HEALTHCARE REFORM AND THE EFFECTS ON NEW YORK

By Gary Slavin

HISTORY OF EMPLOYEE BENEFITS

- During World War II the Federal government in 1949 enacted wages and price controls and the Supreme Court ruled labor unions could legally negotiate for their members employee benefits.
- These two events shifted businesses to offer employee benefits to their employees in an attempt to attract and retain talented individuals.

SUPREME COURT DECISION

- What was Constitutional: In a 5-4 decision the Court ruled Congress had the tax authority to require the individual mandate.
- What was Unconstitutional: By a 7-2 majority the Spreme Court held the expansion of the federal-state Medicaid program for the poor was unconstitutional, because Medicaid is a voluntary program, therefore States could not be coerced into participating in the expansion of the state program. The federal government threated to eliminate all Federal funds if the states didn't expand the program, in accordance with the Affordable Care Act.

PENDING COURT CASES

- **Contraception**: Granted exemption to certain organizations with religious objections to the mandate. 42 religious colleges and other employers who didn't receive the exemption have sued to receive this exemption.
- **Process of passing the law is unconstitutional**: Tax bills must start in the house. The A.C.A. started in the Senate.
- **State of Oklahoma**, lawsuit against the federal government regarding Federal subsidies in federal exchanges. This cases has to do with taxation without representation and State sovereignty

SUMMARY OF THE AFFORDABLE CARE ACT

- The ACA makes sweeping changes that impact the availability, affordability, and funding of health insurance coverage in the United States
- Establishing a framework for near-universal coverage over the next decade.
- The reform law expands Medicaid and reconfigures eligibility standards under the program.
- Mandates the creation of a health insurance exchange in each state through which individuals and businesses can purchase health insurance coverage, provides subsidies to eligible consumers to improve affordability of insurance coverage, and mandates a wide range of reforms to commercial insurance markets.

NEW YORK STATISTICS

- Today, there are 2.6 million uninsured children and non-elderly adults in the State. Of these, 1.1 million (42%) are currently eligible for Medicaid but uninsured, 1.1 million (42%) are not eligible for Medicaid due to their family incomes, and almost 400,000 (15%) are undocumented immigrants.
- With the implementation of ACA public coverage and exchange provisions, a large majority of uninsured New Yorkers will be eligible for free or subsidized health insurance. Most of the 1.1 million New Yorkers who were eligible for Medicaid pre-ACA, but not enrolled, will remain eligible. An estimated 90,000 individuals will become newly eligible for Medicaid. Nearly 700,000 New Yorkers are estimated to become eligible to receive tax subsidies to purchase coverage through the exchange. An additional 340,000 uninsured people are estimated to become eligible to purchase coverage through the State exchange without Federal subsidies.

THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

- The goals of the Act is to broaden access to health care benefits, increase the scope of benefits provided, and increase efficiency in providing health care to all Americans.
- It also established essential benefits that must be in every plan, they are:
- Ambulatory care
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use, including behavioral health 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

CHANGES TO NY HEALTHCARE PLANS DUE TO A.C.A.

- **Premium Rate Review -** New York State already provides significant regulatory oversight of plan premium increases, and recently enacted new legislation that will revise and more tightly regulate health insurer premiums. In June 2010, New York State voted to end its current "file and use" process, through which plans file premium increase proposals with the State Insurance Department and implement the rate without "approval" from the State agency. On October 1, 2010, New York State implement ed a "prior approval" process for all commercial health insurance premiums that will require insurers to submit premium proposals to the Superintendent of Insurance for review and approval prior to their use in the market.

CHANGES …CONTINUED

- **Medical Loss Ratios**:
- ACA requires health insurance issuers offering individual or group coverage to annually report

to the Secretary the percentages of premiums spent on reimbursement for clinical services,

and activities that improve health care quality, a term known in the insurance industry as

"medical loss ratios" (MLR).

- The law also requires insurers to provide enrollee rebates if this spending does not meet minimum standards defined by statute.
- 85% for coverage offered in the Large Group market (or a higher percentage that a given

state may have determined by regulation); or

- 80% for coverage offered in the Small Group market or in the Individual market (or a higher

percentage that a given state may have determined by regulation), except the Secretary may

adjust this percentage for a state if the Secretary determines that the application of the 80%

minimum standard may destabilize the individual market in that state).

CHANGES … CONTINUED

- **Lifetime or Annual Limit Prohibition-** As of January 1, 2014, health plans will be prohibited from setting any annual limits on the dollar value of coverage.
- Plans are not prevented from placing annual or lifetime limits on specific covered benefits that are not essential health benefits as long as such limits are permitted under other applicable Federal or State law.

