



**After *NFIB v. Sebelius*
—Employer Health Care Strategy for 2013 and Beyond**

August 2012

**Prepared by Consulting
Health & Benefits Legal Update**



AON | **Hewitt**

Agenda

- Supreme Court ruling in *NFIB v. Sebelius*
- After *NFIB v. Sebelius*
 - The future of U.S. health care coverage
 - Optional Medicaid Expansion
 - Impact on uninsured
 - Impact on free rider penalty
 - Impact on cost-shifting to employers
 - More legal challenges to the ACA
- ACA Compliance Strategy
 - ACA Checklist
 - What's in effect now?
 - ACA Timeline through 2018
 - ACA Guidance—State of Play
 - Major ACA provisions
 - 2012-2018
- Which Road to Take? Which Road are Employers Taking?

After all the controversy and the protest, the Supreme Court ruled that...



...the ACA was constitutional (mostly). And Chief Justice Roberts...



...announced that he would be spending his summer vacation...



...“in an impregnable fortress”



NFIB v. Sebelius answered “the Broccoli Question”

Q: If the government can make you buy health insurance, can the government make you eat broccoli too?*



A: No, the government can't make you buy health insurance or eat broccoli. But if you don't, they can tax you.**

*Professor Randy Barnett, Georgetown University Law Center

**U.S. Supreme Court

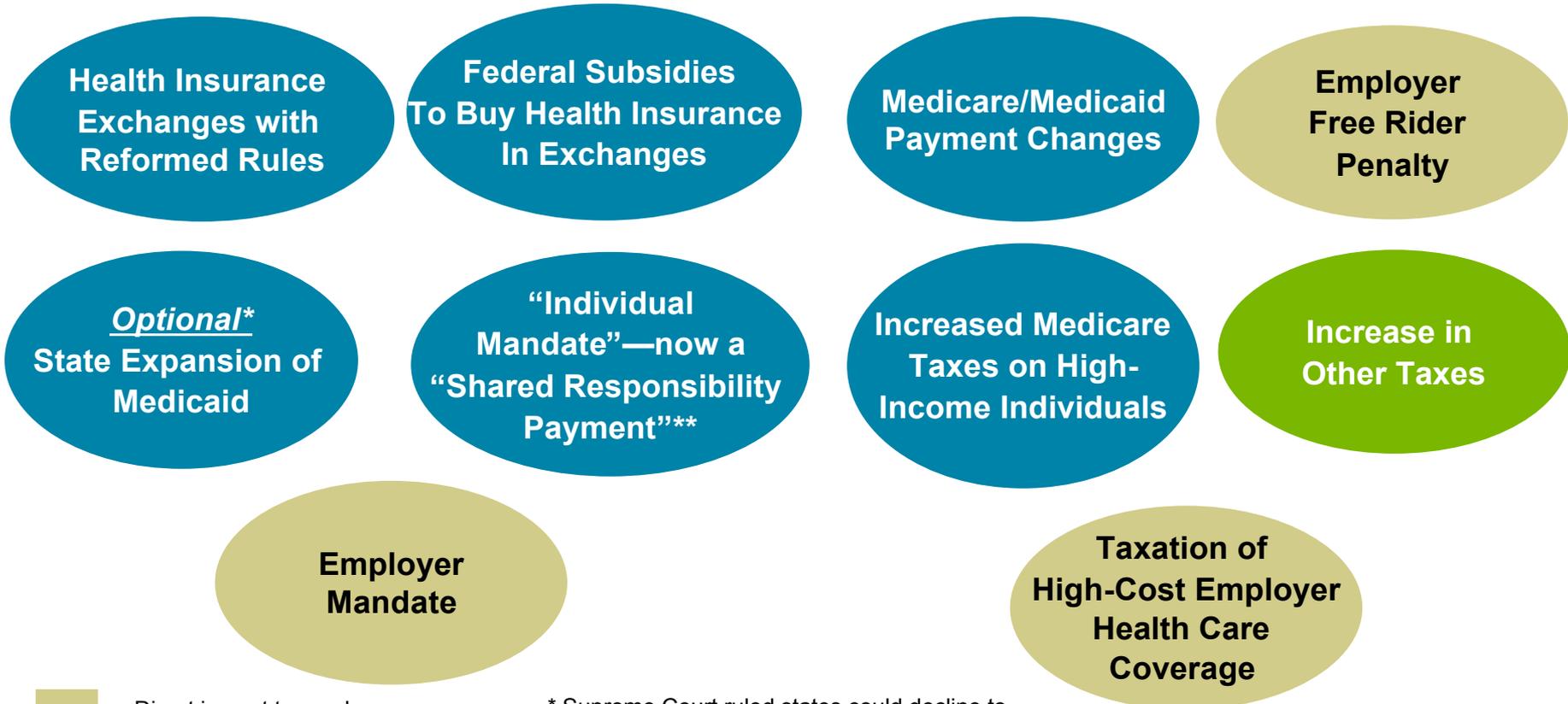
When is a Penalty Really a Tax?

- Supreme Court ruled that the individual insurance mandate is not a valid exercise of Congress's commerce power
 - Congress can regulate commercial activity, not commercial inactivity
 - But Congress cannot create commercial activity in order to regulate it
- But the Supreme Court upheld the individual insurance mandate as a valid exercise of Congress's taxing power
 - Court ruled the penalty/mandate was a tax on not having health insurance
 - “The Constitution does not guarantee that individuals may avoid taxation through inactivity.”
- Court ruled that Congress could not coerce states to expand Medicaid eligibility by threatening to withhold all Medicaid matching funds
 - Threat of losing more than 10% of a State's overall budget is “economic dragooning that leaves the States with no real option but to acquiesce in the Medicaid expansion”
 - Court ruled that HHS may withhold only the additional matching funds from states that do not expand Medicaid eligibility, but may not withhold existing Medicaid matching funds

