North Carolina State Health Plan

ACA Impact on Benefit Planning for 2016

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Health Care Reform

Timeline for Group Health Plans

2014

- **Health Insurance Exchange** coverage begins for individuals and small employers; premium assistance tax credits available to certain low-income individuals
- **Individual Mandate** starts, requiring individuals to obtain minimum essential coverage or pay a personal income tax penalty; 2014 penalty is the greater of $95/adult or 1% of taxable income
- **Medicaid** expansion to 133% of Federal Poverty Level (at state option)
- Group health plan standards for **all plans** (effective for plan year beginning on/after January 1, 2014): ban on waiting periods that exceed 90 days, ban on annual dollar limits on essential health benefits, ban on pre-existing condition limitations (regardless of age), wellness incentives can be raised from 20% to 30% (up to 50% for smoking cessation programs)
- Group health plan standards for **non-grandfathered plans** (effective for plan year beginning on/after January 1, 2014): cost-sharing limits, coverage relating to routine patient costs associated with approved clinical trials, provider nondiscrimination and protection of employees
- **Health Insurance Provider Fee** starts (annual fee)
- **W-2 Reporting** on the value of employer-sponsored coverage for 2013 (January 2014)
- **Comparative Effectiveness Research Fee/PCORI** rises to $2 per covered life (return/fees due by July 31)
- **Temporary Reinsurance Program Fee** enrollment count due November 15, 2014 ($63/covered life for 2014) Fee sunsets after 2016
- Use **Early Retiree Reimbursement Program (ERRP)** reimbursement monies by end of 2014
- Deadline for certain amendments to cafeteria plan documents (December 31, 2014)

2015

- **Individual Mandate Penalty** is the greater of $325/adult or 2% of taxable income
- **Employer Shared Responsibility Penalty** begins
- **W-2 Reporting** on the value of employer-sponsored coverage for 2014 (January 2015)
- First installment of 2014 **Temporary Reinsurance Program Fee** due by January 15, 2015
- **Comparative Effectiveness Research Fee/ PCORI** continues (return/fees due by July 31)
- **Temporary Reinsurance Program Fee** enrollment count due by November 15, 2015 ($44/covered life for 2015)
- Second installment of 2014 **Temporary Reinsurance Program Fee** due by November 15, 2015

2014 → **2015**

Effective Dates to be Determined in Regulations

- Auto-enrollment of new hires (awaiting guidance)
- Reporting related to transparency in coverage (for non-grandfathered plans, not sooner than 2015)
- Quality reporting (for non-grandfathered plans, awaiting guidance)
- Nondiscrimination rules for insured plans (for non-grandfathered plans, awaiting guidance)
- Plans certify compliance with HIPAA EDI standards and operating rules (proposed deadline: December 31, 2015)

August 20, 2014

Health Care Reform

Timeline for Group Health Plans

2016

- **Individual Mandate Penalty** is the greater of $695/adult or 2.5% of taxable income
- **Employer Shared Responsibility Penalty** continues
- First installment of 2015 **Temporary Reinsurance Program Fee** due by January 15, 2016
- **Large Employer Reporting to IRS** on 2015 coverage offered to full-time employees. This includes **employer reporting to employees by January 31, 2016**
- **Plan Reporting to IRS on 2015 coverage.** This includes **plan reporting to participants by January 31, 2016**
- **W-2 reporting** on the value of employer-sponsored coverage for 2015 (January 2016)
- **Comparative Effectiveness Research Fee/PCORI** continues (return/fees due by July 31)
- **Temporary Reinsurance Program Fee** enrollment count due by November 15, 2016 (final year); national per capita rate for 2016 set in 2015
- Second installment of 2015 **Temporary Reinsurance Program Fee** due by November 15, 2016

2017

- **Individual Mandate Penalty** is the greater of $695 (indexed)/adult or 2.5% of taxable income
- Exchanges may permit **large employers** to purchase Exchange coverage
- **Employer Shared Responsibility Penalty** continues
- First installment of 2016 **Temporary Reinsurance Program Fee** due by January 15, 2017
- **Large Employer Reporting to IRS** on 2016 offers of coverage (to employees by January 31, 2017)
- **Plan Reporting to IRS on 2016 coverage** (to participants by January 31, 2017)
- **W-2 reporting** on the value of employer-sponsored coverage for 2016 (January 2017)
- **Comparative Effectiveness Research Fee/PCORI** continues (return/fees due by July 31)
- Second installment of 2016 **Temporary Reinsurance Program Fee** due by November 15, 2017

2018

- **40% Excise Tax** on health plans that cost above $10,200 (single) and $27,500 (family), indexed to the CPI-U
- **Individual Mandate and Employer Shared Responsibility Penalties** continue
- **Large Employer Reporting to IRS** on 2017 offers of coverage (to employees by January 31, 2018)
- **Plan Reporting to IRS on 2017 Coverage** (to participants by January 31, 2018)
- **W-2 reporting** on the value of employer-sponsored coverage for 2017 (January 2018)
- **Comparative Effectiveness Research Fee/PCORI** (return/fees due by July 31)

