
The Latest Developments

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MARSH & McLENNAN COMPANIES

Key Elements of Health Care Reform for Employers

2010

- Change in tax treatment for over-age dependent coverage
- Early retiree medical reinsurance
- Accounting impact of change in Medicare retiree drug subsidy tax treatment
- Medicare prescription drug "donut hole" beneficiary rebate
- Break time/private room for nursing moms

2011

- No lifetime dollar limits on essential health benefits[1]
- Restricted annual dollar limits on essential health benefits, phased amounts until 2014[1]
- Dependent coverage to 26 (grandfathered plans may limit to children without access to other employer coverage, other than parent's coverage)[1]
- No pre-existing condition limitations for enrollees up to age 19[1] and no rescissions[1]
- 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 in network with no cost-sharing, appeal and external review, provider choice, and non-discrimination rules for insured plans[3]
- Income-based Medicare Part D premiums
- Pharmaceutical importers and manufacturers' fees start
- Medicare, Medicare Advantage benefit and payment reforms
- Insurers subject to medical loss ratio rules

2012

- Employers to distribute uniform summary of benefits and coverage (SBC) to participants (deadlines vary with group of recipients)
- 60-day advance notice of mid-year material modifications to SBC content
- Form W-2 reporting for health coverage (track in 2012 for W-2 form provided in early 2013)[4]
- Coverage for additional women's preventive care services [5]

2013

- Health insurance exchange coverage
- Individual coverage mandate[6]
- Financial assistance for exchange coverage of lower-income individuals
- State Medicaid expansion (possibly only some states)
- Dependent coverage to age 26 for any covered employee's child[2]
- No annual dollar limits on essential health benefits[2] (generally banning standalone HRAs)
- No pre-existing condition limits[2]
- No waiting period over 90 days[2]
- $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
- Employers notify employees about exchanges by Oct. 1, 2013
- 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

2014

- Wellness limit increase allowed[2]
- Health insurance industry fees
- Additional standards for non-grandfathered health plans, including limits on out-of-pocket maximums, provider nondiscrimination, and coverage of routine medical costs of clinical trial participants
- Small market, non-grandfathered insured plans must cover essential health benefits with limited deductibles (initially $2,000/individual, $4,000/family), using a form of community rating
- Insurers must apply guaranteed issue and renewability to non-grandfathered plans of all sizes
- Auto enrollment some time after 2014

2015

- Temporary reinsurance fees first due in late 2014/early 2015
- Possible additional reporting and disclosure
- Employer shared responsibility

2018

- 40% excise tax on "high cost" or Cadillac coverage

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 of employers.*
5. *Applies to nongrandfathered plans, effective for plan years on or after August 1, 2012.*
6. *A temporary exemption applies to employees of employers with non-calendar-year plans.*

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Section I

SHARED RESPONSIBILITY DELAY

Employer Mandate Delayed Until 2015
What We Know So Far…

- ***Employer shared responsibility penalties will not apply until 2015.*** Employers will not be penalized for failing to offer or provide health coverage to full-time employees in 2014 as originally scheduled. Under a newly announced one-year delay, employer penalties will first apply for 2015.
- ***The Treasury will also delay associated employer and insurer information reporting requirements for one year.*** Information reporting will be required for 2015, instead of for 2014, with the first reports now due in 2016. The Treasury plans to issue proposed regulations on the information reporting requirements this summer.
- ***Premium subsidies to help individuals buy public exchange policies*** will be available in 2014 as slated.

What This Means for Employers
What's delayed?

- Employer mandate to offer coverage to employees who work on average 30+ hours per week.
- Minimum value requirement for plan offering.
- Affordable contribution requirement.
- Employer reporting to IRS on full-time employees and health coverage status.

What This Means for Employers
What's not delayed?

- Enrollment in employer-sponsored plans could still increase with individual mandate requirement effective January 1, 2014.
- Public exchanges and expanded Medicaid (in some states) still slated for January 1, 2014 effective date.
- Summaries of Benefits and Coverage and exchange notices to employees this fall, including data on whether employer plan provides minimum value.
- Employers may still want to respond to coverage verification requests for employees attempting to enroll in public exchange coverage. Employees eligible for minimum value, affordable coverage will still be ineligible for exchange subsidies.
- ACA fees: PCORI, Temporary Reinsurance, and Health Insurer Fees.

What This Means for Employers
What's not delayed? (cont'd)

- Plan design requirements for all plans, including maximum 90-day waiting period, no limits on pre-existing conditions or essential health benefits, expansion of wellness incentives, dependent coverage to age 26.
- Plan design requirements for non-grandfathered plans, including preventive care coverage requirements, limits on out-of-pocket maximums, application of co-payments toward out-of-pocket maximums, coverage for clinical trial-related services, and provider nondiscrimination. Limits on annual deductibles apply to small group health plans only.
- Still to come: Auto enrollment and nondiscrimination requirements for insured (non-grandfathered) plans (timing unknown); excise tax in 2018.
- Waiver for limited medical plans still expected to expire at the end of the 2013 plan year.

