2013 Health Care Reform Planning Strategies

January 23, 2013
Your Presenters

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How To Vote Via Texting

1. Standard texting rates only (worst case US $0.20)
2. We have no access to your phone number
What is your favorite color?

Text a **CODE** to 22333  
Submit a **CODE** to [website link]

- **Red**: 16% 313696
- **Blue**: 313700

Poll: What is your favorite color?
What We Will Cover Today

• Reflections on 2012
  – Update on 12/28/2012 “Pay or Play” Guidance

• What’s Happening in 2013?
  – Path to Compliance

• Looking Ahead to 2014 and Beyond
  – Overview of the Health Insurance Exchange
  – Impact on Employer-Sponsored Health Benefits, the Health System, the Uninsured and Workforce Strategies

• Questions and Answers
Reflections on 2012

• SCOTUS decision & the Election provided some clarity, but many questions remain
  – Although repeal of PPACA is “off the table” (American Benefits Council) other items remain, such as industry taxes, exchange subsidies, etc.

• “Nothing approaching the complexity of this roll-out has ever taken place in U.S. peacetime history, with the start-up challenges vastly more complicated than Social Security or Medicare ever were.” (Henry Aaron, The Brookings Institution)
Reflections on 2012

- Compliance with SBCs were difficult for those self-funded employers who carved out Rx
- Religious Liberty lawsuits continue and will likely wind up at SCOTUS
  - Beginning 1/1/2013 Hobby Lobby is incurring daily fines equal to $1.3 million
  - Will religious employers have no other choice but to give up their health plans once their temporary enforcement safe harbor periods expire?
Reflections on 2012

• MLR Rebates paid beginning August 2012 totaled more than $1.3 billion
  – Spawned significant changes in agent/broker compensation as carriers reduced administrative expenses
  – Reduced compensation from health insurance is leading to many agency acquisitions and mergers
Reflections on 2012

- Increased regulatory activity to hold insurers “accountable”
  - 37 state legislatures have given their OICs authority to deny or roll back requested rate hikes
  - Per 1/5/2013 New York Times, 36% of requests to raise rates >10% were deemed reasonable; 12% of the requests were withdrawn; 26% were modified; and 26% were found to be unreasonable
Highlights of New Wellness Rules

• DOL/HHS/IRS issued joint proposed regulations on 11/20/2012; comments due by 1/25/2013
• Legal requirements for financial incentives within wellness programs are complex
  – Must consider not only HIPAA, but also GINA, ADEA and ADA
  – EEOC has not adopted the % caps on financial incentives as the standard for determining whether a wellness program is “voluntary”
New Wellness Rules

• Proposed rules implement the PPACA changes to the current HIPAA rules
  – The maximum incentive of 20% of the cost of employee-only coverage may increase to 30% effective 1/1/2014;
  – The incentive may increase to 50% for plans designed to prevent or reduce tobacco use
• Proposed rules also address;
  – Participatory wellness programs
  – Health-contingent wellness programs
New Wellness Rules

• Participatory wellness programs
  – Made available to all similarly-situated employees; does not provide a reward; or does not include a condition that an employee satisfy a health factor-related standard
  – Reimbursement for a gym membership is the most common example
New Wellness Rules

- **Health-Contingent Wellness Programs**
  - Employee must satisfy a standard relating to a health factor for the reward (discounts, rebates, full or partial waiver of costs, or additional benefits)
  - Imposing a surcharge on smokers is a common example of a health-contingent program
  - There are 5 requirements that must be met:
    - Employees must have the opportunity to qualify for the reward at least once/year
    - The total reward is limited to the “applicable percentage” (i.e. up to 30% or 50% for tobacco programs); if dependents are enrolled, use the cost of coverage for the appropriate tier (i.e. EE +1)
New Wellness Rules

• The reward must be available to all similarly-situated employees, including the use of a “reasonable alternative standard” for those whose medical conditions make it unreasonably difficult to meet the wellness standard, or for whom attaining the standard would be medically inadvisable
  – Employer must pay the costs of any educational programs designed to be an alternative standard
New Wellness Rules

- Program must be reasonably designed to promote health or prevent disease and not be overly burdensome or a “subterfuge” for discrimination based on a health factor; must offer reasonable means of qualifying for a reward to anyone who does not meet the standard for the reward based on any measurement, test or screening.
- The availability of alternative means of qualifying for a reward must be disclosed in all program materials; sample notice language was provided.
Do you provide financial incentives for wellness today?

