


Gallagher Benefit Services, Inc.
thinking ahead

Patient Protection and Affordable Care Act (PPACA) Overview

Professional Liability and Underwriting Society

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Overview of Legislation

- Patient Protection and Affordable Care Act signed March 23, 2010
  - Legislation was over 2,400 Pages
  - Regulations (as of September of 2013) over 10,500 pages

- Ten Sections of PPACA. Employers really focus on two of the Sections.
  - **Title I: Quality, Affordable Health Care for All Americans**
    - Individual Mandate Tax
    - Employer Penalties
    - Plan Design Mandates
    - Reporting and Disclosure Requirements
  - **Title IX: Revenue Provisions**
    - Cadillac Tax
    - W-2 Reporting

Note: The other eight sections not being addressed today have less direct impact to employers that sponsor of group health plans and relate more to the healthcare market, delivery and quality.




Calendar Year Highlights

- 2010
  - Retiree Drug Subsidy now Taxable to Employers providing Retiree medical benefits
  - Early Retiree Reinsurance Fund of $5 Billion established
    - The Government giveth & taketh away !!

- 2011
  - Dependents covered to age 26
  - Elimination of Pre-existing condition to age 19
  - FSA and HSA now exclude OTC medications
  - Insurers subject to MLR rules
    - (15% for >99 ees & 20% for <100 ees)
    - Insurers sent Notifications to individual members
      - Created first administrative and communication challenge for employers
  - Non-GF Plans now required to cover Preventative Care at 100%




Calendar Year Highlights

- 2012
  - Employers required to distribute uniform Summary of Benefits and Coverage (SBC) to plan participants
  - W-2 reporting for total cost of health coverage (track in 2012 and report in 2013)
  -
- 2013
  - $2,500 limit for FSA contributions (indexed for inflation)
  - Employers notify employees about exchanges
  - Higher Medicare tax on wages exceeding certain limits
    - $200K for Individuals / $250K for Couples
  - Exchanges initial open enrollment to begin October 1
    - Healthcare.gov
  - 25 states elected to utilize Federal exchange vs developing state specific exchange




Calendar Year Highlights

- 2014
  - Individual coverage mandates apply
  - Employer mandates apply
    - Delayed until 2016 for groups between 50-99 ees
    - Delayed until 2015 for groups with 100+ ees
    - Safe harbor for offering coverage reduced from 95% to 70%* for employers >99 ees.
  - Financial assistance for Federal exchange coverage for low income individuals and families
    - Subsidies available up to 400% of FPL
    - Individuals = $11,670 & Family of 4 = $23,850
    - Individuals = $46,680 & Family of 4 = $95,400
  - Pre-existing conditions removed for adults
  - No waiting period over 90 days
  - Health insurance fees begin
    - 2.5% of premium, TRF of $63 PMPY

*70% increases to 95% in 2016 and later years. 80 decreases to 30 in 2016 and later years.

Individual Mandate




Minimum Essential Coverage

OR

Tax

OR

Exception

Premium Assistance

For example:
- Below federal income tax filing threshold
- Uninsured for short coverage gaps of less than 3 months
- Received hardship waiver from Secretary
- Residing outside of US
- Members of Indian tribe




Minimum Essential Coverage

- A medical plan provides "minimum essential coverage" if it covers certain "essential health benefits" and the plan pays at least 60% of the average costs of individual's medical expenses under the plan.

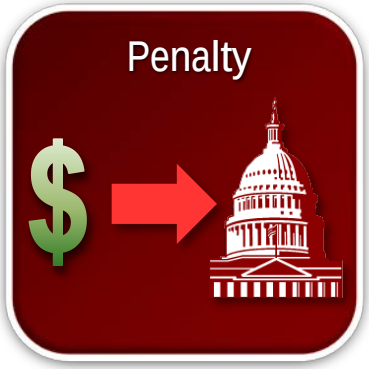
- Example:
  - Assume an average employee has claims of $5,000 of medical expenses during the year that are eligible under the plan. The plan must pay, on average, at least $3,000 of the $5,000 and that average employee is responsible for the other $2,000 (in the form of premiums, deductibles, copayments, etc.). Since the plan pays at least 60% of eligible medical expenses on average, the plan meets the "minimum essential coverage" requirement.

