Health Care Reform – Challenges and Opportunities

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Agenda

First Hour

• The Patient Protection and Affordable Care Act (PPACA) – legislative history, SCOTUS, and the political landscape
• PPACA’s first couple years (2010-2011)
• PPACA’s 2012 SCOTUS ruling
• PPACA’s next couple years (2012-2013)

Break
Agenda

Second Hour

• PPACA changes since enactment (parts of the law repealed, delayed, etc.)
• PPACA’s individual and employer mandates
• PPACA’s near term future (2014-2018)
• Strategies to help clients mitigate their exposure to employer mandate penalties and better manage costs for smaller groups (under 50 employees)
• Q&A
Before we start, though, because a picture is worth a thousand words…
GOOD NEWS! WE HAVE A FULL SHIP. 7.1 MILLION PASSENGERS.
“I was all for Obamacare until I found out I was paying for it.”
Guess you should have worried when he said, "If you like your cabinet job, you can keep your cabinet job. Period!"
OBAMA YEAR OF ACTION FIGURE

COMES WITH PEN AND PHONE

CONSTITUTION NOT INCLUDED
Harry Reid said that I should be made a saint because of Obamacare!

That's because if it ever works, it will be a miracle!
First, what is the actual name of the law?

- **PPACA** – The **Patient Protection and Affordable Care Act** is the actual name of the law when enacted in 2010.
- Has since been shortened for ease of reference to the “**Affordable Care Act**”, or “**ACA**”.
- **ObamaCare** – Originally not politically correct to call it that, but during the 2012 presidential debates Obama said he was okay with this reference because, after all, he really does care.
- **Healthcare Reform**, or “**HCR**”.
- **I will call it PPACA for purposes of my talk.**
Recap: Legislative history

On March 23, 2010 President Obama signed H.R. 3590, the Patient Protection and Affordable Care Act ("PPACA") into law, and on March 30, 2010 H.R. 4872, the Health Care and Education Affordability Reconciliation Act of 2010, a companion package of "fixes" to H.R. 3590.

Taken together, these two Acts propose to make the most profound changes to our country's health care delivery and financing systems since the enactment of Medicare and Medicaid in 1966.
Recap: Legislative history

The PPACA passed the Senate on December 24, 2009 by a vote of 60–39 with all Democrats and two Independents voting for and all Republicans voting against. It then passed the House of Representatives on March 21, 2010 through a legislative process known as “budget reconciliation” by a vote of 219–212, with 34 Democrats and all 178 Republicans voting against the bill.
Recap: Legislative history

Because of the unexpected election (at the time) of Scott Brown to the Senate in January of 2011, “the 41st vote against the federal healthcare law”, the House actually ended up passing the Senate-passed version of the bill with all of its glaring imperfections and inconsistencies. This is one of the reasons there are over 1,000 occurrences of the phrase “The Secretary Shall…”. 
Recap: Legislative history

Then there was the November 2, 2010 mid-term election

The Republican Party gained 63 seats in the House, recapturing the majority and making it the largest seat change since 1948 and the largest for any midterm election since 1938.

In the mid-term elections the GOP also gained 6 seats in the Senate, expanding its minority, and gained 680 seats in state legislative races to break the previous majority record of 628 set by Democrats in the post-Watergate elections of 1974. This left the GOP in control of 29 state legislatures, compared to the 15 still controlled by Democrats, and it also took control of 29 of the 50 State Governorships.
Recap: Legislative history

As soon as the 112th Congress was convened, HR 2 AKA “Repealing the Job-Killing Health Care Law Act” was filed on January 3, 2011 and just 16 days later it was passed in the House by a 245-189 margin largely along party lines.

The “McConnell Amendment,” the House-passed legislation for repeal of the Affordable Care Act, subsequently failed in the Senate by a vote of 51 to 47 on February 2, 2011.