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For those with wellness incentives, will the amount of the incentives increase the maximum allowed? 

Text a **CODE** to **22333**

Submit a **CODE** to **ht**

Yes 13% **285570**

No **285571**

Poll: For those with wellness incentives, will...
Highlights for 2013

- Increased Medicare tax; new taxes on Medical Devices; surtax on Investment Income; higher threshold for Itemized Medical Deductions
- Employers issuing > 250 W-2s must report value of aggregate cost of employer-sponsored health benefits on W-2s for 2012 (issued in January 2013)
  - This does not mean the value of health coverage will become taxable income
Highlights for 2013 (W-2 cont’d)

• Does not apply to Health Care FSAs if contributions only occur through IRC 125 employee salary deferrals
• Does not include Dental and/or Vision coverage that is considered limited scope or unbundled from Medical/Rx benefits
• Does not include any amounts contributed to a Health Savings Account (but continue reporting on HSAs in box 12 using code W); and
• Does not include costs under an EAP, wellness program, or on-site medical clinic if the employer does not charge a premium for that coverage under COBRA
Highlights for 2013

- Effective 1/1/2013 Health Care Flexible Spending Accounts are limited to $2,500
  - Limit applies only to employee salary deferrals and not to employer non-elective FSA contributions
  - This amount will be indexed for inflation
  - Continue to remind employees about the ability to use their HSAs to help pay for orthodontia and other qualified medical expenses
  - Update cafeteria plan documents before 12/31/2014
Highlights for 2013

- New Patient-Centered Outcomes Research Institute (Comparative Effectiveness) fees due July 31, 2013
  - Requirement began with plan years ending on/after 10/1/2012 (i.e. 2012 calendar plan year; will end with 2018 calendar plan year)
  - Applies to insured and self-funded health plans; includes COBRA and retiree-only plans
  - Does not apply to HIPAA-excepted benefits
  - Employers will use IRS Form 720 to remit the initial $1/member (i.e. employees & dependents) fee
  - Fee increases to $2/member for 2013
  - Treated as an excise tax; not tax deductible; can’t be paid with ERISA plan assets
Highlights for 2013

- Employers were to issue a notice to employees by 3/1/2013 on the availability of a health insurance exchange in their state
- No model language or guidance has been released
- We expect the 3/1/2013 deadline to be extended, but have no further details
Highlights for 2013

- Be ready to amend or terminate insured plans that discriminate in favor of highly compensated employees
  - PPACA non-discrimination rules were going to take effect in 2011, but guidance was delayed
  - We expect guidance soon
  - We also expect the rules to be similar to those governing self-funded plans: Section 105(h) where the value of discriminatory benefits is taxable to the executive
  - Be mindful of IRC 125 non-discrimination rules, too
Highlights for 2013

• Watch for guidance on filing a “Quality of Health Care Report”
  – Requirement was to have taken effect for plan years beginning after 3/23/2012, but guidance from HHS was delayed
  – Employers are required to report on “quality, safety, health promotion and case management activities”
Highlights for 2013

• Covered entities as defined by HIPAA were to have been compliant with new operating rules for health plan and health claim status electronic claims transactions no later than 1/1/2013

• On 1/2/2013 CMS indicated it will not enforce these rules until 3/31/2013

• Presumably covered entities will still need to certify by 12/31/2013 that they are in compliance with these rules
Highlights for 2014

• Transitional Reinsurance Program
  – Both insured and self-funded plans will pay into state-based program during 2014-2016 to cover high cost claimants enrolled for individual coverage in and outside the exchange
  – The per member fee in 2014 is $63; states can charge additional fees to reinsure their individual, small and large group insured markets
  – Post-65 retiree coverage excluded along with HIPAA-excepted benefits; includes COBRA
  – Tax Deductible; may be paid from ERISA plan assets
Will the imposition of the Transitional Reinsurance Program Fee cause many and mid-size employers to drop their benefits?

