# SHRM MEETING
# 07 MARCH 2013

# “Health Reform Update”

# Presented By:

- Francis Santos, StayWell
- Eugene Roberts, NetCare
- Dave Torre, TakeCare
- Gina Ramos, Calvo's SelectCare
- Frank Campillo, Calvo's SelectCare

# Key Discussion Issues

1. Health Insurance Exchanges
2. Individual Mandate & Employer Mandate
3. Taxes / Medicaid Expansion
4. Employer Updates
5. Cost Trends / Cost Containment
6. Essential Health Benefits
7. Q&A

# Health insurance exchanges

# Health Insurance Exchanges - Background

- One of the most significant reforms contained within the Patient Protection and Affordable Care Act is the requirement that states create-or have the federal government create-health insurance exchanges.
- Exchanges are designed to help individuals and small business **shop for** and **purchase** health insurance, **access** premium and cost-sharing subsidies, and **facilitate** health plan competition based on price and quality.
- Initially Exchanges will serve primarily **individuals** purchasing insurance on their own and **smaller employers**; states will have the option of opening Exchanges to larger employers a few years after implementation.

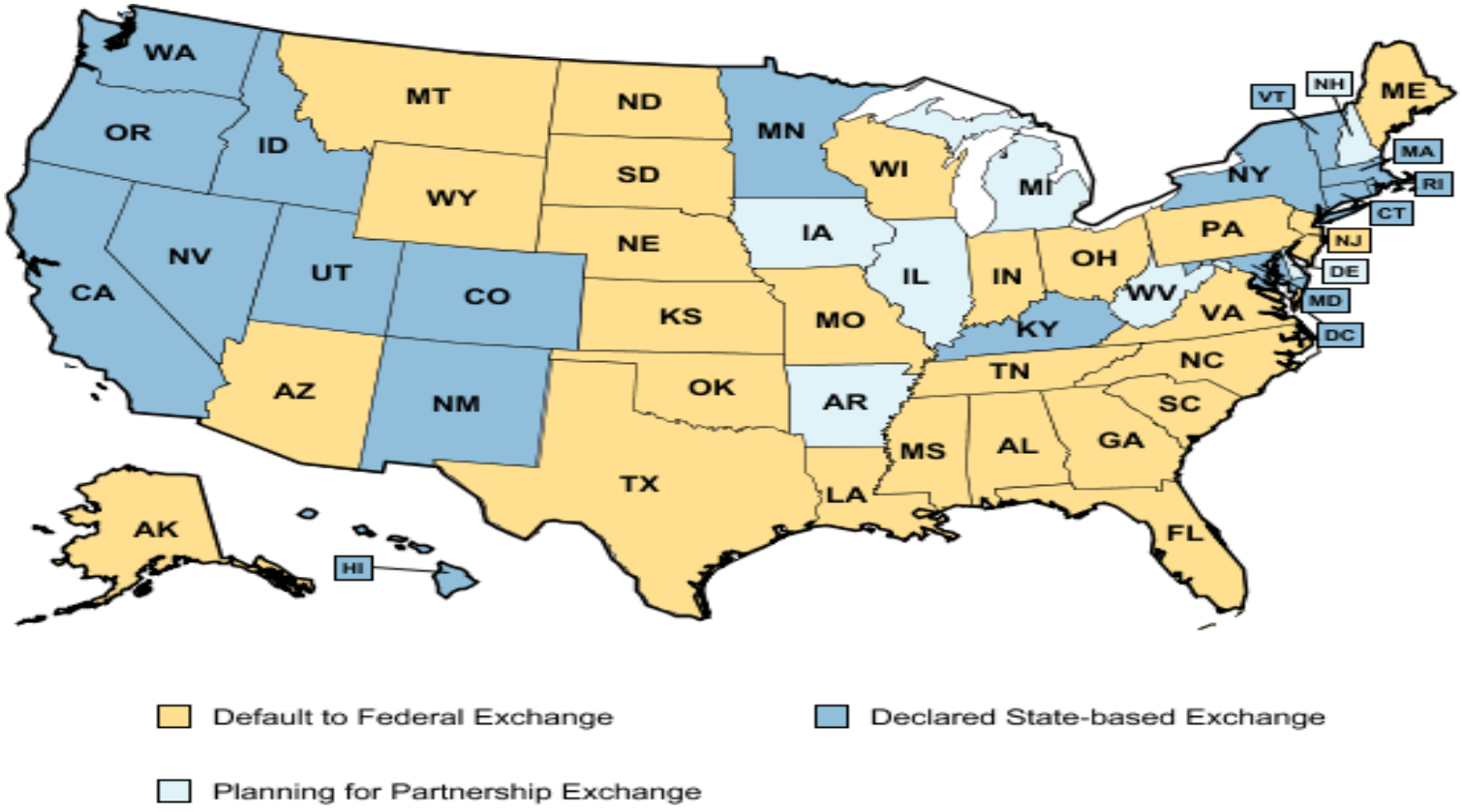
# Health Insurance exchanges - Background

- General overview
  - Starting in 2014, federally supervised, but state-operated, **marketplaces** where health insurance policies that are being offered must meet specific eligibility and benefits requirements.
  - Basically, Health insurance exchanges are **web-based** health insurance "**supermarkets**" that will help individuals and small groups use new federal tax subsidies to buy high-quality, standardized packages of health coverage.
  - Each state must establish at least one exchange (federal government will operate one if a state chooses not to establish its own)
  - **U.S. TERRITORIES** – If U.S. Territory chooses not to establish an exchange then default option is Medicaid Expansion *(Sec'y Sebeleius Letter to Governors dated 10 December 2012)*
- 4 different actuarial value coverage tiers of benefit packages will be available – *Bronze (60%), Silver (70%), Gold (80%), Platinum (90%)*
- Coverage subject to modified community rating (guaranteed issue with no individual medical underwriting)
  - Rates can vary **only based on (1) individual or family coverage; (2) geographic area; (3) tobacco use (but only within 1.5:1 ratio band); and (4) age (but only within 3:1 ratio band for adults)**

# Health Insurance Exchanges – Basic Services

An Exchange performs five basic services:

1. **Certifying** health plans as meeting federal (and in some cases, State) standards for an "essential health benefits package;
2. **Offering** these certified plans for purchase to qualified individuals and qualified employers (generally, individuals who cannot purchase affordable insurance through an employer) and small businesses employing 100 or fewer workers;
3. Providing **assistance** to the purchaser in evaluating and enrolling in a plan;
4. Facilitating **application** for federal premium assistance tax credits and cost-sharing reductions for eligible individuals and small businesses
5. Providing a **single, streamlined access point** for eligibility determination and enrollment of individuals in health coverage subsidy programs, including Medicaid, CHIP, or a plan subsidized through the exchange




State Decisions For Creating Health Insurance Exchanges, as of February 15, 2013: Exchange Decision

THE HENRY J. KAISER FAMILY FOUNDATION statehealthfacts.org
Your source for state health data

**18** Declared State-based Exchange
**7** Planning for Partnership Exchange
**26** Default to Federal Exchange

# Health Insurance Exchanges – Two models

- Exchanges are not new.
- Two states have garnered national attention for illustrating different approaches states may take to establishing and maintaining an exchange.
- **Utah** Exchange – "Open Market Model"
- **Massachusetts** Exchange – "Active Purchaser Model"

# Health Insurance Exchanges – How about Guam?

*"If a territory does not elect to establish an Exchange, the funding allocation for the territory's Medicaid program will be increased to the amount allocated to the territory under section 1323 in the form of federal Medicaid matching funds during the time period between 2014 and 2019.*

Kathleen Sebelius

Sec' y of Health and Human Services

10 December 2012

# Individual Mandate

# Individual Mandate – Internal Revenue Code

**CHAPTER 48—MAINTENANCE OF MINIMUM ESSENTIAL COVERAGE**

Sec. 5000A. Requirement to maintain minimum essential coverage.