2016 | **2017 and beyond**

August 20, 2014

Coming ACA Requirements for Employers/Plans

2014

- Temporary Reinsurance Program Fee - $63/covered life for 2014

2015

- Employer Shared Responsibility Penalty begins

2016

- Large employer reporting to IRS on coverage offered to full-time employees
- Plan reporting to IRS on 2015 coverage
- Employer and Plan reporting to individual participants

2018

- 40% Excise Tax on plans that cost above $10,200/$27,500

1. 40% Excise Tax Implications
2. Strategies for Avoiding the Excise Tax
3. Splitting the Retiree Population from Actives
4. Medicaid Implications

ACA Imposes a CEILING on Tax Free Benefits

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

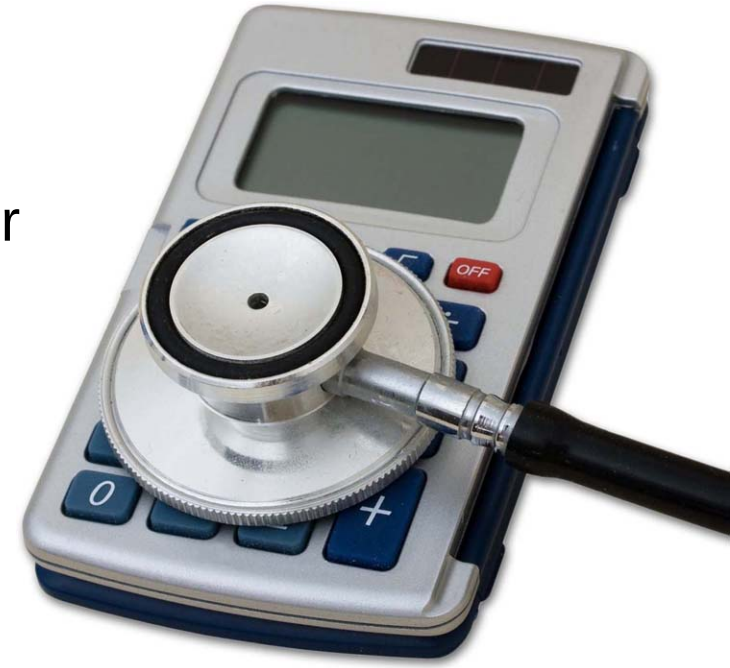
- Threshold **$10,200/$27,500** indexed to the CPI-U, not medical inflation
  - Based on total cost of coverage – Employer + Employee cost
  - No regional adjustment for cost of medical care
- Increased thresholds **($11,850/$30,950)** for **retirees** and high risk professions
  - Includes law enforcement, fire protection, out-of-hospital emergency medical care (EMTs, paramedics, first-responders)
  - Also, construction, mining, agriculture, forestry, fishing
  - Where high risk employees are majority of population
- Tax payable by plan administrator
- **No guidance yet!**

Which Plans Are Included for the Excise Tax?