After *NFIB v. Sebelius*—The Future of U.S. Health Care Coverage

Expanding/Improving Coverage

Paying for Expanded Coverage



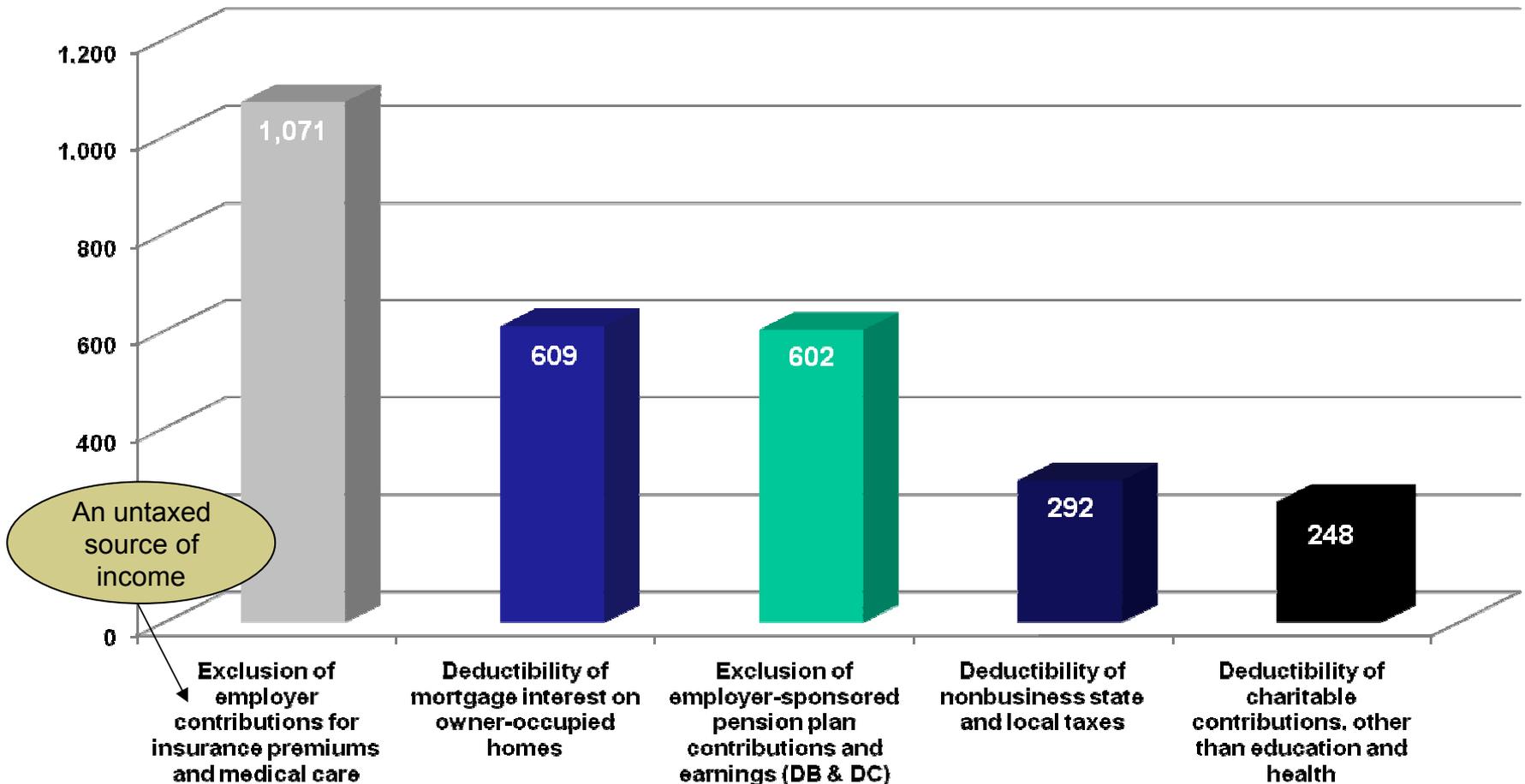
- = Direct impact to employers
- = Indirect impact to employers
- = Direct and indirect impact to employers

* Supreme Court ruled states could decline to expand Medicaid eligibility without losing existing Medicaid funding

** Supreme Court ruled "mandate" is a tax on *not* having health insurance

Potential Sources of Deficit Reductions

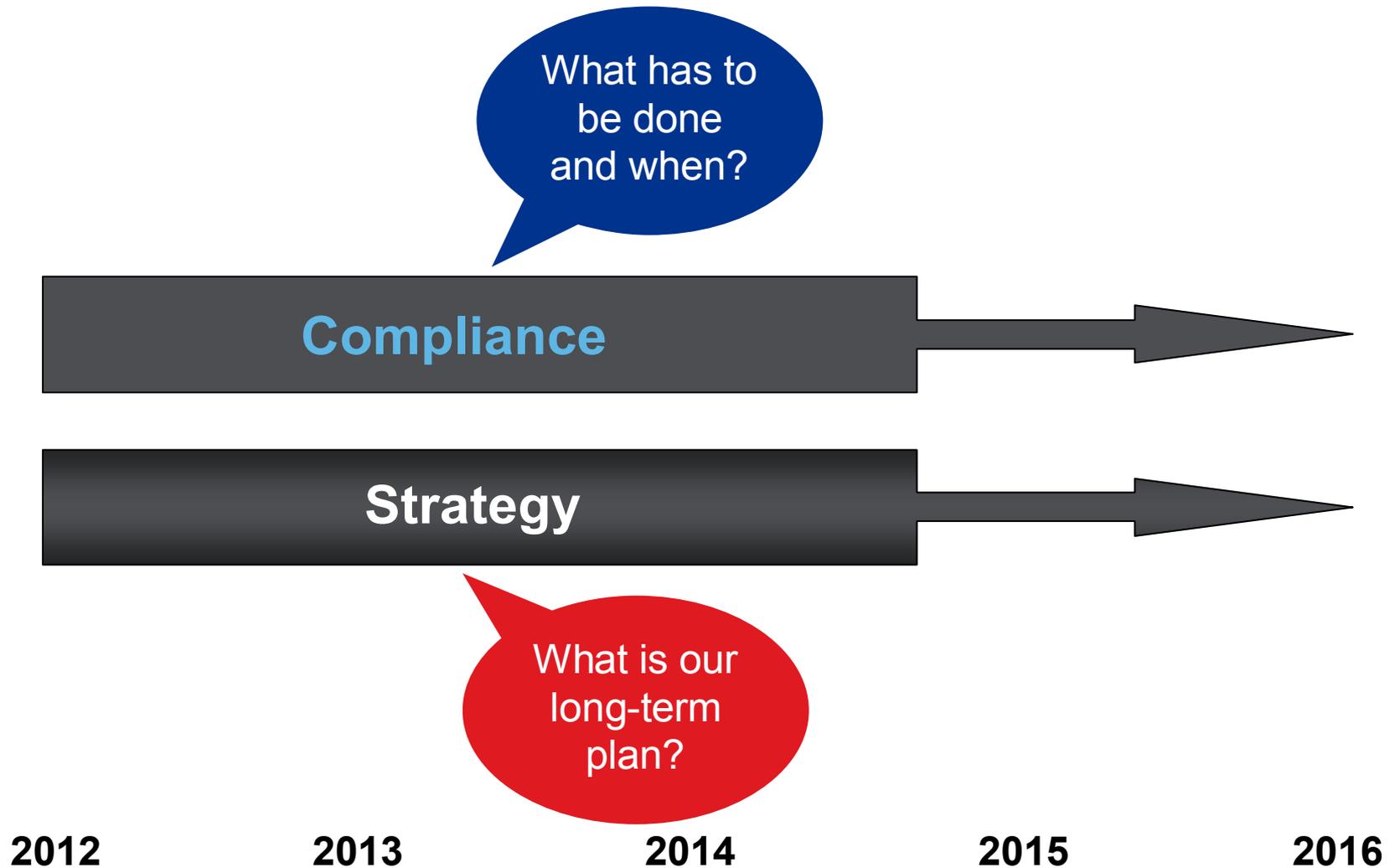
Fiscal Years 2012-2016, \$=B



Source: U.S. Office of Management and Budget (OMB), *Analytical Perspectives, Budget of the United States Government, Fiscal Year 2012*