DELAY = OPPORTUNITY

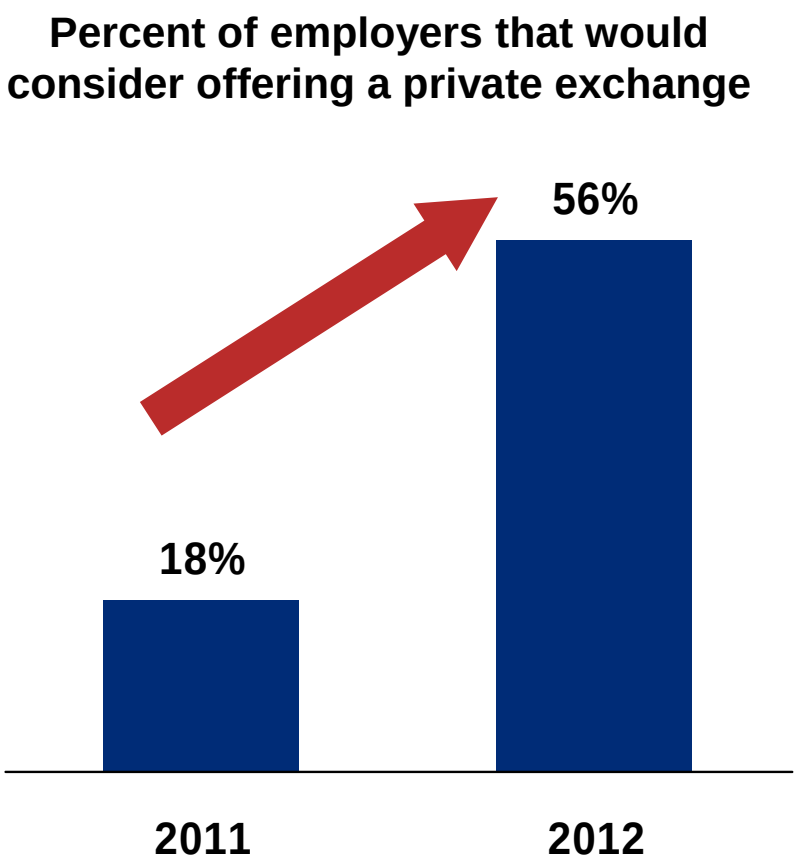
RE-EXAMINE THREE CHALLENGES ACCELERATED BY HEALTH CARE REFORM

- **COST MANAGEMENT,**
- **EMPLOYEE COMMUNICATION, AND**
- **BENEFITS ADMINISTRATION**

Challenge #1: Cost Management

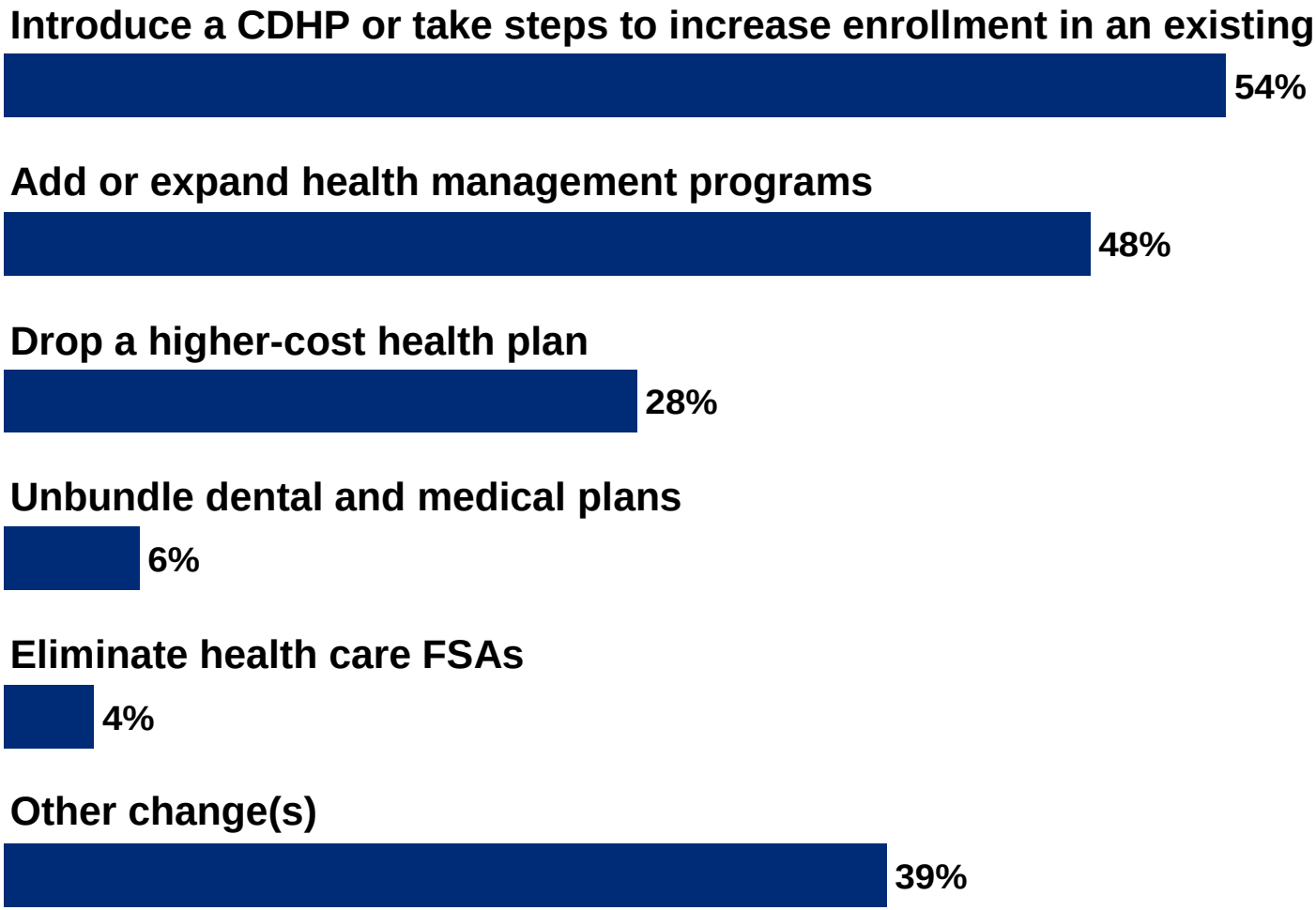
Even with this delay, medical plan cost will continue to increase an estimated 2 to 3% (or more) a year on top of trend due to other ACA requirements.

- Leverage benefit design, efficient care delivery, health management and wellness programs that offer short-term savings and avoid the 2018 excise tax.
- Private exchanges, such as **Mercer Marketplace**, offer a way to manage benefit spend and maximize the value of benefits delivered to employees.
- Voluntary Benefits-only offering for medical-ineligible employees is an attractive feature for employees covered by mini-med waivers that expire at the end of 2013.



Challenge #1: Cost Management
Employers Taking Steps Now to Avoid the Excise Tax in 2018

Based on the 36% of respondents who say changes they are making for 2014 are influenced by their concerns over the 2018 excise tax



Source: Mercer's Survey on Health Care Reform: The Road to Implementation

Challenge #2: Effective Employee Communication

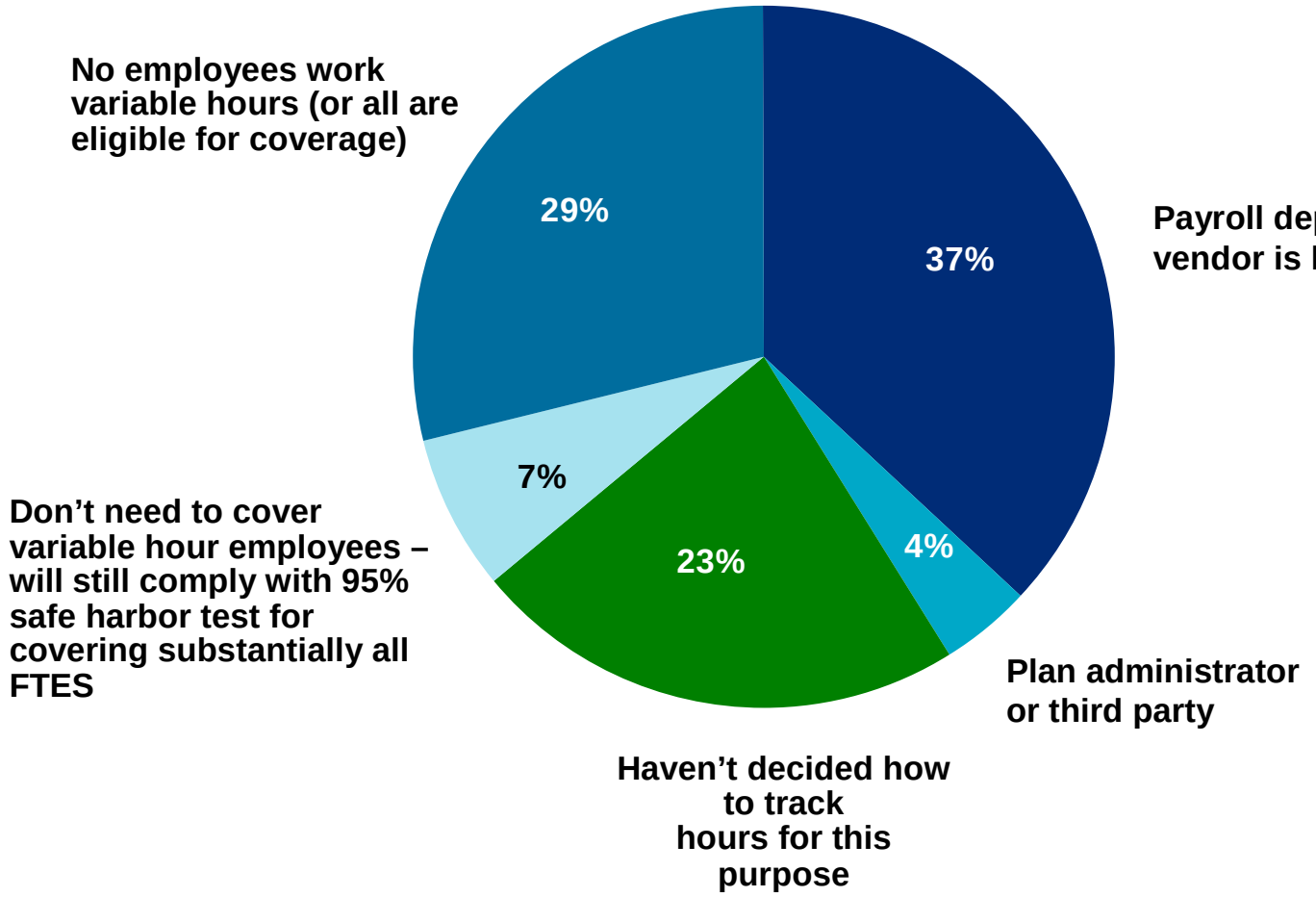
More Than Three Quarters of Survey Respondents Say Communication Requirements Are a Significant Concern

