USD #261 – Haysville School District

Healthcare Report Impact

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Changes Coming - 2013

- *Uniform Summary of Benefits and Coverage.*
  All health plans must provide a uniform summary of the plan's benefits and coverage to participants. The summary must be written in easily understood language and is limited to four double-sided pages. 2014
- *Limiting Health Flexible Savings Account Contributions.*
  Effective for plan years beginning after Dec. 31, 2012, ACA limits the amount of salary reduction contributions to health FSAs to **$2,500 per year**, indexed by CPI for subsequent years.
- *Employee Notice of Exchanges.*
  By **March 1, 2013**, employers must provide a notice to employees regarding the availability of the health care reform insurance exchanges. HHS has indicated that it plans on issuing model exchange notices in the future for employers to use. On Jan. 24, 2013, the Department of Labor (DOL) announced that employers will not be held to the March 1, 2013, deadline. They will not have to comply until final regulations are issued and a final effective date is specified. The DOL expects that the timing for distribution of notices will be the late summer or fall of 2013, which will coordinate with the open enrollment period for Exchanges.

FEES AND TAXES

- *Additional Medicare Tax for High Wage Workers.*
  ACA increases the Medicare hospital insurance tax rate by 0.9 percentage points on wages over $200,000 for an individual ($250,000 for married couples filing jointly). The tax is also expanded to include a 3.8 percent tax on net investment income in the case of taxpayers earning over $200,000 ($250,000 for joint returns).
- *CER Fees.*
  For plan years ending on and after Oct. 1, 2012 and before Oct. 1, 2019, self-insured plans and issuers must pay fees per covered life. The initial fee is $1 per covered life, increasing to $2 per covered life for plan years ending on or after Oct. 1, 2013 (and adjusted annually for later plan years). The first possible payments are due on **July 31, 2013**.

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Changes Coming - 2014

COVERAGE MANDATES

- *Individual Coverage Mandates.*
  ACA requires most individuals to obtain acceptable health insurance coverage or pay a penalty, beginning in 2014. The penalty will start at $95 per person for 2014 and increase each year. The penalty amount increases to $325 in 2015 and to $695 (or up to 2.5 percent of income) in 2016, up to a cap of the national average bronze plan premium. After 2016, dollar amounts are indexed. Families will pay half the penalty amount for children, up to a cap of three times the adult penalty for that year. Individuals may be eligible for an exemption from the penalty if they cannot obtain affordable coverage.

- *Employer Coverage Requirements*
  Employers with 50 or more employees that do not offer coverage to their employees will be subject to penalties if any employee receives a government subsidy for health coverage. The penalty amount is up to $2,000 annually for each full-time employee, excluding the first 30 employees. Employers who offer coverage, but whose employees receive tax credits because the coverage is unaffordable or does not provide minimum value, will be subject to a fine of $3,000 for each worker receiving a tax credit, up to an aggregate cap of $2,000 per full-time employee (excluding the first 30 employees). Employers will be required to report to the federal government on health coverage they provide.

Changes Coming – 2014 Continued

Affordability and employer penalties

- In 2014 large employers will be required to offer full-time employees (FT employees) (and their dependents) the opportunity to enroll in minimum essential coverage
  - Full-time employee - average at least 30 hrs. of service/week
  - Dependent does not include spouse…
- Plan has to be "unaffordable" and the employee has to have household income between 100% and 400% of the federal poverty level to be ***eligible*** for subsidies in the exchange
- For purposes of determining who is eligible for subsidies in the exchanges, affordability is based on 9.5% of household income and ***single-only coverage*** of the least expensive plan
- Because household income is unknown to the employer, there are three safe harbors used when determining if the employer pays a penalty on each employee who goes to the exchange with a subsidy
  - If you meet one of the safe harbors for an employee, even if they go to the exchanges with a subsidy, you do not have to pay the penalty for that employee

Under the current law, "affordability" is based on the single-only tier, even if the employee has dependents

- One strategy is to reduce the single-only employee contributions (in order to avoid penalties) but increase employee contributions in other tiers to discourage dependents from enrolling
  - This may be a good financial strategy, but consider also the non-financial implications on employees

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Changes Coming – 2014 Continued

- *W-2 pay safe harbor*

  Determine affordability based on the employee's W-2 pay for that calendar year (there are rare instances where W-2 pay for the employee could be higher than household income, which is based on modified adjusted gross income)

  Note the employer won't know for certain until end of year whether or not the safe harbor is satisfied for any given person, unless contributions are set as a percentage of income

- *Rate of pay safe harbor*

  Determine affordability based on the employee's rate of pay

  Multiply hourly rate by 130 and determine affordability based on that monthly wage

