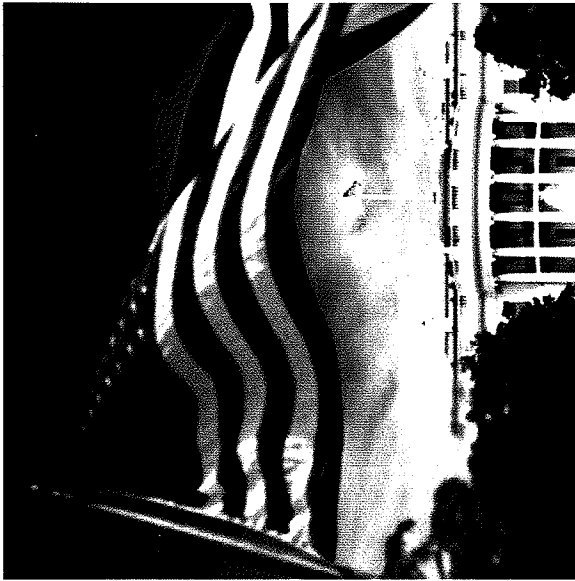


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January 18, 2011

## Washington County Federal Health Care Reform

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## **Health Care Reform – Beaverton School District**

- Elements discussed today may or may not effect the plans that Washington County offers employees.
- Any changes due to Health Care Reform initially will be fairly minor and are mostly enhancements to your current plans.
- Different elements of reform have different effective dates.
- Focus of the presentation is on the next few years and potential impact.

# Health care reform issues for employer-sponsored plans Beginning in 2010

| Issue  | Patient Protection and Affordable Care Act, as amended  |
|--|---|
| <p><b>Health plan standards – all plans</b></p> <p>Effective for plan years beginning on or after Sept. 23, 2010</p> | <p>Insured and self-insured plans must:</p> <ul style="list-style-type: none"> <li>▪ Offer extended dependent coverage to age 26 for covered employee’s child (regardless of whether tax dependent, student, married, or residing with employee)               <ul style="list-style-type: none"> <li>– If grandfathered, can limit offering to those adult children without access to other employer coverage until 2014 except for other parent coverage</li> <li>– Effective March 30, 2010, extend tax-free treatment for employer-provided health care to an employee’s child until the end of the year in which the child turns age 26</li> </ul> </li> <li>▪ No lifetime dollar limits on essential health benefits</li> <li>▪ Restrict annual dollar limits on essential health benefits</li> <li>▪ No pre-existing condition exclusions for any enrollee under age 19</li> <li>▪ No rescissions</li> </ul> |

# Health care reform issues for employer-sponsored plans Beginning in 2010

| Patient Protection and Affordable Care Act, as amended   |  |
|--|--|
| Issue  |  |
| <p><b>Health plan standards</b><br/>– new and nongrandfathered plans*</p> <p>Effective for plan years beginning on or after Sept. 23, 2010</p> | <p>Insured and self-insured plans must:</p> <ul style="list-style-type: none"> <li>▪ Provide mandated preventive services in network with no cost-sharing</li> <li>▪ Establish and provide notice of internal and external appeals procedure               <ul style="list-style-type: none"> <li>– Add to ERISA internal claim and appeal procedures</li> <li>– Require that self-insured plans offer external review</li> <li>– Temporary safe harbor external appeals procedures for self insured plans</li> </ul> </li> <li>▪ Emergency services coverage               <ul style="list-style-type: none"> <li>– Cannot be limited to in-network providers</li> <li>– Cannot include higher cost-sharing for out-of-network providers</li> <li>– Cannot require preauthorization</li> </ul> </li> <li>▪ Plans requiring or providing for primary care physician designation               <ul style="list-style-type: none"> <li>– Must allow designation of any participating primary care physician or pediatrician</li> <li>– May not require preauthorization or referral for OB/GYN services</li> </ul> </li> <li>▪ Insured plans cannot discriminate in favor of highly compensated individuals</li> </ul> |

\*"Grandfathered plans" A grandfathered plan is one in place *before* March 23, 2010. Plans won't lose grandfathered status for voluntary changes made to increase benefits or adopt consumer protections in the health reform law, or to conform with legal rules. But plans will have only limited ability to decrease covered benefits, increase enrollees' contributions or cost sharing, or change annual or lifetime limits without losing grandfathered status. Insured plans generally can't change carriers without losing such status. Coverage subject to a Collective Bargaining Agreement (CBA) in effect on March 23, 2010, must comply with the same coverage and cost-sharing standards at the same time non-CBA grandfathered plans must comply. However, insured CBA coverage will be considered grandfathered until the last agreement in effect on March 23, 2010, expires – even if the insurance carrier changes in that period.