**§ 5000A. Requirement to maintain minimum essential coverage**

**(a) Requirement to maintain minimum essential coverage**

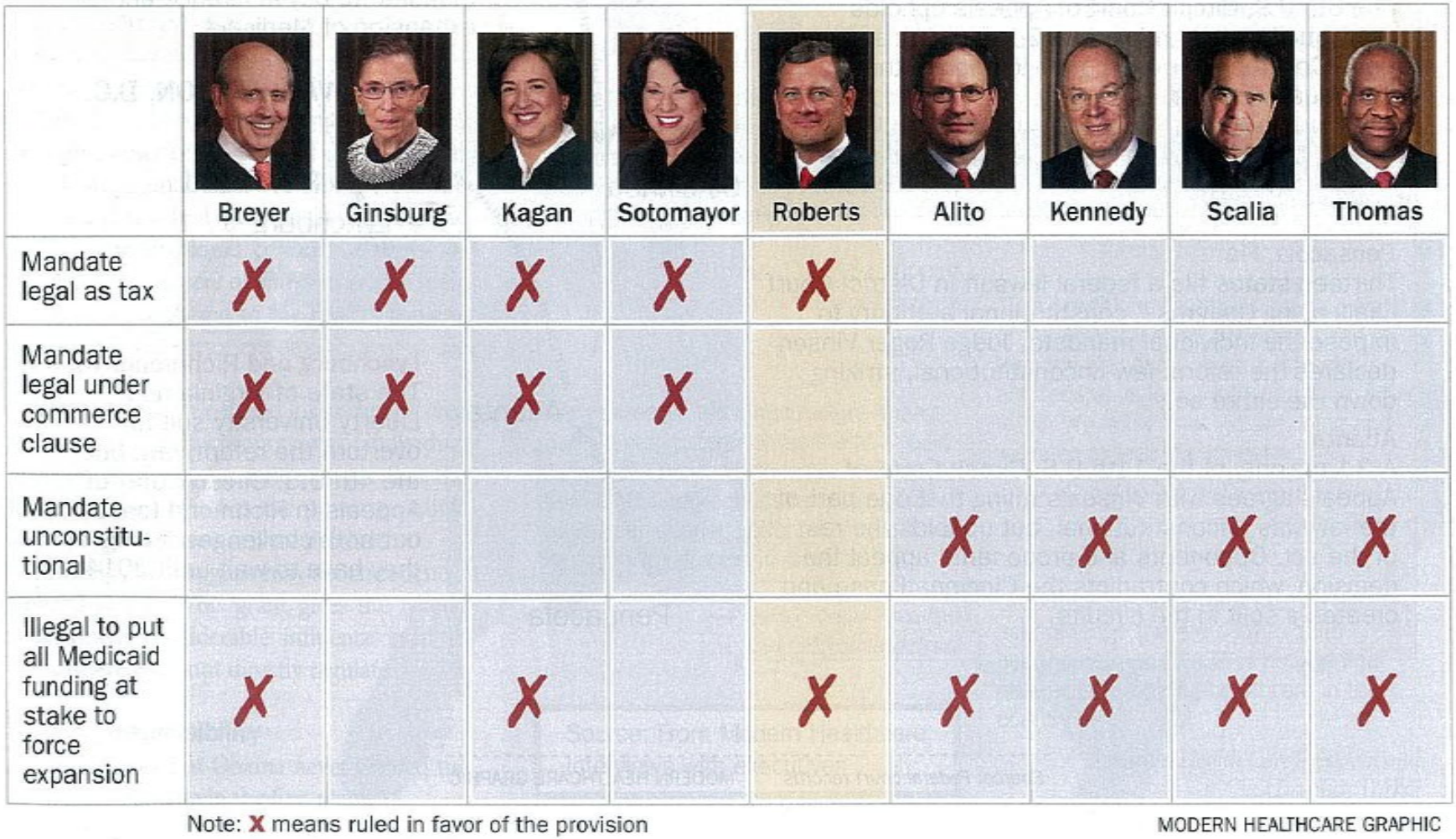
An applicable individual shall for each month beginning after 2013 ensure that the individual, and any dependent of the individual who is an applicable individual, is covered under minimum essential coverage for such month.

# Individual Mandate – Background

- The keystone of PPACA is an unprecedented **individual mandate** tax requiring virtually all U.S. citizens and legal residents to either have health insurance or pay a tax for not doing so beginning in 2014.

- Responding to the lawsuit by the National Federation of Independent Business (NFIB) and 26 states, the Supreme court refashioned the mandate and penalty into a choice between two options: **buy insurance** or **pay a tax for failing to do so.**

# How The Supreme Court Ruled on PPACA Key Provisions



| | Breyer | Ginsburg | Kagan | Sotomayor | Roberts | Alito | Kennedy | Scalia | Thomas |
|---|---|---|---|---|---|---|---|---|---|
| Mandate legal as tax | X | X | X | X | X | | | | |
| Mandate legal under commerce clause | X | X | X | X | | | | | |
| Mandate unconstitutional | | | | | | X | X | X | X |
| Illegal to put all Medicaid funding at stake to force expansion | X | | X | | X | X | X | X | X |

Note: X means ruled in favor of the provision

MODERN HEALTHCARE GRAPHIC

# Individual Mandate – Background

- Beginning in **2014**, PPACA requires most U.S. citizens and legal residents to have **"qualifying"** health insurance coverage (public or private) or pay a tax for not carrying insurance.
- **"Insurance"** must meet PPACA's definitions.
- The individual mandate tax rests on a **legal** definition of insurance and PPACA's definitions differ across markets.
- Government programs like Medicare, Medicaid, and CHIP automatically qualify, as do self-insured ERISA policies (mostly for larger employers).
- Small group and individual policies (except for grandfathered plans) must cover services comprising an **"essential health benefits" (EHB)** package.

# Individual Mandate – Minimum Essential Coverage

Minimum Essential Coverage includes:

- **Government-sponsored** programs including: Medicare, Medicaid, Children's Health Insurance Program coverage (CHIP), TRICARE, coverage through Veteran's Affairs, and Health Care for Peace Corps volunteers;
- **Employer-sponsored** plans including governmental plans, grandfathered plans and other plans offered in the small or large group market;
- **Individual** market plans, including grandfathered plans; or
- Other coverage designated as minimum essential coverage by HHS and/or the Dept. of the Treasury

# Individual Mandate – Taxes

- Individual Mandate Taxes (penalties) begin in 2014 and rise in years following.
- In each year, the tax consists of the ***higher*** of a dollar amount or a percentage of household income.
- For a given household, the tax applies to each individual, up to a maximum of three.
- Following is a schedule of taxes:
  - **2014**: Higher of **$95**/person (up to 3 people = $285) OR 1.0% of taxable income
  - **2015**: Higher of **$325**/person (up to 3 people = $975) OR 2.0% of taxable income
  - **2016**: Higher of **$695**/person (up to 3 people = $2,085) OR 2.5% of taxable income
  - **After 2016**: Same as 2016, but adjusted annually for cost-of-living expenses

# Individual Mandate – How About Guam?

TITLE 26—INTERNAL REVENUE CODE **§ 5000A**

**(4) Individuals residing outside United States or residents of territories**

Any applicable individual shall be treated as having minimum essential coverage for any month—

(A) if such month occurs during any period described in subparagraph (A) or (B) of section 911(d)(1) which is applicable to the individual, or

(B) if such individual is a bona fide resident of any possession of the United States (as determined under section 937(a)) for such month.

