

North Carolina State Health Plan

How ACA is Changing Employer Health Benefits and the Marketplace

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1. Overview of ACA Provisions

2. Impact on Large Employers

3. Market Implications

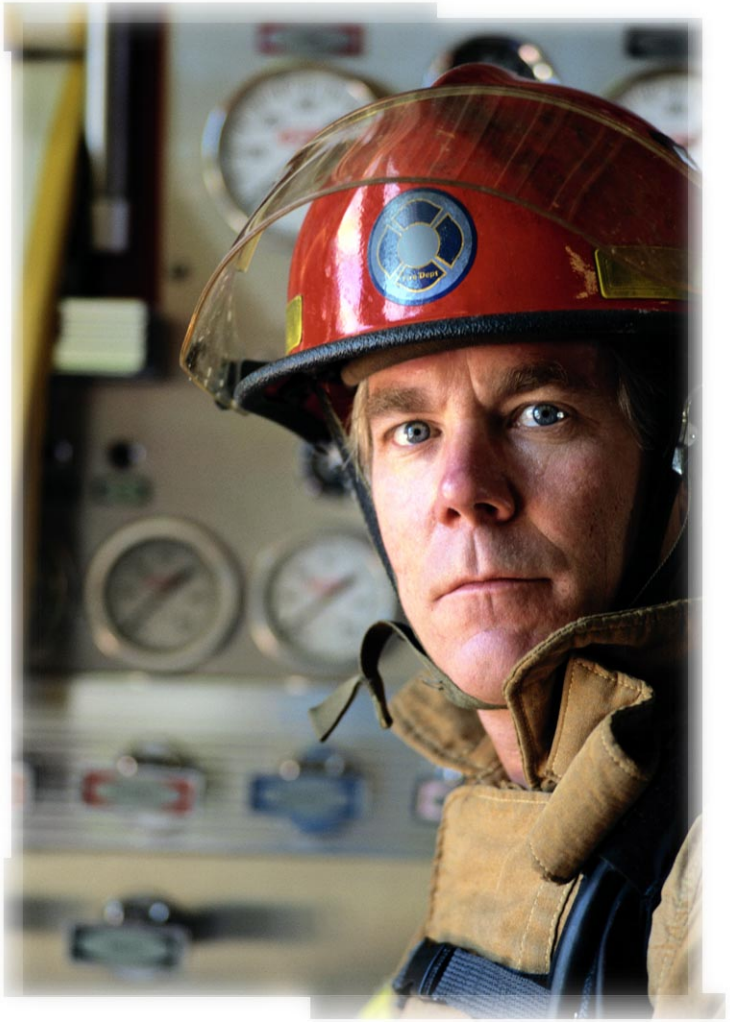
4. SHP Impact

ACA Mandates a FLOOR for Health Insurance

- **Extends access** to health insurance coverage to all citizens by imposing mandates:
  - **Individual Mandate**: have health coverage with minimum essential benefits or pay a tax penalty
  - **Employer Shared Responsibility**: provide a minimum level of affordable health care for full-time employees or pay tax penalties
  - **Insurers**: Fully insured policies must have no pre-existing conditions; limits on carrier profit margins
- **Expands Medicaid** eligibility
  - To individuals under 65 with income under 133% of Federal Poverty Level (FPL)
  - Increases Medicaid funding to states that expand coverage
- Expands certain **Medicare** benefits
- **Creates new virtual marketplaces** (exchanges) to buy coverage
  - Provides subsidies for low-income individuals to buy Exchange coverage

ACA Mandates and Requirements Since 2010

- Dependent coverage to age 26
- No annual or lifetime dollar limits
- No preexisting condition exclusions
- No waiting period over 90 days
- Coverage of preventive care benefits
- Increased wellness program incentive allowances
- Medical Loss Ratios for insured and Medicare plans (85%)
- Uniform information disclosure
- Summary of Benefits and Coverage
- Comparative Effectiveness Research Fees
- W-2 Reporting of health benefit costs
- Employer Exchange-Related Notices