Text a CODE to 22333  
Submit a CODE to ht1

Yes: 285579

Probably: 285580
Highlights for 2014

• Deductibles in the small group market (< 100 employees) may not exceed $2,000/individual or $4,000/family

• Non-grandfathered plans must cover routine costs and services in connection with a clinical trial

• Employers > 200 employees will auto-enroll new employees in their health plans, but provide an opt-out provision
  – Was to have happened coincidental with enactment of the PPACA in March, 2010 but guidance was pushed back
Highlights for 2014

- Medicaid expanded to people under age 65 with incomes of 100% to 133% of FPL
- June 2012 SCOTUS decision: the expansion of Medicaid is NOT constitutional under Congress’ spending power.
- Ohio elected not to expand Medicaid (CBO estimates possibly one-half to two-thirds of the states may not expand Medicaid eligibility above 100% of the FPL)
- The result is those individuals with incomes of 100%-133% FPL will be eligible for subsidized coverage through the health insurance exchange (see 12/2012 NCPA white paper on Exchanging Medicaid for Private Insurance)
Proposed Rules for Employer Shared Responsibility Provisions (aka “Pay or Play”) under Code Section 4980H

- Issued on 12/28/2012 by Treasury/IRS; comments due by 3/18/2013; public hearing on 4/23/2013
- IRS said if future guidance is more restrictive than the Proposed Rules, the future guidance will not be retroactive and employers will be given sufficient time to comply
Proposed 4980H Rules

• In 2014 an “applicable large employer” with at least 50 full-time equivalent employees must offer at least 95% of its actual full-time employees and their eligible dependents minimum essential health coverage
  
  – Otherwise, if more than 5% of the FTEs receive a federal subsidy to buy coverage through a state-based health insurance exchange, the employer must pay a penalty
Proposed 4980H Rules

• The penalty is: # actual FTEs (minus 30) x 1/12 of $2,000 for each month the employer does not offer minimum essential coverage
• The penalty is treated as an excise tax and is not tax deductible for the employer
Proposed 4980H Rules

• “Dependent” does not include spouses
  – Employers do not have to offer coverage to spouses or contribute towards the cost to cover them
• The employer must offer coverage to dependent children up to age 26 as defined under Code Section 152 (f)(1); includes foster and step children
  – Have until 2015 to comply with the this definition of children
  – The employer does not have to contribute towards the cost to cover dependent children
Proposed 4980H Rules

• In deciding whether an entity is an “applicable large employer” for the purpose of assessing penalties, must consider the entire controlled group
  – Determination of any penalty amounts is done on a member company basis
• An employer can choose any 6 consecutive months in 2013 to determine its status as an applicable large employer
  – If the workforce > 50 FTEs for fewer than 120 days in a calendar year, and the excess during that 120 days is attributed to seasonal workers, those seasonal workers can be excluded only for purposes of determining large employer status
Proposed 4980H Rules

- An FTE is defined as someone who works, on average, 30 hours/week or 130 hours/month
  - Part-time employees are aggregated as equivalent FTEs
- Hours of service include each hour for which the employee is paid or entitled to payment by reason of vacation, holiday, illness, disability, layoff
  - Unpaid leave for jury duty, FMLA or USERRA is considered “special unpaid leave” with a method for averaging hours when applying the measurement period
Proposed 4980H Rules

• There is no limit amount of paid leave that must be taken into account in determining FTE status
• May exclude any hours worked outside the U.S.
• Special rules apply to teachers, adjunct faculty and other employees of educational organizations
  – Take into account many of these employees work an academic year and are precluded from working normal hours during periods when the institution is closed
• There will be “anti-abuse” rules to address an employer’s use of temporary staffing agencies to avoid obligations under 4980H
Proposed 4980H Rules