70%	Educating employees about their choices and supporting informed decisions
50%	Handling increased volume of employee questions
43%	Establishing processes for interacting with public exchanges
24%	Identifying employee groups who will need communication
22%	Not concerned – prepared to handle all the above

Source: Mercer's Survey on Health Care Reform: The Road to Implementation

Challenge #3: Reduce Benefit Administration Complexity

How Employers Will Track and Record Variable Hours so They Can Respond to a Request for Payment of Shared Responsibility Penalties



Source: Mercer's Survey on Health Care Reform: The Road to Implementation

Employer Shared Responsibility

A Solution to the Employee Eligibility and Affordability Requirements

Calculations

- Conducts variable **"look-back"** measurement periods to assess the past 3–12 months.
- Determines employee **eligibility** based on average hours of service worked including breaks in service / special leaves.
- Determine **medical plan affordability** at the employee level based on the lowest-cost medical plan.

Reporting

- Full-time eligible population counts by month and hourly trending by employee.
- Annual employee eligibility and affordability by entity for each month.
- Data is stored and can be tapped on a case basis to support proof of coverage offered.

Enforcement

- Data feedback files that can be imported to the client's HRIS/Payroll system (non Benefits Administration clients).
- Enforcement of full-time and part-time status as part of Mercer's administration services (Benefits Administration clients).

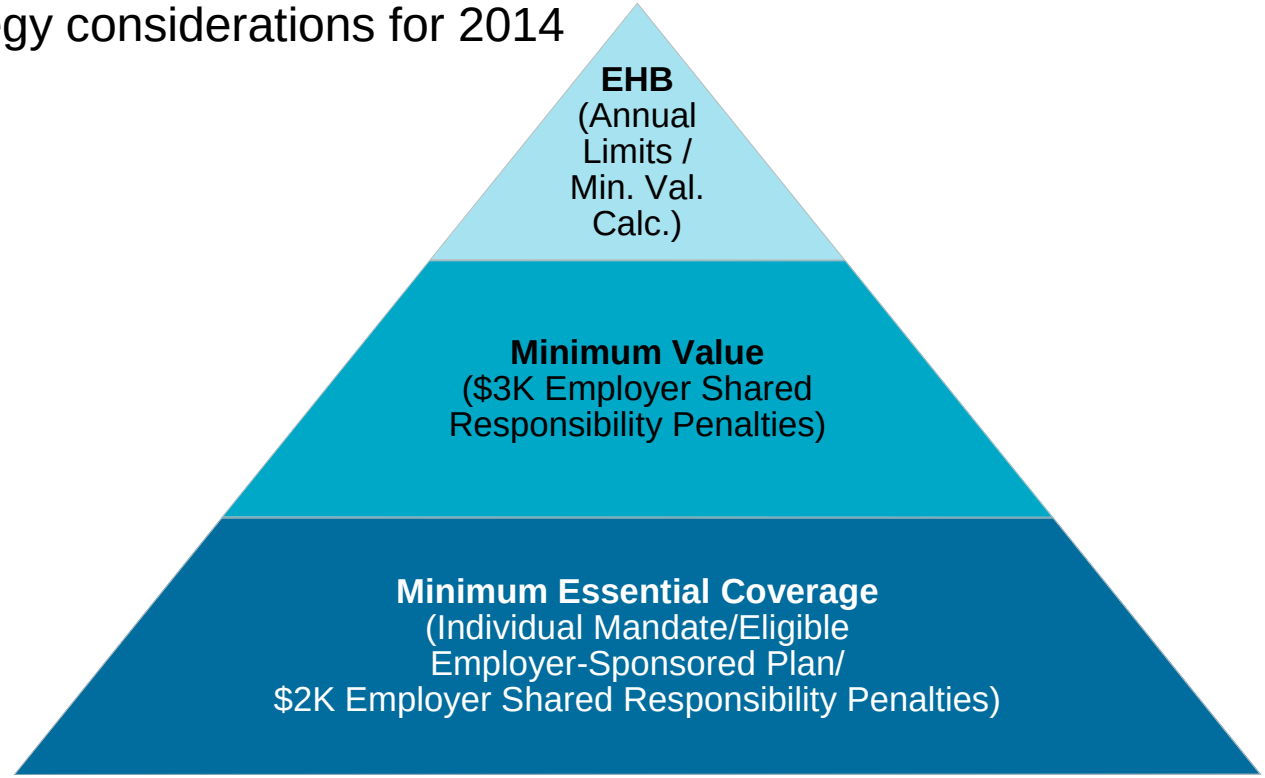
Section II

MINIMUM ESSENTIAL COVERAGE, MINIMUM VALUE & ESSENTIAL HEALTH BENEFITS

Interplay Between Minimum Essential Coverage, Minimum Value, And Essential Health Benefits

Why Does It Matter?