Since taking its initial vote to repeal, the House has voted to repeal the PPACA yet another 40+ times. However, there have been no further Senate votes on the matter.
According to *Real Clear Politics*, since July 4, 2009, 458 polls have been taken on the PPACA. Twenty have shown Americans liking it, five have shown ties, and 433 (95%) have shown them disliking it. Perhaps even more strikingly, 299 (65%) — including the five most recent polls done within the past couple weeks — have shown Americans opposing the health care law by double-digits.
The Political Landscape

In Washington:

- Washington’s political dynamic is fractured as never before
- Compromise is extraordinarily difficult -- moderates are unable to move
- Both parties trying to balance delivering on promises now and goals for 2014 mid-term elections
- Following his announcement in April of the March 31st enrollment results President Obama laid out the blueprint he thinks his party should follow on the health care law as the midterms approach: “forcefully defend and be proud” of the law — and then move on, hitting Republicans for Washington dysfunction and inaction on the economy.
- It appears that Repeal and Replace will be the GOP’s mantra this fall. It also appears rather likely that the GOP will gain some seats in the House and possibly become the new majority in the Senate during the 114th Congress.
The Political Landscape

In the States:

- Budget deficits
- Refusal on the part of many states to accept federal funds or to implement Medicaid expansion
- Extreme variations in the states’ political climates.
- Illinois is among the bluest of blue states, but a small glimmer of hope can be seen in polling that’s finally beginning to reflect citizens’ concerns about the state’s fiscal condition.
- States are dealing with a host of health reform issues.
- Exchanges - Illinois is one of 7 “partnership marketplaces”
- Medicaid is blowing up state budgets, particularly in our state.
- Extreme variances in attitudes about implementation and implementation success
PPACA’s first couple years – THE SWEETENERS
PPACA’s first couple years (2010)

- Preexisting Condition Insurance Plan (PCIP) – Temporary high risk pools established.
- Early Retiree Reinsurance Program – Temporary reinsurance program for employers providing benefits for retirees age 55 and older who were not yet eligible for Medicare.
- Small Business Health Care Tax Credit launched for employers with less than 25 FTEs earning average annual wages less than $50,000.
PPACA’s first couple years (2010)

- No lifetime limits and restricted annual limits
- Adult children permitted to remain on their parents' insurance plan until their 26th birthdays
- No coverage rescissions except in the case of fraud
- No pre-existing condition exclusions for children under 19
- First dollar coverage for preventive care (NGPs only)

NGP = Non-grandfathered plan
PPACA’s first couple years (2010)

- Revised appeals process
- Grandfathered status disclosure notice
- Transparency disclosure (guidance not yet issued)
- Nondiscrimination rules extended to insured NGPs (delayed indefinitely until further guidance)
- Prohibition on ER restrictions (NGPs only)
- Prohibition on PCP restrictions (NGPs only)

NGP = Non-grandfathered plan
PPACA’s first couple years (2011)

- The excise tax for non-qualified HSA withdrawals was doubled from 10% to 20%.
- Flexible spending accounts (FSAs), health reimbursement accounts (HRAs), and health savings accounts (HSAs) cannot be used to pay for over-the-counter drugs, purchased without a prescription. The exception to this is insulin.
- $200 million was allocated for worksite wellness grants for businesses with less than 100 employees.
- HHS issued a final regulation aimed at controlling large health insurance premium increases.
PPACA’s first couple years (2011)

- SIMPLE cafeteria plans for employers < 100 EEs
- The free choice voucher provision was repealed by Congress, and the CLASS (Community Living Assistance Services and Supports Act) program was suspended.
- HHS issued final regulations, effective 1/1/2012, about the medical loss ratio (MLR) rule. Insurers must spend a certain % of earned premiums (80% individual and small group, 85% large group) on eligible expenses. If an insurer does not spend at these levels a rebate must be issued to the policyholder.

The PPACA provides that individual and group health insurance markets are to continue to exist outside of the exchanges.

In different parts of the country not-for-profit cooperatives have been established. Illinois now has such an arrangement – Land of Lincoln Health.

Subsidies are only available through the exchanges.
The Supreme Court upheld the constitutionality of the PPACA and the individual mandate by a 5-4 margin.

Although the mandate was ruled as being not constitutional under the Commerce Clause, it was nevertheless deemed to be an appropriate use of the Congressional power of taxation.

**Bottom line:** Congress can’t force Americans to obtain broccoli, but they can tax or penalize Americans who don’t.
The court also ruled 7-2 to allow the law’s expansion of the Medicaid program, but it struck down the portion of the law that would have penalized states that chose not to expand their Medicaid programs by taking their existing federal Medicaid funds away. This part of the ruling gives states significant leverage, as it will create a coverage hole in states that choose not to expand their programs for financial reasons.
PPACA’s next couple years - COMPLIANCE
Enid was finally ready to admit that compliance was a bit more complicated than she first thought.
The W-2 reporting requirement (first applied to W-2s issued in January 2013 for calendar 2012):

- The PPACA requires employers to report the value of group health plan coverage on the Form W-2. The IRS issued guidance making reporting voluntary in 2011.
- Nonexempt employers were required to include the value of the coverage on W-2s issued after 1/1/2013.
- The new reporting requirements did not change the tax treatment of employer-provided health coverage. The reporting is for informational purposes only.
Who is subject to the W-2 reporting requirement?