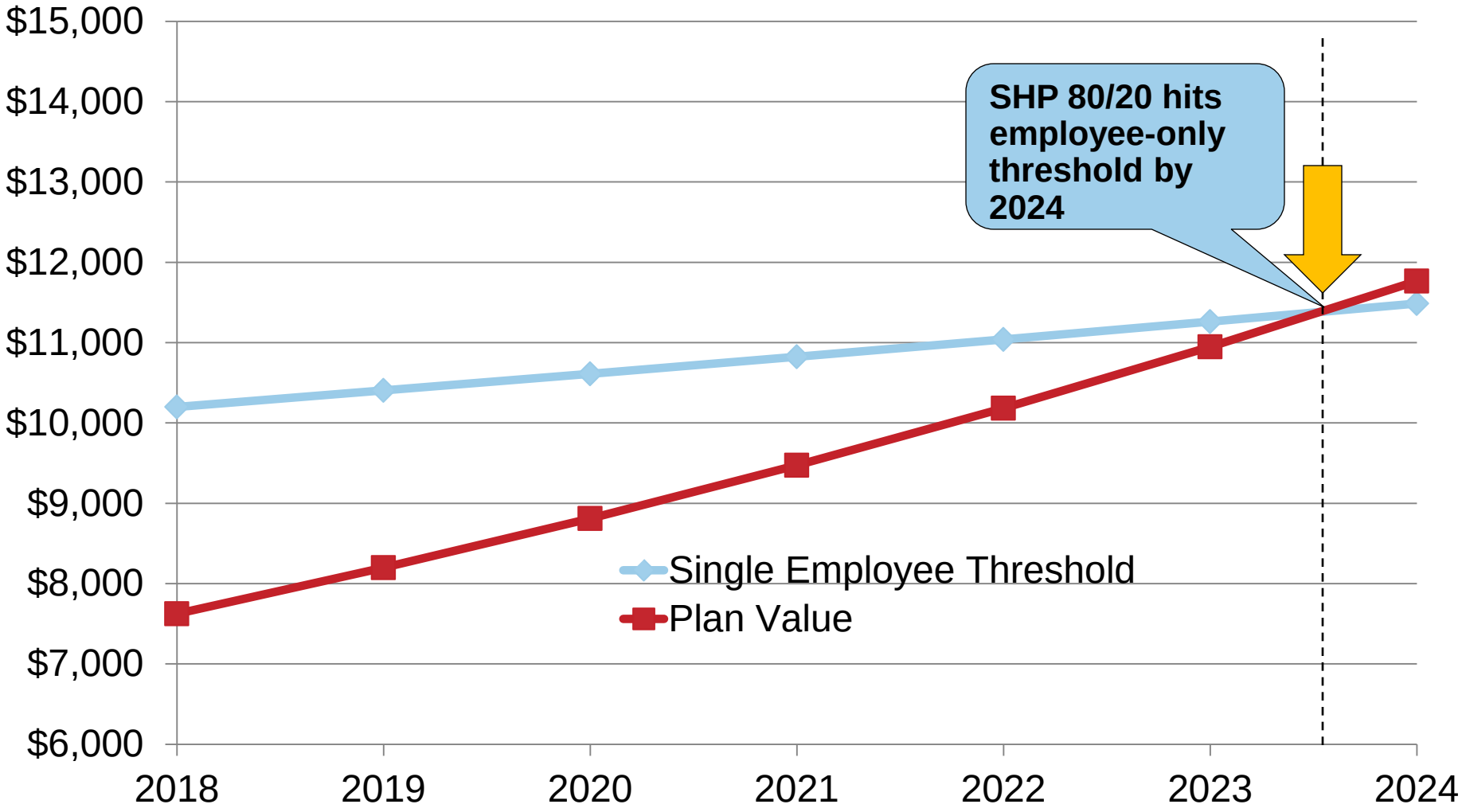
- **Medical / Hospitalization / Prescription drug**
- **Dental and vision**
  - If included under the medical plan election
- **Health Flexible Spending Accounts (FSAs)**
  - Includes amount of employee's salary reduction plus any additional employer contributions
  - No guidance yet on whether entire available amount is included or the amount each person actually elects to reduce pay for the Health FSA
- **Health Reimbursement Arrangements (HRAs)**
  - If the HRA is used for payment of health plan premiums, the HRA is counted
- **Health Savings Accounts (HSAs)** and **Archer Medical Savings Accounts (MSAs)**
  - Includes the employer contributions, but not employee contributions
- **Onsite Medical Clinic** value

Cost Threshold

- Cost threshold based on **COBRA** cost
- Combined total cost for all non-excepted plans
- Health cost adjustment increases thresholds if the actual growth in the cost of U.S. health care between 2010 and 2018 exceeds the projected growth for that period
- The value of the plan must be lowered to avoid reaching the threshold— shifting of premium cost to participants does not lower the value of the plan