• In 2014 a penalty also applies to an employer with at least 50 full-time equivalent employees who offers minimum essential health coverage that is “unaffordable”, causing at least one FTE to receive:
  – a federal subsidy to buy coverage through a state-based health insurance exchange; or
  – a federally-subsidized cost-sharing reduction
Subsidies for individuals

For exchange plans only

- To be eligible, individuals must:
  - Have income between 133% and 400% of federal poverty level (FPL)
  - Not have access to minimum essential coverage through their employer or have access to coverage, but it is not affordable
- **Premium credits** for any exchange plan
- **Cost-sharing subsidies** – Silver plan only

Income ranges for 133% to 400% FPL

- **Individual:**
  - $14,856 to $44,680
- **Family of four:**
  - $30,656 to $92,200

Based on 2012 guidelines for the 48 contiguous states and D.C.
Proposed 4980H Rules

• Coverage is unaffordable if:
  – The FTE’s contribution for self-only coverage > 9.5% of the employee’s W-2 income; or
  – The plan does not provide “minimum value”, because the employer’s share of covered expenses is < 60%

• Penalty is # FTEs receiving a subsidy x 1/12 of $3,000 for each month the coverage is unaffordable
Proposed 4980H Rules

- Affordability requirements apply only to the FTE
  - Do not apply to Dependent Children or PTEs
- The Proposed Rules provide 3 safe harbors in measuring the affordability of employee coverage
  - W-2 Safe Harbor
  - Rate of Pay Safe Harbor
  - Federal Poverty Line Safe Harbor
Will employers be less likely to pay for Dependent coverage?

Poll: Will employers be less likely to pay for...
Proposed 4980H Rules

• Special transition rule for non-calendar-year or fiscal year plans
  – The employer is not subject to penalties under 4980H until the 1\textsuperscript{st} day of the plan year that commences in 2014

• Since employees may want to discontinue coverage in their employer’s plan and enroll in an exchange in 2014, there is an opportunity to amend the cafeteria plan document by 12/31/2014 retroactive to 1/1/2013 to allow for the employee to revoke their election once during the plan year without having to experience a change in status
Proposed 4980H Rules

• There will be new reporting requirements for applicable large employers under IRC Section 6056 beginning in 2015 (IRS will issue new, separate regulations)
• Employers will have the ability to contest an employee’s assertion they were not offered qualifying coverage
  – Appeal mechanism has yet to be established
  – The appeal comes after the penalty has been assessed
Is an Employee “Full-time”?  

- The safe harbors can be relied upon for measurement periods that begin on or after 1/1/2013  
- A Measurement Period must be at least 3 months and no more than 12 months  
- The duration of the Stability Period may not exceed the duration of the Measurement Period  
- If employee is a FTE, the Stability Period must be at least 6 months  
- The Administrative Period can not exceed 90 days and is included in the overlapping Stability Period
Is an Employee “Full-time”?

• May use different measurement and stability periods for:
  – Salaried and hourly employees;
  – Collectively bargained and non-collectively bargained employees;
  – Each group of collectively bargained employees covered by a separate bargaining agreement; or
  – Employees in different states
2013 – 2016
9 Month Measurement/Stability Period
Is an Employee “Full-time”?

• A transition rule enables employers to use a 12-month stability period in 2014, so long as their transition measurement period is at least 6 months long, commences no later than 7/1/2013 and ends no earlier than 90 days before the start of the 2014 plan year.

  – Example: An employer with a calendar year plan wants a 12-month stability period in 2014, and their administrative period coincides with an Open Enrollment running from 10/15/2013-12/31/2013. They must start their transition measurement period no later than mid-April 2013.
Key Points About On-Going Employees

• “On-going” means the employee has been employed for at least one complete standard measurement period

• If the employee is clearly full-time, they’re “in”
  – You don’t have to administer measurement and stability periods; continue with your normal eligibility and enrollment practices
  – Note eligibility waiting periods cannot exceed 90 days beginning 1/1/2014
  – However, employers can make an employee eligible on the date of hire and have coverage commence 90 days after benefit election
Key Points About On-Going Employees