- Applies to all employers that provide “applicable employer sponsored coverage”. This includes:
  - All private-sector employers
  - Union plans
  - Federal, state, and local governments
  - Churches and religious organizations
  - Employers exempt from COBRA (except for self-funded COBRA exempt plans)

- There are exemptions for Indian tribal governments and transition-eligible small employers.
Small Employer Exception to W-2 reporting requirement: Employers issuing fewer than 250 W-2s in the preceding calendar year continue to be exempt from the reporting requirement.

- May be on an entity (i.e., FEIN) rather than controlled group basis
- The 250 threshold relates to the number of W-2s issued, NOT the total number of employees. Therefore many employers with high turnover or seasonal help end up getting dragged into this compliance requirement.
What to report on the W-2: Employers are required to report the value of all “applicable employer-sponsored coverage”. Generally, group health plans, including:

- Major medical
- Mini-meds
- On-site medical clinics
- Medicare supplemental coverage
- Health FSA contributions (employer)
- Employee assistance & wellness programs (with separate COBRA rates)
W-2 reporting: Determining the “Aggregate Cost”

- Must report the “aggregate cost”
- Include pre-tax and post-tax coverage
- Include employer and employee contributions (e.g. employer premium contribution or employee cafeteria plan contributions)
- General Rule: Use COBRA equivalent premium costs (without the 2% surcharge)
- Sources of IRS guidance: Notices 2010-69, 2011-28, and 2012-9 and the Form W-2 Instructions
On February 9, 2012 the Center for Consumer Information and Insurance Oversight (CCIIO) issued final regulations. The actual effective dates for compliance are (i) the first day of the plan’s open enrollment period on or after September 23, 2012 for disclosures required to be provided to re-enrollees or late enrollees; and (ii) the first day of the plan year that begins on or after September 23, 2012 for individuals newly eligible for coverage (such as new hires or special enrollees).
PPACA in 2012

Summary of Benefits & Coverage (SBC) and Uniform Glossary requirements

Who has to comply?

• Insured plans
• Self-insured plans
• Large (>50), small (2-50), and individual market
• Grandfathered health plans
• Excludes HIPAA excepted benefits (e.g. stand-alone dental, vision, specific disease, indemnity), Expat plans, FSAs, HSAs
PPACA in 2012

Summary of Benefits & Coverage (SBC) and Uniform Glossaryary requirements

Who has to provide the SBC, when, and how?

Who?

• Issuers must provide SBC to group health plans and in the individual market
• Group health plans must provide to participants and beneficiaries
PPACA in 2012
Summary of Benefits & Coverage (SBC) and Uniform Glossary requirements

Who has to provide the SBC, when, and how?

When?
• At the time of one’s initial application for coverage
• 1st day of coverage if there are changes
• Upon request or at the time of renewal

How? Paper or electronic
PPACA in 2012

Summary of Benefits & Coverage (SBC) and Uniform Glossary requirements

Uniform Format

• 4 pages, double sided, at least 12 point font
• Linguistically and technologically appropriate
• May be provided with SPD if prominently displayed
• “Best efforts” standard to describe unique plan terms.
PPACA in 2012

Summary of Benefits & Coverage (SBC) and Uniform Glossary requirements

Required Content

• Set template
• Uniform glossary of terms
• Coverage facts label: birth, type II diabetes
• Notice of modification (60 days prior to change)
PPACA in 2012

Summary of Benefits & Coverage (SBC) and Uniform Glossary requirements

• To view the final template for the summary of benefits and coverage, visit: http://go.cms.gov/QXXBFY
• To view the final regulations, visit: http://1.usa.gov/1fOBqYB
• Other technical information is available at: http://cciio.cms.gov/
• To view the fact sheet, visit: http://go.cms.gov/1fOBI1B
PPACA in 2012

Auto-Enrollment (Notice 2012-17)

• The Administration notified employers that guidance on auto-enrollment would not be published before 2014.
• Auto-enrollment is not effective until guidance is issued.
• As of the date of this presentation, auto-enrollment guidance has yet to be issued.
PPACA in 2012

Affordability Safe Harbor (Notice 2012-17)

- Treasury proposed allowing employers to use a safe-harbor for the affordability test based on 9.5% of employee wages rather than 9.5% of household income.