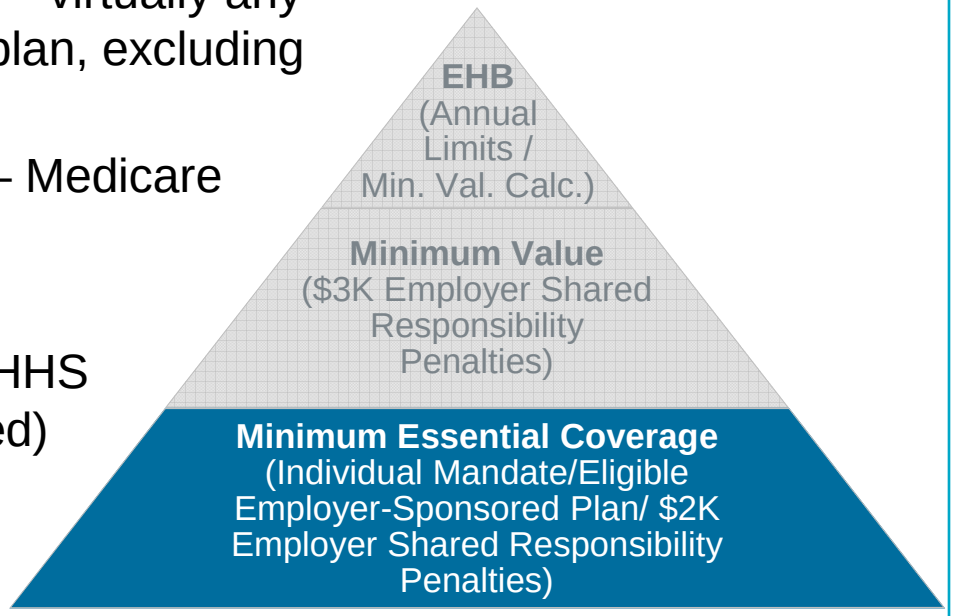
- Similar terms that are not synonymous
- Factors into understanding compliance goals for 2014
- Factors into strategy considerations for 2014



Interplay Between Minimum Essential Coverage, Minimum Value, And Essential Health Benefits

What Is Minimum Essential Coverage?

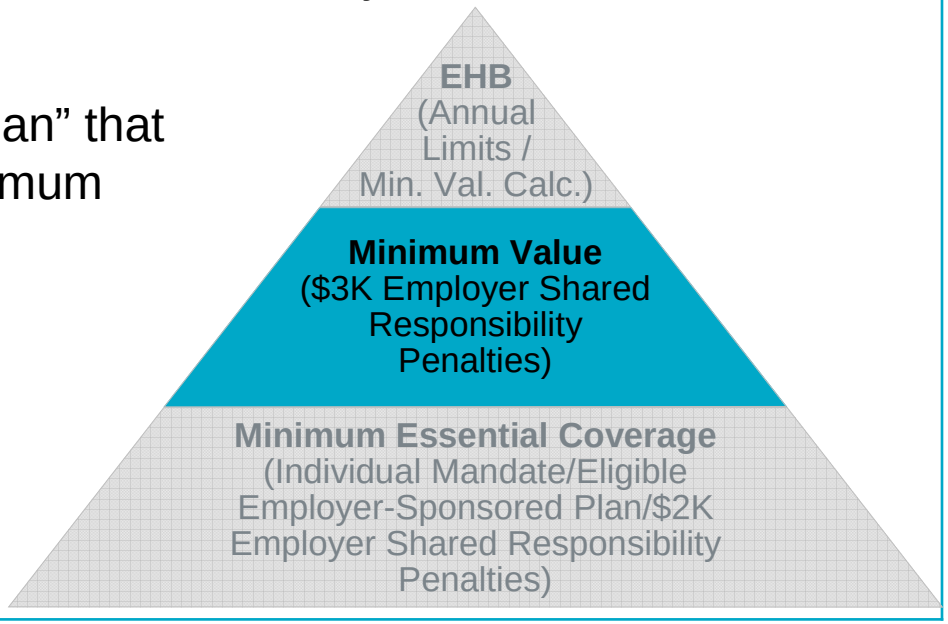
- What individuals must have in order to satisfy individual mandate
- What employers must offer to 95% of FTEs to avoid $2,000 x (all - 30 FTEs) shared responsibility penalty
- Defined very broadly:
  - "Eligible employer-sponsored plan" – virtually any employer-sponsored group health plan, excluding HIPAA-excepted benefits
  - Government sponsored programs – Medicare Part A, Medicaid, CHIP, TRICARE
  - Individual coverage
  - Other health benefits coverage as HHS recognizes (some regulations issued)



Interplay Between Minimum Essential Coverage, Minimum Value, And Essential Health Benefits

What Is The Minimum Value Test?

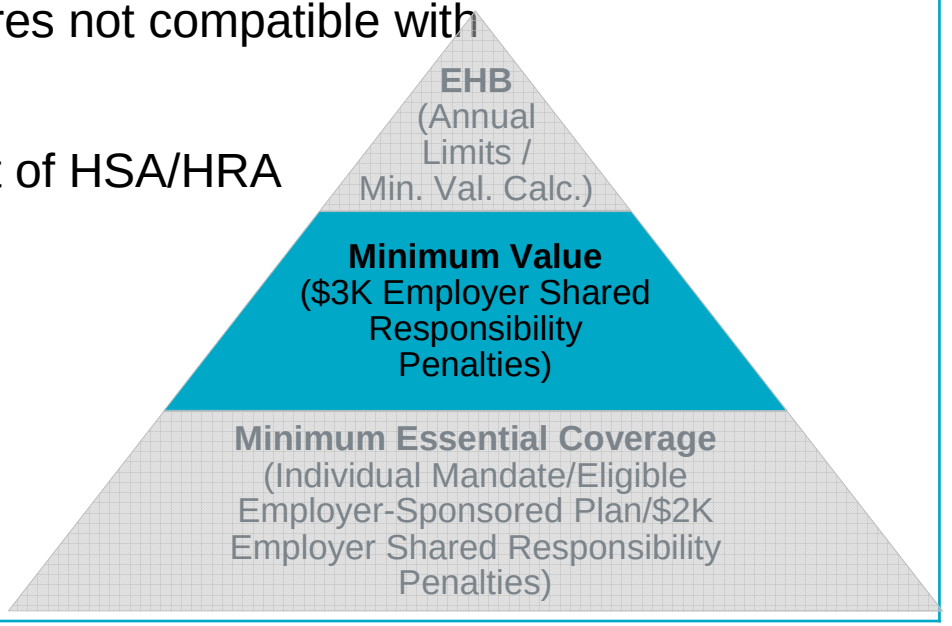
- One of the elements an employer's plan must meet to avoid the $3,000 x subsidized FTEs employer shared responsibility penalty
- Plan option must pay at least 60% of total costs for essential health benefits (see next slide)
- Providing minimum essential coverage is not necessarily the same as providing minimum value
- But an "eligible employer-sponsored plan" that provides minimum value provides minimum essential coverage because it is an "eligible employer-sponsored plan"



Interplay Between Minimum Essential Coverage, Minimum Value, And Essential Health Benefits

How Do We Calculate Minimum Value?