Excise Tax Collision is Coming



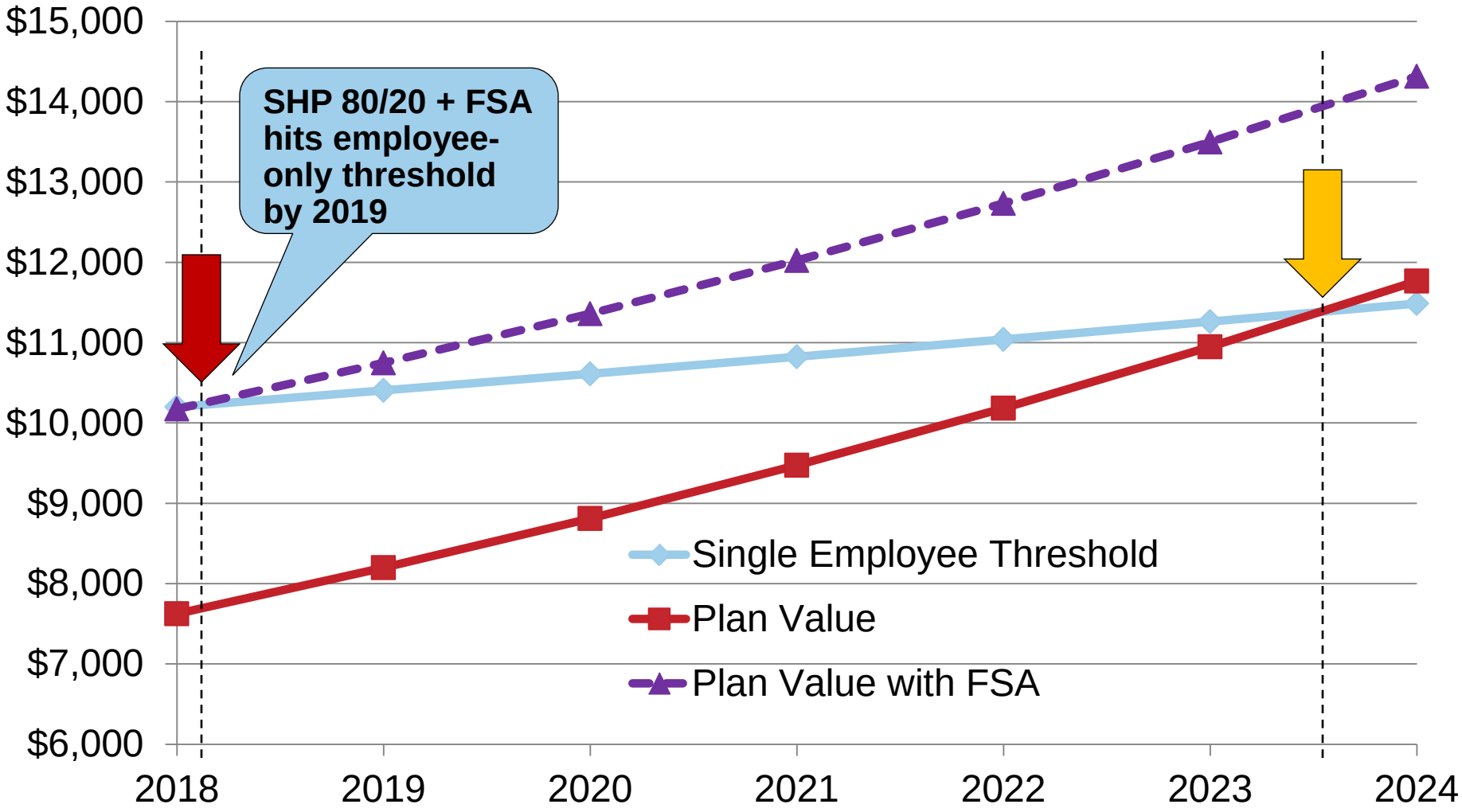
Assumptions:
- SHP projected cost of $7,625 for employee only in 80/20 plan
- Trends: 7.5% for SHP plan cost; 2% for CPI-U

How Close Will the State Health Plan Be in 2018?

- Illustration assuming 7.5% trend increase in overall plan cost
- $2,550 maximum health care flexible spending account salary reduction for 2015 remains constant through 2018

	Employee Only	Employee + Family
COBRA Rate 2015 – 80/20	$521.91	$1,201.62
Annual Cost *(x0.98 x12 months)*	$6,138	$14,131
7.5% Trend – 3 yrs. to 2018	1.2423	1.2423
2018 Projected Annual Cost	$7,625	$17,555
FSA Maximum *(OSHR NC Flex)*	$2,550	$2,550
Total Plan Cost 2018	**$10,175**	**$20,105**
Excise Tax Threshold 2018	**$10,200**	**$27,500**

Excise Tax Collision is Coming Sooner



Assumptions:
- SHP projected cost of $7,625 for employee only in 80/20 plan + **$2,550 FSA**
- Trends: 7.5% for SHP plan cost; 2% for CPI-U

Who Pays?

- Insurer for insured plan
- Plan administrator for self-insured group health plan, Health FSA or HRA
- Where the employer acts as plan administrator to a self-insured group health plan, a Health FSA or an HRA, the excise tax is paid by the employer
- Where an employer contributes to an HSA or an Archer MSA, the employer pays

Employer Responsibility

- The employer is responsible for calculating the excise tax on an employee's coverage
  - The employer must combine the cost of the different benefits, calculate the amount of the excess benefit, and determine the pro rata share of the excess attributable to each type of benefit
  - Then, the employer must report the taxable excess benefit attributed to each coverage provider to both the provider and the IRS
- Penalties may be assessed on employers or plan sponsors who do not accurately perform the required calculations
  - No penalty to coverage providers, but they must pay any additional tax assessment
  - The penalty amount is 100% of the additional excise tax that must be paid by coverage providers due to the miscalculation, plus interest based on IRS underpayment interest rate
  - Penalties do not apply in certain cases, e.g., if error due to reasonable cause and not to willful neglect and was corrected within 30 days of discovery