# Individual Mandate – How About Guam?

*"The minimum coverage provision of section 5000A of the federal code, however, provides an explicit exemption for residents of the territories by operation of section 5000A(f)(4)(B). It is our understanding that the territories with mirror codes generally are not obligated to mirror federal Code provisions that explicitly address treatment of residents of the territories."*

Ms. Kathleen Sebelius

Sec' y of Health and Human Services

10 December 2012

# Employer Mandate

# Employer Mandate - Background

- Beginning in 2014, the PPACA will impose large financial penalties on certain employers who do not provide health insurance coverage and, in some cases, on employers who do provide coverage.

- Under Internal Revenue Code (IRC) Section 4980H, an "applicable large employer" is subject to a penalty if either:

  1) The employer **fails to offer** its full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan, and any full-time **employee is certified to receive** a federal premium tax credit or cost-sharing reduction, OR

  2) The employer **offers** its full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage, and one or more full-time **employees is certified to receive a federal premium tax credit or cost-sharing reduction** (generally because the employer's coverage either is not "affordable" or does not provide "minimum value").

# Employer Mandate – Which Businesses Face Potential Penalties?

The penalty only applies to a business ("an applicable large employer") that meets **two conditions**:

1) A business with an average of **50** or more full-time employees (FTs) or full-time equivalents (FTEs) during the preceding year.

   An FT is one working **120** or more hours per month (at least 30 hours of service per week). Each 120 hours per month of part-time labor counts as an FTE.

AND

2) If one or more of its employees receive premium credits (government subsidies) to help purchase health insurance in the exchange. If no employees receive subsidies, the business owes no penalty.

# Employer Mandate – How Much are the Penalties?

- If an "applicable large employer" does ***not*** provide insurance ***and*** if at least one employee receives federal insurance subsidies in the exchange, the business will pay **$2,000** per employee (minus the first 30).

  **Example:** A business with 50 employees, two of whom are subsidized, would pay **(50 – 30) x $2,000 = $40,000**

- If an "applicable large employer" ***does*** provide insurance, ***and*** if at least one employee receives insurance subsidies, the business will pay **$3,000** per *subsidized* employee OR **$2,000** per employee (minus the first 30 = $40,000) whichever is less.

  **Example:** A business with 50 employees and with two subsidized employees would be fined **$6,000**. With 14 or more subsidized employees (above the tipping point of the formula, the penalty for a 50-employee firm would be $40,000).

Page 1 :: Page 2

**Beginning in 2014, the Patient Protection and Affordable Care Act (PPACA) imposes an employer mandate penalty on certain employers who do not provide health insurance coverage and, in some cases, on employers who do provide coverage. This sheet explains the calculations.**

CribSheet 12 7 7/13/12

**Observations from nine scenarios:** The table below shows employment data for nine hypothetical businesses.

| Scenarios | #1 | #2 | #3 | #4 | #5 | #6 | #7 | #8 | #9 |
|---|---|---|---|---|---|---|---|---|---|
| Total number of employees | 49 | 50 | 50 | 50 | 51 | 51 | 52 | 51 | 31 |
| Number of unsubsidized employees | 48 | 50 | 49 | 48 | 50 | 26 | 27 | 25 | 6 |
| Number of subsidized employees | 1 | 0 | 1 | 2 | 1 | 25 | 25 | 26 | 25 |
| Number of full-time equivalents (part-time hours in a month divided by 120) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 20 |
| Penalty for a business that DOES provide health insurance | $0 | $0 | $3,000 | $6,000 | $3,000 | $42,000 | $44,000 | $42,000 | $2,000 |
| Penalty for a business that DOES NOT provide health insurance | $0 | $0 | $40,000 | $40,000 | $42,000 | $42,000 | $44,000 | $42,000 | $2,000 |

**#1:** Unless the business has 50 or more full-time employees or FTEs, there are no penalties. ($0 with 49 employees, 1 of whom is subsidized)

**#2:** Unless the business has at least 1 subsidized employee, there are no penalties. ($0 with 50 employees, none of whom are subsidized)

**#3 vs. #5:** The mandate penalizes a non-providing firm $2,000 for creating an additional job. ($40K→$42K)

**#3 vs. #4:** The mandate DOES NOT penalize a non-providing firm for having more subsidized employees . ($40K in both cases)

**#3 vs. #4:** The mandate penalizes a providing firm with few subsidized employees $3,000 for each additional subsidized employee. ($3K→$6K)

**#3 vs. #5:** The mandate DOES NOT penalize a providing firm with few subsidized employees for creating an additional job – as long as the new employee is not subsidized. ($3K in both cases)

**#6 vs. #7 vs. #8:** A providing firm with many subsidized employees pays the same penalty as a non-providing firm of the same size.

**#6 vs. #7:** For a providing firm with many subsidized employees, the mandate penalizes the firm $2,000 for creating an additional job. ($42K→$44K)

**#6 vs. #8:** For a providing firm with many subsidized employees, the employer mandate DOES NOT penalize the firm for having more subsidized employees. ($42K in both cases)

**#6 vs. #9:** A firm can reduce its penalties tremendously by replacing full-time employees with part-timers. ($44K vs. $2K)

PPACA: Employer Mandate Penalty Calculations



1201 F St NW, Suite 200, Washington, DC 20004 = _____ = _____

# Employer Mandate – What Determines Whether An Employee Qualifies For Subsidies?

To qualify for subsidies, an employee must meet **two** criteria:

1. His or her household income must be less than **400%** of the **federal poverty level** ($89,400 for a family of four in 2011)

2. The employee's portion of the health insurance premium must exceed **9.5%** of household income

# Employer Mandate – How About Guam?

*"Furthermore, it appears that the employer responsibility provision of section 4980H of the federal Code* ***would not apply*** *in a territory with a mirror code because it is categorized as an excise tax in the federal Code. It is our understanding that the territories with mirror codes generally are not obligated to mirror excise tax provisions. Each territory with a mirror code, however, must undertake its own analysis of whether these sections of the federal Code would be mirrored in the territory's own tax code."*