Individual Mandate - 2014

The Individual

- Must be covered under *minimum essential* health coverage (including employer-sponsored or Medicare coverage) OR pay a penalty
  - Penalty is *the greater of:*
    - 2014: **$95 per adult or 1% of income**
    - 2015: **$325 per adult or 2% of income**
    - 2016: **$695 per adult or 2.5% of income** (indexed after 2016)
  - No penalty if:
    - Cost of coverage exceeds 8% of household income
    - Coverage lapses of 3 months or less
    - Income is below income tax filing threshold
    - Native American
- Individual penalty accounted for as an additional amount of federal tax owed

Employer Shared Responsibility Penalty - 2015

- Applies to ***large employers*** - 50 or more full-time employee equivalents
- Full time = 30 or more ***hours of service*** per week (130 hours per month)
- Penalty triggered when a full-time employee receives a federal subsidy in a state Exchange
- Cannot retaliate against employees for subsidies
- Employees must have ***access*** to at least one plan of health benefit coverage for themselves and dependent children that is both
  - **Minimum actuarial value**
    - Provides at least a value of 60% of the cost of services
  - **Affordable**
    - Plan of minimum essential actuarial value must be at an affordable price for self only coverage (9.5% of gross taxable wages)

The 4980H(a) and (b) Penalties – The Details

(a) If a large employer **does not** offer "minimum essential coverage" to at least **95%*** of its full-time employees (and dependent children under age 26) and if one full-time employee receives subsidized coverage on the Exchange:

- *Penalty is **$2,000** (annualized) times the **total #** of full-time employees (minus first 30 workers)*

(b) If a large employer **does** offer coverage to 95% of its full-time employees (and their dependent children under 26), but the coverage is either:

- **Not affordable** (premium for self-only coverage is 9.5% or more of household income), or
- **Not of minimum value** (actuarial value is less than 60%)

and one full-time employee receives federally subsidized coverage in the Exchange

- *Penalty is **$3,000** (annualized) times the **# of full-time employees getting a tax credit** in an Exchange (subject to a penalty maximum)*

*Under a 2/10/14 transition rule, large employers (100 or more employees) must offer coverage to least 70% of employees for 2015, then 95% of employees for 2016 and after.