1. 40% Excise Tax Implications
2. Strategies for Avoiding the Excise Tax
3. Splitting the Retiree Population from Actives
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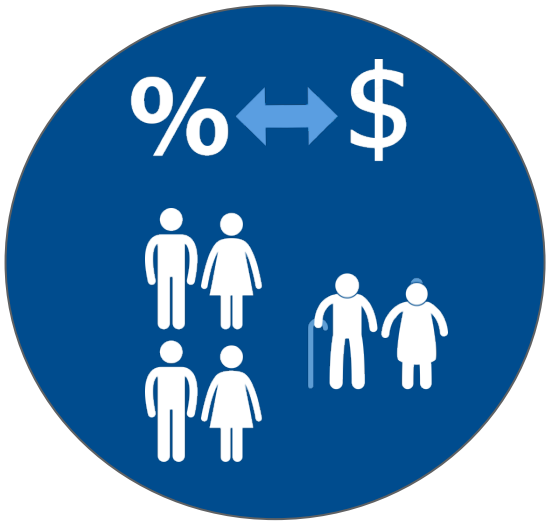
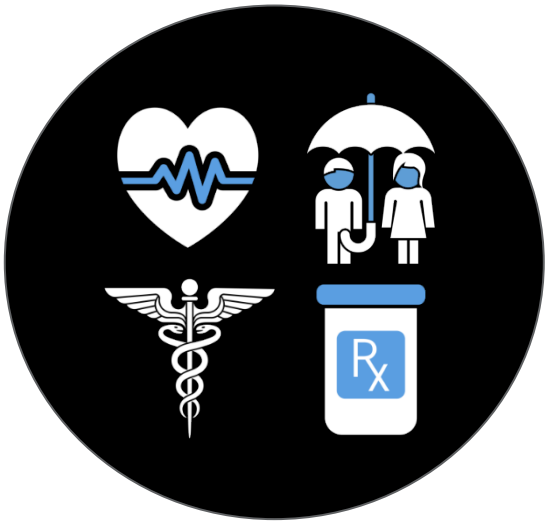
Strategy: Lower the Baseline Cost

Cost Control Strategies

Calculation Strategies



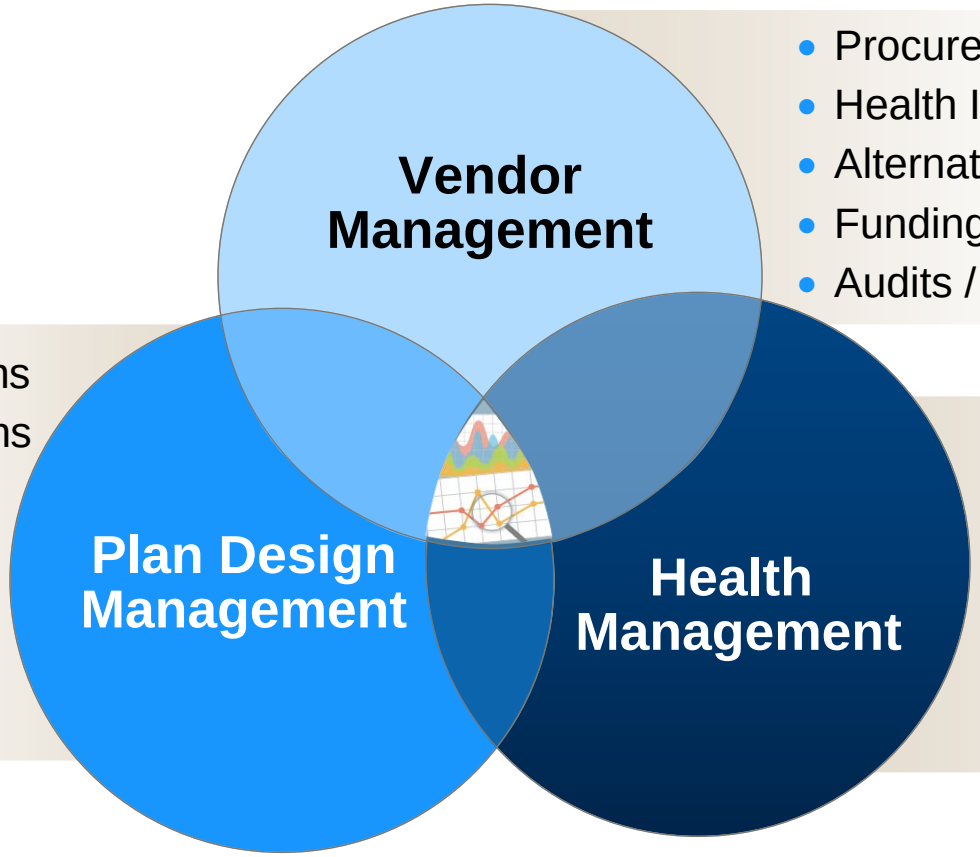
Retiree Strategies



Calculation Strategies

- Review all pre-tax benefits available to members to determine which are excepted and which must be counted for excise tax purposes
  - Dental/vision
  - Health Reimbursement Arrangements (HRAs)
  - Medical Flexible Spending Accounts (FSAs)
  - Other benefits
- Determine strategy for participating employers who sponsor their own pre-tax benefits outside of State control or monitoring
- Which plan takes precedence if there will be an excise tax issue?