Ms. Kathleen Sebelius

Sec' y of Health and Human Services

10 December 2012

# Taxes
# Premium Credit Assistance
# Medicaid Expansion

| | 2011 |
|---|---|
| FSA, HRA, HSA | Prohibits individuals from using Flexible Savings Accounts, Health Reimbursement accounts and Health Savings accounts to purchase over-the-counter drugs |
| Non-Qualified Withdrawal Penalty | Increased penalty from 10% to 20% for non-qualified withdrawals from Health Savings Accounts and Archer Medical Savings accounts. |
| Pharmaceuticals | Levies a new annual tax $2.5 billion in 2011 on branch name pharmaceutical companies and pharmaceutical importers based on the company's market share of sales |
| Indoor Tanning Services | 10% excise tax for indoor tanning services except for phototherapy provided by a licensed medical professional on his premises |
| Employers | Employers must report the value of employee's health benefits on their W-2 tax form, effective for tax years starting after 12/31/10 |
| Employer Filing | Employers that pays more than $600 during any year to corporate and non-corporate providers file a report to the IRS similar to the W-2 |
| Small business health tax credit | Creates tax credits for small business with 1 – 24 full time equivalent employees (FTE). Employer pays 50% of health insurance premium for each single (not family) employee. The employees have an average salary of less than $50,000 per year. Maximum 35 % tax credit from 2010-through 2013 |

| | 2013 |
|---|---|
| Additional Medicare Tax | There is a 0.9% additional Medicare tax in addition to the existing 1.45% that applies to earned income that exceeds the threshold amount of $200,000 for single filers and head of household filers, $250,000 for married taxpayers filing jointly, $125,000 for married taxpayers filing separately. Employers are responsible for withholding additional Medicare Tax for wages to each employee paid in excess of $200,000. |
| New Medicare Tax | A 3.8% new Medicare tax on unearned income such as interest, dividends, rents, royalties and certain capital gains. The tax applies to the lesser of (1) net investment income or (2) modified adjusted gross income above $200,000 for individuals and heads of household, $250,000 for joint filers and $125,000 for married filing separately. |
| Medical Devise Excise Tax | A new tax of 2.3% medical devise excise tax must be paid by manufacturers and importers on sales of certain medical devises. |
| Comparative Effectiveness Research Assessment | $1 assessment per covered life assessed on issuers of health insurance plans and self-funded plans |
| $500,000 tax deductible limit | For corporate tax filing purpose each health insurer is limited to $500,000 remuneration per each highly paid individual. The impact is less deduction on the tax of health insurers. |

| | 2014 |
|---|---|
| Annual Fee on Insurers | $8 Billion starting 2014 increasing to $14.3 billion in 2018, indexed to premium growth thereafter. Distribution of fees is based on prior year net written premium. The fee excludes the first $25 million and one half of the second $25 million. The fee applies to all premiums in excess of $50 million based on the net premiums written for health insurance to total applicable net premiums written for all such entities. |
| Comparative Effectiveness Research Assessment | $2 assessment per covered life in 2014 – 2019 applied on issuer of health insurance plan and self-funded issuer. The assessment ends in 2019. |
| Health Insurance Premium Tax Credit | If Guam shall establish an Insurance Market (Exchange), individuals and families are eligible for new premium tax credits. The credit starts from 133 up to 400 of Federal Poverty Level (PFL) The household income level for a family of 4 eligible for premium tax credit at 133% FPL is $30,657 and at 400 FPL is $92,200. The computation for tax credit amount is found in 26 CFR Parts 1 and 602, §1.36B-3. The estimated burden for GovGuam for one year tax premium tax credit is $74 million. Under current tax structure, there is no money to fund this $74 million. |
| Cadillac Tax | This is an excise tax on high value plans called Cadillac plans. The tax is 40% of costs of benefits above the threshold beginning in 2018. The tax is on various health plans but collected and payable by the health insurance issuer. |

# Premium and Assistance Credit Amount

26 CFR Parts 1 and 602, § 1,36B-3 Computing the premium and assistance credit amount.

(g) *Applicable percentage*—(1) *In general*. The **applicable percentage** multiplied by **a taxpayer's household income** determines the taxpayer's required share of premiums for the benchmark plan. This **required share** is subtracted from the adjusted monthly premium for the applicable benchmark plan when computing the **premium assistance amount**. The applicable percentage is computed by first determining the percentage that the taxpayer's household income bears to the Federal poverty line for the taxpayer's family size. The resulting Federal poverty line percentage is then compared to the income categories described in the table in paragraph (g)(2) of this section (or successor tables). An applicable percentage within an income category increases on a sliding scale in a linear manner and is rounded to the nearest one-hundredth of one percent. The applicable percentages in the table may be adjusted in published guidance, see § 601.601(d)(2) of this chapter, for taxable years beginning after December 31, 2014, to reflect rates of premium growth relative to growth in income and, for taxable years beginning after December 31, 2018, to reflect rates of premium growth relative to growth in the consumer price index.

# Premium and Assistance Credit Amount

| Household income % of Federal Poverty Line | Initial Percentage | Final Percentage |
|---|---|---|
| Less than 133% | 2.0% | 2.0% |
| At least 133% but < 150% | 3.0% | 4.0% |
| At least 150% but < 200% | 4.0% | 6.3% |
| At least 200% but < 250% | 6.3% | 8.05% |
| At least 250% but < 300% | 8.05% | 9.5% |
| At least 300% but < 400% | 9.5% | 9.5% |

Guam Household Income & Advance Premium Tax Credit Estimate

| | Medicaid, MIP 133% FPL | APTC 175% FPL | APTC 200% FPL | APTC 250% FPL | APTC 300% FPL | APTC 400% FPL | APTC Estimated |
|---|---|---|---|---|---|---|---|
| Family size 1 | $14,484 | $19,058 | $21,780 | $27,225 | $32,670 | $43,560 | |
| Family size 4 | $29,726 | $39,113 | $44,700 | $55,875 | $67,050 | $89,400 | |
| | | | | | | | |
| Guam Household Income per group (assume Family of 4) | | | | | | | |
| Percentage limitation premium contribution per group | 2.0% | 4.0% | 6.3% | 8.05% | 9.5% | 9.5% | |
| Dollar contribution per group | $595 | $1,565 | $2,816 | $4,498 | $6,370 | $8,493 | |
| Dollar Average annual premium @ $2,483 x 4 persons | $9,932 | $9,932 | $9,932 | $9,932 | $9,932 | $9,932 | |
| Dollar subsidy per group | $9,337 | $8,367 | $7,116 | $5,434 | $3,562 | $1,439 | |
| Est number of household per group (assume 4 persons) | 11,094 | 3,631 | 1,929 | 2,988 | 2,649 | 3,366 | |
| Estimated subsidy, Medicaid, MIP | $103,590,003 | $30,382,320 | $13,726,571 | $16,236,979 | $9,436,400 | $4,843,674 | $74,625,944 |
| (FY2011 Expenditures of $52,500,000) | | | | | | | |

| | Population |
|---|---|
| 2010 Number of persons per DOL BLS data | 119,720 |
| Estimated 4 persons per household | |
| Government of Guam Insured | 15,333 |
| Large group Insured | 28,389 |
| Individual and Small group Insured | 29,609 |
| Estimated population Insured | 73,331 |
| Medicaid program & SCHIP | 35,357 |
| Medical Indigent Program | 14,650 |
| Total Medicaid & MIP | 50,007 |
| Total Insured & Social programs | 123,338 |

# 2012 Annual Federal Poverty Guidelines

**48 Contiguous States and DC**

| Household size | 100% | 133% | 150% | 200% | 300% | 400% |
|---|---|---|---|---|---|---|
| 1 | $11,170 | $14,856 | $16,755 | $22,340 | $33,510 | $44,680 |
| 2 | 15,130 | 20,123 | 22,695 | 30,260 | 45,390 | 60,520 |
| 3 | 19,090 | 25,390 | 28,635 | 38,180 | 57,270 | 76,360 |
| 4 | 23,050 | 30,657 | 34,575 | 46,100 | 69,150 | 92,200 |
| 5 | 27,010 | 35,923 | 40,515 | 54,020 | 81,030 | 108,040 |
| 6 | 30,970 | 41,190 | 46,455 | 61,940 | 92,910 | 123,880 |
| 7 | 34,930 | 46,457 | 52,395 | 69,860 | 104,790 | 139,720 |
| 8 | 38,890 | 51,724 | 58,335 | 77,780 | 116,670 | 155,560 |
| For each additional person, add | $3,960 | $5,267 | $5,940 | $7,920 | $11,880 | $15,840 |