- Notice proposed allowing employers to use W-2 wages to calculate the affordability safe harbor.
PPACA in 2012

Other guidance contained in Notice 2012-17

- 90-day eligibility waiting period
- Newly hired employees
- FAQ ([http://go.cms.gov/1mWJwGd](http://go.cms.gov/1mWJwGd)) on EHBs (essential health benefits)
Patient-Centered Outcomes Research Institute (PCORI) fee

- For policy or plan years ending after Sept. 30, 2012, issuers and employers sponsoring certain group health plans were required to pay a fee of $1 per member per year. The fee increased to $2 per member per year for policy years ending after Sept. 30, 2013.
PPACA in 2012

Patient-Centered Outcomes Research Institute (PCORI) fee

• The first policy year to which the fee applied was for any policy year ending on or after Oct. 1, 2012, and if the policy or employer plan was a calendar year plan, the first fee applied for the 2012 calendar year and was due and payable by July 31, 2013.

• The fee does not apply to policy years ending after Sept. 30, 2019.
PPACA in 2013

- Exchange notification requirements for employers: Employers that are subject to compliance with the Fair Labor Standards Act were initially required to provide notice to the then current employees by / before October 1, 2013 (and new employees at the time of hire following this date) with information about the PPACA exchanges, now known as “Marketplaces”.
PPACA in 2013

- Exchange notification requirements for employers: The U.S. Department of Labor has two model notices to help employers comply. There is one model for employers who do not offer a health plan and another model for employers who offer a health plan to some or all employees, and they’re posted at http://www.dol.gov/ebsa/faqs/faq-noticeofcoverageoptions.html.
As reported on my blog (at http://johngarven.com/?p=2732), on 9/11/2013 in its online FAQ the DOL confirmed the fact that currently there will be no penalties for employers surrounding a failure to issue Marketplace Notices (also known as “Notice of Exchange Coverage”) to employees.

Despite the fact there is no statutory penalty, there could be ERISA fiduciary issues under case law related to the failure to communicate to participants in the absence of the employer communication. In general, employers that sponsor ERISA plans have a duty to be straightforward with participants. Therefore, we recommend that compliance with this requirement going forward.
PPACA in 2013

- **Surtax on investment income** - New 3.8% surtax on investment income earned in households making at least $250,000 ($200,000 single).
- **Medicare payroll tax increase** of 0.9% on incomes in excess of couples making $250,000 ($200,000 single).
- **Excise tax on medical device manufacturers**
- **Raise "Haircut"** for medical itemized deduction on Schedule A from 7.5% to 10% of AGI
- **New $2,500 Flexible Spending Account (FSA) Cap** (which has helped fuel interest in HSAs that have much higher limits and may be rolled over from year to year).
Taxed Enough Already? Just wait until Obamacare kicks in

To pay for generous subsidies to purchase health insurance, a huge expansion of Medicaid, and other new spending, Obamacare raises taxes and adds 17 new taxes or penalties that will affect all Americans.


- Excise tax on “Cadillac” employer health plans
- Individual and Employer Mandate penalties
- Health insurance premium tax
- Increase in Medicare Hospital Insurance (HI) tax and extension to investment income for high-income earners
- Excise tax on medical devices
- New restrictions on HSA, FSA plans
- Fee on pharmaceutical companies
- Revenue from 8 other taxes

Source: Heritage Foundation calculations based on data from the Joint Committee on Taxation, March 2010 report.

Obamacare in Pictures © heritage.org
The Internal Revenue Service has a site dedicated to the tax-related provisions of the health reform law. In addition, they have a separate site with news releases, multimedia and legal guidance.

**PPACA Tax Provisions**

**Affordable Care Act of 2010: News Releases, Multimedia and Legal Guidance**
http://1.usa.gov/VeixHX
The Department of Labor (DOL) also has jurisdiction over many PPACA provisions. The Department’s overview page contains a wealth of information, and their Frequently Asked Questions pages give detailed answers to very specific PPACA implementation scenarios.