CHANGES … CONTINUED

- **Rescission Prohibition**- ACA prohibits plans from retroactively rescinding, or terminating, coverage of individuals except on grounds of intentional fraud and abuse. Consistent with new Federal requirements, New York Insurance Law does permit revisions related to fraud and abuse.
- This comes into play only when employees pay toward the cost of the plan.

If the employee did not pay anything towards the cost of the plan, the employee should be terminated from the health plan the same day

the employee terminates their employment and be placed on cobra

CHANGES … CONTINUED

- **Preventive Health Services-** In plan years beginning on or after September 23, 2010, plans are required to provide coverage for a designated set of preventive health services without consumer cost-sharing.

CHANGES … CONTINUED

- **Dependent Coverage Extension-** After September 23, 2010, plans are required to extend coverage for children up to age 26, if providing coverage for dependent children.
- **New York enacted a statute during 2009 that allows an unmarried child to remain on a parent's insurance up to age 29** if he or she is a resident of New York ,and the dependent must not have other employer-sponsored coverage available to them.

CHANGES … CONTINUED

- **Prohibition on Discrimination in Favor of Highly Compensated Individuals** - As of September 23, 2010, insured group health plans must comply with the nondiscrimination requirements for self-funded plans (IRC Sec. 105(h)(2)), including rules that the plan does not discriminate in favor of highly compensated individuals with regard to eligibility or benefits provided under the plan. The new prohibitions against discrimination in fully insured plans prevent employers from providing executives and key employees with tax-free reimbursements for out-of-pocket medical, dental, and vision expenses under plans that are not "grandfathered." The penalty for offering a discriminatory insured medical plan appears to be a $100-per-day excise tax.

CHANGES … CONTINUED

- **Pre-Existing Condition Exclusions Prohibition or Other Discrimination Based on Health Status**- As of September 23, 2010, health insurers are prohibited from withholding coverage for children under the age of 19 due to a preexisting condition. In 2014, the prohibition on pre-existing condition exclusions will be extended to all individuals.
- **New York State is a guaranteed issue State**—no one is rejected from purchasing coverage because he or she has a pre-existing condition and/or any prior medical history or risk factors. However, New York does permit a waiting period of up to 12 months (after coverage begins) for coverage of those pre-existing conditions that were actually treated or for which an individual consulted a physician in the six months prior to the commencement of coverage (coverage for other medical problems begins immediately).

CHANGES … CONTINUED

- **Access to Pediatric Care-** Health insurance issuers that require beneficiaries to select a primary care provider must permit families to designate a provider who specializes in pediatrics as a child's primary care provider to the extent that pediatric specialists participate

  in the plan network.

CHANGES … CONTINUED

- **Patient Access to Obstetrical and Gynecological Care** - Health insurance plans must provide female beneficiaries with “direct access” to obstetrical and gynecological (OB/GYN) care provided by participating providers. Specifically, plans may not require prior authorization or referrals for OB/GYN care. Providers must in turn agree to adhere to the health plans policies and procedures with respect to referrals and obtaining prior authorization for services.

CHANGES … CONTINUED

- **Standardized Format for Benefits and Coverage Summaries -** ACA requires that plans provide standard consumer oriented information using a standardized format in areas including benefits summaries, coverage information, quality, and complaints and appeals processes.

CHANGES … CONTINUED

Community Rating- The ACA requires that health insurance issuers in the Individual or Small Group market employ modified community rating in establishing premium rates so that

rates vary only by:

* whether the coverage is for an individual or family;

* rating area;

* age (3:1 variation for adults); and

* tobacco use (1.5:1 variation).

The law also requires states to establish one or more state rating areas for purposes of applying modified community rating. New York State already requires community rating in its Individual and Small Group markets. However, NY State employs a “pure” community rating mechanism, meaning that insurers are not permitted to use age or gender to vary premium rates. New York will have to decide whether and how it will adjust its community rating rules to align with new Federal rules.

CHANGES … CONTINUED

- **Waiting Periods -** Effective January 1, 2014, health plans are prohibited from applying waiting periods for health coverage that exceed 90 days. This provision applies to all group health plans.

CHANGES … CONTINUED

- **Coverage of Emergency Services** - Effective September 23, 2010, health insurance issuers in the Individual and Small Group markets that cover emergency services provided in a hospital are required to cover those services:
- without the need for any prior authorization determination;
- regardless of whether the hospital or physician providing the services is a participating provider in the plan's network; and
- without imposing any authorization requirements or coverage limitations when services are provided by out-of-network providers that are more restrictive than the requirements of in-network providers.
- Additionally, the ACA requires that if emergency services are provided out of network, the consumer cost-sharing requirement (co-payment amount or coinsurance rate) is the same as would apply if services were provided in-network.