# Health care reform issues for employer-sponsored plans Beginning in 2010

| Patient Protection and Affordable Care Act, as amended  |   |
|---|---|
| Issue   |   |
| <b>Reinsurance for early retiree medical plans</b><br><br>By June 2010 and ending by Jan. 1, 2014 | <p>Temporary reinsurance program will reimburse cost of providing health coverage to retirees aged 55 – 64 (and not Medicare eligible)</p> <ul style="list-style-type: none"><li>▪ Eligible plans may submit claims and receive 80% reimbursement of costs between \$15,000 and \$90,000 for a covered individual (including spouse, surviving spouse or dependent)</li><li>▪ To be eligible, plan must use cost-saving procedures for chronic and high-cost conditions</li><li>▪ Reimbursement may only be used to reduce retiree costs (such as premiums, coinsurance or deductibles) and may not be treated as general revenue</li><li>▪ Reimbursements are tax-free</li><li>▪ Program capped at \$5 billion</li><li>▪ HHS has issued regulations addressing the program's administration<ul style="list-style-type: none"><li>– <a href="#">Website</a> where those with approved applications will submit claims has launched; first payments expected in October 2010</li></ul></li></ul> |

# Health care reform issues for employer-sponsored plans

## Beginning in 2011

| Patient Protection and Affordable Care Act, as amended |   |
|--|---|
| Issue  |   |
| No reimbursement for over-the-counter drugs            | <ul style="list-style-type: none"><li>No reimbursement for over-the-counter drugs from a health plan, health flexible spending account, health reimbursement arrangement, or health savings account<ul style="list-style-type: none"><li>Reimbursements limited to physician-prescribed drugs and insulin</li></ul></li></ul> |

# Health care reform issues for employer-sponsored plans

## Effective date is unclear

| Patient Protection and Affordable Care Act, as amended  |  |
|---|--|
| Issue   |  |
| <p><b>Auto-enrollment requirement for employers with more than 200 full-time employees</b></p> <p>Effective date is unclear</p> | <ul style="list-style-type: none"> <li>▪ Unclear when it applies; may be effective:               <ul style="list-style-type: none"> <li>– March 23, 2010</li> <li>– Once DOL issues regulations</li> </ul> </li> <li>▪ Must automatically enroll new full-time employees in employer-sponsored plan</li> <li>▪ Must automatically continue plan enrollment for current employees</li> <li>▪ Required notice and opt-out opportunity</li> </ul>                                  |
| <p><b>60-day advance notice of plan design changes</b></p> <p>Effective date is unclear</p>                                     | <ul style="list-style-type: none"> <li>▪ Unclear when it applies; may be effective:               <ul style="list-style-type: none"> <li>– Plan years starting on or after March 23, 2010</li> <li>– March 23, 2012</li> </ul> </li> <li>▪ Must give 60-days prior notice before any material modifications can be made to the plan               <ul style="list-style-type: none"> <li>– Includes premium and cost-sharing increases, benefit decreases</li> </ul> </li> </ul> |

## Health care reform issues for employer-sponsored plans Beginning in 2012

| Patient Protection and Affordable Care Act, as amended |   |
|--|---|
| <b>Group health plan fee</b>                           | <ul style="list-style-type: none"> <li>▪ Group health plans must pay a fee of \$1 per covered life, increasing to \$2 for the second year and then a formula thereafter, to fund federal research on comparative effectiveness research</li> <li>▪ Sunsets in 2019</li> </ul>   |
| <b>Uniform benefit summary</b>                         | <ul style="list-style-type: none"> <li>▪ Employers must provide a 4-page uniform benefit summary at initial enrollment and annual enrollment</li> <li>▪ Includes information about covered benefits, exclusions, cost-sharing and continuation coverage</li> <li>▪ In addition to SPD and other currently required disclosures</li> </ul> |

# Health care reform issues for employer-sponsored plans

## Beginning in 2013

| Patient Protection and Affordable Care Act, as amended |  |
|--|--|
| <b>\$2,500 health FSA contribution cap</b>             | <ul style="list-style-type: none"><li>▪ Annual contributions to health FSAs capped at \$2,500<ul style="list-style-type: none"><li>– Adjusted annually for increases in the cost of living</li></ul></li></ul> |
| <b>Tax on medical devices</b>                          | <ul style="list-style-type: none"><li>▪ A 2.3% tax will apply to medical devices</li></ul>   |