Mandates on Insurance Companies

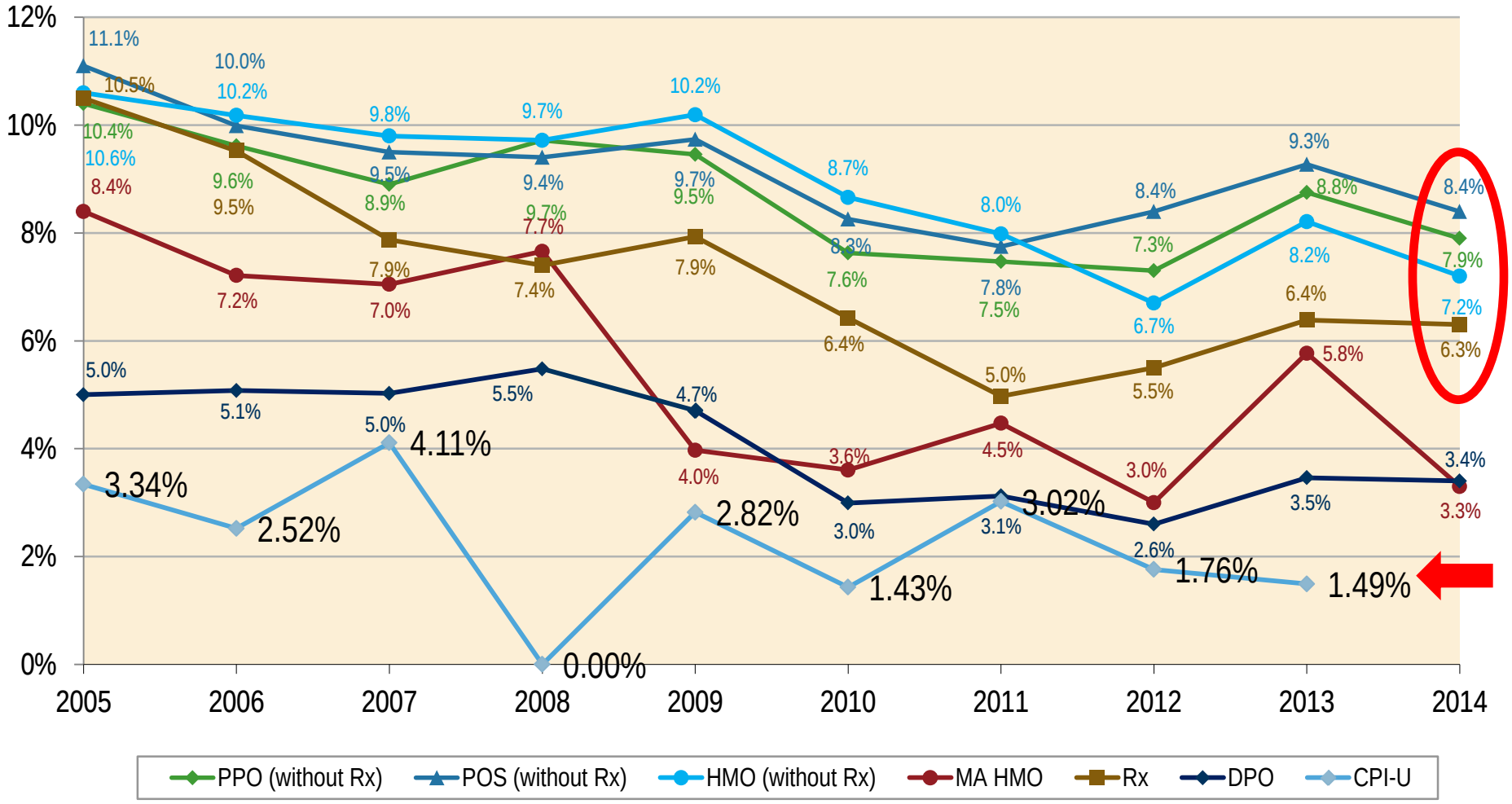
- Pay premium tax on premium income proportionate to total health insurance share of market (1.5% - 3.5% estimate. Not for profit is 50% of for profit companies)
- Pay comparative effectiveness fees and reinsurance fee to subsidize Exchange
- Fees estimated to add 3.5%-4% to the renewal rates for 2014
- Charge the same rate to individuals as it does through the Exchange, if it offers coverage inside the Exchange and outside the Exchange
- Eliminate all exclusions due to pre-existing conditions
- Establish rates through the Exchange based on certain factors:
  - Coverage tier (single, two party, family)
  - Geography
  - Age (maximum rate difference of 3 to 1)
  - Smoker versus non-smoker (maximum of 150% of non-smoker)
- Range of rates from youngest to oldest applicant cannot exceed a factor of 3
- Guarantee the renewal of the insurance policy

ACA Imposes a CEILING on Tax Free Benefits

40% Excise Tax on High Cost Health Plans *(2018)*

- Threshold $10,200/$27,500 indexed to the CPI-U
  - Based on total cost of coverage – Employer + Employee cost
  - No regional adjustment for cost of medical care
- Increased thresholds **($11,850/$30,950)** for high-risk professions and **retirees**
  - Includes public safety, construction, etc.
- Appears to exclude most dental and vision;
- Includes health FSAs and HRAs
- Tax payable by plan administrator
- No guidance yet!

Ten-Year Summary of Selected Medical, Prescription Drug Carve-Out and Dental Trends: 2005 – 2012 Actual and 2013 and 2014 Projected[1]



Source: 2014 *Segal Health Plan Cost Trend Survey*

[1] All trends are illustrated for actives and retirees under age 65, except for MA HMOs.

[2] Prescription drug trend data for 2005 – 2007 only reflects retail. For 2008 – 2014, prescription drug retail and mail order delivery channels are combined.

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Rethinking Plan Eligibility

- Redefining eligibility
  - Seasonal and part-time employees with multiple part-time positions
  - Adjunct faculty working full-time but not previously benefit eligible
- New Federal ACA penalty rules create a change of perspective in managing health benefit plan eligibility
  - Previous eligibility definitions may no longer work under the ACA “full-time” employee rules
  - Manage to “the rule” of no part-timer over 29 hours?
  - Allow coverage in existing plans – but how to fund the employer subsidy?
  - Create separate minimum benefit plans for these employees – but what about equity among “full-time” employees?