NEW TAXES UNDER A.C.A.

- **Pharmaceutical industry fee** – an annual fee on branded prescription drug manufacturers and importers; Applies to any branded prescription drug sales after December 31, 2008; Manufacturers or importers with gross receipts from branded prescription drug sales; Amount is determined by the branded prescription drug sales during the calendar year and percentage of gross receipts taken into account.

NEW TAXES … CONTINUED

- **Medical device manufacturer fee** – an annual fee on medical device manufacturers and importers;

Applies to any medical device sales after December 21, 2008

- Manufacturers or importers with gross receipts from medical device sales; Amount is determined by the medical device sales during the calendar year and percentage of gross receipts taken into account.

NEW TAXES … CONTINUED

- **Indoor tanning services tax** – a tax on any service that uses an electronic product with 1 or more ultraviolet lamps for skin tanning; Applies to services performed on or after July 1, 2010 Individuals that use the services Tax equal to 10% of the amount paid for a service.

NEW TAXES … CONTINUED

- **Comparative effectiveness research fee** – this fee funds research on the effectiveness, risks and benefits of medical treatments through the Patient-Centered Outcomes Research Institute; Plan/policy years that end after September 30, 2012 and beginning before October 1, 2019;
- Issuers of fully insured plans Self-insured plan customers; For plan years that end during October 1, 2012, through September 30, 2013, this fee is $1 per participant per year. For plan years that end during October 1, 2013, through September 30, 2014, the fee increases to $2 per participant per year.
- After that, the rate increases each year by the medical inflation rate.

NEW TAXES … CONTINUED

- **Tax on high earners and unearned income** – an annual tax on wages or unearned income of more than $200,000 for singles and $250,000 for married couples; Tax years beginning January 1, 2013 and Later; Individual taxpayers 0.9% Medicare surtax on wages in excess of $200,000 single/$250,000 married couples. 3.8% tax on unearned income for taxpayers with modified adjusted gross

  income in excess of $200,000 single/$250,000 married couples.
- Starting 2013, the maximum rate on long term capital gains will be increased by 5% to 20% and the maximum rate on dividends will increase to 39.6%.
- The net investment tax includes the following: interest, dividends, royalties, annuities, rents, income from passive business activities income from trading in financial instruments, and gains from assets held for investment like stock and other securities.
- The Congressional Budget Office (CBO) estimates this tax will raise $318 billion over 10 years.

NEW TAXES … CONTINUED

- **ACA insurer fee** – an annual excise tax on health insurance to fund premium subsidies and Medicaid Expansion;
- Tax years beginning January 1, 2014 and later; Issuers of fully insured plans; Based on the insurer's market share of net premiums written based on the previous year.
- For example, the 2014 fee will be based on 2013 premiums. Total fee amount to be collected across all insurers starts at $8 billion in 2014 and increases to $14.3 billion in 2018.After 2018 the fee increases annually based on premium growth. Starting in 2014 the fee is 2.46% of premium.

NEW TAXES … CONTINUED

- **ACA reinsurance fee** – this will support the transitional reinsurance program that aims to stabilize premiums for coverage in the individual market and lower the effects of adverse selection; Plan/policy years beginning in the 3-year period starting January 1, 2014; Issuers of fully insured plans Sponsors/administrators will collect and send the contributions on behalf of self-insured plans; Funds will be used to make reinsurance payments to health insurance issuers that cover high cost individuals in non-grandfathered individual market plans. This fee is $6.35 per participant per month.

NEW TAXES … CONTINUED

- **High-cost insurance tax –** an annual excise tax on high-cost health plans; Tax years beginning January 1, 2018 and later Issuers of fully insured plans Sponsors/ administrators of self-insured plans;
- Tax of 40% on health plan costs that exceed "Cadillac" plan thresholds of $10,200 for single coverage or $27,500 for family coverage. These numbers include employers' contributions to FSA, HRA, HSA and supplemental health insurance coverage. The CBO estimates this tax will raise

  $ 111 billion over five years.
- Most employers will not be affected by this tax, unless they employ middle class workers with strong union contracts. Most of this tax will be passed along to the employees.
- Some are predicting that every plan will be over this limit, based on estimates that the bronze plans in 2014 will cost between $20,000- $24,000

NEW TAXES … CONTINUED

- **$2,500 cap on Health care FSA contributions-** Starting 2013 the cap in an FSA will be $ 2500. The importance of this cap is that most people use this benefit to reimburse themselves on a tax free basis, to pay for qualified medical expenses.
- **Higher threshold for itemized medical expense deductions-** Currently the threshold to itemize your medical expenses is 7.5%, however starting in 2013 the threshold will be raised to 10%. CBO estimates this tax will raise $ 19 billion over 10 years.
- These last two changes will cause lower income and middleclass income workers to pay more in income taxes.