# Health care reform issues for employer-sponsored plans Beginning in 2014

| Patient Protection and Affordable Care Act, as amended   |  |
|--|--|
| Issue  |  |
| <p><b>Health plan standards – all plans</b></p> <p>Effective for plan years beginning on or after Jan. 1, 2014</p> | <p>Insured and self-insured plans</p> <ul style="list-style-type: none"> <li>▪ Offer coverage to dependent children to age 26 regardless of access to other employer coverage</li> <li>▪ No preexisting condition exclusions</li> <li>▪ No waiting periods exceeding 90 days</li> <li>▪ No annual dollar limits on essential benefits</li> </ul> |
| <p><b>Health plan standards – new and nongrandfathered plans*</b></p>  | <p>Insured and self-insured plans</p> <ul style="list-style-type: none"> <li>▪ Mandated coverage of costs in connection with clinical trials</li> <li>▪ Annual cost-sharing and deductible requirements</li> <li>▪ Provider nondiscrimination</li> </ul> <p>Insured plans—guaranteed availability and renewability of coverage</p>               |
| <p><b>Free choice vouchers for certain employees</b></p> <p>Beginning in 2014</p>                                  | <ul style="list-style-type: none"> <li>▪ Offer vouchers to employees with household incomes at or below 400% of the federal poverty level (FPL) if their contribution for employer-sponsored coverage would be 8% to 9.8% of household income</li> </ul>   |

# Health care reform issues for employer-sponsored plans Beginning in 2014

| Issue   | Patient Protection and Affordable Care Act, as amended   |
|---|--|
| <p><b>Employer shared responsibility penalties</b></p> <p>Beginning in 2014</p> | <ul style="list-style-type: none"> <li>▪ Shared responsibility provision apply to employers with more than 50 full-time employees (FTEs) defined as employees working 30 or more hours per week on average in a month (or full-time equivalents based on separate statutory formula)</li> <li>▪ Employers <i>offering coverage</i> to full-time employees that is unaffordable (i.e., employee contribution constitutes more than 9.5% of household income) or pays less than 60% of benefits covered by the plan (i.e., 60% minimum actuarial value)               <ul style="list-style-type: none"> <li>– Up to \$3,000 annually for each FTE receiving income-based assistance for health insurance exchange coverage</li> <li>– Penalties capped at \$2,000 times total number of FTEs - not counting first 30 FTEs</li> </ul> </li> <li>– Employers <i>not offering coverage</i> <ul style="list-style-type: none"> <li>– Up to \$2,000 annually for every FTE if at least one FTE receives income-based premium assistance to buy coverage through new health insurance exchanges</li> <li>– Penalties do not apply to first 30 FTEs</li> </ul> </li> </ul> |

# Health care reform issues for employer-sponsored plans

## Beginning in 2014

| Patient Protection and Affordable Care Act, as amended             |   |
|--|---|
| Issue  |   |
| <p><b>Individual coverage mandate</b></p> <p>Beginning in 2014</p> | <ul style="list-style-type: none"> <li>▪ Individuals must obtain minimum essential coverage</li> <li>▪ Certain exceptions (e.g., lowest cost plan exceeds 8% household adjusted gross income, no coverage for less than 3 months, income below the income tax filing threshold)</li> <li>▪ Penalty would be the greater of a flat dollar amount (\$325 in 2015, rising to \$695 in 2016) or a specified percentage of income</li> </ul>   |
| <p><b>Health Insurance Exchanges</b></p> <p>Beginning in 2014</p>  | <ul style="list-style-type: none"> <li>▪ Federal funding for states to create health insurance exchanges to facilitate purchase of insurance by individuals and small groups</li> <li>▪ Employer size initially limited to 50 or fewer employers                             <ul style="list-style-type: none"> <li>– Federal threshold gradually rises to 100 or fewer, with state flexibility to let employers of any size participate</li> </ul> </li> <li>▪ Income-based assistance for individuals or families with incomes below 400% of federal poverty level</li> </ul> |
| <p><b>New Industry fees</b></p> <p>Beginning in 2014</p>           | <ul style="list-style-type: none"> <li>▪ Health insurer fees begin</li> </ul>   |

# Health care reform issues for employer-sponsored plans 2018 and beyond

| Patient Protection and Affordable Care Act, as amended                                |   |
|---|---|
| Issue   |   |
| <p><b>Excise tax on high cost coverage</b></p> <p>Effective for all plans in 2018</p> | <ul style="list-style-type: none"> <li>▪ 40% excise tax on “high cost” coverage, including medical, health FSA contributions, onsite medical clinics, and employer contributions to HSAs               <ul style="list-style-type: none"> <li>– Does not include stand-alone insured dental and vision coverage</li> </ul> </li> <li>▪ Initial cap set at \$10,200/single and \$27,500 family               <ul style="list-style-type: none"> <li>– Higher thresholds (\$11,850/\$30,950) for retirees and workers in high-risk professions</li> <li>– Higher threshold (\$27,500) for single multiemployer plan coverage</li> <li>– Indexed to CPI+1%</li> </ul> </li> <li>▪ Aggregate cost determined using a methodology similar to that used for determining applicable COBRA premiums</li> <li>▪ Employers must determine aggregate cost               <ul style="list-style-type: none"> <li>– Insurers responsible for tax for insured coverage</li> <li>– Benefit administrators responsible for tax for self-insured coverage</li> <li>– Employers responsible for tax for HSA contributions</li> </ul> </li> </ul> |