How Long Do We Try to Remain Grandfathered?

- **Purpose** is to preserve existing coverage; **Advantage** is plan does not have to comply with certain coverage mandates
- Limits on changes – Cannot have:
  - Elimination of all or substantially all benefits to diagnose or treat a particular condition
  - Any increase in percentage cost-sharing requirement (i.e., coinsurance)
  - Increase in deductible or out-of-pocket maximum by an amount that exceeds medical inflation + 15 percentage points
  - Increase in copays by an amount that exceeds medical inflation +15 percentage points (or, if greater, $5 + medical inflation)
  - Decrease in employer's contribution rate by more than 5 percentage points (and related increase in employee's contribution rate)
  - Imposition of annual limits on the dollar value of benefits below certain amounts
- Only about 20% of plans in place in March 2010 remain grandfathered today
- Medical cost inflation keeps increasing employer's share of cost. At some point the additional design and pricing flexibility outweighs the additional preventive benefits and other requirements

What Options For Retiree Coverage?

- Retirees are still subject to the individual mandate – but not to the employer shared responsibility penalty
- Retirees not yet eligible for Medicare may:
  - Purchase coverage on the state exchanges even if eligible for employer plan coverage
  - Qualify for Medicaid and/or federal exchange subsidies due to limited (retirement benefit) income
- Potential options:
  - Carve out retirees to their own plans and trusts
  - Push non-Medicare retirees to the Exchange to capture the Federal and Medicaid subsidies
  - Implement private exchanges for Medicare retirees
  - Move to defined contribution employer subsidies

How Should We Integrate Exchange Benefits?

Add the SHOP Exchange as a plan option

- Keep existing group plan
- Add a Metal Color option
  - Participant may select any plan available at Gold Level OR
  - Employer subsidizes specific plan in the Gold level
- Employer collects employee contributions and pays total premium to exchange, including its subsidy

Offer only Exchange options

- Employer will pay a defined contribution premium subsidy amount to exchange for a selected metal level.
- Participant may select up or down from subsidized plan, but pays the difference (or gets a reduced premium) to the exchange

Rethinking Total Compensation Philosophy

- What is the employer's responsibility to provide and/or subsidize health insurance benefits beyond compliance with the law?
- What role will health benefits play in attracting and retaining talent?
- With limited budgets, what is the tipping point between benefits subsidy and infrastructure repair?
- Redefinition of "full-time benefits eligible" will drive significant changes to workforce composition
- Potential reduction or removal of pre-tax status for health benefit premiums
- What is the tipping point between group health plan cost and state exchange policy cost?

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Affordable Care Organizations

What are ACOs and how do they work?

- Networks formed by groups of doctors, hospitals and other health care providers to receive financial incentives for coordinating care for people with Medicare and disabilities
- Delivery system ties predetermined quality of care and outcome measures to reimbursement for care. If successful in improving efficiency, patient care and health, the ACO keeps extra Medicare and Medicaid reimbursements
- Puts doctors' groups and hospitals at additional risk to prove what they are doing makes a difference