Slide Courtesy of the American Benefits Council

Employers Need to Comply with ACA and *Still* Need to Reduce Costs



ACA Timeline—2011 to 2018

2011 Plan Year	2011	2012	2013	2014	2018
<ul style="list-style-type: none"> ▪ Lifetime dollar limits on Essential Health Benefits (EHB) prohibited* ▪ Preexisting Condition Exclusions Prohibited for Children under 19* ▪ Overly restrictive annual dollar limits on EHB prohibited* ▪ Extension of Adult Child Coverage to Age 26* ▪ Prohibition on Rescissions* ▪ No Cost Sharing and Coverage for Certain In-Network Preventive Health Services** ▪ Effective Appeals Process** ▪ Consumer/patient protections** ▪ Nondiscrimination requirements on fully insured plans** (<i>DELAYED</i>) ▪ Certain Retiree Medical Claims Reimbursable (ERRP) ▪ Retiree Drug Plan FAS Liability Recognition 	<ul style="list-style-type: none"> ▪ Over-the-Counter Medicines Not Reimbursable Under Health FSA, HRAs, or from HSAs Without a Prescription, Except Insulin ▪ HSA Excise Tax Increase ▪ Public Long-Term Care Option (CLASS Act) –<i>No Longer Supported by HHS</i> ▪ Medicare Part D Discounts for Certain Drugs in “Donut Hole” 	<ul style="list-style-type: none"> ▪ Employer Distribution of Summary of Benefits and Coverage to Participants* ▪ Comparative Effectiveness Fee ▪ Employer Quality of Care Report** ▪ Medical Loss Ratio rebates (insured plans only)* ▪ Employer Reporting of Health Coverage on Form W-2 (<i>due January 31, 2013</i>) 	<ul style="list-style-type: none"> ▪ Notice to Inform Employees of Coverage Options in Exchange ▪ Limit of Health Care FSA Contributions to \$2,500 (Indexed) ▪ Elimination of Deduction for Expenses Allocable to Retiree Drug Subsidy (RDS) ▪ Medicare Tax on High Income ▪ Addition of women’s preventive health requirements to No Cost Sharing and Coverage for Certain In-Network Preventive Health Services ** 	<ul style="list-style-type: none"> ▪ Individual Mandate to Purchase Insurance or Pay Penalty ▪ State Insurance Exchanges ▪ Employer Responsibility to Provide Affordable Minimum Essential Health Coverage*** ▪ Preexisting Conditions Exclusions Prohibited* ▪ Annual Dollar Limits on EHB Prohibited* ▪ Automatic Enrollment ▪ Limit of 90-Day Waiting Period for Coverage* ▪ Employer Reporting of Health Insurance Information to Government and Participants ▪ Increased Cap on Rewards for Participation in Wellness Program** ▪ Cost-sharing limits for all group health plans, not just HDHPs/HSA (deductibles and OOP maximum)** ▪ Transitional reinsurance fees 	<ul style="list-style-type: none"> ▪ Excise Tax on High-Cost Coverage
	<p>*Denotes group/insurance market reforms applicable to all group health plans. **Denotes group/insurance market reforms not applicable to grandfathered health plans. *** This requirement applies to full time employees (e.g., 30 hours per week) and will require coverage that is affordable and satisfies a certain actuarial value to avoid the penalty. Guidance forthcoming.</p>				

Major ACA Provisions Already in Effect

- ACA Group Market/Insurance Reforms
 - No lifetime \$\$ limits on essential health benefits
 - Transition rule on annual \$\$ maximums
 - Adult children covered to age 26
 - No pre-existing condition exclusions for children under age 19
 - Rescissions prohibited
 - Changes to Claims & Appeals process
- Health-Related Accounts
 - OTC drugs need Rx to be reimbursed thru FSA, HRA, and HSA
 - Penalty for nonqualified HSA withdrawals raised to 20% from 10%
- Medicare Part D
 - Discounts for certain drugs in “Donut Hole”
- Early Retiree Reinsurance Program
- Preventive care with no cost-sharing
- Medical loss ratio rules (insured plans only)
- Emergency services with no prior authorization
- Grandfathering rules apply

Plans exempt from ACA reforms

- Retiree only plans—fewer than 2 active employees on first day of the plan year means *plan* is exempt
- Limited excepted dental/vision benefits
 - Separate contract of insurance; or
 - Separate election and separate contribution
- Other limited exceptions exist, such as insured MedSupp

ACA Guidance—State of Play

- **Guidance delayed**
 - Automatic enrollment (2014 at earliest)
 - Nondiscrimination rules for fully insured plans (2014 at earliest)
- **Guidance not issued yet**
 - Employer Quality of Care Report (2012)
 - Distribute Notice to Employees of Coverage Options in Exchange (2013)
 - Medicare Tax on Investment Income (2013)
 - HDHP/HSA cost-sharing limits (deductibles and OOP maximums) (2014)
- **Guidance issued, but questions remain**
 - W-2 reporting on employer health care coverage (2012)
 - Comparative Effectiveness Fee (2012)
 - RDS double-dip repealed (2013)
 - \$2,500 cap on FSA contributions (2013)

Major ACA Provisions

- Summary of Benefits and Coverage Notices
 - Four-page uniform summary of benefits for all plans
- W-2 Reporting of Employer Health Care Coverage
 - Due January 31, 2013
- Reporting
 - Quality of care reports to HHS
 - Additional reports to state and local governments
- Comparative Effectiveness Fee
 - \$1 per covered live in first year, \$2 per covered live thereafter
 - Paid by employer/insurer
 - Due July 2013
- Medical loss ratio rules (insured plans only)
- Reinsurance Fees
 - States will charge employer plans a reinsurance fee for 2014, 2015, and 2016.
 - Final rules on amount of fee are expected from Federal government in October 2012
 - Could be up to \$60 PMPM or PEPM basis.