- Who might be subject to Individual Mandate Tax?
  - Employees who opt-out of employer coverage
  - "Full-time" employees who are not eligible for benefits
  - Family members of employees who are not enrolled in spouse or individual plans




Individual Mandate Tax

Penalty amount is the greater of*:



Year	Flat Dollar Amount** (max of 300 % for family)	% of Household Income
• 2014	• $95	• 1.0
• 2015	• $325	• 2.0
• 2016	• $695	• 2.5
• After 2016	• $695, indexed for inflation in $50 increments	• 2.5

*Capped at the national average of the annual cost of a bronze level health insurance plan, for the family size, offered through the Marketplace.
**Halved for dependents under age 18 (but do not halve when determining 300% cap on dollar amount for those NOT insured by taxpayer)




What's a Public Marketplace/Exchange?

- A Federal or State agency created to facilitate purchase of health insurance through "qualified health plans" (QHPs) by individuals and small employers

- Marketplace expected to:
  - Certify, recertify and decertify QHPs eligible to offer coverage
  - Assign quality and price ratings to each QHP and provide standardized consumer information
  - Operate internet website and toll free hotline for individuals and small businesses to get information
  - Process exemptions for individuals/hardship
  - Establish a "Navigator" program to help consumers make choices about options and accessing health insurance through Marketplace

Public Marketplaces/Exchanges - 2014




Individuals

Small Employers (under 100 employees)

CHOICE POOL

- Bronze Plan → 60% → Minimum Essential Coverage
- Silver Plan → 70%
- Gold Plan → 80%
- Platinum Plan → 90%

Notes:

- Large employers may enroll in Private Exchanges. Federal/State Marketplaces may be available to Large Employers starting in 2017.
- Catastrophic plans are available to individuals under 30 years old and to those not otherwise subject to Individual Mandate penalty.




Florida Marketplace

- Florida defaulted to the Federal Marketplace administered by the Department of Health and Human Services
- Each Florida County is its own Marketplace (67 Counties)
- Benefit-eligible employees can enroll in a Marketplace plan but will not qualify for financial assistance to purchase Marketplace coverage if at least one of their employer's plans are affordable and offer minimum essential coverage




Plan Affordability Rules

- Plans are considered affordable if the cost of the employee only coverage does not exceed 9.5% of the individual's household income. Most employers will use employee only income as variable to determine affordability.
- Example: Joe makes $12 per hour or about $24,000 per year. 9.5% of $24,000 is $2,280 or about $190 per month.
- As long as at least one plan offered to Joe meets at least 60% coverage requirement and does not exceed $190 per month cost to Joe – Employer avoids penalties
- Employers must assess cost for all employees and determine potential penalties




Private Exchanges

- Employers may utilize Private Exchanges
- Design varies by Private Exchange Offeror
  - Insurers
  - Insurance products (medical, dental, voluntary, etc.)
  - Funding methodology (fully insured; self-funded)
- How it works
  - Employer selects carrier(s) and plan(s)
  - Employer sets budget (i.e., how much they will contribute)
  - Employee makes insurance choices based on needs
  - Employee is responsible for difference between employer contribution and cost of selected plan


Overview
Employer Penalties/Fees





Employer Shared Responsibility Penalties (Delayed until 2015)

- Employer either: (a) Discontinues group medical insurance altogether; or (b) fails to offer group medical to at least 70%* of its full-time employees
  - Excise tax = $2,000 per year x full-time employees (minus 80*)
  - Example:
    - ABC Employer has 10,030 full-time employees and does not offer group medical coverage to its employees in 2015
    - ABC Employer owes an excise tax = $20 Million (10,000 x $2,000) for 2015

*70% increases to 95% in 2016 and later years. 80 decreases to 30 in 2016 and later years.




Employer Shared Responsibility Penalties

- Employer continues to offer group medical coverage to at least 70%* of its full-time employees in 2015 but the coverage is either:
  - Unaffordable: meaning the cost for employee-only coverage for the employer's least expensive plan option is greater than 9.5% of that employees wages OR
  - Does not meet minimum value requirements OR
  - Is not offered an employee that is considered "full-time" by the PPACA

- ABC Employer could be subject to:
  - $3,000 excise tax per year per each full-time employee who goes to Public Marketplace and qualifies for financial assistance, but only if ABC Employer's medical plan is either:
    - Unaffordable to that employee OR
    - Doesn't meet the minimum value requirements OR
    - Is not offered to that full-time employee

* 70% increases to 95% in 2016 and later years.