- If the employee is “part-time” but is regularly scheduled to work at least 30 but less than 40 hours/week, consider your workforce strategy and employment value proposition. You may decide to:
  - Make them benefits-eligible; or
  - If you want to minimize health care costs & exposure to penalties, reduce their hours to < 30/week
Key Points About New Employees

- If the new employee is not full-time and you can’t reasonably determine if they will work, on average, 30 or more hours/week, then they are considered a “variable hour employee”

- If the variable hour employee meets the FTE definition during the initial measurement period, then they are deemed an FTE during the following stability period, regardless of their hours in that stability period
Transitioning the New Employee to an Ongoing Employee

- The employer must test the new variable hour employee’s full-time status under the measurement period that applies to ongoing employees.
- If the employee worked a full-time schedule during the measurement period for ongoing employees, the employer must treat the employee as full-time as of the start of the next stability period that applies to ongoing employees, even if the initial stability period that applies to the new employee has not expired.
Change in Employment Status for New Employee

• If a new variable hour employee changes positions during the initial measurement period, or has a change in status, so that the person would have been treated as an FTE from DOH, had they been first hired into that position, then they must be treated as an FTE on the 1st day of the 4th month following the change in status.
Change in Employment Status for On-Going Employee

- A change in status for an ongoing employee does not change the employee’s status as a FTE during the stability period
Termination and Rehire

- If the employee terminates and is rehired 26 or more weeks later, the employee may be treated as a new employee.
- If the employee terminates and is rehired fewer than 26 weeks later, the employee is treated as a continuing employee.
  - If the rehire is in the same measurement period, the rehired employee gets credit for their hours worked before their termination.
Seasonal Employees

- Employers may use reasonable good faith interpretation of the term “seasonal employee” in 2014 to include retail employees employed during the holiday season, or agricultural workers
  - The preamble to the Proposed Rule indicates the IRS may issue a future rule that defines a seasonal EE that works less than a specified period of time within a calendar year
  - Treas. Reg Section 1.1.05-11: any employee whose customary annual employment is < 9 months may be considered a seasonal employee
Overview of Health Insurance Exchange

• Individual Responsibility Tax
• The Big Picture
  – For Individuals
  – For Small Employers
  – For Large Employers
• How the Health Insurance Exchange Will Work
  – In Ohio, it will be a “federally-facilitated” exchange; carriers will be charged 3.5% of premiums to fund exchange operations
What did the States Decide?

- PPACA allows each state to establish its own health insurance exchange, or let HHS operate a “federally facilitated” exchange
  - HHS also allowed for two state-federal partnership models
    - State Plan Management Partnership Exchange
    - State Consumer Partnership Exchange
  - Generally, HHS would handle the exchange web site and call center, accept applications and determine eligibility for premium subsidies
  - Generally, the State would handle health plan management and provide consumer education and enrollment assistance
What did the States Decide?

- Oklahoma has sued the federal government, arguing PPACA provides for premium subsidies and employer penalties only in a state-based health insurance exchange.
- 17 states and the District of Columbia will operate a state-based exchange:
  - California
  - Colorado
  - Connecticut
  - Hawaii
  - Idaho
  - Kentucky
  - Maryland
  - Massachusetts
  - Minnesota
  - Mississippi
  - Nevada
  - New Mexico
  - New York
  - Oregon
  - Rhode Island
  - Utah (has had its own exchange since 2009)
  - Vermont
  - Washington
What did the States Decide?

• 7 states elected a partnership model with HHS
  – Arkansas
  – Delaware
  – Illinois
  – Iowa
  – North Carolina
  – West Virginia
  – Michigan indicated they would pursue a partnership, too, but no blueprint has been submitted
How confident are you that a federally facilitated exchange will be operational in time for an October 2013 enrollment?

Poll: How confident are you that a federally facilitated exchange will be operational in time for an October 2013 enrollment?