2012 Employer Checklist Post-*NFIB v. Sebelius*



	Administration	Communication
SBC	<ul style="list-style-type: none"> ▪ Electronic ▪ Paper 	<ul style="list-style-type: none"> ▪ Development ▪ Distribution
\$2,500 FSA Limit	<ul style="list-style-type: none"> ▪ Enrollment ▪ Decision support 	<ul style="list-style-type: none"> ▪ Enrollment guide ▪ SPDs/SMMs
W-2 Reporting	<ul style="list-style-type: none"> ▪ Calculation ▪ Coordination with Payroll 	<ul style="list-style-type: none"> ▪ Education
Comparative Effectiveness Fee	<ul style="list-style-type: none"> ▪ Calculation ▪ Coordination with carriers 	
Medical Loss Ratio	<ul style="list-style-type: none"> ▪ Calculation ▪ Coordination with carriers 	<ul style="list-style-type: none"> ▪ Education

Major ACA Provisions

- Health FSA \$2,500 limit
- Deductibility of expenses allocable to RDS payments eliminated
- Coverage of Women's Preventive Health Services
 - Effective plan years after August 1, 2012
- Medicare Taxes
 - Increases Medicare tax by 0.9% to 2.35% for individuals earning over \$200,000 and joint filers over \$250,000
 - New 3.8% tax on unearned income (interest, dividends, capital gains) for individuals earning over \$200,000 and joint filers over \$250,000
- Notify all employees about Exchanges, eligibility, services and contact information



Major ACA Provisions

- Employer Mandate
 - Full-time employees (over 30 hours)
 - 60% minimum actuarial value
 - No waiting periods over 90 days
 - No pre-existing condition exclusions or annual/lifetime limits
 - Affordability threshold of 9.5% of AGI
- Individual Insurance Tax
 - Maintain minimum essential coverage OR
 - Pay penalty based on taxable income



Major ACA Provisions

- Free rider penalty depends on whether employee went to Exchange because employer's plan
 - was not "minimum essential coverage" or
 - was either "unaffordable" or did not provide "minimum value"
- Employer that does not offer "minimum essential coverage" to all full-time employees faces a tax penalty of \$2,000 for each of its full-time employees, until the employer offers such coverage
 - subject to an exemption for the first 30 full-time employees
 - Penalty applies if at least one FTE receives a subsidy
- If coverage offered by employer is "unaffordable" or not "minimum value", employer pays a free rider penalty of \$3000 for each FTE who
 - Turns down employer coverage
 - Purchases a qualified health plan in the Exchange
 - Receives a Federal subsidy

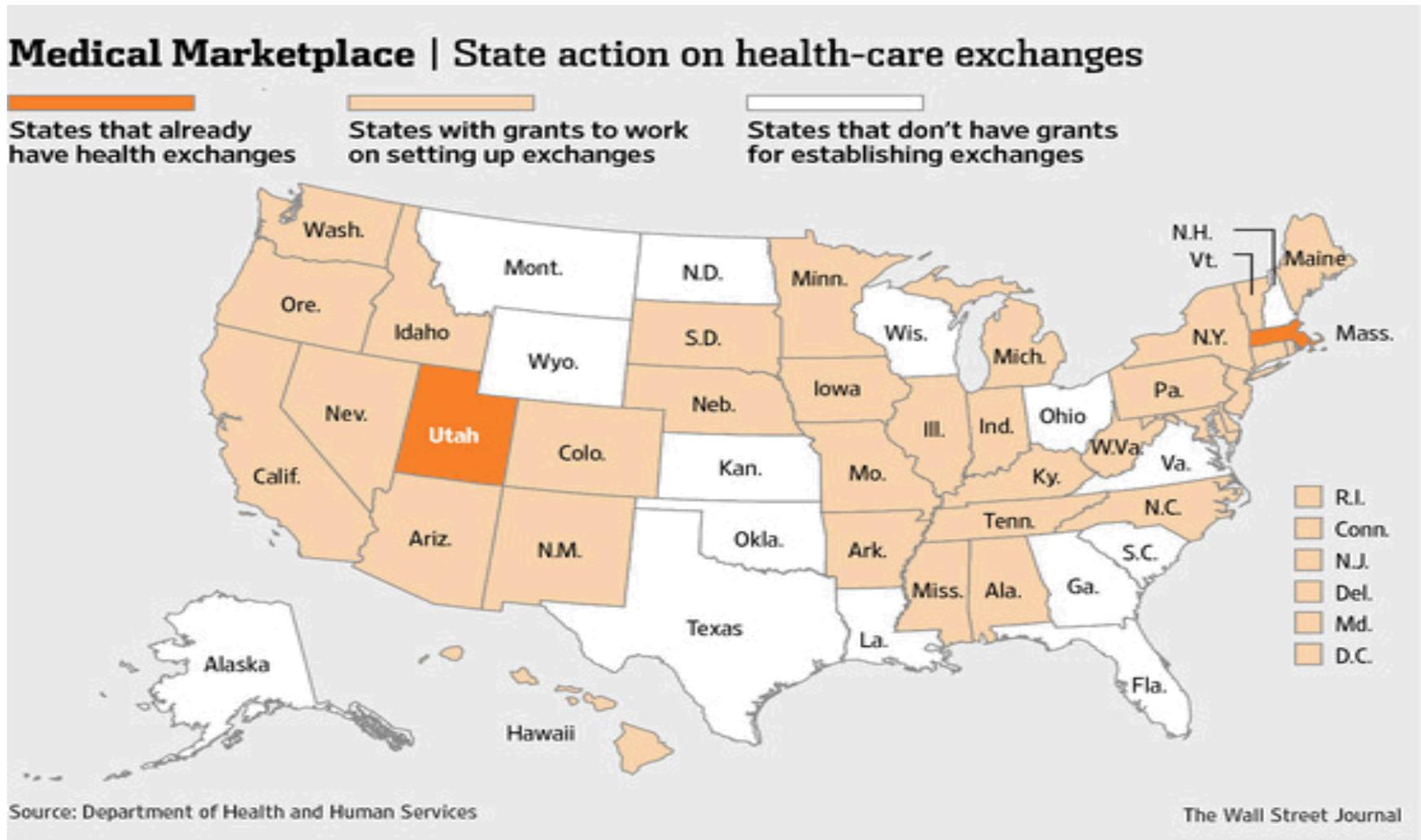


Major ACA Provisions

- Group Market/Insurance Reforms fully effective
 - No pre-existing condition exclusions
 - No annual \$\$ limits on essential health benefits
 - States define “essential health benefits”, generally based on predominant plan in the state
 - HDHP/HSA cost-sharing limits (deductible and OOP maximum) apply to all non-grandfathered group health plans
- State Exchanges
 - Exchanges open (bronze, silver, gold, platinum, “young invincibles”)
 - Subsidies from 133% to 400% of Federal Poverty Level
 - Fees on insurance companies
- Auto-Enrollment
 - New and currently enrolled employees (postponed)
- Wellness Program Rewards Cap
 - Cap on rewards for participating in wellness programs increased from 20% to 30% of cost of employee’s coverage



States Slow to Set Up Health Insurance Exchanges



What is an Exchange?