- DOL Affordable Care Act Overview page – http://1.usa.gov/SBE3Qo
- DOL FAQ page - http://1.usa.gov/Rz8yd9
BREAK
PPACA changes since enactment (parts of the law repealed, delayed, etc.)
Changes / Delays

There is NO BETTER READ on this subject than the article that’s posted at http://www.galen.org/newsletters/changes-to-obamacare-so-far/.

The list was last updated on April 4\textsuperscript{th}, and to date, since the law’s enactment, 40 changes / delays are documented.
2014
Main Events

- Exchanges / marketplaces are in operation
- Compression of the small group (2-50) rate bands (Modified Community Rating)
- Individual mandate
- “Employer Responsibility” mandate aka “The Employer Mandate” was supposed to take effect, but it has been delayed twice (July 2, 2013 and February 10, 2014)
Exchanges / Marketplaces

- PPACA required all states to create two types of exchanges (“marketplaces”) to be operational this year:
  - American Health Benefit Exchange (AHBE) - An individual exchange
  - Small Business Health Options Program ("SHOP") - A Group Exchange for groups (in Illinois) with < 51 employees and with a multi-carrier option
- The tax subsidies are only available in the AHBE exchange for people earning less than 400% of the FPL, and small businesses are only able to access the small business tax credits through the public SHOP exchanges after 1/1/2014.
Exchanges to add 12 million?

What will the newly insured look like?
The newly insured compared to the currently insured are...

- **Race**: 75% White, 79% Excellent/Very good/Good
- **Health status**: 88% Excellent/Very good/Good, 92% Excellent/Very good/Good
- **Marital status**: 52% Single
- **Language**: 69% English
- **Educational attainment**: 88% College degree or higher
- **Employment status**: 42% Employed full-time

- ...less likely to be white
- ...less likely to rank self excellent/very good/good
- ...more likely to be single
- ...less likely to speak English
- ...less likely to have a college degree
- ...less likely to have full-time employment

Sources: PwC HRI analysis for year 2021, Current Population Survey, Medical Expenditure Panel Survey and CBO
Individual Coverage Subsidies

- The PPACA’s premium tax credits (subsidies) are only available to qualified individuals purchasing coverage through the ABHE exchanges after January 1, 2014. In Illinois the “official health marketplace” is GetCoveredIllinois (www.getcoveredillinois.gov).

- Individuals with family incomes between 100%-400% of the federal poverty level are eligible for a premium tax credit. Individuals with family incomes at or below 250% of the FPL also qualify for reduced cost-sharing.

- Individuals and their dependents who have been offered coverage through an employer meeting minimum value & affordability tests are not eligible to purchase government-subsidized coverage through an exchange.
Individual Coverage Subsidies

- The premium subsidy will come in the form of a refundable and advanceable tax credit paid directly to the individual’s insurer.
- The amount of the refundable premium tax credit received is based on the premium for the second lowest cost qualified health plan in the exchange (the silver plan) and in the rating area where the individual is eligible to purchase coverage.
Modified Community Rating

- The principal cost-driver in 2014 for the small employer group health insurance market – employers with 2-50 employees - is a little known or understood provision of the PPACA, something called "Modified Community Rating" (MCR).

- Because of MCR groups that are younger on average will see fairly large rate increases, whereas much older than average groups are likely to see little in the way of rate changes and possibly even slight rate decreases.
December 1, 2013 “early renewals”: We have a 35-employee securities trading firm in Chicago that was offered an option to pay $23,000 per month if they went with a 12/1/13 renewal date, but almost $29,000 per month if they waited one month. This firm’s average employee age is like 34. Conversely, another one of our small employer groups, a social service agency in Lake County with around 10 employees insured experienced a 15% rate decrease @ January 1st. That particular group's average age is around 58.
Emerging trend for smaller employers: We are seeing a big surge in interest among younger, healthier groups in partially self-insuring plans since these arrangements help employers avoid the Modified Community Rating trap plus avoid the “health insurance tax” of around 3%. The market is responding with all of the carriers other than Blue Cross Blue Shield offering partial self-insurance options for groups with as few as 15-20 insured employee lives.
PPACA’s near term future (2014-2018)
2014-2016 individual mandate penalties

- **2014 penalties** of $95 per adult and $47.50 per child, up to a family maximum of $285 or 1% of family income, whichever is greater.

- **2015 penalties** of $325 per adult and $162.50 per child, up to a family maximum of $975 or 2% of family income, whichever is greater.