- Three methods for calculating minimum value:
  1. Minimum value calculator, based on coverage of certain essential health benefits
  2. Design-based safe harbors for plans covering all essential health benefits in the minimum value calculator
  3. If plan contains non-standard features not compatible with 1 and 2, certification by an actuary
- New proposed guidance on treatment of HSA/HRA contributions and wellness incentives

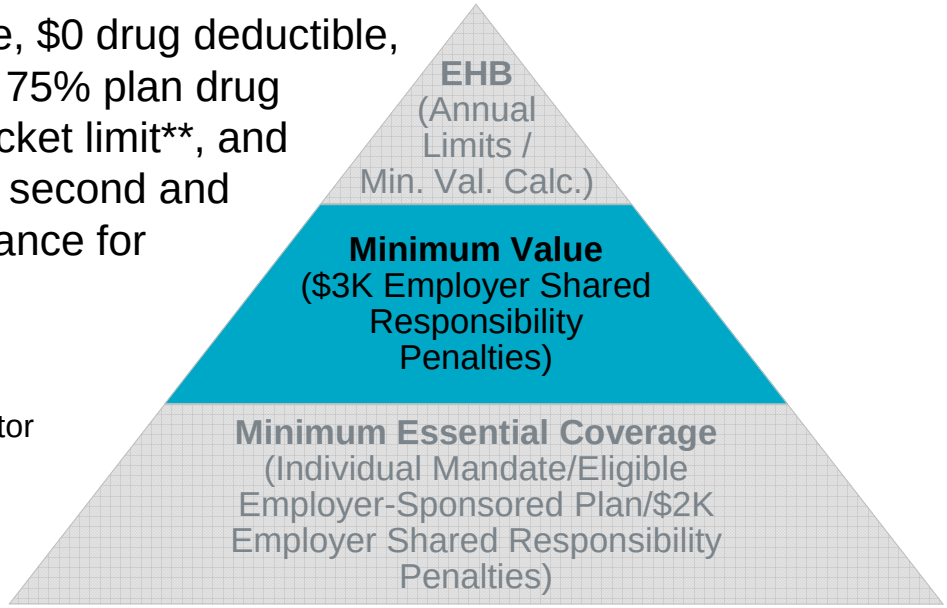


Interplay Between Minimum Essential Coverage, Minimum Value, And Essential Health Benefits

What Are The Design-based Safe Harbors For Minimum Value?

NOTE: Guidance still pending on these safe harbors

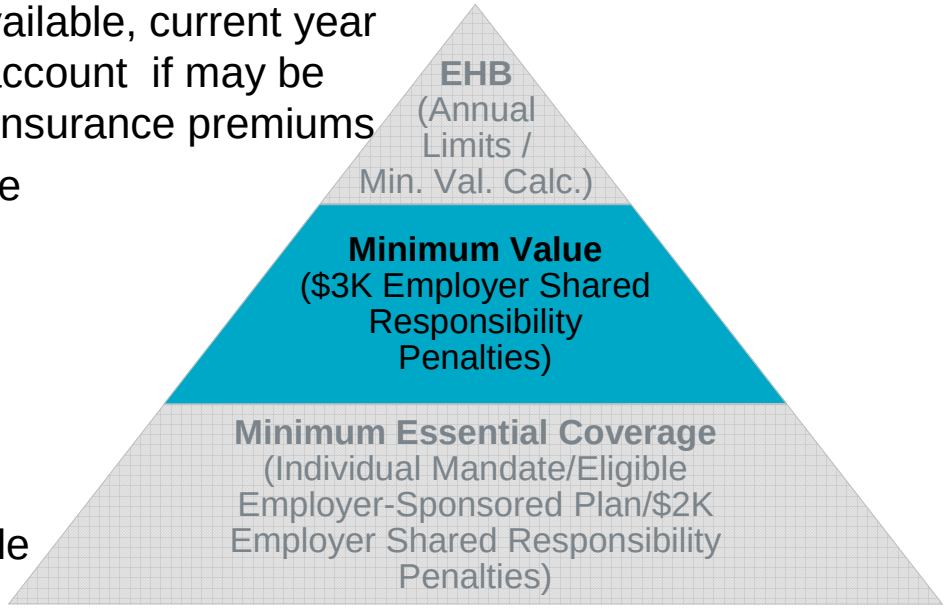
- Safe Harbor 1: $3,500 integrated medical and drug deductible, 80% plan cost-sharing, $6,000 maximum out-of-pocket limit
- Safe Harbor 2: $4,500 integrated medical and drug deductible*, 70% plan cost-sharing, $6,400 maximum out-of-pocket limit**, $500 employer contribution to an HSA
- Safe Harbor 3: $3,500 medical deductible, $0 drug deductible, 60% plan medical expense cost-sharing, 75% plan drug cost-sharing, $6,400 maximum out-of-pocket limit**, and drug co-pays of $10/$20/$50 for the first, second and third prescription drug tiers, 75% coinsurance for specialty drugs
- Notes:
  - Assumes coverage of all benefits in the MV calculator
  - *$4,500 exceeds self-only maximum deductible for HSA-compatible plans
  - **Still have to comply with out-of-pocket maximum limit rules (apply to non-grandfathered plans, for in-network EHB costs)



Interplay Between Minimum Essential Coverage, Minimum Value, And Essential Health Benefits

What Impact Do Non-Wellness Related HSA/HRA Contributions And Wellness Incentives Have on Minimum Value?

- HSA Contributions
  - Expected cost to employer of current year employer contributions may be taken into account
  - Treated as available for first dollar coverage
- HRA Contributions
  - Expected cost to employer of newly available, current year HRA contributions may be taken into account if may be used only for cost-sharing and not for insurance premiums
  - HRA must be integrated with an eligible employer sponsored plan
- Wellness Incentives
  - Can only take into account incentives for nondiscriminatory tobacco-related wellness program
  - Appears 2014 transition rule is available



Employer Shared Responsibility
Minimum Value

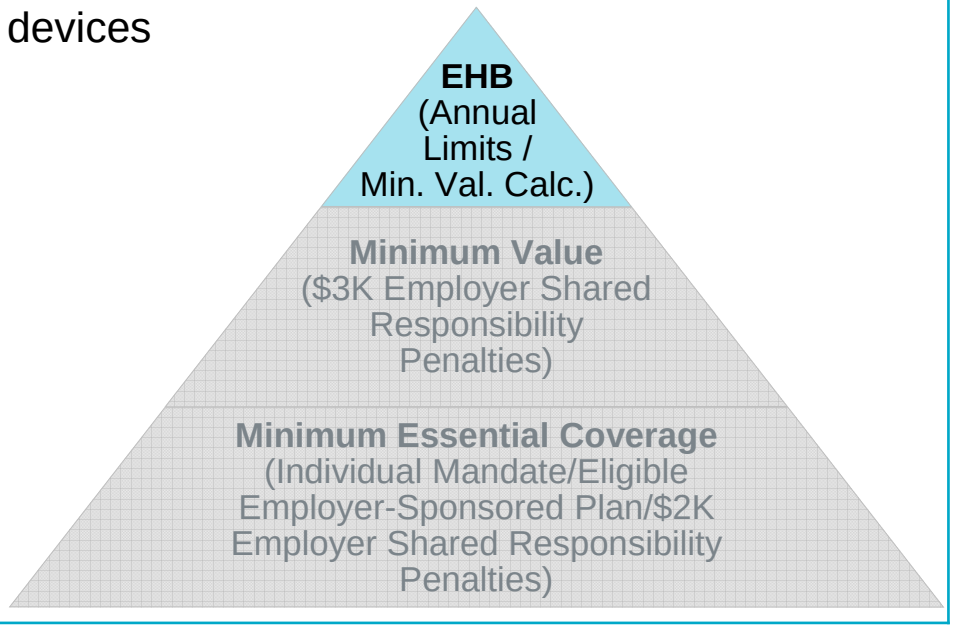
What Impact Do Non-Tobacco Related Wellness Incentives Have On Minimum Value?