An exchange is a competitive marketplace that consists of suppliers and buyers



The Aon Hewitt Corporate Exchange Concept



Key Features

- Employers set a defined subsidy that will follow a compensation-like rate of cost growth
- Employees have flexibility to choose from a variety of carriers and plan types (more than today)
- Employees can “buy up” using pre-tax dollars to purchase the coverage that best meets their needs
- Market competition in “retail” channel dampens trend
- Unused or upon termination, credits revert to the employer

2017 and 2018

Major ACA Provisions

- Large employers may be allowed into Exchanges
- Excise Tax on “Cadillac” Plans
 - 40% excise tax on insurers and TPAs that offer health care coverage costing more than
 - \$10,200 individual (indexed)
 - \$27,500 family (indexed)
 - Increased threshold applies for retirees ages 55-64 and for selected high-risk occupations
 - \$11,850 individual
 - \$30,950 family
 - ♦ adjusted for age and sex



Optional Medicaid Expansion Could Affect Coverage of Uninsured

- ACA expands health care coverage by subsidizing coverage through insurance exchanges and Medicaid expansion
 - Federal subsidies are available in exchanges to individuals with incomes between 100% and 400% of Federal Poverty Level
 - States would expand Medicaid eligibility to individuals with incomes up to 138% of FPL, covering up to 17 to 22 million new Medicaid beneficiaries
- As many as one-quarter to one-third of States might opt out of Medicaid expansion, thus jeopardizing goal of universal coverage
 - Texas, Florida, Louisiana, Mississippi, and South Carolina have said “no” to Medicaid expansion (20% of potential new Medicaid beneficiaries)
 - Other governors might opt for Medicaid block grants
- If a state sets up exchanges but does not expand Medicaid, individuals with incomes between 100% and 138% of FPL would be eligible for federal subsidies to purchase insurance in the exchange
 - Without Medicaid expansion, individuals below 100% of FPL but not currently eligible for Medicaid (approximately 11.5 million individuals*) would remain uninsured

* Source: The Urban Institute

Optional Medicaid Expansion Could Affect Coverage of Uninsured

- Impact on employers would result from
 - Cost-shifting due to uninsured
 - Free rider penalty
- If a state declines to expand Medicaid eligibility, subsidized participation in health exchanges will likely be higher than initially projected, since individuals with incomes between 100% and 138% of FPL would be eligible for exchanges and subsidies
 - In a state without expanded Medicaid coverage, these individuals could buy federally subsidized coverage on the state exchanges
 - If these individuals are full-time employees and are not entitled to employer coverage, employer will be liable for a penalty of \$2000 times each FTE
- Some states are arguing *NFIB v. Sebelius* allows them to cut Medicaid eligibility now
 - ACA had required states to keep their existing Medicaid eligibility standards for current beneficiaries in place until 2014 or risk losing federal funding
 - Some state officials are arguing Supreme Court ruling nixed that penalty too
 - Maine plans to challenge U.S. government and cut back Medicaid eligibility

CBO projects more uninsured, drop in Federal Medicaid costs

- Congressional Budget Office said Supreme Court ruling would change CBO's projections of
 - Number of uninsured
 - Cost of ACA
- CBO said some states will ultimately opt out of Medicaid expansion
 - Predicts that six million fewer people would be insured by Medicaid than originally projected
 - Projects that half of them will gain private insurance coverage through state health insurance exchanges
- With fewer people covered by Medicaid or federal insurance subsidies, CBO projects that the ACA will cost \$84 billion less than previously predicted
- CBO said that repealing the health care law would add \$109 billion to federal budget deficits over the next 10 years
 - Repeal would reduce spending by \$890 billion and reduce revenues by \$1 trillion in the years 2013 to 2022

More Legal Challenges to ACA on the Way

Just when you thought it was safe to go back to the courtroom

- Contraception requirements
 - 23 lawsuits already filed in courts across the country challenging the law's requirement that religious-affiliated institutions, such as schools and hospitals, provide insurance coverage for birth control and other contraceptives
- Exchange Subsidies
 - If state does not set up an exchange, Federal government will offer a Federal exchange as a backstop, but ACA as written only permits subsidies if insurance is purchased on a state exchange
 - Supporters of ACA call it a drafting error, but ACA opponents say that government can't open the federal exchanges to subsidies if it wasn't in the law in the first place
 - Employer is likely to sue if employer gets hit with free rider penalty in a state that does not establish an exchange
- Independent Payment Advisory Board
 - IPAB's role is to keep Medicare spending from rising too fast, but critics say IPAB usurps Congress's role
 - Lawsuit put on hold pending *NFIB v. Sebelius*

You Need a Health Care Compliance Strategy, BUT—

A Health Care Compliance Strategy is not a Health Care Strategy!

- Reform Addressed Access to Coverage—**NOT** Cost or Population Health
- Congressional repeal unlikely
- Politics will dominate 2012
- Major implications for
 - Employers & Employees
 - Providers
 - Health Plans

2012

Comparative Effectiveness Fee
W-2 Reporting
SBC Notices

2013

- Increased Medicare tax
- \$2,500 FSA limit

2014

- Individual mandate & free rider penalty
- State exchanges open
- Wellness incentives increase to 30%

Stage Setting—The Realities in the Wake of Health Reform

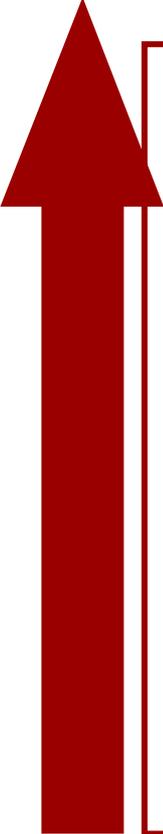
- This is just the beginning
 - Regulatory guidance, and potentially additional legislation, will be on the table...forever
- Without aggressive action, employer health care costs will increase 60% in the next five years
 - No one will be standing still
 - The era of the copay is over; designs will be meaner and leaner
 - Companies will be more requiring of their employees (carrots and sticks)
 - Some will move towards defined contribution approach in health care
 - All benefits are “on the table” as the employment deal is re-assessed