“Full-Time” Employees

- Penalties are based on “Full-Time” employees for purposes of Employer Shared Responsibility Penalties
- **For this purpose, “Full-Time” is defined as an employee who works on average 30 or more hours per week**
- There’s a difference between “full time” as defined by employer policies and “full time” as defined for purposes of PPACA application
- Employers must monitor how many hours certain employees work over a 12-month “measurement period” to determine whether such employees are “Full-Time” for purposes of these penalties




Excise Tax on High-Cost Health Coverage ("Cadillac Tax")

- In 2018, Employers will owe a 40% excise tax if the aggregate value of the Employer's health insurance coverage for an employee exceeds threshold . Threshold is $10,200 single; $27,500 family
  - Increased threshold for non-Medicare eligible early retirees receiving employer-sponsored retiree coverage. Also for high-risk professionals (including law enforcement, fire protection, etc.)
  - Based on current per employee per year cost and 8% trend per year, Cadillac Tax in 2018 could be:

Plan	Tier	Threshold	Forecasted Cost	Difference	Potential Tax
High HMO	Single	$10,200	$10,509	$309	$1,379,000
	Family	$27,500	$23,701	-$3,799	0
POS	Single	$10,200	$20,318	$10,118	$22,782,000
	Family	$27,500	$39,256	$11,756	$2,069,000

Example: In 2018, single employee enrolls in POS at cost described above. Employer would owe an excise tax = $4,047.20 for that employee as follows: ($20,318 - $10,200 = $10,118 x 40% = $4,047.20)




Patient-Centered Outcomes Research Institute Fee

- The Institute is to help patients, clinicians, purchasers and policymakers in making informed decisions by advancing clinical effectiveness research.

- Payable by the employer sponsoring a self-funded plan or the insurer of a fully insured plan.

Plan Year	Fee (Per Member Per Year)	Payable by
2012	$1	July 31, 2013
2013	$2	July 31, 2014
2014 – 2018	TBD	July 31 of following year




Transitional Reinsurance Program Fee

- Each state to create a reinsurance program for high-risk individuals by January 1, 2014 to last for 3 years
  - Program will make reinsurance payments to health insurance issuers that cover high-risk individuals in the individual market for any plan year beginning in the 3-year period
  - Assessed against "contributing entities" (health insurance issuers and employers of self-funded group health plans
  - Target revenue collection: $12B for 2014; $8B for 2015; and $5B for 2017.

Year	Fee (Per Member Per Year)	Payable by*
2014	$63	January 14, 2015
2015	$44 (proposed)	January 14, 2016
2016	$26 (estimated)	January 14, 2017

* Approximation. The due date is 30 days after contributing entity receives notification from HHS.


Summary of Penalties/Fees


Penalty/Fee	Amount	Years Owed
Failure to offer coverage to at least 95% of full-time employees	$2,000 per year per each full-time employee (minus 80 for 2015)	2015 and beyond
Failure to offer affordable, minimum coverage to certain employees	$3,000 per year for each full-time employee for whom such coverage is not offered	2015 and beyond
Cadillac Tax	40% of Excess of Plan Value over Threshold	2018 and beyond
Transitional Reinsurance Program Fee	$63 per member per year (PMPY) for 2014 (proposed $44 for 2015; estimated $26 for 2016)	2014 - 2016
Patient-Centered Outcomes Research Fee	$1 PMPY for 2012; $2 PMPY for 2013; TBD for 2014 - 2018	2012 - 2018


Mandated Plan Design Changes AKA “If you like your plan you can keep it.”



Plan Design Mandates


Mandate	Effective Date
Aggregate lifetime limit elimination	Renewal in 2011
Aggregate annual limit elimination	Renewal in 2011
Pre-existing Condition Exclusion Elimination for under 19	Renewal in 2011
Direct access to Obstetrician/Gynecologist	Renewal in 2013
Ability to designate Primary Care Physicians	Renewal in 2013
Similar treatment for in and out of network emergency room*	Renewal in 2013
Pre-existing Condition Exclusion Elimination for any age	Renewal in 2014




Plan Design Changes Due to Mandates

Mandate	Change Effective Date
Dependent children can stay on plan without conditions through year they attain 26	Renewal 2011
External review for denied appeals	Renewal 2011
Coverage of certain preventive services with no cost-sharing	Renewal 2013
Emergency room non-network copay reduced	Renewal 2013
Out-of-Pocket Maximums cannot exceed certain dollar limits	Renewal 2013
Waiting period reduction from 90 days to 60 days	Renewal 2013
Autism coverage elimination of annual and lifetime limits	Renewal 2014
Durable medical equipment elimination of annual limit	Renewal 2014
Coverage of routine patient costs for certain approved clinical trials	Renewal 2014

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What are Accountable Care Organizations?