Control Costs Where Possible



- Procurement / Contracting
- Health Insurance Exchanges
- Alternative Delivery Models
- Funding Arrangements
- Audits / Ongoing Monitoring

- Value-Based Designs
- Account-Based Plans
- Eligibility Provisions
- Employee Contributions
- Quality-Based Networks

- Culture Change
- Individual Behavior Modification / Incentives
- Disease Management
- Communications
- Health Status Metrics

To avoid the ACA Excise Tax, plan sponsors can deploy strategies in all three areas.

Top Medical and Prescription Drug Plan Cost-Management Strategies Implemented in 2014

Medical Plan Strategies

- Expand use of low-cost primary-care access (Telehealth, Walk-in Clinics, Worksite Clinics)
- Reference-based pricing[1]
- Follow the Medicare Hospital Readmissions Reduction Program to reduce hospital readmissions
- Value-based contracting, including:
  - Accountable Care Organizations (ACOs)[2]
  - Patient-Centered Medical Homes (PCMHs)[3]
  - Use of Narrow/Tiered Networks[4]
- Defined contribution approaches with or without the use of private exchanges
- Continued focus on wellness

Prescription Drug Plan Strategies

- Medication Therapy Management Program
- RetroDUR Program[5]
- EGWP[6] Implementation
- Formulary Management
- Prior Authorization
- Step Therapy
- Physician Dispensing and Pharmacy Network Management
- Specialty Pharmaceutical Management

Source: **2015 *Segal Health Plan Cost Trend Survey***

[1] Reference pricing involves designs where a plan sets a maximum price for covering the cost of a particular service to steer patients away from higher-priced providers who have no evidence of providing higher-quality services.

[2] ACOs, which have mainly been developed for the Medicare population, are networks of providers and suppliers that agree to be jointly accountable for managing the health of participating populations across the care continuum.

[3] PCMHs focus an increased level of comprehensive health care resources on primary care and prevention for patients with chronic conditions.

[4] Tiered networks require lower cost sharing if participants use high-quality, preferred providers within a network.

[5] RetroDUR stands for retrospective drug utilization review.

[6] EGWP is an abbreviation of Employer Group Waiver Plan.

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Carve Retirees Into a Separate Pool and Trust

Rationale

- Can provide clear picture of actual costs by employee/retiree group
- Allows cross-subsidization among groups to be identified where there are multiple funding sources
- Matches approach used for GASB OPEB liability calculations
- Allows tailoring of separate plan designs for actives and retirees to meet specific needs of each group
- May allow avoidance of many ACA requirements for retirees if there are no active employees in those plans
  - Many ACA benefit mandates do not apply (e.g., lifetime / annual maximums)

Impacts

- To maintain equity and consistency, adjustment of overall employer subsidy for active employees and for retirees is required.
  - Typically increases Pre-Medicare retiree and dependent rates
  - Reduces Active employee and Medicare retiree rates
- Does not help contain the overall cost of the program for actives and retirees
- Medicare retirees already reflect savings from Federal subsidy

Separate Retiree Pool – SHP Dynamics

Funding philosophy

- Employer contributions already support most of the employee/retiree cost
- Medical loss ratios are fairly close for active and retiree groups, so cost leverage between actives and retirees is not a primary factor
  - Medicare retirees and pre-65 retirees are balanced within the overall cost for reitrees
- Carving retirees out may not generate savings over current single value funding approach
  - State funding requirement might be reduced somewhat for active employees
  - But, per member cost for retirees separately could require Increased State funding through Retirement System

Premium subsidy policy

- Would require adjustment of employer subsidy share to maintain current member premium cost
- May require State to provide a direct subsidy of dependent costs for retirees

Plan design

- SHP has already created Medicare specific plan options through the Medicare Advantage plans