- **2016 penalties** of $695 per adult and $347.50 per child, up to a family maximum of $2,085 or 2.5% of family income, whichever is greater.
Individual mandate penalties

- The individual mandate’s penalties only affect Americans who file tax returns.

- Many are exempted from compliance -
  - If you are between jobs and without insurance for up to three months
  - Religious objections
  - Undocumented immigrants
  - Jail inmates
  - Members of Indian tribes
Employer mandate aka “Pay or Play”

In 2016 employers with less than 100 FT (full-time) and FTE (full-time equivalent) employees will be required to offer “minimum essential coverage” to all PPACA eligible employees (working 30+ hours). Employers with 100+ such employees are generally subject to compliance with this mandate @ January 1, 2015.

If an employer does not provide coverage and at least one full-time employee receives coverage through a public Exchange for which a federal premium / cost sharing subsidy is received, the employer will be assessed a financial penalty in the form of a non-deductible excise tax.
Employer mandate aka “Pay or Play”

- In 2015 the non-deductible excise tax penalty does not apply to the first 80 full time employees.
- The "applicable payment amount" in 2015 is $166.67 ($2,000 annually), which will be indexed for inflation in the years that follow.
- In 2016 the non-deductible excise tax penalty does not apply to the first 30 full time employees.
Employer mandate aka “Pay or Play”

- If an employee is offered coverage under an employer-sponsored plan that satisfies prescribed Quality and Affordability standards, then the employee is ineligible for a federal premium or cost-sharing subsidy for health insurance purchased through a public exchange.

- Employees will generally be eligible for a federal premium / cost sharing subsidy if their income is between 138% to 400% of the federal poverty level and the employer's plan fails to satisfy both of the following standards:
Employer mandate aka “Pay or Play”

- **Quality Standard**: The plan must have at least a 60% Actuarial Value (i.e., the plan must be expected to pay at least 60% of covered medical expenses across a typical population).

- **Affordability Standard**: The premium for single coverage under the lowest cost plan offered by the employer cannot exceed 9.5% of the employee's W-2 wages (per the Affordability Safe Harbor Notice 2012-17, permitting employers to use an employee's current W-2 wages instead of household income).
**Employer mandate aka “Pay or Play”**

- If an employer fails either the Quality or Affordability standard, the non-deductible excise tax penalty is equal to $250 (1/12 of $3,000) times the number of full time employees for any month who are in receipt of a federal premium or cost sharing subsidy.

- The $3,000 figure is for 2015, and will be adjusted for inflation annually thereafter. The number of employees is not reduced by 30 for purposes of calculating this penalty, and this penalty tax is capped at an overall limitation equal to the penalty calculation above for an employer who does not offer coverage.
Notification of tax penalty

How?

• The IRS will contact employers to inform them of potential liability and provide an opportunity for response. If an “Employer Shared Responsibility” (ESR) penalty is confirmed, IRS will then send notice to the employer along with a demand for payment.

When?

• After the employees’ individual tax returns are due claiming premium tax credits and after the due date employers must file the information returns identifying their FTEs and describing any coverage.
Employer Reporting

Employers will have to report certain information about health coverage to the

Applies to:

- “Applicable large employers” – generally, employers with at least 100 full-time equivalent employees (FTEs) in 2015, and 50 or more FTEs in 2016.
- Applies to coverage offered after Jan. 1, 2015
- First returns to be filed in 2016
Employer Reporting

Employer Data:

• Employer identifying information
• Whether employer offers health coverage to FT employees and dependents
• Number of full-time employees for each month
• Length of any waiting period
• Monthly premium for lowest-cost option in each enrollment category
• Employer’s share of cost of benefits
• Names and contact information re employees and months such employees were covered by the employer’s medical plan(s).
2014 Plan Changes

- No pre-existing condition exclusions or limitations
- Wellness program changes - maximum reward increases to 30%
- Limits on out-of-pocket expenses and cost-sharing
- No waiting periods over 90 days
- Coverage of clinical trial participation
- Guaranteed issue and renewal
- No annual limits on essential health benefits
- Insurance premium rating restrictions in the small group market.
Health Insurance Tax

- PPACA’s Health Insurance Tax (HIT) will amount to $145 billion in assessments between 2014 and 2024 alone, and it’s levied on health insurance companies which, in turn, is simply passed on to consumers who are covered by fully insured plans in both the individual and group markets.