GOV. CUOMO EXECUTIVE ORDER

- Governor Andrew M. Cuomo today issued an Executive Order to establish a statewide Health Exchange, a move that will significantly reduce the cost of coverage for individuals, small businesses, and local governments. The Exchange will be entirely financed by the federal government and will be instrumental in establishing the first-ever comparative marketplace to bring down the cost of health insurance. By lowering the cost of insurance, the exchange will also help more than one million uninsured New Yorkers afford coverage.

NEW YORK REGIONAL ADVISORY COMMITTEES

- Western NY
- Central NY/Finger Lakes
- Capital District/Mid-Hudson/Northern NY
- New York City/Metro
- Long Island

NEW YORK HEALTH BENEFIT EXCHANGE

- New York will establish two types of exchanges:
- The individual exchange, where eligible individuals, and self-employed workers will be able to buy coverage.
- The SHOP Exchange, which will deal with the needs of small businesses

WHAT TYPE OF SERVICES WILL BE COVERED IN N.Y.

- N.Y.S. selected the largest small group plan in the state, Oxford's EPO to be its benchmark plan. N.Y. will fill in the required benefits by adding :
- Pediatric dental/vision coverage
- Habilitative services
- Mental health/substance abuse parity

Exhibit 3
New York State
Essential Health Benefits Study
Illustrative Essential Health Benefits

TYPE OF SERVICE	Commercial Plans Oxford EPO	Illustrative Essential Health Benefits
Inpatient Hospital Services	Covered	Covered
Outpatient Hospital Services	Covered	Covered
Preadmission Testing	Covered	Covered
Emergency Medical Services	Covered	Covered
Maternity Care	Covered	Covered
- Including newborn care	Covered	Covered
- Midwifery Services	Covered	Covered
Skilled Nursing Care Facility	Covered, 200 days per calendar year. Riders are available for unlimited coverage.	Covered, 200 days pe year
Hospice	Covered, 210 days per calendar year combined inpatient/outpatient days. (One outpatient visit, either facility based or at home, equals 1 day.)	Covered, 210 days pe year combined inpatien days
Home Health Care Services	Covered, 40 visits per calendar year.	Covered, 40 visits pe year.
Therapy Treatments		
- Chemotherapy	Covered	Covered

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TYPE OF SERVICE	Commercial Plans Oxford EPO	Illustr Esse Hea Bene
- Physician's Office	Covered	Cove
- Surgical Centers	Covered	Cove
Chronic Disease Management	Covered	Cove
Eating Disorders - Comprehensive Care Centers	Covered	Cove
Diabetes Equipment, Supplies and Self Education	Covered	Cove
Durable Medical Equipment	Covered by **R** for standard DME and medical supplies up to $1,500 per calendar year. **OR** with unlimited coverage available. Motorized equipment, electronic and neuromuscular stimulators, and myoelectric prosthesis are not covered benefits.	Covered for sta medical s Motorized equipr and neuromuscula myoelectric pro covered b
Prostheses	Covered for Internal and External Prosthetic Devices.	Covered for Inter Prosthetic
Orthotics	Not Covered	Not Co
Habilitative Services (awaiting HHS definition)		

Exhibit 3

New York State

Essential Health Benefits Study

Illustrative Essential Health Benefits

TYPE OF SERVICE	Commercial Plans Oxford EPO	Illustrati Essentia Health Benefits
MENTAL HEALTH/SUBSTANCE ABUSE		
Mental Health Treatment Services	**R**	
- Inpatient Services	**R**-- Covered, 30 inpatient days per calendar year. **OR--**unlimited MH coverage.	Covered, no limit du health and addicti requireme
- Outpatient Services	Covered, **R** -- 30 outpatient visits per calendar year. This number includes office and facility visits.	Covered, no limit du health and addicti requireme
Chemical Dependence Services		
- Inpatient Services	Covered, 30 days per calendar year.	Covered, no limit du health and addicti requireme
- Outpatient Services	Covered, 60 visits, including 20 family counseling visits per calendar year. This number includes office and	Covered, no limit du health and addicti requireme
- Detoxification Services	Covered, 7 days of inpatient detoxification per calendar year.	Covered, no limit du health and addicti requireme
- Rehab	Covered, 7 days of inpatient	Covered, no limit du

Exhibit 3
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Essential Health Benefits Study
Illustrative Essential Health Benefits