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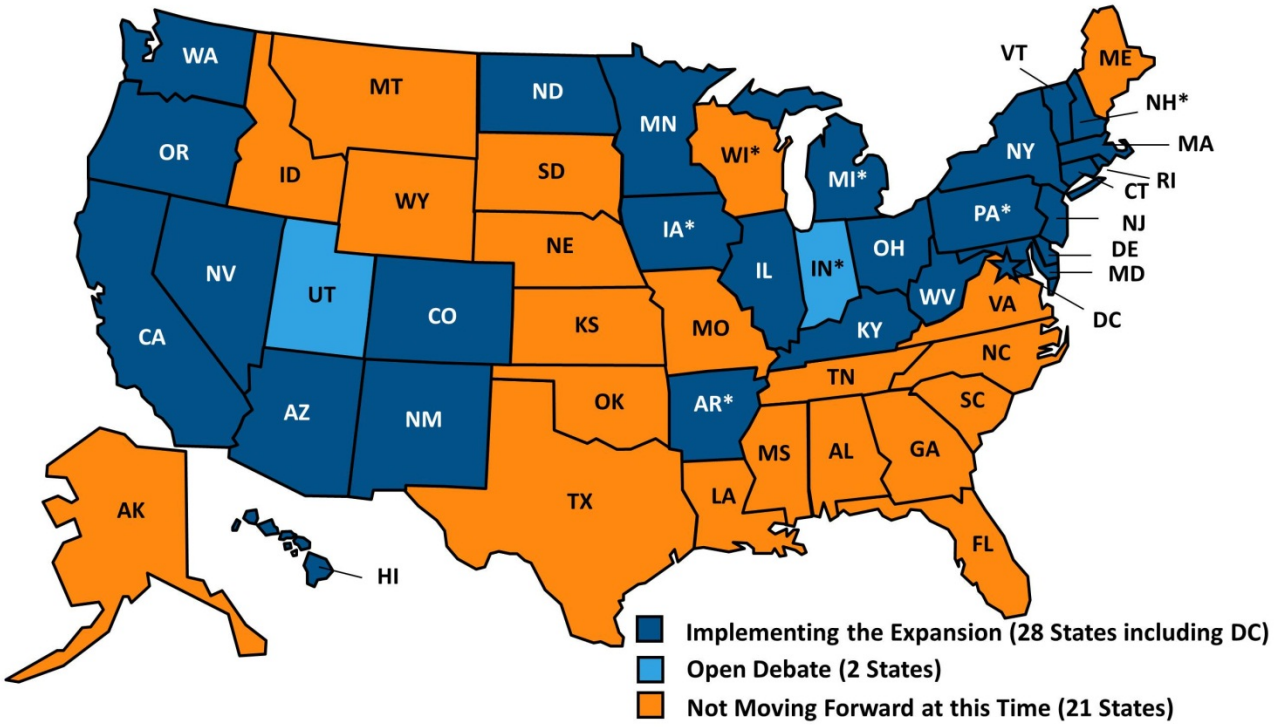
Medicaid Expansion

Current Status of State Medicaid Expansion Decisions



NOTES: Data are as of August 28, 2014. *AR, IA, MI, and PA have approved Section 1115 waivers for Medicaid expansion. In PA, coverage will begin in January 2015. NH is implementing the Medicaid expansion, but the state plans to seek a waiver at a later date. IN has a pending waiver to implement the Medicaid expansion. WI amended its Medicaid state plan and existing Section 1115 waiver to cover adults up to 100% FPL in Medicaid, but did not adopt the expansion.

SOURCES: Current status for each state is based on data from the Centers for Medicare and Medicaid Services, available here, and KCMU analysis of current state activity on Medicaid expansion.

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Medicaid Expansion – Impact

- Expansion to 133% of Federal Poverty Level
  - Increases number of citizens eligible for programs
  - Puts pressure on state budget
  - But also brings in more Federal revenue to help pay for care that the state is likely already providing through indigent care and the uninsured
  - Forces reconsideration of Medicaid models (managed care growth) to provide the most efficient delivery of care
- More citizens will be eligible for Medicaid benefits
  - Even if state doesn't expand Medicaid eligibility
  - Enrollment in state exchange triggers determination of eligibility for Medicaid and Federal subsidies
  - Lower paid employees may meet the Medicaid eligibility requirements for themselves and/or for their dependents
  - Early retirees eligible for exchange subsidies even if eligible for employer plan

Medicaid Expansion – Considerations

- Coordination with employer provided benefits
  - Working poor may be better off in Medicaid than in employer plan
  - As employers trim benefits to fit between minimum required (Shared Responsibility and mandates) and maximum allowed (40% Excise Tax), more lower paid employees are likely to find Medicaid more attractive
    - This is already happening among private sector employers
    - Not yet a major trend among public employers
  - Similar dynamics for child dependents – is it better to qualify them for CHIP benefits or to pay premiums to employer plan?
  - Rebalancing of employer provided benefits availability vs employee's ability to pay premiums
  - Can/should State allow Medicaid participation along with or instead of employer health plan participation?