- Transition Rule for Non-Tobacco Related Wellness Incentives
  - 2014 only: May take into account all nondiscriminatory non-tobacco related wellness program incentives
    - Nondiscriminatory wellness program must have existed on 5/3/13
    - Terms of the nondiscriminatory wellness program must be the same as were in effect on 5/3/13
    - May only take into account wellness incentives to extent they existed under the program on 5/3/13
      - (Can't take into account expanded incentives permissible in 2014)
    - May only take into account the incentives for the participants who are eligible for the wellness program under the eligibility terms as they existed on 5/3/13, regardless of hire date
      - (Could be problematic if planning to expand medical plan eligibility to satisfy 30-hour rule and also planning to expand wellness program eligibility to match medical plan)
  - 2015 and later: No transition rule. May only take into account incentives for nondiscriminatory tobacco-related wellness programs

Interplay Between Minimum Essential Coverage, Minimum Value, And Essential Health Benefits

What Are Essential Health Benefits?

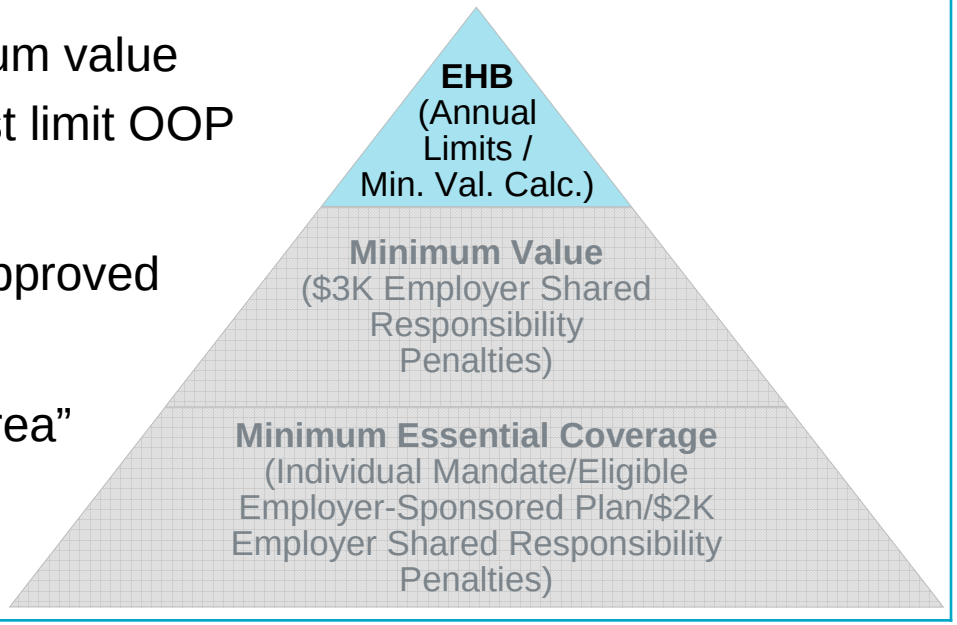
- Essential health benefits are the types of benefits that insured plans offered on the exchanges (and all of the individual and small group market) must cover
- Statutory categories:
  - Preventive & wellness services & chronic disease management
  - Mental health & substance use disorder benefits, including behavioral health treatment
  - Pediatric services, including oral & vision care
  - Rehabilitative & habilitative services & devices
  - Ambulatory patient services
  - Emergency services
  - Hospitalization
  - Maternity & newborn care
  - Prescription drugs
  - Laboratory services
- For 2014, states get to choose their own benchmark plan. EHBs may vary from state to state



Interplay Between Minimum Essential Coverage, Minimum Value, And Essential Health Benefits

Why Do We Care About Essential Health Benefits?

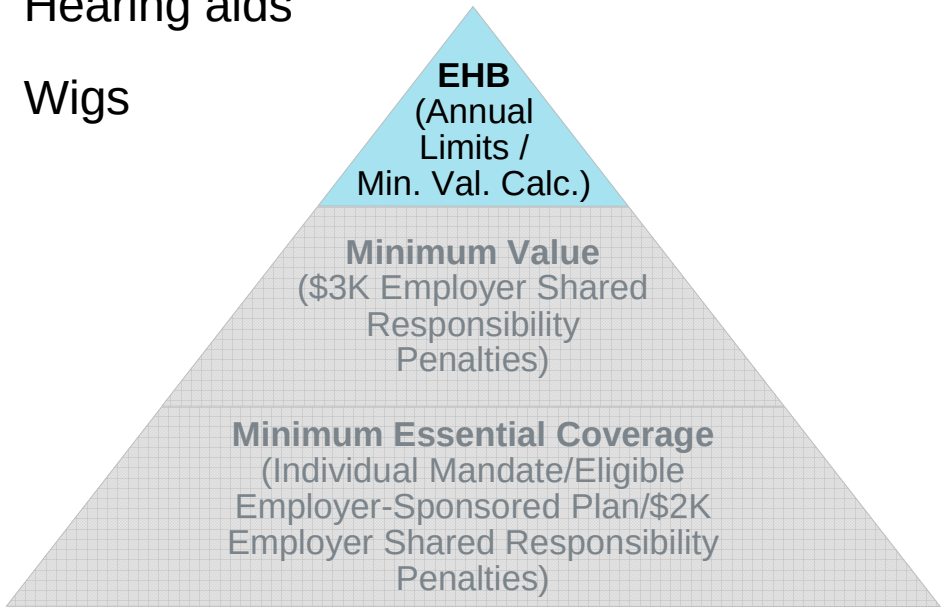
- Must a large or self-funded group health plan provide essential health benefits?
  - **No**
- Should a large or self-funded group health plan care about essential health benefits?
  - **Yes,** can't impose annual or lifetime dollar limits on them (but visit or treatment limits okay)
  - **Yes,** factor into calculating minimum value
  - **Yes,** nongrandfathered plans must limit OOP spending for in-network services.
- HHS says employers can use state-approved benchmark plans or FEHBP to define
- May be a good time to review "gray area" categories



Interplay Between Minimum Essential Coverage, Minimum Value, And Essential Health Benefits

What Are Some Services Or Treatments That May Or May Not Be Essential Health Benefits For Purposes Of Annual/Lifetime Dollar Restrictions?