Annual gross trend of 10% per year; net trend of 7% per year



Even a 7% CAGR is unsustainable long-term; there needs to be a “new normal”

Going Forward—Employer Costs Will Rise 60% on a “Stand Still” Basis



Upward Pressures

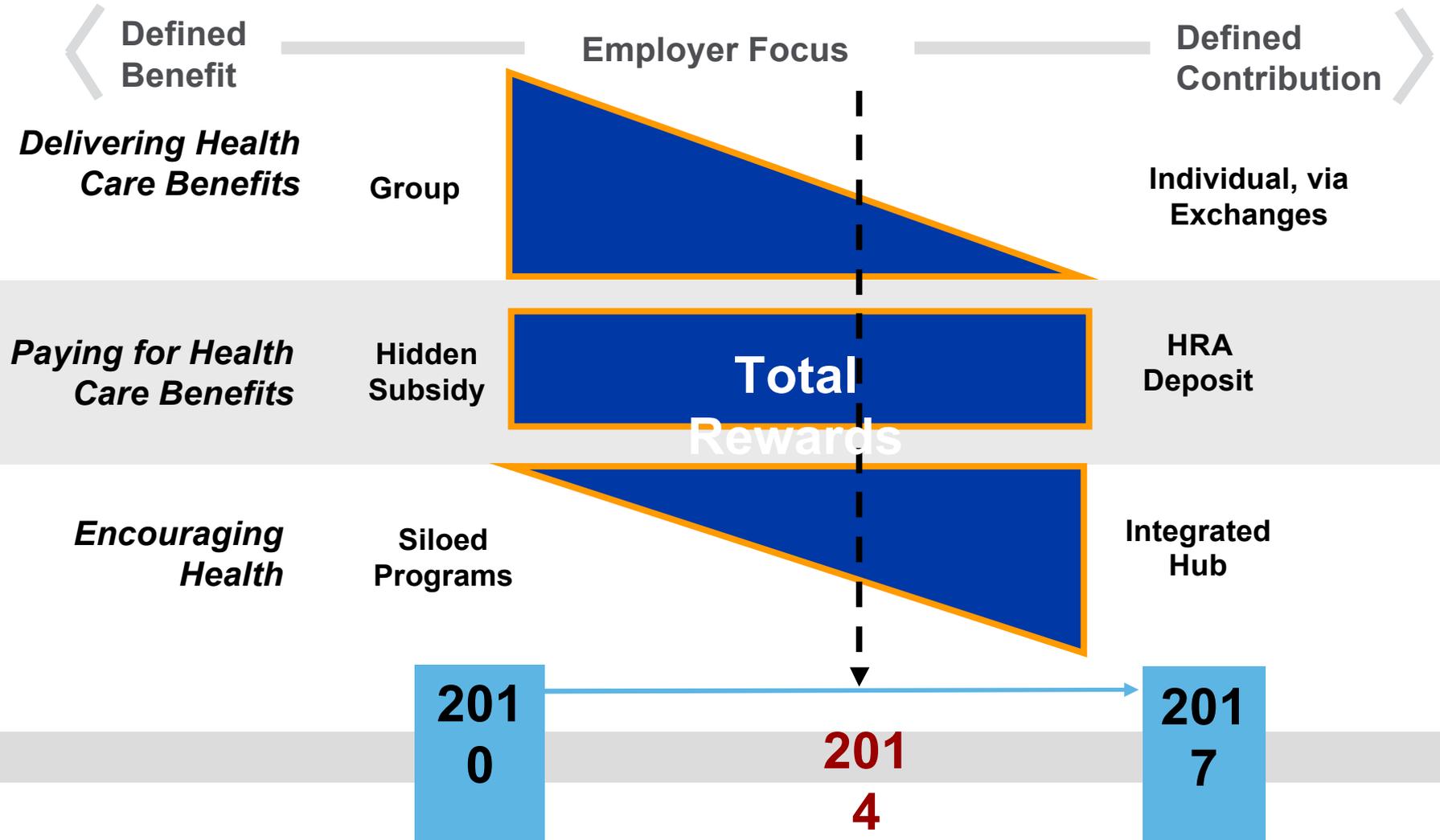
- Demographics
- Obesity-related chronic illness—including children
- New therapies and technologies
- Cost shift from Medicare / Medicaid
- Industry fee pass-throughs
- New coverage provisions
- Individual mandate



Downward Pressures

- Plan design value
- Discretionary purchasing
- Uncompensated care
- Brand drug patent expirations
- Focused care management
- Investments in health

A Movement Toward Individual Coverage



DC Health Care—Retiree Health Will Be First to Move

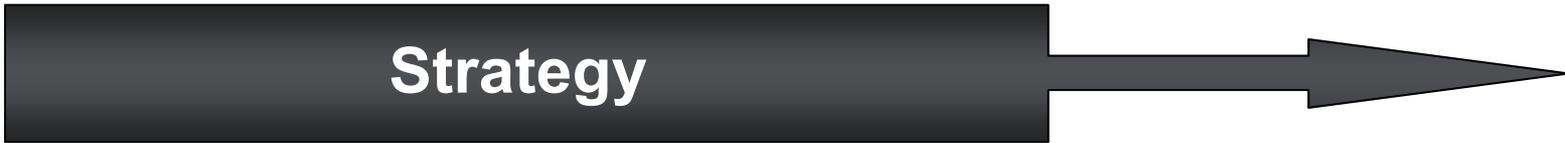
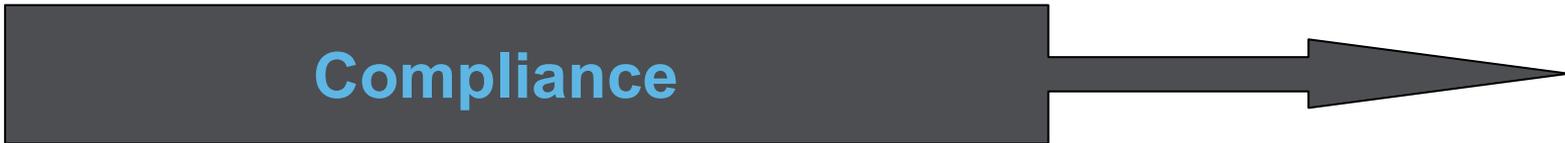
Reform exchanges facilitate employer “exit” strategies, but may not effectively address immediate cost savings, retiree enrollment decision support, and employer funding vehicles