Source: Calculations by Families USA based on data from the U.S. HHS

# 2012 Annual Federal Poverty Guidelines

**Alaska**

| Household size | 100% | 133% | 150% | 200% | 300% | 400% |
|---|---|---|---|---|---|---|
| 1 | $13,970 | $18,580 | $20,955 | $27,940 | $41,910 | $55,880 |
| 2 | 18,920 | 25,164 | 28,380 | 37,840 | 56,760 | 75,680 |
| 3 | 23,870 | 31,747 | 35,805 | 47,740 | 71,610 | 95,480 |
| 4 | 28,820 | 38,331 | 43,230 | 57,640 | 86,460 | 115,280 |
| 5 | 33,770 | 44,914 | 50,655 | 67,540 | 101,310 | 135,080 |
| 6 | 38,720 | 51,498 | 58,080 | 77,440 | 116,160 | 154,880 |
| 7 | 43,670 | 58,081 | 65,505 | 87,340 | 131,010 | 174,680 |
| 8 | 48,620 | 64,665 | 72,930 | 97,240 | 145,860 | 194,480 |
| For each additional person, add | $4,950 | $6,584 | $7,425 | $9,900 | $14,850 | $19,800 |

Source: Calculations by Families USA based on data from the U.S. HHS

# 2012 Annual Federal Poverty Guidelines

**Hawaii**

| Household size | 100% | 133% | 150% | 200% | 300% | 400% |
|---|---|---|---|---|---|---|
| 1 | $12,860 | $17,104 | $19,290 | $25,720 | $38,580 | $51,440 |
| 2 | 17,410 | 23,155 | 26,115 | 34,820 | 52,230 | 69,640 |
| 3 | 21,960 | 29,207 | 32,940 | 43,920 | 65,880 | 87,840 |
| 4 | 26,510 | 35,258 | 39,765 | 53,020 | 79,530 | 106,040 |
| 5 | 31,060 | 41,310 | 46,590 | 62,120 | 93,180 | 124,240 |
| 6 | 35,610 | 47,361 | 53,415 | 71,220 | 106,830 | 142,440 |
| 7 | 40,160 | 53,413 | 60,240 | 80,320 | 120,480 | 160,640 |
| 8 | 44,710 | 59,464 | 67,065 | 89,420 | 134,130 | 178,840 |
| For each additional person, add | $4,550 | $6,052 | $6,825 | $9,100 | $13,650 | $18,200 |

Source: Calculations by Families USA based on data from the U.S. HHS

# EMPLOYER UPDATES

# Employer Updates – Past 12 Months

Looking Back To 2012 – Creating Administrative Standards

Insurers are required to standardize documents and implement new reporting requirements

- Encouraging integrated health systems
- Summary of Benefits and Coverage
  - 60 day advance notice of mid-year material modifications to SBC content
- Quality care reporting
- Reducing paperwork and administrative costs
- Patient-Centered outcome research fee
- Form W-2 reporting for health coverage
  - Not required for employers who filed fewer than 250 W-2's for the preceding calendar year
- Coverage for additional women's preventive care services (FDA approved contraceptive methods, sterilization procedures, domestic violence screening

# Summary of Benefits and Coverage

## Insurance Company 1: Plan Option 1

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage Period: 01/01/2013 – 12/31/2013**

**Coverage for:** Individual + Spouse | **Plan Type:** PPO

**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.[insert] or by calling 1-800-[insert].

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| What is the overall deductible? | **$500** person / **$1,000** family<br>Doesn't apply to preventive care | You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**. |
| Are there other deductibles for specific services? | Yes. **$300** for prescription drug coverage. There are no other specific **deductibles**. | You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services. |
| Is there an out–of–pocket limit on my expenses? | Yes. For participating providers **$2,500** person / **$5,000** family<br>For non-participating providers **$4,000** person / **$8,000** family | The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses. |
| What is not included in the out–of–pocket limit? | Premiums, balance-billed charges, and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the **out-of-pocket limit**. |
| Is there an overall annual limit on what the plan pays? | No. | The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits. |
| Does this plan use a network of providers? | Yes. See **www.[insert].com or call 1-800-[insert]** for a list of participating providers. | If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**. |
| Do I need a referral to see a specialist? | No. You don't need a referral to see a specialist. | You can see the **specialist** you choose without permission from this plan. |
| Are there services this plan doesn't cover? | Yes. | Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about **excluded services**. |

**Questions:** Call 1-800-[insert] or visit us at www.[insert].
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.[insert] or call 1-800-[insert] to request a copy.

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146

Corrected on May 11, 2012

# Employer Updates – 2013 Final Preparations

Focus on the final preparations for the new state health insurance exchanges.

- Annual dollar limit on Essential Health Benefits cannot be lower than $2M
- Flexible Spending Account limits - $2,500 per plan year health FSA contribution cap (plan years on or after January 1, 2013)
- Threshold for claiming itemized medical expense deductions increased to 10% of income from current 7.5%
- Higher Medicare payroll tax on wages exceeding $200,000/individual; $250,000couples
- 2.3% Excise tax on medical devices begin

# Employer Updates – 2013 Final Preparations

Focus on the final preparations for the new state health insurance exchanges.

- Employer notify employees about exchanges
  - Health Insurance Exchanges may or may not apply to Guam
- Change in Medicare retiree drug subsidy tax treatment takes effect
- Health Insurance Exchanges initial open enrollment period
  - Health Insurance Exchanges may or may not apply to Guam

# Employer Updates – 2014 Key Reform Provisions Take Effect

PPACA comes to a crescendo in 2014. Many key changes will be implemented

- Health insurance exchange coverage
  - Health insurance exchanges may or may not apply to Guam
- Individual and Employer mandates
- Financial assistance for exchange coverage of lower-income individuals
- Medicaid expansion
- Employer shared responsibility

# Employer Updates – 2014 Key Reform Provisions Take Effect

PPACA comes to a crescendo in 2014. Many key changes will be implemented

- No annual dollar limits on essential health benefits
- No pre-existing condition limits
- No waiting period over 90 days
- Guaranteed issue, renewability and rating variations
- Auto enrollment
- Coverage of routine medical costs of clinical trial participants
- Small market, non-grandfathered insured plans must cover essential health benefits with limited deductibles ($2,000 Individual, $4,000 Family)

# Employer Updates – Overview to 2020

2015

- Establishes an independent payment advisory board aimed at extending the solvency of Medicare
- Paying physicians based on value and not volume. A new provision will tie physician payments to the quality of care they provide

2016

- Health claim attachment standards for electronic transmission of health related documents
- Encounter, enrollment, disenrollment, premium payment and referral certification standards