North Carolina ACOs

- Currently 14 or more formed and approved
- 360+ now approved nationally

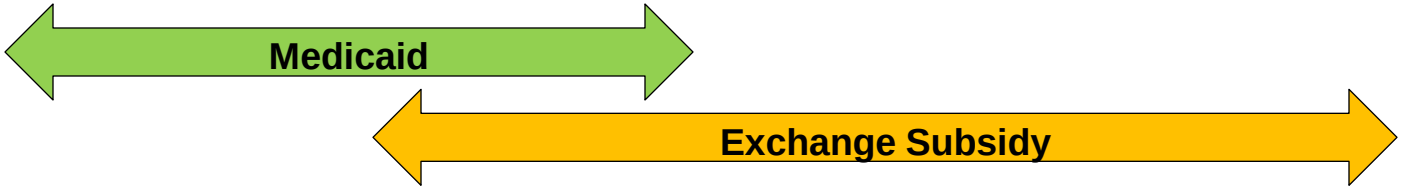
Potential Impact

- Hold down medical trend increases
- Redefine traditional networks

Medicaid Expansion

- Expansion to 133% of Federal Poverty Level
  - Puts pressure on state budgets
  - But also brings in more Federal revenue
  - Forces reconsideration of Medicaid models (managed care growth)
- Even if state doesn't expand, more citizens likely will be determined as eligible for Medicaid benefits who never applied directly in the past
- Now must consider how Medicaid coordinates with
  - Employer provided benefits
  - Medicare
  - Federal exchange subsidies
- No clear-cut best solution

Income Eligibility for Subsidized Coverage–
Between 100% & 400% FPL

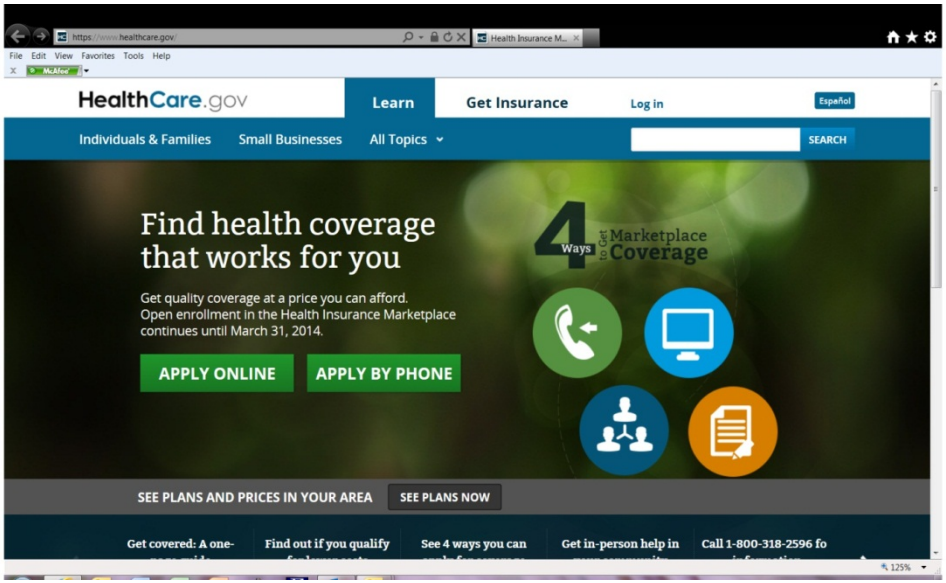


Persons in Family	100% FPL	133% FPL	250% FPL	400% FPL
1	$11,490	$15,282	$28,725	$45,960
2	$15,510	$20,628	$38,775	$62,040
3	$19,530	$25,975	$48,825	$78,120
4	$23,550	$31,322	$58,875	$94,200
5	$27,570	$36,668	$68,925	$110,280
6	$31,590	$42,015	$78,975	$126,360
7	$35,610	$47,361	$89,025	$142,440
8	$39,630	$52,708	$99,075	$158,520

2013 Federal Poverty Line guidelines for the 48 contiguous states

Health Exchange Implications

- Exchange becomes the standard against which all other plans are measured
  - Metal levels drive plan design corridors
  - Skinnier provider networks on some exchange options may limit patient options, but also help hold down costs
  - More options against which the SHP will ultimately compete
  - Will also influence employer subsidy levels in the future
- NC Health Exchange
  - 200,000 enrolled (March 1, 2014)
  - 18.7% of estimated potential enrollees
  - Potentially more than 50% of U.S. households could qualify for exchange subsidies (based on Bureau of Labor Statistics (BLS) estimates)



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The Playing Field Has Changed!