Confident: 6% 285575
Skeptical: 285577
No way is it going to work: 285577
Penalties for individuals

2014:
Greater of $95 or 1% of taxable income

2015:
Greater of $325 or 2% of taxable income

2016:
Greater of $695 or 2.5% of taxable income

2017 and beyond:
Annual adjustments

Information provided by Anthem
Blue Cross and Blue Shield 1/15/13
The big picture for individuals

- Every American not covered under a government plan will have three options for health insurance in 2014:
  1. Employer-sponsored coverage
  2. Buy an individual market plan through:
     - Individual market exchange
     - Off-exchange market
  3. Go uninsured (will pay penalty unless they qualify for an individual exemption)

Information provided by Anthem Blue Cross and Blue Shield 1/15/13
Subsidies for employers

- 25 or fewer employees + average wages less than $50,000
  - Available on the exchange only
  - Only for **first two years they offer coverage** though an exchange
  - Credit up to 50% of employer cost
  - Credits decrease on a sliding scale as group size and employee wages increase

Information provided by Anthem Blue Cross and Blue Shield 1/15/13
The big picture for small groups

Starting in 2014, employers with 2-50 employees can:

1. Offer a fully insured plan through either:
   - A SHOP exchange – Employer may be eligible for a temporary two-year tax credit to offset part of the employer premium contribution
   - The off-exchange market

2. Offer an ASO plan, if allowed by state law, where minimum coverage level requirements don’t exist

3. Stop offering coverage and let employees buy through the Individual market

Other options may exist, such as defined contribution, adjusting contribution levels by employee, etc.
The big picture for large groups

Starting in 2014, employers with 51 or more employees can:

- **Offer health insurance** – either fully insured or ASO – that meets the minimum coverage definition and is affordable
- **Offer some level of coverage** that does not meet minimum requirements and pay the employer penalty
- **Stop offering coverage**, let employees buy through the Individual market and pay the employer penalty

**Note:** The employer mandate does NOT:

- Require employers to contribute to the premium (though not doing so would likely make the plan not affordable, putting the employer at risk for penalties)
- Require employers to offer dependent coverage
Underwriting changes

For small group and individual markets:

- **Guaranteed issue**
- **No health status rating** (Also known as modified community rating)
- **3:1 age rating bands**

Information provided by Anthem Blue Cross and Blue Shield 1/15/13
Exchange functions

- Consumer assistance
- Financial management
- Plan management
- Enrollment
- Eligibility

Information provided by Anthem Blue Cross and Blue Shield 1/15/13
Exchanges

Exchange plan product requirements

- **Platinum**
  - 90% actuarial value
  - All will include Essential Health Benefits

- **Gold**
  - 80% actuarial value

- **Silver**
  - 70% actuarial value

- **Bronze**
  - 60% actuarial value

Plus catastrophic plan offering for individuals younger than 30 or facing financial hardship
The bottom line

**Exchanges won’t replace the private health insurance market.**

They’re simply another channel for qualified individuals and groups to obtain coverage.
**Private Exchange:**
The consumer experience

- Employer funds employee’s defined contribution account.
- Employee uses funds to purchase benefits online or via call center.
- Employee purchases products/services that align with his/her family’s needs.
- Generates tailored list of recommendations.

Information provided by Anthem Blue Cross and Blue Shield 1/15/13.

Findley Davies
consultants in human resources
Will Employers Drop Their Health Plans?

- June 2011 McKinsey survey found “30% of employers will definitely or probably stop offering employer-sponsored insurance after 2014”
- July 2012 Deloitte survey of 560 employers found:
  - Only 9% of employers representing 3% of the workforce said they were likely to drop coverage within the next 3 years
  - Only 1% of employers with 1,000-2,499 employees were likely to drop vs. 13% of employers with 50-150 employees
Will Employers Drop Their Health Plans?

• September 2012 Towers Watson survey of 440 midsize to large firms found:
  – 88% do not plan on dropping health coverage in the future
• October 2012 MBGH survey of 111 employers found only 9% planning to drop coverage and participate in an exchange
• November 2012 IFEBP survey of 593 employers found 84% are very likely or definitely will continue to provide employer-sponsored coverage to FTEs in 2014
Will Employers Drop Their Health Plans

- December 2012 Mercer Survey of 2,809 employers found:
  - Only 7% of employers > 500 employees were likely to drop their plans compared to 22% of those firms with less than 500 employees
Will Employers Drop Their Health Plans

  - There is no immediate or long term cost advantage for employers to eliminate group health benefits
  - It will cost employers more to “make employees whole” when shifting their benefits to an exchange than to continue existing group health plans
  - Should employers choose to eliminate group health benefits, employees will suffer a significant reduction in overall compensation when they assume the incremental cost of benefits
Based on what you know, how likely are employers with < 100 EEs to drop their benefits?

