Clay County District Schools
Board Workshop

June 6, 2013

Prepared by Consulting
Health and Benefits

Presentation to Clay County District Schools

AON Hewitt

Topics for Discussion

- 2013-2014 Clay County District Schools Benefit Program as Recommended by the Insurance Committee
  - Medical Plan Marketing and Final Selection
  - Life Insurance and Disability Insurance Renewal, Marketing and Final Selection
  - Renewals for All Other Insured Benefits

NOTE ALL RATES SHOWN IN THIS PRESENTATION ARE SUBJECT TO COLLECTIVE BARGAINING.

- Health Care Reform
  - Overview of the Patient Protection and Affordable Care Act (PPACA)
  - Impact to Clay County District Schools
  - PPACA Compliance Timeline

Medical Plan RFP Process

November 8, 2012

The CCDS Insurance Committee voted to market the medical insurance

- Renewal from Aetna had not yet been provided or projected
- All Insurance Committee Members agreed to be included in the RFP review and final selection process

December 12, 2012

Aon draft of the Medical RFP and Questionnaire was reviewed and revised by the Insurance Committee

- Consideration of self funding methodology and pricing and selection of plan designs for proposal

January 7, 2013

Medical RFP was posted by CCDS Purchasing Department

February 4, 2013

CCDS Purchasing Department received and distributed responses to all Insurance Committee Members for review and to AonHewitt for analysis.

February 27, 2013

Aon Hewitt presented a complete comparative analysis of all RFP responses to Insurance Committee, Director of Purchasing, and Assistant Superintendent of Business Affairs. The Insurance Committee selected two finalists.

March 18, 2013

Finalists were interviewed by Insurance Committee and Aon Hewitt. The Insurance Committee voted to change carriers from Aetna to Florida Blue.

Medical RFP Response Summary

The purpose of the RFP was to compare medical insurance carriers in the marketplace who may provide an equal or better program for the same or lower cost. The RFP requested rates and benefit deviations based on the current and alternative plan designs. The RFP also requested self-insured pricing, including Administrative Services Only (ASO) fees, Stop Loss fees, and expected claim costs.

Medical carriers were requested to provide:

- Fully insured and self insured proposals
- Pricing for the current plan design, the St. Johns County Schools PPO Plan design, and a multiple plan option
- A match of current $100,000 Wellness Allowance provided by Aetna annually
- A Premier Wellness Package valued at 0.5% of total premium
- Flexible Spending Account administration

Three medical carriers responded:

- Aetna, Florida Blue (formerly Blue Cross Blue Shield of Florida), and United Healthcare

Vendors were scored based on the following criteria:

- Net cost considerations
- Carrier qualifications and network features
- Benefit Provisions
- Administrative Services; and
- Other Features (Wellness, Flexible Spending, Health Risk Assessments, etc.)

The Insurance Committee eliminated UHC from consideration

- Elimination based on overall cost, omission of rate guarantee, inability to match the current wellness allowance, and other non-competitive responses.

Aetna and Florida Blue Initial Response

Aetna

- Priced current plan at 12.3% over current
- Priced Alternative #1 (St. John's PPO) at 53% over current
- Priced Alternative #2 (Multiple Options) at 23.4% over current
- Rate cap guarantee based on experience from 7.2% with a loss ratio under 85% up to 19.2% if the loss ratio is less than 97%
- In addition to the annual $100,000 Wellness Allowance, Aetna included a premier wellness package that included free maintenance prescriptions, incentives for employees and spouses for completing online health assessments, free onsite screenings, and a designated team of nurses for health coaching and improving disease management participation.

Florida Blue

- Priced current plan at 19% over current
- Priced Alternative #2 at 43% over current (with deviations from plan design)
- Priced Alternative #3 at 15.8% over current
- Provided a rate cap of 12%, without any contingency
- In addition to the existing $100,000 Wellness Allowance, Florida Blue included their Better You From Blue (BYFB) that provides free onsite biometric screenings, health coaching, and interactive onsite workshops for nutrition, smoking cessation, and behavior change sessions.