TYPE OF SERVICE	Commercial Plans Oxford EPO	Illustra Essent Healt Benefi
VISION SERVICES		
- Vision services related to specific medical condition	Covered	Covere
- Routine Vision Services	Covered, one vision screening examination (without refraction) within a 12 month period. This screening is performed by the PCP for both children and adults. **OR**- $50 reimbursement every 12 months for a comprehensive exam including refraction.	Covered, one visi examination (witho within a 12 month screening is perform for both children a eye exams for chil
Appliances (e.g. glasses and contact lenses)	**OR**--Groups that purchase the vision rider may also purchase a $70-200 benefit for one set of appliances.	Covered for c
DENTAL SERVICES		
- Emergency Dental Services (e.g., treatment of accidental injuries to sound, natural teeth)	Covered	Covere
- Routine Dental Services	Covered by **OR**. There are 2 levels of coverage and Oxford has a provider network in place for dental services.	Covered for chi exams/cleaning per Class I, II, or III se no orthod

Exhibit 3
New York State
Essential Health Benefits Study
Illustrative Essential Health Benefits

TYPE OF SERVICE	Commercial Plans Oxford EPO	Illustrati Essentia Health Benefits
Infertility Services	**R and OR**	
- Diagnosis and treatment of infertility	**R**--Covered for basic infertility services.	Covered for basic infer
- Assisted reproductive technology procedures	Not covered	Not covere
Family Planning/ Reproductive Health Services		
- Contraceptives	**R**--Covered	Covered
- Voluntary sterilization	Covered	Covered
- Abortion (medically necessary)	Covered, therapeutic abortions and non-therapeutic abortions in cases of rape, incest, or fetal malformation.	Covered, therapeutic a non-therapeutic abort of rape, incest, malformatic
- Abortion (elective)	Covered subject to benefit limits. Benefits may be excluded based on religion.	Covered subject to b Benefits may be exclu religion.
Foot Care Services		
- Foot Care related to a specific medical condition	Covered	Covered
- Routine Foot Care (Such as cutting, trimming, or removal of corns, calluses, etc.)	Not Covered	Not Covere

WHO CAN BUY COVERAGE IN THE N.Y. EXCHANGE

- Uninsured residents, and people who cannot get insurance through their employer.
- Individuals must live in NY and be a citizen, national, or legal immigrant.
- Self –employed workers will able to buy coverage through the individual exchange
- Small businesses will able to buy coverage through NY SHOP Exchange

WHO CANNOT BUY COVERAGE IN THE EXCHANGE

- Undocumented immigrants
- Individuals who have access to coverage through their employer except if the cost of the coverage exceeds 9.5% of their income or the employers coverage pays less than 60% of the cost of covered benefits

WHAT PLANS WILL BE AVAILABLE IN THE EXCHANGE

- Through the insurance exchanges there will be four benefit plans plus a separate catastrophic plan, the plan benefits are:
- **Bronze plan-** represents the minimum creditable coverage and provides the essential health benefits, covers 60% of the benefit cost of the plan, with an out-of-pocket limit equal to the health savings account; at the time of passage of the law, HSA limit was $5,950 for individuals and $11,900 for families. In 2014 the HSA out-of-pocket limit is $6,250 for individuals and $12,00 for families.

WHAT PLANS WILL BE AVAILABLE IN THE EXCHANGE

- Silver plan- same as the bronze plan except it covers benefit cost at 70%
- Gold plan- same as the bronze plan but covers benefit cost at 80%
- Platinum plan – same as bronze plan but covers benefit cost at 90%
- Catastrophic plan- available to individuals up to age 30 or to those who are exempt from the mandate to purchase coverage; provides catastrophic coverage only, with the coverage level set at the HSA current law limit (max out of pocket single $ 6,050 family $ 12,100, these limits will be increased based on inflation) prevention benefits and three primary care visits would be covered and are exempted from the deductible. This plan is only available in the individual exchange

PREMIUMS

- The premiums for individual and small group plans will not be based health status. Instead, they will be based on:
- family tier
- income
- age
- geography
- tobacco use.
- These plans also must use “3 to 1” age bands. This means the highest premium cannot be more than three times the lowest premium for the same plan.

HOW INCOME IS CALCULATED

- Inside the exchange: Section 5000A(c)(4)(B) defines taxpayer household income as the sum of the taxpayer's modified adjusted gross income and the modified adjusted gross income of any member of household. This income is increased by any tax-exempt interest a taxpayer receives or accrues.
- Shop exchange as part of share responsibility: W-2 income from that employer

INCOME GUIDELINES FOR GOVERNMENT PREMIUM SUBSIDIES

- Individuals making under 133% of the FPL will automatically be enrolled in Medicaid
- 133% to 400% of federal poverty level (adjusted annually)
- For an individual that equals $14,856 to $44,680 per year
- For a family of four that equals $30,656 to $92,200 per year