2018

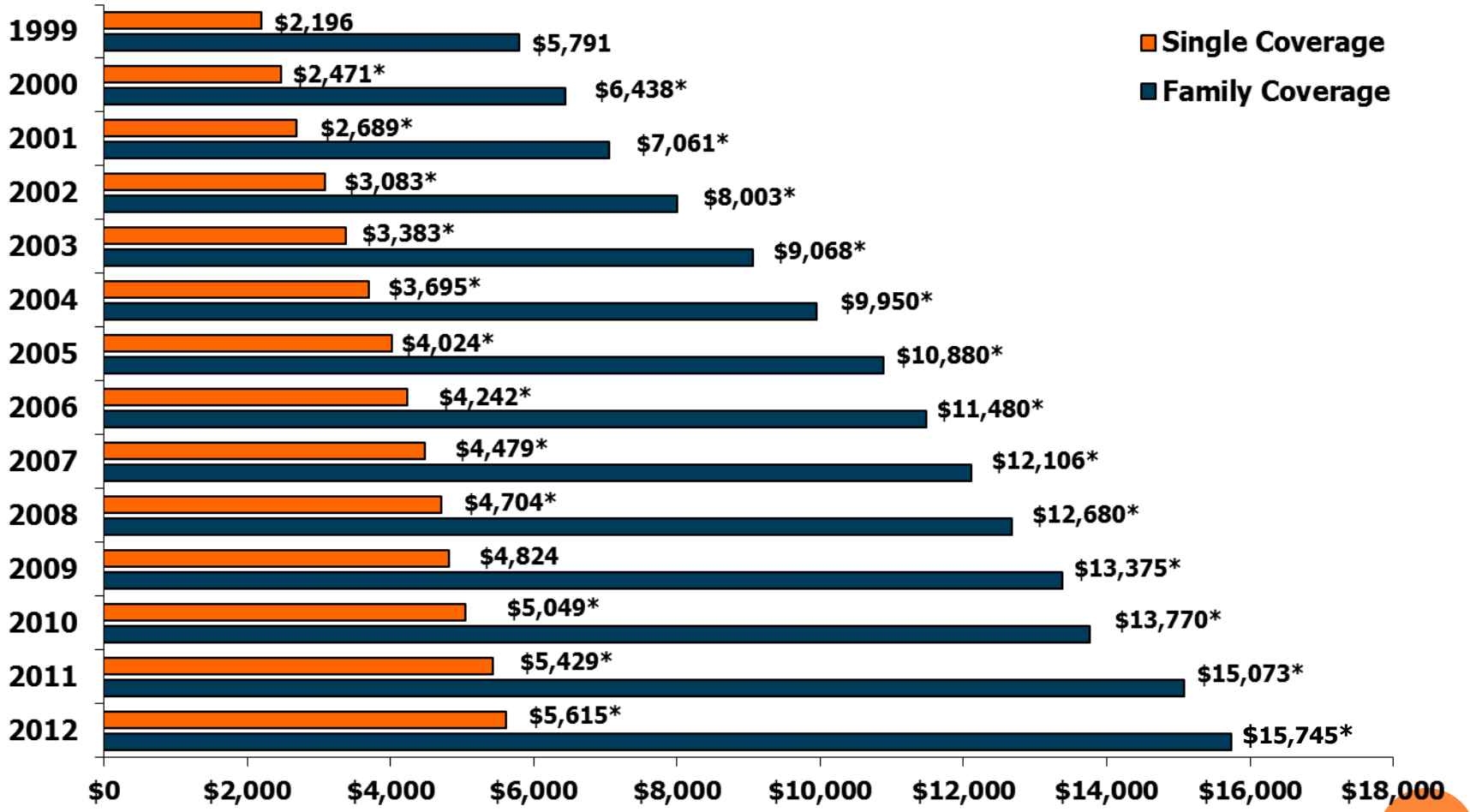
- Cadillac excise tax on plans with rich benefits

2020

- Donut hole coverage gap in Medicare prescription drug benefit is fully phased out. Seniors will continue to pay the standard 25% of their drug costs until they reach the threshold for Medicare catastrophic coverage

# Cost and Trends

# Average Annual Premiums for Single and Family Coverage (1999-2012)




* Estimate is statistically different from estimate for the previous year shown (p<.05).

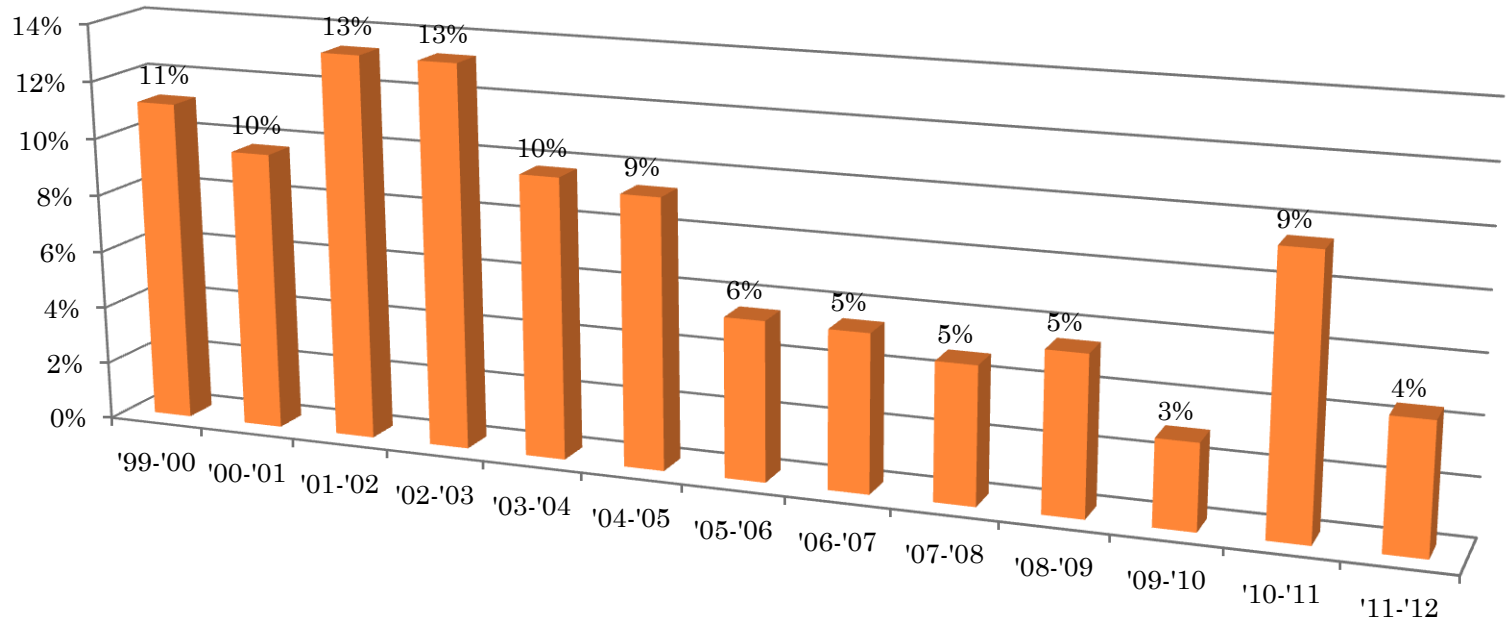
Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2012.