- Text a CODE to 22333
- Submit a CODE to http://www.govsite.com

80 - 100%: 285582
50 - 79%: 285584
20 - 49%: 285585
How likely are employers with > 1,000 employees to drop their health benefits?

- 80 - 100%: 285622
- 50 - 79%: 285623
- 20 - 49%: 285624

Poll: How likely are employers with > 500 EEs ...
What is the Impact of PPACA on Workforce Strategies?

- Walmart announced if part-time employees hired after 2/1/2012 fail to work 30 hours/week, they will lose their health benefits the following January 1st
  - FTEs who lose hours or go part-time will lose their spousal coverage immediately and their Life and Dental benefits in the following pay period
- 12/5/2012 Huffington Post: Darden Restaurants won’t bump full-time workers to part-time status after negative publicity
- For hospitals, consider the impact on staffing, patient care and patient satisfaction if nursing hours are reduced
Are you planning to reduce hours to avoid health benefit costs?

Text a **CODE** to **22333**

Submit a **CODE** to [http://healthcare.com](http://healthcare.com)

Poll: Are you planning to reduce hours to avoid health benefit costs?

- Yes: **285626**
- Have not fully developed our strategy: **285629**
- Have fully developed our strategy: **285628**
Looking Ahead

- Due to the Debt and Deficit, how long can the tax exemption on employer-provided health benefits survive? (National Center for Policy Analysis estimates the federal tax subsidies for those with employer-provided health benefits is $300 billion/year)
- What to do with the uninsured? CBO estimates that up to 30 million people will remain uninsured after the PPACA is fully implemented
Would the loss of the tax exemption on employer-provided health benefits make employers more likely to drop health coverage?

- Yes: 17% 285634
- Most likely yes: 285644
- Most likely no: 17% 285645

Poll: Would the loss of the tax exemption on employer-provided health benefits make employers more likely to drop health coverage?
Looking Ahead

• Will we have controlled health care costs or slowed down the rate of increase?
  – Consider Nixon’s Wage and Price Controls (1971) to DRG payments to hospitals (1983) to RBRVS payments to MDs (1989)
  – “None of these massive interventions worked to do what they promised—hold down the rise in health care costs. In some cases, they made conditions worse, but in every case they whip-sawed the entire health care sector back and forth and required enormous spending just to keep up and comply with all the new and changing regulations.” (Greg Scandlen)
Will a fully implemented PPACA succeed in holding down health care costs?

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Looking Ahead

• To what extent will voluntary, employee-paid benefits expand in the worksite?
  – CFO.com survey found 71% of finance executives would replace some employer-paid benefits with voluntary benefits; 69% indicated they expected to expand the range of voluntary benefits offered
Will employers trade employer-sponsored benefits for voluntary, employer benefits?

- Text a **CODE** to **22333**
- Submit a **CODE** to http

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<tr>
<td>Probably Not (1 - 25%)</td>
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Looking Ahead

• Expect continued consolidation of community hospitals into larger, regional health systems
  – Will the larger systems use their size to negotiate higher prices?

• Will we see the demise of fee-for-service medicine in favor of global payments?

• Some ACOs will evolve into risk-bearing entities to compete with regional and national carriers

• Emergence of Patient Centered Medical Homes
  – Employers will promote coordinated care with plan design incentives to use PCMHs
Looking Ahead

• Employers should assess the effectiveness of the health insurance exchange in Ohio, as well as the market acceptance and success of private exchanges
• This information will help determine the feasibility of adopting a defined contribution approach for 2016
Questions and Answers

• Thank you for your participation
• Please call us if we can be of assistance
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• Watch for details on our next webinar
• Refer to www.findleydavies.com for health care reform references