Finalist Selection and Interviews

The Insurance Committee selected Aetna and Florida Blue as Finalists.

During the February 27 meeting, the Committee selected three plans that they wished the Finalists to provide “Best and Final” pricing. One of these plans was the current Aetna POS plan design.

Each Finalist received a Finalist Agenda that requested the following:

- Best and Final pricing on three Committee requested plans
- Agreement that the Insurance Committee will select two plans of their choice
- Presentation of the value added benefits contained within their proposals:
- Premier Wellness Program
- FSA Administration
- Onsite representative

Without deviations from plan design, the following was the rate response from the Finalists, represented as a percentage of increase over current:

Finalist	Plan Option 1	Plan Option 2	Plan Option 3
Aetna	12.8%	9.7%	20.6%
Florida Blue	9.0%	5.4%	14.7%

Insurance Committee Finalist Selection

The Insurance Committee selected Florida Blue as the new medical insurance carrier for 2013-2014.

Post-award negotiations between Aon Hewitt and Florida Blue included:

- Agreement to provide maintenance prescriptions at no cost to members (closely matching the Aetna proposed Premier Wellness program)
- Agreement to match Aetna's additional $100,000 in Wellness Allowance for 2013-2014 only
- Review of pricing and plan design for 8 new plan designs and 3 previously presented plans ranging in benefits and overall impact
  - Total costs were compared without contribution analysis or migration assumptions
  - Three (3) POS/PPO plans – Two proposed in the original RFP and one proposed in the Finalist Meetings
  - Five (5) HMO plans - only available to employees and retirees who live in the HMO area
  - Three (3) new PPOs - offer out of network coverage and a national provider network
  - Final selection included Plan Option #3 from the Finalist Meeting and a new HMO option

Final Plans Recommended by Insurance Committee

- BlueCare HMO 50 – 3% over current
- BlueOptions PPO 5774 – 14.7% over current

Medical Plan Recommendation 2013-2014 (Rates subject to collective bargaining)

TYPE OF SERVICE	POS - Current Plan 1 CURRENT PLAN DESIGN (Member Pays) In-Network	POS - Current Plan 1 CURRENT PLAN DESIGN (Member Pays) Out-of-Network	HMO Member Pays In-Network	PPO Member Pays In-Network	PPO Member Pays Out-of-Network
Deductible (single/family)	$2,500/$5,000	$5,000/$10,000	**$3,000/$6,000**	**$3,000/$6,000**	**$6,000/$12,000**
Annual Out of Pocket Maximum (single/family) Includes Deductible, PADs and Medical Copays	$8,500/$17,000	$15,000/$30,000	**$6,500/$13,000**	**$6,000/$12,000**	**$12,000/$24,000**
Primary Care office visit	$45 copayment	40% after deductible	**$35 copayment**	**$40 copayment**	40% after deductible
Specialist office visit	$60 copayment	40% after deductible	**$65 copayment**	$60 copayment	40% after deductible
PREVENTIVE CARE					
Routine Preventive Care, Mammogram, Well Child visit, etc.	0%	40% after deductible	0%	0%	40% after deductible
HOSPITAL					
Inpatient Hospital	30% after deductible	40% after deductible	**$100 PAD + Ded, then 30%**	**20% after deductible**	40% after deductible
Outpatient Hospital	30% after deductible	40% after deductible	30% after deductible	**20% after deductible**	40% after deductible
DIAGNOSTIC X-RAY/LAB					
Physician's Office, Hospital, or Facility	$0 copayment	40% after deductible	$0 copayment	$0 copayment	40% after deductible
X-Ray	$60 copayment	40% after deductible	**$50 copayment**	$60 copayment	40% after deductible
Advanced Imaging (MRI, PET, CT)	$300 copayment	40% after deductible	**$300 copayment**	$300 copayment	40% after deductible
EMERGENCY SERVICES					
Emergency Room	$300 copayment	$300 copayment	$300 copayment	$300 copayment	$300 copayment
Urgent Care Center	$50 copayment	40% after deductible	**$70 copayment**	$50 copayment	40% after deductible
PRESCRIPTION DRUG RIDER (UP TO 30 DAY SUPPLY)					
Pharmacy Deductible	$200	$400	**$0**	**$0**	**Not Covered**
Select Generic Maintenance Drugs			**$0**	**$0**	**Not Covered**
Tier 1	$20 copayment after Rx deductible	Not Covered	$20 copayment	**$15**	Not Covered
Tier 2	$40 copayment after Rx deductible	Not Covered	$40 copayment	**$30**	Not Covered
Tier 3	$70 copayment after Rx deductible	Not Covered	$70 copayment	**$60**	Not Covered
Mail Order Pharmacy	2x Retail	Not Covered	2x Retail	2x Retail	Not Covered