Why it's different now and for the future

1. Health Care Reform places new and increasingly more stringent requirements onto public sector health plans
2. The Federal Government is now a player in every state and local jurisdiction health plan.
3. Medicaid will now impact more employees and dependents
4. State and local government's traditional role in providing "hire to grave" health benefits for active and retired employees is changing
5. Public employers will have to make possibly significant changes to their health plan eligibility and/or workforce composition
6. Public plans have a developing new competitor (*state health insurance exchanges*) that may eventually be more cost effective for some groups

And Don’t Forget the Environmental Factors

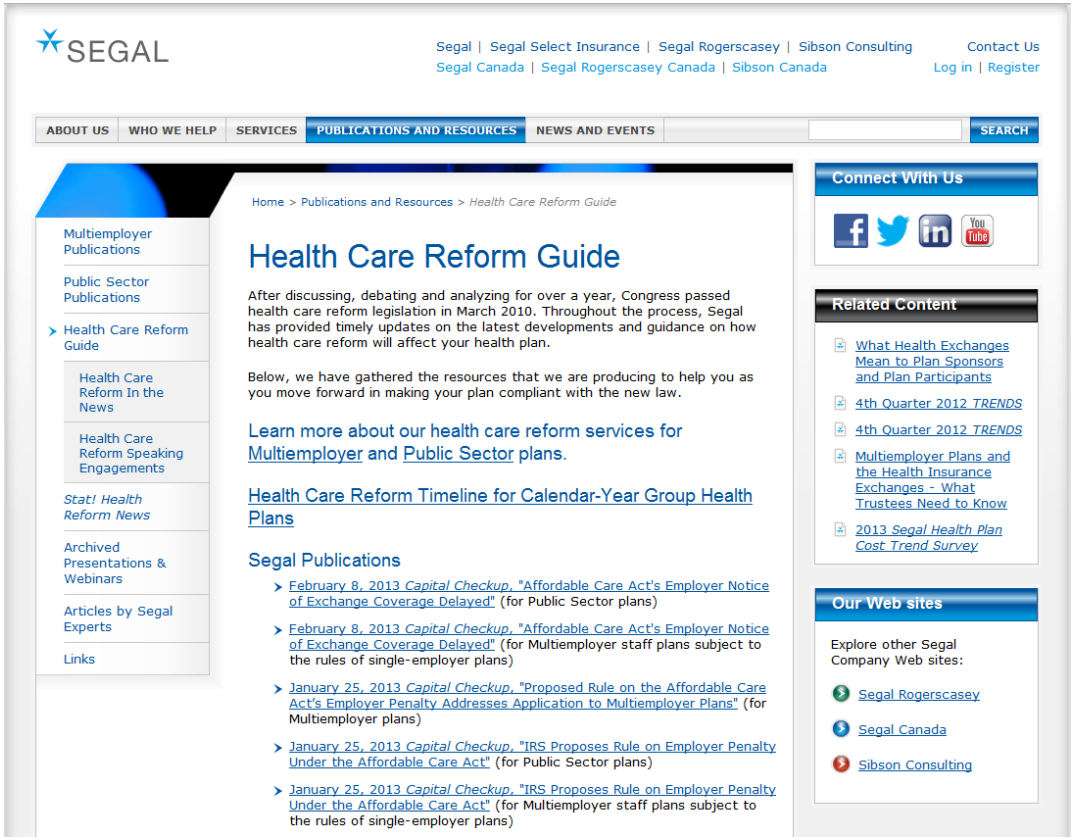
- The population is aging (Older = Sicker = Costlier)
- The cost of health care keeps rising faster than inflation
- Private employers will likely continue to cut or curtail employer sponsored and subsidized health benefits, making public employers even more attractive
- Public employees are likely to work longer just to keep subsidized health benefits (impact on budgets and retirement plan costs?)

Key Takeaways for SHP

- Expect an influx of new eligibles and possible pressure to offer a minimum benefit plan option
- The 70/30 and 80/20 plans will eventually lose grandfathered status
- There will be increased emphasis on Patient Centered Medical Home and Accountable Care Organization delivery networks as the market evolves
- Increased emphasis on wellness based premiums is possible
- Over time, there may be pressure to provide selected member groups an option to elect Plan subsidized coverage on the exchange
- Eventually, pressure may build to allow incoming employees to continue their previous exchange participation instead of joining the SHP
- While not imminent, eventually the 40% excise tax will force plan design changes

Health Reform Resources

On the Segal Website:



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