Employer Strategy	Description	Sourcing Alternative
Manage Through the Group Insurance Program	<ul style="list-style-type: none"> Employer-centric group insurance model Employer determines annual coverage details Premium subsidy likely 	<ul style="list-style-type: none"> Traditional Employer-Sponsored Group Insurance (Pre-65 and Post-65)
Sponsor by Partnering with Third-Party Platforms	<ul style="list-style-type: none"> Employer narrows choices; limited market Provider determines coverage details Premium subsidy likely 	<ul style="list-style-type: none"> Aetna’s HR Policy Association Retiree Health Access (RHA) Initiative (Pre-65 and Post-65) CIGNA/Marsh Consumer Connections Initiative (Pre-65 and Post-65) UHC/AARP Health Care Options Program (Post-65 only)
Facilitate by Leveraging Exchanges	<ul style="list-style-type: none"> Open market purchasing Employer facilitates selection through education Premium subsidy possible 	<ul style="list-style-type: none"> Extend Health (Post-65 Only) Hewitt Health Exchange (Post-65 Only) United’s Connector Model (Post-65 Only)
Exit Entirely	<ul style="list-style-type: none"> No access No premium subsidy May provide information 	<ul style="list-style-type: none"> COBRA and HIPAA (Pre-65 Only) Buyouts or Settlements (Pre-65 and Post-65) Direct Individual Market Approach (Post-65 Only)

Reform Sends You Down Two Concurrent Paths...

What has to be done and when?



What is our long-term plan?

2010

2011

2012

2013

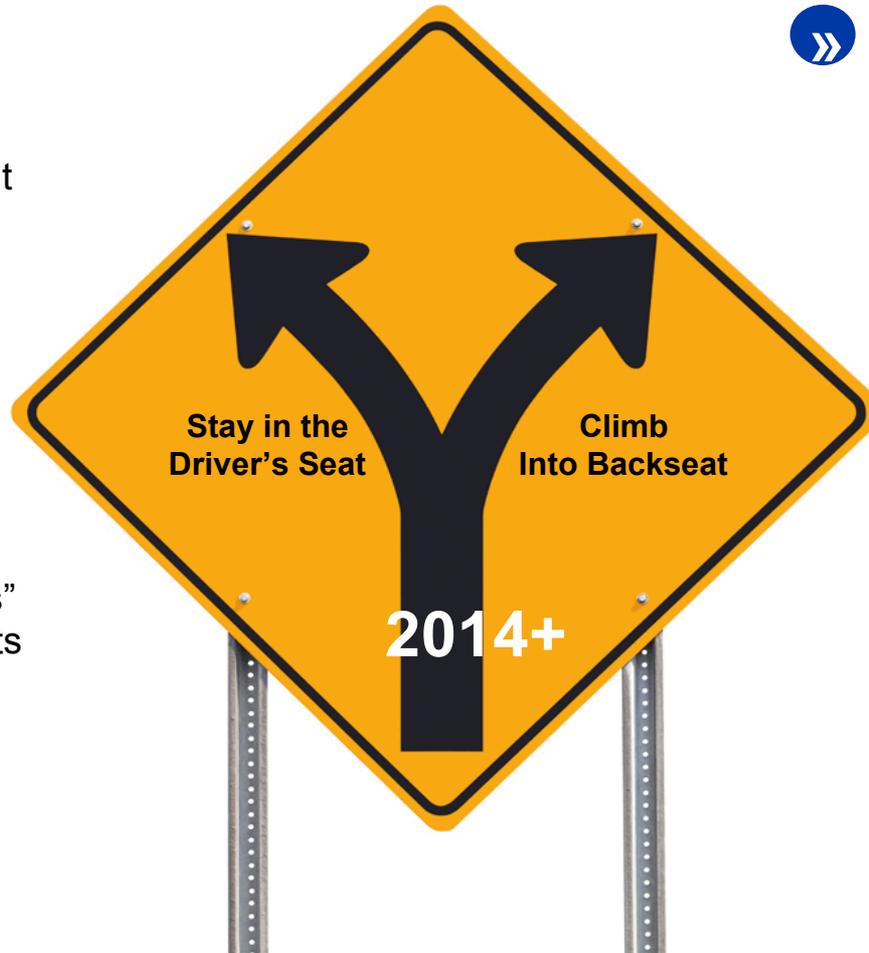
2014

...Leading to a Fork in the Road

Down either path, employers have a persistent need to have a workforce that is healthy, present, and productive; that is imperative for all businesses

» Aggressive Health Management

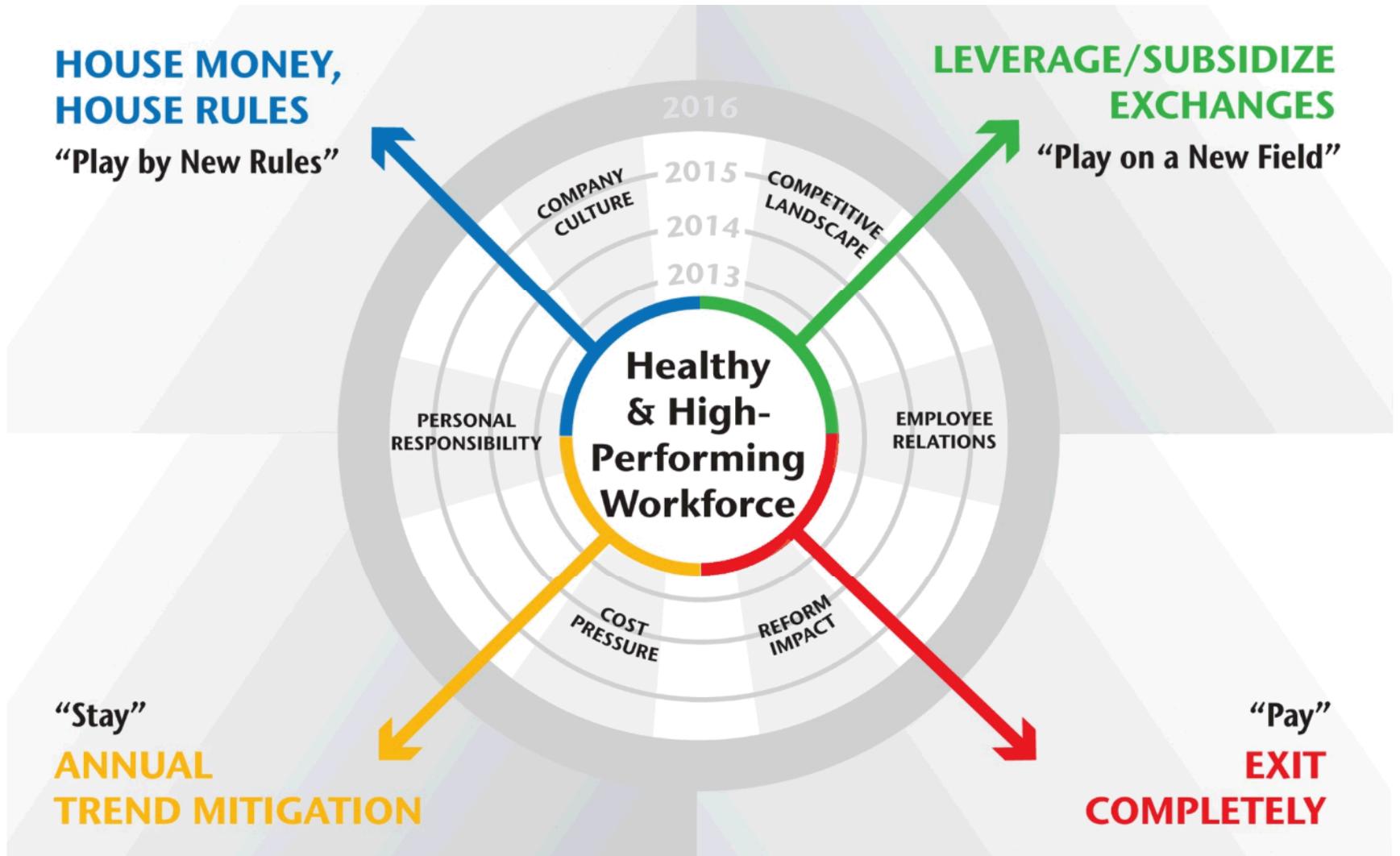
- Heavy emphasis on health risk improvement and cost management
- Sophisticated use of data analytics to drive design, program management, vendor accountability
- Migration from incentives to penalties and “requirement gates” to access better benefits
- Alignment with pay for performance business culture
- House money, house rules