Current Plan Design

Total	Enrollment	Current Monthly Rates	FLBlue Monthly Rates	FLBlue Monthly Rates		FLBlue Monthly Rates
EE	2,639	$ 430.82	**$ 469.59**	**$ 443.64**		**$ 494.07**
EE+SP	275	$ 832.44	**$ 907.36**	**$ 857.19**		**$ 954.67**
EE+CH	122	$ 794.12	**$ 865.59**	**$ 817.76**		**$ 910.72**
Family	358	$ 1,090.85	**$ 1,189.03**	**$ 1,123.32**		**$ 1,251.03**
	3,394					
Annual Premium		**$ 22,239,143**	**$ 24,240,561**	**$ 22,900,902**		**$ 25,504,339**
$ Difference From Current			**$ 2,001,418**	**$ 661,759**		**$ 3,265,196**
% Increase From Current			9.0%	3.0%		14.7%

Life and Disability Marketing

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Life and Disability Combined Summary and Aon Hewitt Analysis

- Unum has held Life and Disability rates for several years (no rate increases)
- In January, Aon's underwriter evaluated the life and disability experience to project the anticipated renewal
- Based on the analysis the combined experience for life and disability is running higher than target.
- Unum's initial renewal was higher than the projection,
- Through negotiations, Aon was able to bring UNUM's overall increase down to +10% however there was still a significant increase to the LTD (90% increase)
- However, due to the rate structure for Board Paid (Plan B) and Employee Paid (Plan A) classes, the School District of Clay County would pay a 29% rate increase on the STD and a 51% rate increase on the LTD.
- To reduce their initial LTD renewal of 90% to 51%, Unum removed the EAP and conversion provisions from the LTD policy.

Life and Disability RFP Overview

Vendors were requested to

- Match current plan designs
- Match plan provisions
- Provide multi-year rate guarantees
- Offer a one-time open enrollment event
- Include value added programs, including an Employee Assistance Program
- Obtain pricing to standardize elimination periods for Plan A (30 days) and Plan B (15days)

Six carriers responded

- Aetna
- Cigna
- ING
- Liberty Mutual
- MetLife
- Minnesota Life (Life Insurance only)

Alternative Plan Design – Short Term Disability

- Insurance Committee voted to reduce the elimination period on the Voluntary Plan A STD from 30-days to 15-days

Life and Disability Renewal: Unum vs. Liberty Mutual

The Insurance Committee selected Liberty Mutual as the new Life and Disability carrier for 2013-2014. Liberty Mutual was selected for their competitive pricing, rate guarantee, open enrollment allowance, and ability to match current plan provisions.