  This safe harbor doesn't apply if the employer reduces wages during the year

- *Federal poverty level safe harbor*

  Design-based safe harbor is satisfied if the single-only cost of coverage does not exceed 9.5% of the most recently published federal poverty level for a single individual ($11,170 is the FPL for a single in 2012—9.5% of the monthly level is $88.42 per month)

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Changes Coming – 2014 Continued

- *Essential Health Benefits Plans include:*
  - Ambulatory patient services
  - Emergency services
  - Hospitalization
  - Maternity and newborn care
  - Mental health and substance abuse disorder services, including behavioral health treatment
  - Prescription drugs
  - Rehabilitative and habilitative services and devise
  - Laboratory services
  - Preventive and wellness services and chronic disease management
  - Pediatric services, including oral and vision care

- *Your plan must have at least a 60% actuarial value to avoid penalties*

  60% corresponds to the Bronze level plan in the exchanges

- *Actuarial value is the portion of medical expenses covered by the plan, the other portion being covered by the member through deductibles, copays, etc.*

  A 100% actuarial value plan means everything is covered at 100% (no deductible, no coinsurance, no copays, etc.)

  Actuarial value has nothing to do with employee's share of premium (employee contributions)

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Examples of 80% actuarial value plans

There are many ways to get to a particular actuarial value through plan design:

	Example 1	Example 2	Example 3
Deductible	$1,000	$2,200	$800
Coinsurance	80%	100%	70%
Out-of-Pocket Max	$5,000	$2,200	$5,000
PCP Copay	$20	None	$20
Specialist Copay	$40	None	$40
ER Copay	$200	None	$100
Rx Copays	$10/$40/$60	None	$10/$30/$60

For illustration only. In-network, individual values shown.

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Changes Coming – 2014 Continued

HEALTH INSURANCE EXCHANGES

- Kansas will not offer a state run exchange. They will send through the Federal exchange program.

HEALTH INSURANCE REFORM

- *Pre-existing Condition Exclusions*.
  Effective Jan. 1, 2014, group health plans and health insurance issuers may not impose pre-existing condition exclusions on any covered individual, regardless of the individual's age.
- *Insurance Premium Restrictions*.
  Health insurance issuers in the individual and small group markets will not be permitted to charge higher rates due to heath status, gender or other factors. Premiums will be able to vary based only on age (no more than 3:1), geography, family size and tobacco use. The rating limitations will not apply to health insurance issuers that offer coverage in the large group market unless the state elects to offer large group coverage through the state exchange (beginning on or after 2017). Also, these restrictions do not apply to grandfathered coverage.
- *Annual Limits*.
  Restricted annual limits will be permitted until 2014. However, in 2014, the plans and issuers may not impose annual limits on the coverage of essential health benefits.
- *Excessive Waiting Periods*.
  Group health plans and health insurance issuers offering group or individual health insurance coverage will not be able to require a waiting period of more than 90 days.

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Changes Coming – 2014 Continued

- *EMPLOYER WELLNESS PROGRAMS*

  Under health care reform, the rules for employer wellness programs will be changed slightly. Existing wellness regulations under HIPAA permit wellness incentives of up to 20 percent of the total premium, as long as the program meets certain conditions. Under health care reform, the potential incentive increases to 30 percent of the premium in 2014 for employee participation in the program or meeting certain health standards. Employers must offer an alternative standard for those employees whom it is unreasonably difficult or inadvisable to meet the standard. Following a governmental study on wellness programs, the incentive may be increased to as much as 50 percent.

FEES AND TAXES

- *Individual Health Care Tax Credits.*

  ACA makes premium tax credits available through the exchanges to ensure people can obtain affordable coverage. Credits are available for people with incomes above Medicaid eligibility and below 400 percent of poverty level who are not eligible for or offered other acceptable coverage. The credits apply to both premiums and cost-sharing.

2018

- *HIGH COST PLAN EXCISE TAX*

  A 40 percent excise tax is to be imposed on the excess benefit of high cost employer-sponsored health insurance. This tax is also known as a "Cadillac tax." The annual limit for purposes of calculating the excess benefits is $10,200 for individuals and $27,500 for other than individual coverage. Responsibility for the tax is on the "coverage provider" which can be the insurer, the employer or a third-party administrator. There are a number of exceptions and special rules for high coverage cost states and different job classifications.

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What Does This Mean to USD #261

- USD 261 will be required to offer all employees working 30 hrs per week (and their dependents) the opportunity to enroll in **minimum essential coverage**
- Plan must cover all essential benefits. This means that all plans must include prescription drug coverage. The current low cost alternative at USD 261 does not include prescription coverage.
- Plan must have an actuarial value of at least 60% and must be affordable meaning it cannot exceed 9.5% of an employee's income. The current plans offered at USD #261 have a very high actuarial value.
- In the process of having a financial impact analysis performed to look at true financial impact.

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