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What is an ACO?

- An organization made up of healthcare providers who agree to be accountable for the quality, cost and overall care of a defined population of Medicare beneficiaries or other enrollees who are assigned to it.

- Assigned in this context generally means those beneficiaries for whom the ACO providers provide the majority of primary care services.

- Assignment typically does not affect the member's choice of healthcare providers.

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The Goals of ACOs

- Improve quality of care
- Improve health generally across populations
- Reduce growth of health care costs

How are ACOs to Achieve These Goals?

- Accountability
- Better coordination of services provided to members assigned to the ACO
- Investment in infrastructure and redesign of care processes

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Three General Types of ACOs

- Medicare
  - Medicare Shared Savings Program (MSSP)
  - Advance Payment Model
- Commercial (Private Insurers/Payors Health Systems)
- Pioneer – Hybrid Advanced Model

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Underwriting Considerations

- Experience level of the providers involved
- Financial backing
- Business plan and pro-formas
- Board and committee structure and members
- Shared savings ‘sharing plan’
- Potential antitrust issues
- IT investment
- Care management investment/structure




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The Affordable Care Act: Employer Responses & Emerging Causes of Action

April 3, 2014

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Employee Benefits Update: ACA, HIPAA, DOMA

Employer Strategy Considerations:

- ***The Bad***: How can I quickly preserve the status quo of my current business assumptions within the ACA framework?
- ***The Good***: Can I keep/expand my existing group health insurance coverage without incurring significant new burden, expense, or IRS penalty?

Employee Benefits Update: ACA, HIPAA, DOMA

Strategies for Avoiding Employer Mandate:

- **Inc. Up and Divide LLCs, etc:** Myth busted; commonly controlled groups will be aggregated for coverage purposes
- **Terminate Employees or Reduce Hours to Stay Under 50:** litigation/unemployment risks
- **Use Excepted Employees:** volunteers, interns, independent contractors, adjunct faculty, seasonal, temporary employees. Additional litigation risks

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Employee Benefits Update: ACA, HIPAA, DOMA

Strategies for Complying with Employer Mandate:

- **Increase Premiums**: affordability applies only to individual tier
- **Keep/Expand Unaffordable Coverage**: play the odds that only a small group of employees will get subsidies at the Exchange, resulting in a $3,000 penalty for each
- **Use (30% margin of error in 2015) or 5% Margin of Error**: if you offer coverage to (70% in 2015) 95% of your full-time employees, the IRS says that's good enough
- **Reduce Employee Hours <30**
- **Do Not Retain Employees >90 Days**
- **Use Variable Hour Employees**
- **Use Excepted Employees**

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ACA-Based FLSA Litigation

- Reducing employee work hours to <30 hours per week has risks
- Unintended consequences:
  - Employee efforts to circumvent caps on hours;
  - Management incentives to ignore employee circumvention;
  - More supervisory risk: hiring, training, employees to supervise/manage, paperwork, turnover
  - Less engagement: lower quality labor, less engaged workforce
- Employers have tinkered with employee classification systems
- Questions about compensation are protected activity under FLSA. *See Kasten v. Saint-Gobain* (2011)

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ACA-Based ERISA Litigation

- Section 510 of ERISA makes it illegal to interfere with employee benefits, protects the right to present and future benefit entitlements
- Protects employees from adverse employment action for exercising a right to benefits under a plan
  - Employers may not use an adverse employment action to interfere with "the attainment of any right to which such participant may become entitled under the plan." Courts say this requires proof of "specific intent" to interfere
  - Plan participants are protected from retaliation
- Employers have tinkered with employee classification systems
- Actions for violation of Section 510 are filed under Section 502(a)(3)'s remedial provisions: reinstatement, restitution, backpay

ACA's Own Cause of Action

- ACA includes its own anti-retaliation rules (Section 1558):

No employer shall ***discharge or discriminate*** *against "any employee with respect to his or her compensation, terms, conditions, or other privileges of employment,"* ***because****, among other things,* ***the employee has received a credit or subsidy provided pursuant to the ACA***

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ACA's Own Cause of Action cont'd