PREMIUM CREDITS FOR POLICIES PURCHASED THROUGH THE INDIVIDUAL EXCHANGE

- The federal government will require verification of both income and citizenship status in determining eligibility for federal premium credits. The premium credits will be based on the cost of the Silver plan in your area. After the credits the following is what the individual/family would pay in premiums:
  - 100-133% FPL: 2% of income
  - 133-150% FPL: 3-4% of income
  - 150-200% FPL: 4-6.3% of income
  - 200-250% FPL: 6.3-8.05% of income
  - 250-300% FPL: 8.05-9.5% of income
  - 300-400% FPL: 9.5% of income

REDUCTION TO THE OUT OF POCKET FOR THOSE WITH INCOMES UP TO 400% OF FPL

- 100%-200% FPL: one-third of the HSA limits ($1,983/individual & $3,967/family)
- 200%-300% FPL: one-half of the HSA limits ($2,975/individual & $5,950/family)
- 300%-400% FPL: two-thirds of the HSA limits

  ($3,987/individual & $7,973/family)
- Without these reductions the out of pocket would be $6,050/individuals & $12,100 for families. These limit will be adjusted based on inflation. In 2014 these out of pockets will be $6250 for a single and $12,500 for families

ANNUAL PENALTY

- In 2014, every person including dependents must have either public or private health insurance or face an annual penalty.
- The penalty is $ 95 or 1% of taxable income if you do not purchase coverage in 2014.
- In 2015 the penalty is the greater of $325 or 2% of taxable income.
- In 2016 the penalty is greater of $ 695 or 2.5% of taxable income.
- In 2017 and beyond the penalty will be adjusted each year.

EMPLOYER REQUIREMENT

- Employers with ***less than*** 50 full time employees ***do not*** have to offer coverage.
- For employers with over 50 full time employees:
- An employer only has to offer coverage to full-time employees, which is defined as working at least 30 hours per week. If an employer has only 3 full time employees and 75 part-time employees, offering the coverage to just the 3 full time employees meets the requirement of the law.

EMPLOYER PENALTIES'

- If an employer has 50 or more full-time or full time equivalent employees, they will be required to offer health care coverage to the full time employees, which is equal to the plans offered inside the exchange. If the employer has over 50 employees and doesn't offer coverage to his full time employees, the penalty is $ 2,000 per employee minus the first 30 employees.
- If the employer has over 50 employees and offers medical coverage equal to the exchange, but an employee contribution is more 9.5% and the employee goes to the exchange and qualifies for a federal premium tax credit, the employer will be assessed $ 3,000 penalty for each employee receiving the credit.

SMALL BUSINESS TAX CREDITS

- Small business employers with no more than 25 employees and average annual wages of less than $50,000 can purchase health insurance for employees with a tax credit. The full credit will be available to employers with 10 or fewer employees and average annual wages of less than $ 25,000. To receive the credit the employer has to contribute at least 50% of the premium. The credit for small business is 35% of the employer's contribution toward the premium; Tax exempt small businesses meeting the same qualification are eligible for tax credits of up to 25% of the employer's contribution toward the employee's health insurance premium.
- In 2014 if small businesses purchase coverage through the state exchange, they could receive a tax credit of up to 50%, if the employer contributes 50% toward the premium. Tax exempt businesses can get a credit of up to 35% for their contributions toward employee healthcare. This credit is only available for 2 years.
- This credit has been a failure, according to the GAO it has estimated that between 1.4 million and 4 million small businesses qualify for the credit, but only 170,000 businesses have applied for the credit.
- One of the possible reasons for small business not applying for the credit is that according to the GAO, it could take between six and eight hours of tax prep time to get the credit.

WHAT WILL THE EXCHANGE DO

- Help individuals and families enroll in health coverage
- Allow people to apply for coverage online, over the phone, in person and through the mail.
- Allow people to fill out application for both public and private health coverage
- Set up Navigator program to assist people to understand which plan is best for them
- Provide two types of assistance premium tax credits which means you pay less than the full premium and cost sharing reduction, reduces the out of pockets for individuals and families.

BROKER INVOLVEMENT

- The final HHS rule state brokers, producers and agents (collectively referred to as producers) can serve as navigators. However, HHS prohibits Navigators from receiving “any consideration directly or indirectly from any health insurance issuer in connection with the enrollment of any individual or employees in a QHP or non-QHP”.

BROKER INVOLVEMENT

- According to recent discussions with NYS and the NYSAHU, brokers will be able to place business with the exchange and get paid a commission or fee. That fee will be set by the "market". No one knows at this time what that "fee" will be. If the "fee" isn't to your liking, then you could become a healthcare consultant and charge small and large businesses a fee for your assistance in helping them and their employees thru the maze known as the insurance exchange, however you may not be able to take the "fee" and charge a consultant fee.