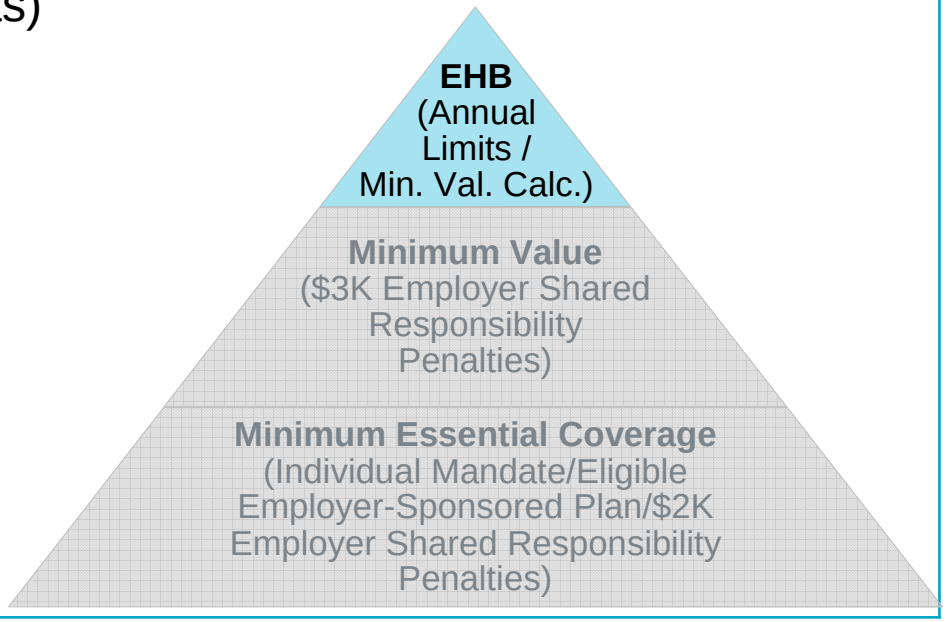
- Infertility treatments
- Chiropractic care
- Speech therapy
- Physical therapy
- Applied behavioral therapy
- Hospice and palliative care
- Acupuncture
- Bariatric surgery and related treatments
- Temporomandibular joint disease (TMJ)
- Prescribed drugs for nicotine addiction
- Hearing aids
- Wigs



Interplay Between Minimum Essential Coverage, Minimum Value, And Essential Health Benefits

Other Mandates

- Even though large or self-funded group health plans are not required to provide essential health benefits, other mandates may require coverage or specific benefits:
  - Nongrandfathered plan requirements (e.g., preventive services, clinical trials)
  - NMHPA (length of stay for newborns and mothers)
  - WHCRA (post-mastectomy benefits)
  - MHPAEA (Mental Health parity)



Section III

FEE'S

Patient-Centered Outcomes Research Institute (PCORI) Fee Overview

- To fund a federal program created by ACA to research the use of comparative effectiveness in medical practice.
- Policy or plan year that ends on or after Oct. 1, 2012, and before Oct. 1, 2019.
  - Due annually by July 31 after CY in which plan year ends.

Plan Year Begins	First Payment Due
10/2/11 through 12/31/11	7/31/13
1/1/12	7/31/13
1/2/12 through 12/31/12	7/31/14

- Paid by:
  - Insurers for fully-insured plans (most insurers will build this fee into client premiums at renewal).
  - Plan sponsors for self-insured, single employer plans. TPAs/vendors cannot report and pay the fee for employers.
- Fees are calculated per covered life, including covered dependents, retirees, and COBRA participants.

CY Plan Year	Fee PMPY	CY Plan Year	Fee PMPY
2012	$1.00	2016	$2.35
2013	$2.00	2017	$2.47
2014*	$2.13	2018	$2.59
2015	$2.23		

* After 2013, fee increase is an estimate based on National Health Expenditure Projections

Patient-Centered Outcomes Research Institute (PCORI) Fee
Applicable Plans

Fee applies to:

- Insured and self-insured health plans.
- Retiree-only plans.
- Certain carved-out Rx benefits.
- Certain HRA benefits.

Fee does not apply to:

- Health-FSA if HIPAA excepted benefit.
- Stand-alone dental and vision plans.
- EAPs, wellness, and disease management plans that don't provide significant benefits in the nature of medical care/treatment.
- On-site clinics.
- Stop-loss.
- Reinsurance policies.

Patient-Centered Outcomes Research Institute (PCORI) Fee
IRS-approved Counting Methods for Self-Insured Plans

- Actual: Sum of total number of covered lives for each day of the PY, divided by 365.
- Form 5500: Add the number of employees reported as covered on the relevant Form 5500 at the start and end of the plan year. Can't use if filing 5500 extension.
- Snapshot: Total the number of covered lives on a date in the first, second, or third month of each quarter, then divide that total by the number of dates on which a count was made.
- Snapshot factor: Same as the snapshot method, but sum the number of employees with single coverage plus the number of employees with other (not self-only) coverage times 2.35.

Transitional Reinsurance Fee
Overview

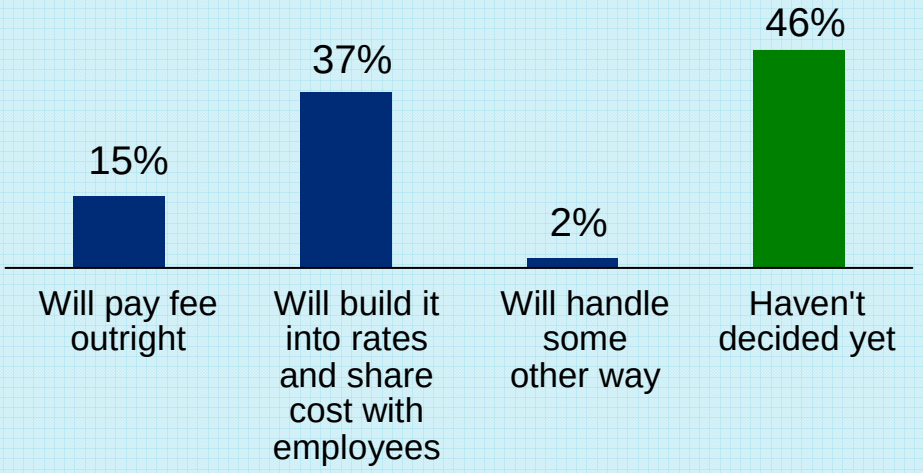
- To fund reinsurance pools to help stabilize the individual insurance marketplace, and to provide revenue to the federal government.
- Paid by "contributing entities," which includes self-insured and fully-insured major medical plans.
- Begins in 2014 and sunsets in 2016.
- Mechanism for payment is not yet known.

	2014	2015	2016
Fee PMPY	$63.00*	$40.00**	$25.00**

* Based on HHS estimate issued on March 11, 2013 in final rule

**Mercer estimates calculated based on 200,000,000 estimated covered lives

In our latest survey, nearly half of the respondents haven't yet decided how they will pay ACA's reinsurance fee of $63 per member.