- In 2014 the estimated tax for the average employee in a fully-insured, employer-sponsored plan in 2014 ranges from $77 for single coverage to $266 for family coverage, increasing by 2018 to almost $200 for single coverage and nearly $500 for family coverage.
Transitional reinsurance fee

- PPACA requires contributions to be paid by health insurance issuers and self-funded group health plans to fund a Transitional Reinsurance Program in place from 2014 to 2016. The program then pays insurers in the individual market that cover high risk individuals, and it’s earmarked to raise $25 billion over these three years.

- In 2014 the transitional reinsurance fee is $63 per member (not just “per employee”). Like the health insurance tax, the cost for this is passed on to consumers.

- The carriers are remitting this fee for its insured clients, whereas self-insured plan sponsors are responsible for the accounting and remittance of the fee.
IRS Notice 2013-54

- Released on September 13, 2013, IRS Notice 2013-54 addresses the viability of individual health insurance plans as a tax-advantaged employee benefit under the PPACA.
- The news was not good for employers wanting to offer such plans to their employees insomuch as the IRS determined that such plans are prohibited under the PPACA.
The following arrangements and/or plans are now prohibited under the Notice:

- Arrangements whereby an employer reimburses employees for individual health insurance premium payments (sometimes called "premium reimbursement arrangements").
- Premium-only (or "POP") plans through which employees can pay for their individual health insurance on a pre-tax basis.
- Any other arrangement or plan through which an employee's individual health insurance premium is reimbursed or subsidized by the employer in a tax-free (or otherwise "tax-favored") manner.
The “Cadillac Tax”

- The Affordable Care Act imposes a non-deductible excise tax of 40% on the value of health insurance benefits exceeding $10,200 for single coverage and $27,500 for family coverage (indexed to CPI).

- The thresholds are higher for qualified retirees and “high risk” professions ($11,850 for single and $30,950 for family.).
Employer Strategies to Avoid Penalties

• The “49ers and 29ers”
  • Reducing the number of hours to UNDER 30
  • Reducing the size of the workplace to UNDER 50 FTE’s

• Reducing benefits to reduce premium

• INCREASING subsidy for single employees and REDUCING for dependents

• Reverse Discrimination / Means-Based Contribution

• Limiting use of seasonal workers
Employer Strategies to Avoid Penalties

• Spousal coverage
  • Carveouts
  • Surcharges
• Is it “cheaper” to NOT offer health insurance?
Facts about the Employer Penalty and Subsidies

- If an employer drops coverage and sends employees to the exchange, employees do not see one dime of the penalty money the employer pays. The entire fine amount goes straight to the federal treasury, and employees reap no coverage assistance from it.

- Many employers think that if they drop coverage and send people to the exchange, their employees will get free or drastically reduced coverage there, but for many employees, particularly those without dependents, the subsidy benefit will not be that great.
The PPACA does very little to address the underlying costs of health care. In the years ahead employers will still need to engage in strategic ways if they expect to be able to reasonably manage health benefit costs.

There is a decided trend, a “tsunami” if you will, from defined benefit (DB) toward defined contribution (DC) health insurance.

This trend in health insurance parallels the shift from DB to DC that we have seen in the qualified retirement plan space over the last 20-25 years.
Takeaways

- Employer-sponsored group health insurance costs too much, and even though trend has moderated recently, at current premium levels even 7%-8% year-over-year rate increases are not sustainable long term.

- If you’re insured in the individual market, are over 50 years of age, and have a grandfathered plan, in the near term you are probably going to be “okay”.

Takeaways

- Younger insureds, particularly those who are under 40 years of age and not eligible for premium assistance, can expect to see steep premium increases.

- If you work for a larger employer you will probably be better off than someone working for a smaller employer, particularly if that employer has a relatively young and healthy workforce.
Takeaways

- It will be very difficult to repeal and replace ObamaCare. As a practical matter that will not be possible until a new president occupies the oval office in 2017. Even if the GOP as a majority in both the House and Senate, until then President Obama’s veto of any repeal legislation will not have enough votes to override it.
Takeaways

- The law is needlessly complex. This is a perfect example of government creating an unsustainable situation, and then coming up with yet a further government solution to solve the problem that government created to begin with.

- Where there is complexity there is also opportunity, in our opinion, for forward-thinking advisors to provide significant value to their clients in helping them navigate through the PPACA maze and be paid handsomely for such.
Thank you for your valuable time and attention!

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