THE EFFECTS THE A.C.A. WILL HAVE ON EMPLOYEE BENEFITS

- In a study done by Mckinsey & Company they sighted that the Congressional budget office estimated that only 7% of employees currently covered by their employers plan would switch to the subsidized exchanged policies in 2014. However, in Mckinsey research they found the following:
- Overall, 30% of employers will definitely or probably stop offering employer sponsored insurance (ESI) in the years after 2014
- Among employers who were highly aware of the reforms (ACA), 50-60% of them will pursue some alternatives to traditional ESI
- At least 30% of employers would gain economically from dropping coverage even if they completely compensated employees for the change through other benefit offerings or increased employees' salaries

EFFECTS …

- Contrary to what employers assume, more than 85% of employees would remain at their jobs if their employer stopped offering ESI, although 60% would expect increased compensation
- Employers, who are considering eliminating ESI, are not contemplating it because they don't care about their employees, but because they realize that after 2014, ESI may **not** be the most efficient way to provide health coverage to their employees.

EFFECTS…

- The average employee contribution towards the cost of healthcare in 2011 was 17% for a single and 27% for a family. Under the ACA the maximum employee contribution is capped at 9.5% of his/her W-2 income. It would be an employer-employee relationship nightmare, to try to convince an employee to pay 17% towards his healthcare cost while the exchange policies will cap their contribution at 9.5% of their household income.
- Because the penalties only affect employers with full time employees, there could be a greater push to either hire only part-time workers in this country or a large increase in the outsourcing of American jobs.

WHY OFFERING E.S.I. MAY NOT THE MOST EFFICIENT WAY TO PROVIDE HEALTH CARE

- If your employee makes less than $44, 680 as a single or $ 92,200 as a family; your premium through the SHOP exchange will be higher than it will cost your employee in the exchange; plus the government will reduce their out of pocket expense.
- As an employer with over 50 employees , you only have to offered employee coverage and pay the balance between the employee's 9.5% contribution an the total premium; you must offer dependent coverage, but you have no legal requirement to pay for the dependent ; many employees will not be able to pay the full cost of dependent coverage and then pay the cost of spousal coverage through the exchange. If you don't offer coverage your employee qualifies for federal subsidies. But you may be required to pay a penalty.

PRACTICAL SCENARIOS FOR EMPLOYER WITH LESS THAN 50 EMPLOYEES

- Single 35,employee making $44,680
- This employer does not have to offer any coverage. If employer offer ‘s coverage there is no requirement to pay any part of the premium. The total annual unsubsidized premium is $4,754; and the employee’s out of pocket is $6,250
- If employer doesn’t offer coverage and your employee applies for coverage through the exchange, his/her annual cost is $4,245, and his/her out of pocket is $4,167.
- The difference is the government subsidies

PRACTICAL SCENARIOS FOR EMPLOYER WITH LESS THAN 50 EMPLOYEES

- Same employee has a family; this employer is not require to offer or pay for healthcare. The total unsubsidized annual cost is $13,324. Your employee's out of pocket is $12,500.
- If the same employee goes to the exchange, his/her cost will be $2,624 and his/her out of pocket will be $4,167.

PRACTICAL SCENARIOS FOR EMPLOYER WITH OVER 50 EMPLOYEES

- Same Single employee. The most the employee can contribute towards the cost of their coverage is 9.5% of their W-2 income
- Annual cost of coverage for a the single employee is $4,754 employee contribution; employee's contribution based on 9.5% of W-2 income is $4,244, employer's cost $509, but the employee's out of pocket is $6,250
- No penalty is paid by employer because you are offering coverage and it is affordable

PRACTICAL SCENARIOS FOR EMPLOYER WITH OVER 50 EMPLOYEES

- Same employee age 35 with a family.
- Estimated cost of unsubsidized family coverage $13,324; single cost $4754
- Employee contribution base on single $4,244
- (employee income $44,680*9.5%=$4,244)
- Employee's cost toward dependent coverage cost $3,816; Employer has no obligation to pay any part of this.
- Employee's spouse has no coverage under his/her employer plan; under current regulation no spousal or domestic partners coverage is required to be offered.

PRACTICAL SCENARIOS FOR EMPLOYER WITH OVER 50 EMPLOYEES, CONTINUED

- Same employee but employer decides not to offer coverage.
- Employer pays a $2,000 fine, employees gets coverage through the exchange
- Total premium cost to employee after government subsidies ……$2,624
- Total out of pocket cost to the employee after government subsidies……$4,167
- Total cost to employee……$6,791

PRACTICAL SCENARIOS FOR EMPLOYER WITH OVER 50 EMPLOYEES, CONTINUED

- Single employee, age 55 earning $ 100,000
- unsubsidized cost health premium $10,193, his out of pocket is $6250.
- As an employee of an over 50 employer, his maximum contribution is 9.5%, 9500, his employer will pay the difference.