THE HENRY J. KAISER FAMILY FOUNDATION -AND- HRET HEALTH RESEARCH & EDUCATIONAL TRUST

# Cost to Employers Group Health Care Plans

- Trend: Group Health Care cost has been increasing, even before ACA – approx. 9% in 2011 and 4% in 2012

- In 2012, companies and their employees saw one of the lowest health care premium rate increases in six years



# Employer Costs & Cost Drivers associated to PPACA

- Unavoidable Costs
  - Employee communication
  - Plan Modifications
  - Changes to administrative and payroll systems

- Cost Drivers for 2013-2014
  - 90 day limit on waiting periods
  - Employer Mandate
  - No Preexisting Conditions Exclusion
  - No annual limits
  - Guaranteed Issue
  - Limits on Small Group Deductibles
  - Annual Out-of-pocket Maximums Limit
  - Essential Health Benefits

# Cost Projections for Guam in 2013-2014

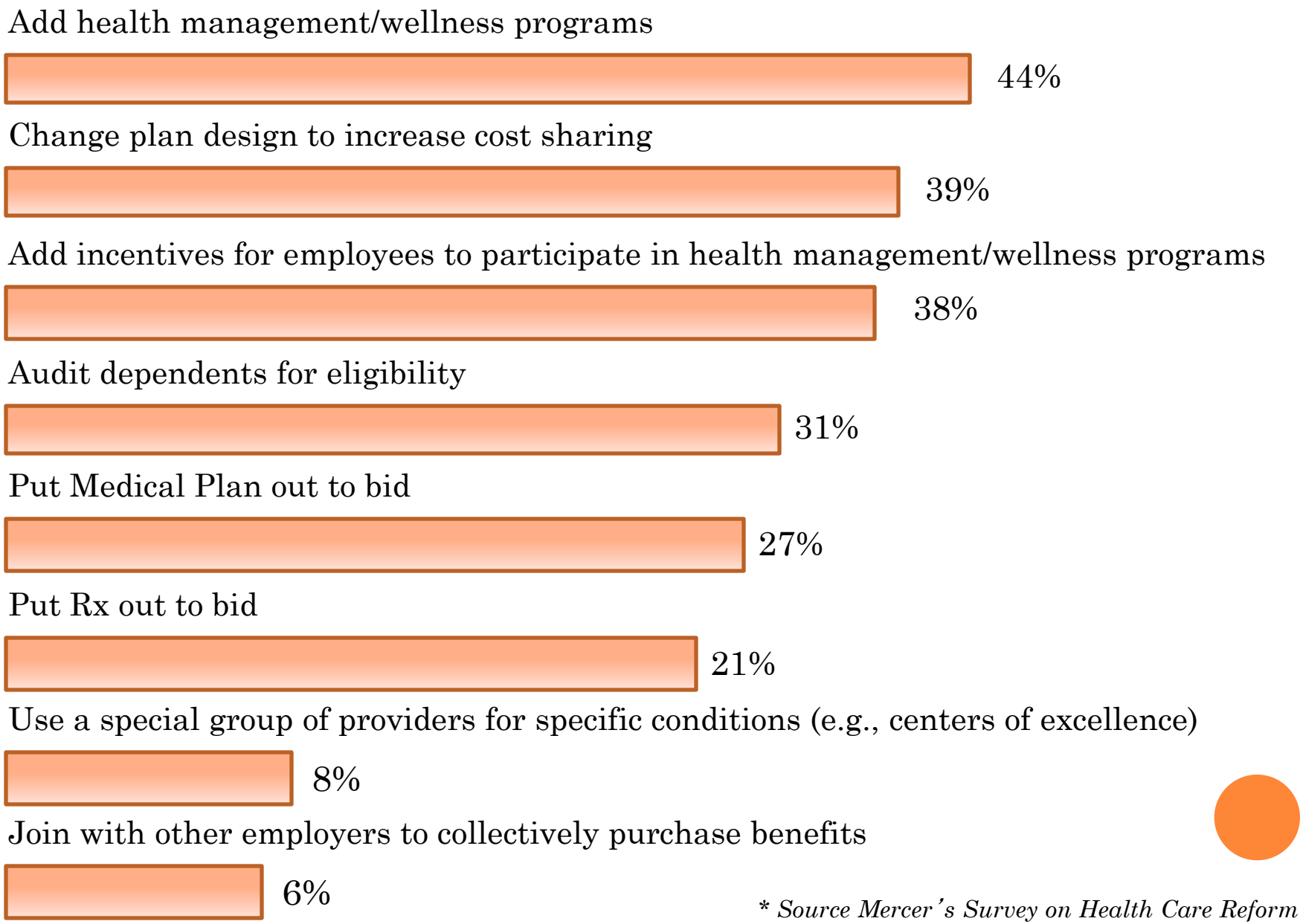
- Based on HHS Final Rule on Essential Health Benefits and other cost drivers, the Guam Market may see an potential increase in health insurance premiums as much as 40%.

- Guam Benchmark Plan:

| Type of Enrollment | Enrollment Code | Non-Postal Premium | | | | Postal Premium | | |
|---|---|---|---|---|---|---|---|---|
| | | Biweekly | | Monthly | | Biweekly | | |
| | | Gov't Share | Your Share | Gov't Share | Your Share | Category 1 Your Share | Category 2 Your Share | |
| **Standard Option Self Only** | 104 | $190.84 | $85.91 | $413.49 | $186.14 | $64.71 | $70.01 | = $599.63/mo |
| **Standard Option Self and Family** | 105 | $424.95 | $200.14 | $920.73 | $433.63 | $152.92 | $164.73 | = $1,354.36/mo |
| **Basic Option Self Only** | 111 | $177.23 | $59.07 | $383.99 | $127.99 | $38.99 | $44.31 | |
| **Basic Option Self and Family** | 112 | $414.98 | $138.32 | $899.12 | $299.70 | $91.29 | $103.74 | |

# Cost Containment

# Actions planned to reduce health benefit cost increases




** Source Mercer's Survey on Health Care Reform*

# Cost Containment Trends

- Increase the employee share contributed to the total cost of health care

- Health Management/Wellness:
  - Permissible penalty/reward for wellness programs increased to 30% of employee's health program cost (currently 20%)
  - HHS has authority to go up to 50%
  - The proposed regulations would further increase the maximum permissible reward to 50 percent for wellness programs designed to prevent or reduce tobacco use.
  - ROI on Wellness is reported $1 -$3 per dollar spent*

- Providing lower-cost generic prescription or over-the-counter drugs

* Source: Study: Wellness Programs Saved $1 to $3 per Dollar Spent

# Essential Health Benefits

# Essential Health Benefits

- The essential health benefits (EHB) package is a menu of health care services that must be covered by all insurance plans in the fully-insured **small-group** market ("small" here means fewer than 100 employees). *Section 1302 PPACA*

- EHB also apply to the **individual** market.

- Self-insured groups (mostly big businesses, labor unions, and governments), fully insured plans covering 100 or more employees, and government-provided insurance, in contrast, are **exempt** from most of the EHB's costly requirements.

  *NOTE: Although large fully insured and self-insured group health plans are not subject to the requirement to cover EHBs (as defined for the small and individual markets), to the extent that such benefits are provided under a large fully-insured or self-insured group health plan, such benefits may not be subject to lifetime or annual limits (except where state law allows).*

# EHBs

The essential health benefits (EHB) package must include items and services in 10 statutory benefit categories:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral treatment
- Prescription Drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services including oral and vision care

# EHB – State Benchmark

- The Affordable Care Act (ACA) directs that EHB be equal in scope to benefits offered by a **"typical employer plan".**
- The final rule defines EHB based on a **state-specific** benchmark plan.
- States were given **the flexibility to select** a benchmark plan from among several options, including largest small group private health insurance plan by enrollment in the state.