Medicaid Expansion – Considerations

- Coordination with Medicare eligible and Pre-Medicare retirees
  - Dual eligibles – Medicare and Medicaid
  - Pre-Medicare retiree eligibility for state health marketplace coverage
- Federal exchange subsidies
  - Only available if not eligible for coverage in an employer plan
  - Early retirees can qualify for federal subsidies even if eligible for employer plan
- State Health Plan considerations
  - Maintain an affordable plan for employees at all pay levels (e.g., minimum value plan option in addition to regular plan offerings)
  - Monitor early retiree participation

Resources

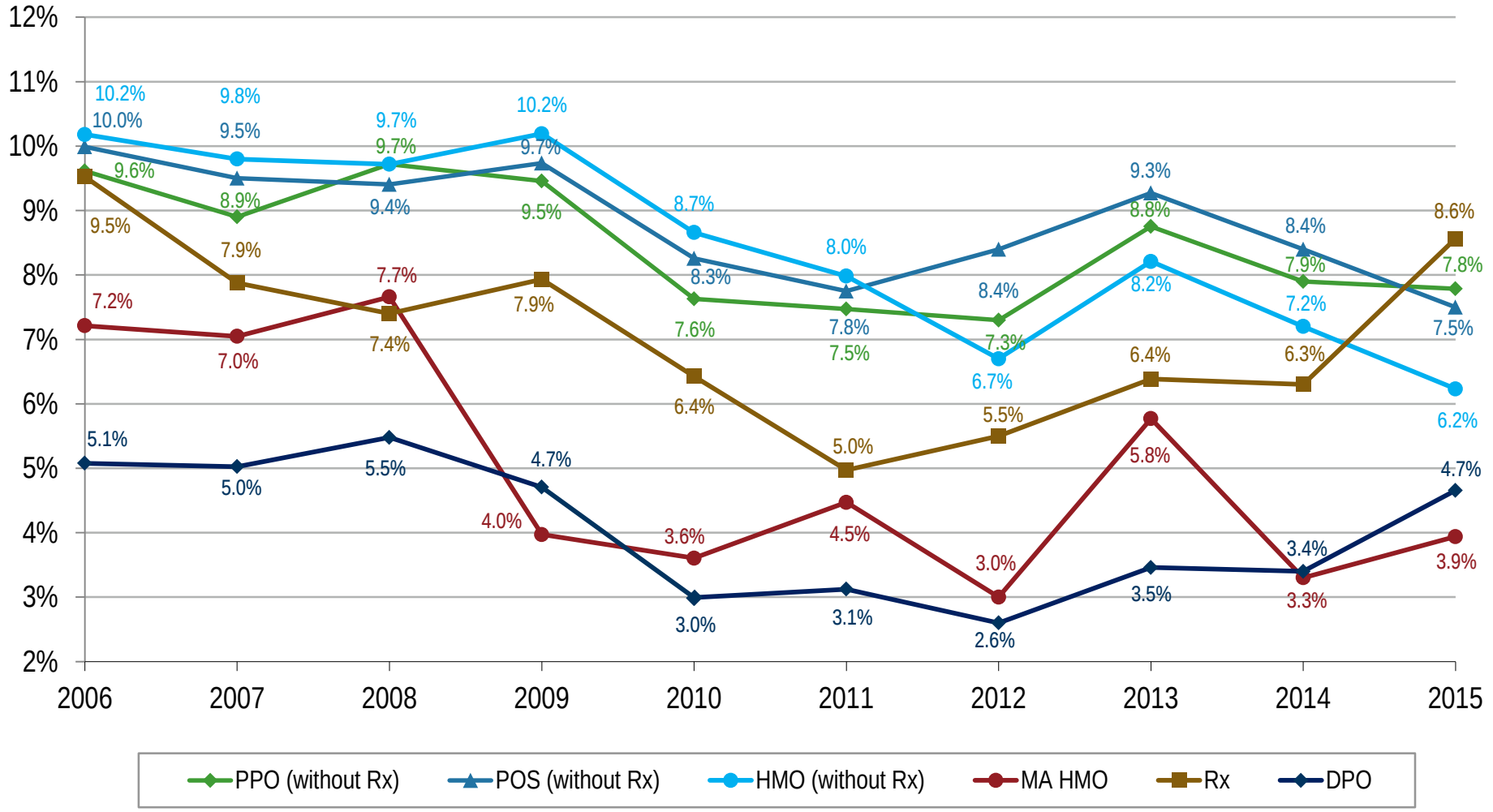
Guidance on the 40% Excise Tax

- No regulations or actuarial guidance yet
- Best resource is Joint Committee on Taxation Report on ACA
  - https://www.jct.gov/publications.html?func=startdown&id=3673
  - ACA Section 9001; IRC Section 4980I
  - Page 57

Affordable Care Act Resources

- Patient Protection and Affordable Care Act of 2010 (Pub. L. 111–148) as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152)
- The Center for Consumer Information & Insurance Oversight
  - http://www.cms.gov/cciio/index.html
- Affordable Care Act Tax Provisions
  - http://www.irs.gov/uac/Affordable-Care-Act-Tax-Provisions
- Department of Labor Affordable Care Act
  - http://www.dol.gov/ebsa/healthreform/

Ten-Year Summary of Selected Medical, Prescription Drug Carve-Out and Dental Trends: 2006 – 2013 Actual and 2014 and 2015 Projected[1]



Source: 2015 *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 2006 – 2007 only reflects retail. For 2008 – 2015, prescription drug retail and mail order delivery channels are combined.