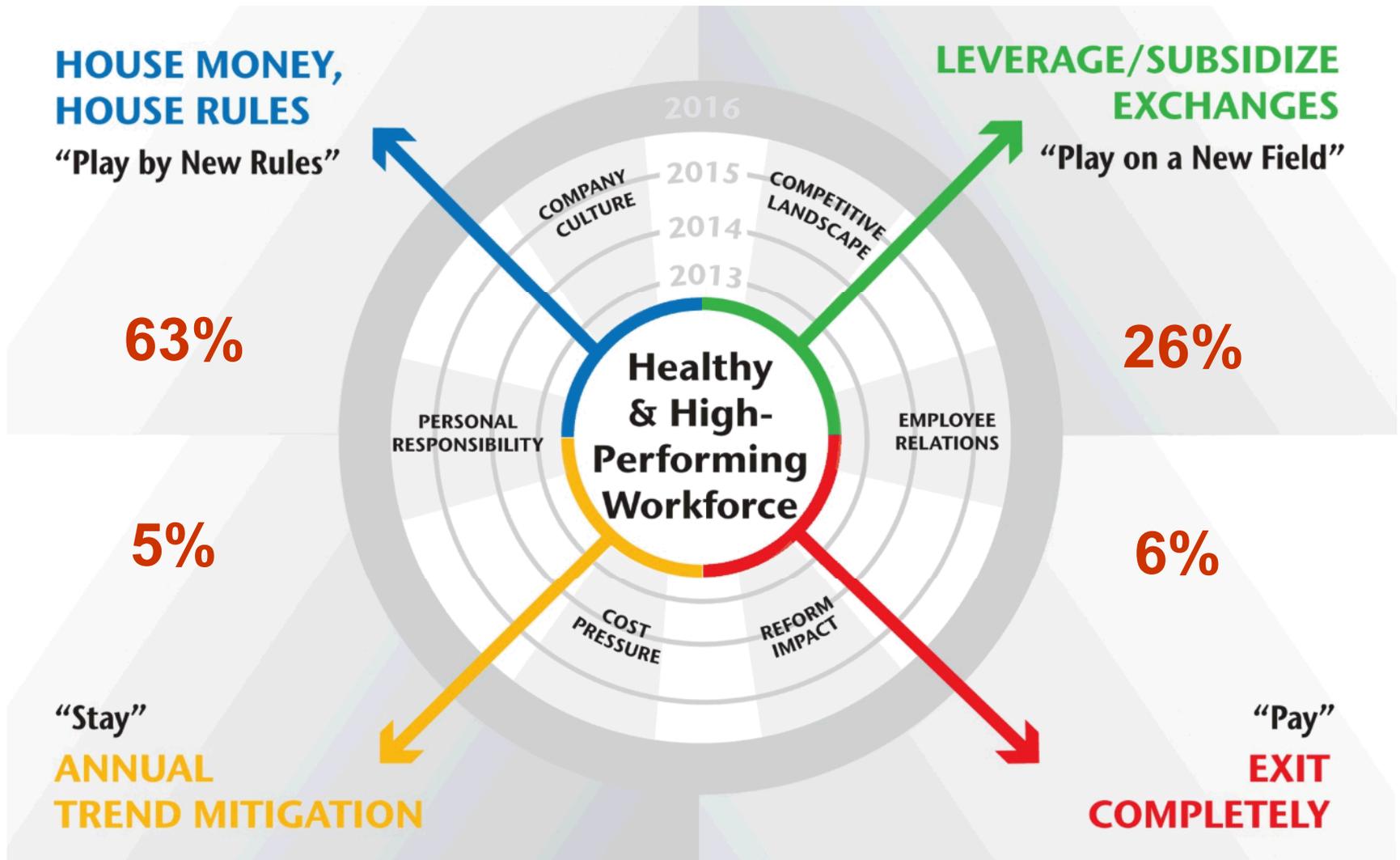
» Managed Defined Contribution

- Subsidy fixed with company-driven increase
- HRA
- Coverage via individual market (private or public Exchanges)
- Worksite health shifts to focus on return to work, absence reduction, productivity gains

After *NFIB v. Sebelius*—Which Road to Take?



After *NFIB v. Sebelius*—Which Road are Employers Taking?



After *NFIB v. Sebelius*, It's Decision Time—Stay, Pay, or Play?

- **Employers need a health care compliance strategy, but—**
 - **A health care compliance strategy is not a health care strategy!**
- The Headwinds Are Strong
 - Demographics, advanced treatments, lifestyle, legislation—all push costs upward
- The Stakes for Your Organization Are High
 - Medical is the most highly valued employee benefit, by a margin of 2 to 1
- There Will be Continued Risk
 - Government will respond to political as well as market shifts, and is not coming to employers' rescue any time soon

Affordable Care Act—Your Compliance Timeline

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Questions?