Source:
Mercer's Survey on Health Care Reform: The Road to Implementation

Transitional Reinsurance Fee
Applicable Plans

Fee applies to:

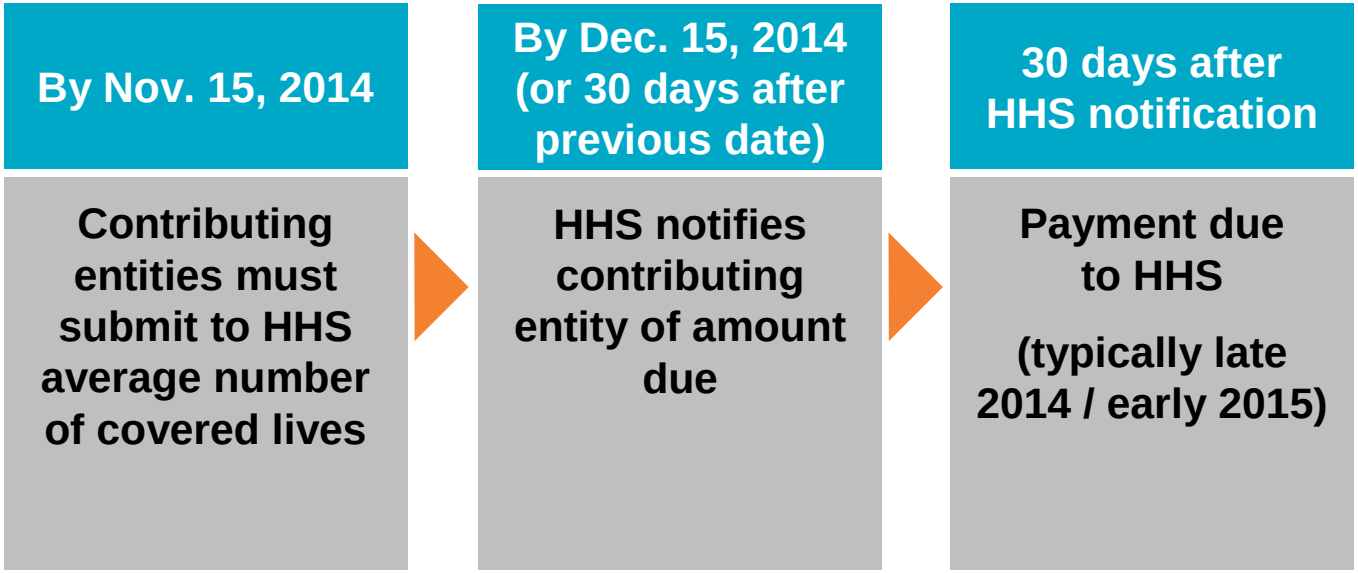
- Insured and self-insured health plans.
- For insured plans, state approved coverage that is part of commercial book of business only.
- Retiree-only plans.

Fee does not apply to:

- Health-FSA if HIPAA excepted benefit.
- Stand-alone dental and vision plans.
- EAPs, wellness, and disease management plans that don't provide significant benefits in the nature of medical care/treatment.
- HSAs offered with HDHPs.
- Stop-loss.
- Certain expatriate coverage.
- HRAs integrated with major medical.

Transitional Reinsurance Fee
Direct Fee

- Paid annually by the "contributing entity."
  - Insured plans: insurance providers (carriers will likely build this fee/tax into renewal pricing).
  - Self-insured plans: the plan sponsor, although TPA or ASO may transfer the fee on behalf of the plan sponsor.
- Important dates and deadlines:



Fee on Health Insurance Providers
Overview

- Begins in 2014 and continues thereafter.
- Paid by health insurance issuers providing health insurance for a US health risk.
- Average estimated percentage is 2.1% for 2014. Secretary of Treasury will determine amount owed each year based on the prior year's market share.
- Fee is nondeductible by the insurer.
- Insurer is expected to recover the fee from policy holders.

Estimated Annual Impact on Average Premium Rates			
	Low	High	Average
2014	1.9%	2.3%	2.1%
2015	2.6%	3.2%	2.9%
2016	2.4%	3.1%	2.8%
2017	2.9%	3.7%	3.3%
2018	2.9%	3.7%	3.3%

Fee on Health Insurance Providers
Applicable Plans

Fee applies to:

- Insured health plans, including dental and vision plans.

Fee does not apply to:

- Self-insured plans.
- LTC.
- LTD.
- Other “excepted benefits” (except for limited dental and vision).
- Stop-loss (unclear).

Fee on Manufacturers of Branded Prescription Drugs
Pass-through Fee

- Begins in 2011 and continues thereafter.
- Paid by companies who manufacture, import or sell branded prescription drugs to certain government programs.
- To provide revenue to the Medicare Part B Trust Fund.
- Fees likely to be passed through indirectly to employers (impact unclear).

Branded Rx Manufacturer Revenue Collected by the Government	
2011	$2,500,000,000
2012	$2,800,000,000
2013	$2,800,000,000
2014	$3,000,000,000
2015	$3,000,000,000
2016	$3,000,000,000
2017	$4,000,000,000
2018	$4,100,000,000
2019+	$2,800,000,000

Fee on Manufacturers of Medical Devices
Pass-through Fee

- Fee, in the form of a 2.3% excise tax, applies to sales of “taxable medical devices” beginning in January 1, 2013.
- Fee must be paid by manufacturers, producers, and importers of taxable medical devices via Form 720, Quarterly Excise Tax Return (first return due April 30, 2013).
- “Taxable medical device” means any device intended for humans (as defined in section 201(h) of the Federal Food, Drug and Cosmetic Act (FFDCA) that is listed as a device under section 510(j) of the FFDCA and 21 CFR Part 807).
- “Taxable medical device” does **not** include certain products that are considered devices for human use under the FFDCA, including eyeglasses, contact lenses, hearing aids, and other devices which are generally purchased by the public at retail for individual use.

And on the Long-term Horizon … Excise Tax on High-cost Plans

- 40% excise tax starting in 2018 on “high cost” employer-sponsored coverage.
  - Employees include former employees and surviving spouses.
- Initial cap set at $10,200/self-only and $27,500 “coverage other than self-only” (family).
  - Higher thresholds ($11,850/$30,950) for retirees and workers in high-risk professions.
  - Higher threshold ($27,500) for single multiemployer plan coverage.
  - Complex cost indexing and adjustments may apply.
- Aggregate cost determined using a methodology similar to that used for determining. applicable COBRA premiums.
- Employers must determine aggregate cost (insurers and benefit administrators will likely pass the cost of this tax on to employers).
  - Insurers responsible for tax for insured coverage.
  - Benefit administrators responsible for tax for self-insured coverage.
  - Employers responsible for tax for employer and pre-tax employee HSA contributions.
- No guidance has been issued yet.

And on the Long-term Horizon … Excise Tax on High-cost Plans

- Coverage included in the excise tax calculation:
  - Medical.
  - Contributions to (and certain reimbursements from) a health FSA.
  - Employer contributions to a HSA or an Archer medical savings account (MSA).
  - Employee HSA or Archer MSA contributions if made through pretax salary reduction.
  - Employer contributions to an HRA.
  - Most employer-sponsored on-site clinics.
  - Employee Assistance Programs
- Coverage excluded from the excise tax calculation:
  - Excepted benefits, including:
    - Accident and disability insurance,
    - Liability insurance, including any automobile or supplemental liability insurance,
    - Workers' compensation,
    - Automobile medical payment insurance, and
    - Credit only insurance.
  - Stand-alone, insured dental and vision plans.
  - Specified illness or fixed indemnity insurance, if paid for on an after-tax basis.

The Colorado Public Plan Coalitions, it's members and conference attendees understands that Mercer is not engaged in the practice of law and this report, which may include commenting on legal issues or regulations, does not constitute and is not a substitute for legal advice. Accordingly, Mercer recommends that The Colorado Public Plan Coalitions, it's members and conference attendees secures the advice of competent legal counsel with respect to any legal matters related to this report or otherwise.

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