- Section 1558 of ACA adopted the whistleblower claims process and remedies of the Consumer Products Safety Improvement Act:
  - employees have 180 days to file complaint with OSHA;
  - OSHA can order preliminary reinstatement if it finds reasonable cause;
  - OSHA issues finding & any objecting party can demand a hearing;
  - within 120 days of hearing OSHA issues final order;
  - final order appealable to Federal Courts of Appeals;
  - if OSHA fails to issue final order within 210 days of the filing of the complaint, employee may seek a de novo review in a Federal District Court, with a trial by jury;
  - employee need only show that protected activity was a "contributing factor" to adverse employment decision; and
  - ACA authorizes make whole remedies, including "special damages," & attorneys' fees/costs

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ACA's Own Cause of Action cont'd

Are employer cost-containment and penalty avoidance strategies in fact discriminatory within the meaning of ACA Section 1558 because they are designed to preclude an employee from receiving a subsidy (which would result in a tax penalty to the employer)?




OneBeacon
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The Affordable Care Act: Employer Responses & Emerging Causes of Action

April 3, 2014

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Medicare Shared Savings Program (MSSP) ACOs

The MSSP provides for statutory and contractual accountability.

"Under the Shared Savings Program … [t]he ACO must become accountable for the quality, cost, and overall care of the Medicare Fee-for-Service beneficiaries assigned to the ACO." 42 CFR 425.100(a)

This accountability is included in ACO provider contracts and ACO contracts with CMS.

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ACOs are required to demonstrate patient-centeredness and define processes to:

1. Promote evidence-based medicine;
2. Report on quality and cost measures; and
3. Coordinate care.

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MSSP ACOs – The Challenges of Patient-Centeredness

1. Beneficiaries may be non-compliant with treatment recommendations of the ACO providers.

2. Beneficiaries are free to choose non-ACO providers.

3. Beneficiaries may elect not to allow sharing of beneficiary identifiable claims data.

Commercial ACOs

- Collaboration between providers and commercial payers
- Value-based contracts
  - Reimbursement based on quality metrics and/or outcomes
  - Risk sharing
- Narrower networks
  - Financial incentive for health plan enrollees to use ACO providers

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Anti-trust Enforcement

The ACA encourages health care providers, including physicians and hospitals, to form ACOs through its Medicare Shared Savings Program in order to improve the quality and reduce the costs of health care services.

If an MSSP ACO provides the same or essentially the same services in the commercial market, and applies the same governance and leadership structures and clinical and administrative processes in the commercial market, then the Rule of Reason and an Anti-trust Safety Zone will apply as follows:

1. The DOJ and FTC will apply the Rule of Reason and treat joint negotiations between competing providers as reasonably necessary.

2. An Anti-trust Safety Zone will apply if certain criteria regarding the Primary Service Area of independent participants are met.

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Fraud & Abuse Laws

The **Physician Self-Referral Law (PSRL)** prohibits physicians from making referrals for certain Medicare services to entities with which they or their immediate family members have a financial relationship.

The **Federal Anti-Kickback Statute (AKS)** prohibits remuneration to induce or reward referrals that are reimbursable under any Federal health care program.

The **Beneficiary Inducements CMP Law** prohibits offering compensation to beneficiaries to influence the beneficiary to order or receive any Medicare or Medicaid item or service from a particular provider.

The **Gainsharing CMP Law** prohibits hospital payments to physicians as inducement to reduce or limit services to a Medicare or Medicaid beneficiary under the physician's care.

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Fraud & Abuse Law Waivers

Self-implicating Waiver	Applicable Laws
Pre-participation Waiver	PSRL, AKS, Gainsharing CMP
Participation Waiver	PSRL, AKS, Gainsharing CMP
Shared Savings Distribution Waiver	PSRL, AKS, Gainsharing CMP
Compliance with the PSRL Waiver	AKS, Gainsharing CMP
Patient Incentive Waiver	AKS Beneficiary Inducements CMP

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ACO Liability Issues & Potential Claims

Medical Professional	Non-medical	Government/Regulatory
Direct v. Vicarious Liability • State law damage caps	Provider Selection • Anti-trust • Defamation	False Claim Act • Quality of care
Credentialing	Contractual Disputes • Shared savings • Risk-sharing • Denial of benefits	• Anti-trust • Stark Physician Self-Referral • Anti-Kickback Statute • Civil Monetary Penalties
Standard of Care v. ACO Evidence-Based Guidelines	Transparency • ACO participation	HIPAA and HITECH • EHRs • Patient consent

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The Meyer Effect

"This case arises from the Defendants' duty to establish and implement a quality assurance program designed and utilized to provide quality health care services to its insureds, members and/or enrollees." Meyer v. Health Plan of Nevada