# EHB – State Benchmark

- HHS instructed each state (and territory) to select an existing health plan as a "benchmark" to establish the services and items included in the EHB package for 2014 and 2015.
- GovGuam could have chosen from **one of four** plan options as a benchmark:
  1. The largest plan based on enrollment in any of the three largest small group products in the state.

     **Example**: Staywell's "Silver" plan, NetCare's Prime plan, SelectCare's SC-10 plan
  2. Any one of the three largest state employee health plans

     **Example:** SelectCare's GovGuam plans
  3) Any one of the tree largest federal employee health plan options
  4) The largest HMO plan offered in the state's commercial market

# EHB – State Benchmark

- The final rule provides that all plans subject to the EHB offer benefits **substantially equal** to the benefits offered by the benchmark plan.

- **Appendix A** of the final regulation includes the final list of EHB-benchmark plans for coverage in 2014 and 2015.

  *Note: Guam and CNMI have the **same** default benchmark plan.*

# Guam's "Default" Benchmark Plan



| State | Plan Type | Issuer and Plan Name | Supplemented Categories | Supplementary Plan Type | Habilitative Services |
|---|---|---|---|---|---|
| Connecticut | Largest State non-Medicaid HMO | ConnectiCare HMO | Pediatric oral ..... Pediatric vision .... | CHIP ..... FEDVIP ..... | No |
| Delaware | Plan from second largest small group product | Highmark Blue Cross Blue Shield Delaware Simply Blue EPO 100 500 | Pediatric oral ..... Pediatric vision .... | CHIP ..... FEDVIP ..... | No |
| District of Columbia | Plan from largest small group product | Group Hospitalization and Medical Services, Inc. BluePreferred PPO | Pediatric oral ..... Pediatric vision .... | FEDVIP ..... FEDVIP ..... | Yes |
| Florida | Plan from largest small group product | Blue Cross Blue Shield of Florida, Inc. BlueOptions PPO | Pediatric oral ..... Pediatric vision .... | FEDVIP ..... FEDVIP ..... | No |
| Georgia | Plan from largest small group product | Blue Cross Blue Shield of Georgia HMO Urgent Care 60 Copay | Pediatric oral ..... Pediatric vision .... | FEDVIP ..... FEDVIP ..... | Yes |
| Guam | Largest National FEHBP | Blue Cross Blue Shield Standard Option PPO | Pediatric vision .... | FEDVIP ..... | Yes |
| Hawaii | Plan from largest small group product | Hawaii Medical Service Association Preferred Provider Plan 2010 | Pediatric oral ..... Pediatric vision .... | CHIP ..... FEDVIP ..... | No |
| Idaho | Plan from largest small group product | Blue Cross of Idaho Health Service, Inc. Preferred Blue PPO | Pediatric oral ..... Pediatric vision .... | FEDVIP ..... FEDVIP ..... | Yes |
| Illinois | Plan from largest small group product | Blue Cross and Blue Shield of Illinois BlueAdvantage PPO | Pediatric oral ..... Pediatric vision ..... | CHIP ..... FEDVIP ..... | Yes |

# Blue Cross® and Blue Shield® Service Benefit Plan

http://www.fepblue.org

**2013**

## A fee-for-service plan (standard and basic option) with a preferred provider organization

**Sponsored and administered by**: The Blue Cross and Blue Shield Association and participating Blue Cross and Blue Shield Plans

**Who may enroll in this Plan**: All Federal employees, Tribal employees, and annuitants who are eligible to enroll in the Federal Employees Health Benefits Program

**IMPORTANT**
- Rates: Back Cover
- Changes for 2013: Page 14
- Summary of benefits: Page 157

**Enrollment codes for this Plan:**
**104 Standard Option - Self Only**
**105 Standard Option - Self and Family**
**111 Basic Option - Self Only**
**112 Basic Option - Self and Family**

The Case Management programs for this Plan are accredited through URAC or NCQA, or through Health Plan accreditation from NCQA.

This Plan has Health Web Site accreditation from URAC.

See the 2013 FEHB Guide for more information on accreditation.

FEHB
Federal Employees Health Benefits Program

Authorized for distribution by the:
United States
Office of Personnel Management

Healthcare and Insurance
http://www.opm.gov/insure

RI 71-005

## 2013 Rate Information for the Blue Cross and Blue Shield Service Benefit Plan

**Non-Postal rates** apply to most non-Postal employees. If you are in a special enrollment category, refer to the *Guide to Federal Benefits* for that category or contact the agency that maintains your health benefits enrollment.

**Postal Category 1 rates** apply to career employees covered by the National Postal Mail Handlers Union (NPMHU), National Association of Letter Carriers (NALC), and Postal Police bargaining units.

**Postal Category 2 rates** apply to other non-APWU, non-PCES, non-law enforcement Postal Service career employees, including management employees, and employees covered by the National Rural Letter Carriers' Association bargaining unit.

Special Guides to benefits are published for American Postal Workers Union (APWU) employees (see RI 70-2A) including Material Distribution Center, Operating Services and Information Technology/Accounting Services employees and Nurses; Postal Service Inspectors and Office of Inspector General (OIG) law enforcement employees (see RI 70-2IN); Postal Career Executive Service (PCES) employees (see RI 70-2EX); and non-career employees (see RI 70-8PS).

Career APWU employees hired before May 23, 2011, will have the same rates as the Category 2 rates shown below. In the Guide to Benefits for APWU Employees (RI 70-2A) this will be referred to as the "Current" rate; otherwise, "New" rates apply.

For further assistance, Postal Service employees should call:

Human Resources Shared Service Center

1-877-477-3273, option 5

TTY: 1-866-260-7507

Postal rates do not apply to non-career postal employees, postal retirees, or associate members of any postal employee organization who are not career postal employees. Refer to the applicable *Guide to Federal Benefits*.

| Type of Enrollment | Enrollment Code | Non-Postal Premium | | | | Postal Premium | | |
|---|---|---|---|---|---|---|---|---|
| | | Biweekly | | Monthly | | Biweekly | | |
| | | Gov't Share | Your Share | Gov't Share | Your Share | Category 1 Your Share | Category 2 Your Share | |
| **Standard Option Self Only** | 104 | $190.84 | $85.91 | $413.49 | $186.14 | $64.71 | $70.01 | = $599.63/mo |
| **Standard Option Self and Family** | 105 | $424.95 | $200.14 | $920.73 | $433.63 | $152.92 | $164.73 | = $1,354.36/mo |
| **Basic Option Self Only** | 111 | $177.23 | $59.07 | $383.99 | $127.99 | $38.99 | $44.31 | |
| **Basic Option Self and Family** | 112 | $414.98 | $138.32 | $899.12 | $299.70 | $91.29 | $103.74 | |



# Benchmark Plan Rates

**Website:**

**http://www.opm.gov/healthcare-insurance/healthcare/plan-information/plan-codes/2013/brochures/71-005.pdf**

# Essential Health Benefits – How About Guam?

**Which health plans must offer essential health benefits?**

Starting January 1, 2014, the ACA requires individual and small group plans to include all essential health benefits, limit consumers' out-of-pocket costs, and meet the Bronze, Silver, Gold and Platinum coverage level standards - however, grandfathered and self-insured plans will be exempt. Large group plans (in most states, groups with more than 100 employees) are required to meet the cost-sharing limits and the benefit levels, but are not required to provide the full scope of benefits in the essential benefits package.

# Q & A