PRACTICAL SCENARIOS FOR EMPLOYER WITH OVER 50 EMPLOYEES, CONTINUED

- Same employee but he is married with a family. Total unsubsidized family health insurance premium $23,700, with an out of pocket of $12,500
- The employee is require to contribute 9.5% of his W-2 income $9500 single cost $10,193.
- Dependent coverage will cost approx. $3700
- Spouse must get coverage from the exchange, his/her premium is based on his/her household income. Approx. cost assuming same age $10,193

BROKER ROLE AND DESIGN OF EMPLOYEE BENEFIT PLANS POST 2014

- Heath care reform is the law of the land and while the law will likely make health coverage available to more people, health care cost will continue to rise. ESI could become less a differentiator when it comes to hiring and retaining workers. One action small business can take, with your assistance, is to offer non-medical benefits. In addition you could offer your services to your small business clients by offering to do the following:

BROKER'S ROLE …

- **A.** Employers should determine what their industry/competitors and what their economic region are offering as their standard employee benefit plan. Everyone in the same industry and region are competing for the same talent. Mckinsey found that 85% of all employees and almost 90% of higher income say they would remain with the employer who dropped ESI. Employees value cash compensation more than health insurance. Younger employees want a career path and work-life balance more than medical benefits.

BROKER'S ROLE…

- **B**. To be sure your benefit program is going to be valued by your employees; you must survey your employees with an Employee Benefit Questionnaire, which asks your employees to value each benefit in your employee benefit program. This survey gives you strategic information on what your employees want and need.
- **C.** To make sure your employees understand and appreciate all the costs you as the employer pay on their behalf, you should send to each employee an annual benefit statement, which outlines the cost of all their benefits for them and their dependents and the cost of all the required governmental programs. Additional simplify benefit communication, small business need to do a better job of effectively educating employees about their benefits.

BROKER'S ROLE…

- **D.** Employers that drop the ESI should determine how best to reinvest those dollars to meet the needs of the employees. One consideration is a defined contribution plan, where the company gives a fixed dollar amount to each employee, per year to spend as they wish on a variety of benefits.
- This approach will work for almost all employees except the higher compensated employees; because they will not receive any federal subsidies, they will have to pay the entire healthcare cost out of their pocket.

BROKER'S ROLE…

- **E.** For higher-income employees, employers should consider offering concierge medicine arrangements, these employees value their time and the ability to get through the maze of medicine quickly and with the best outcome. These services can be provided by third party vendors who specialize in this area. Alternative benefits should also be offered such as supplemental retirement plans or corporately paid protection plans such as life insurance, disability or long term care policies. These will probably be more cost effective then a Cadillac health care plan.

BROKER'S ROLE …

- **F.** Develop wellness programs that help employees maintain their health; these programs should be able to provide documentable proof on their impact. In addition employers could establish clinics at the work sites or partner with local physicians or pharmacies in the area to provide preventive care, such as annual physicals and immunization. Grants maybe available for wellness programs

BROKER'S ROLE …

- **G**. To offer your services or someone your agency partners with, to assist your clients employees with all the issues that will come up with the exchanges; to help your clients understand their employee benefits and which plans might best meet their needs.

BROKER'S ROLE …

H. Offer voluntary benefits such as:

- FSA, and Section 125
- Life insurance
- Dental insurance
- Disability insurance
- Financial planning to help their employees reach financial security
- Pension plans
- Payroll deducted 529 plans college saving plans

Realizing that budgets maybe tight, a good alternative is to offer some employer partially funded benefits combined with supplemental or voluntary options that employees can choose to purchase. Surveys have found employees prefer to pay rather than lose benefits.

BROKER'S ROLE…

- I. Currently, businesses have deemed the financial planning benefit necessary for top executives because they have limited time to deal with their own financial affairs. Having a financial professional deal with the executive's personal financial affairs, allows him/her to devote his/her talents to the important business decisions.
- Businesses long ago have realized the pitfalls that await unprepared retired employees. Now financial planning is benefit that would assist all employees by helping them prepare for retirement and deal with their other personal financial issues.

CONCLUSION

- The A.C.A. has changed employee benefits as we know them. The change will probably be to a defined contribution plan. This option gives employees the freedom and responsibility to choose the benefits that truly meet their needs and financial goals.
- Are you ready to assist your clients/employees through this new benefit maze? If you aren't how will you replace the revenue you will lose when another agent does.

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