Plan	Unum Renewal	Liberty Mutual Rates Compared to Current	Liberty Mutual (Savings)/Cost Compared to Current
Basic Life and AD&D	0%	(7.5%)	($17,426)
Retiree Life	41%	0%	$0
Supplemental Life	0%	0%	$0
STD – Voluntary Plan A (enhanced benefit)	NA	17.4%	$38,243
STD – District Paid Plan B	29%	2.7%	$3,907
LTD – Voluntary Plan A	0%	(9.4%)	($15,379)
LTD – District Paid Plan B	90%	(6.9%)	($ 5,342)
Total annual increase	+$165,218		$4,003

Renewal Action For All Other Benefits

Ancillary Benefit Plan Renewal Snapshot

The table below lists all of the SDCC ancillary benefit plans and the 2013-2014 renewal proposed from each carrier.

Benefit Plan	Carrier	Renewal
Dental	Delta Dental	Rate Pass
Vision	Humana	Rate Pass, Guaranteed until 2015
Medical Gap Plan	Key Benefit Resources	Rate Pass on current plans New Plan in 2013 to match Florida Blue plans
Accident and Injury Plan	Unum	Rate Pass
Interest Sensitive Whole Life	Unum	Rate Pass
Critical Illness	Unum	Rate Pass

Health Care Reform Overview

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Health Care Reform Agenda

- Healthcare Reform Overview
- Employer Impact of the Patient Protection and Affordable Care Act (PPACA)
- Evolution of Medicaid Expansion, Landscape of State Exchanges, and the Individual's Responsibility for Opting Out of Health Insurance
- Appendix:
  - PPACA Provisions by Year

All of the information contained herein is based on the most current legislative information available. Provisions of PPACA are subject to change as further clarification and guidance is issued.

Goals of the Affordable Care Act

How We Got Here

Offer access to health insurance for the uninsured

Pay for expanded access through increased taxes and spending cuts

Bend the health care cost curve downward

PPACA: Goal to Expand Insurance Coverage

- 32 million more Americans will be insured by 2014.
  - More people will be eligible for coverage.
    - 95% of currently uninsured legal residents will have coverage.
  - Self-purchased insurance will be available through exchanges.
  - Children up to age 26 can be covered by parents' insurance.
  - States have option to expand Medicaid eligibility in 2014.
  - Medicare coverage will close the "donut hole" for prescriptions.

PPACA: Add Consumer Protections

- Removed lifetime caps on coverage in 2011
- Removes annual caps on coverage in 2014
- Insurance available for patients with pre-existing conditions in 2014
- No higher premiums based on pre-existing conditions or gender (2014), but can have higher premiums for smokers
- Prohibits insurance companies from dropping coverage if you have paid your premium in 2011

PPACA: Lower Preventive Care Costs

- No co-pay or deductible for preventive care (October 2010), including:
  - Well-person assessment
  - Vaccinations
  - Colonoscopies
  - Pap tests
  - Mammograms

PPACA: Quality Improvement for Medical Care

- Requires transparency and quality indicators so there is as much information on the quality of care as on the quality of a car
- Paying for quality rather than paying for number of procedures
- Increasing continuity of care with:
  - Medical homes
  - Accountable Care Organizations

PPACA: Impact on Women

- Prohibits insurers from charging more based on health or gender
- Requires insurers cover maternity care
- Requires coverage for preventive services:
  - Well-woman visits
  - Gestational diabetes screening
  - HPV DNA testing
  - Sexually transmitted infection counseling
  - HIV screening and counseling
  - FDA-approved contraception methods and contraceptive counseling
  - Breastfeeding support, supplies and counseling
  - Domestic violence screening and counseling

PPACA: Improves and Protects Medicare

- Protects guaranteed Medicare benefits
- Improves Medicare benefits
- Lowers out-of-pocket costs for prescription drugs
- Gradually closes “doughnut hole” and keeps Part D cost sharing

PPACA Compliance Requirements

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Completed Requirements: 2011

2011	Explanation	Implications
Lifetime/Annual Limits Prohibited (effective 1/1/11)	Health plans may not impose lifetime limits on the dollar value of essential health benefits for any participant or beneficiary Until 2014, health plans may impose restricted annual limits on the dollar value of essential health benefits for any participant or beneficiary	➢Ensure the health plans are in compliance. ➢Update Summary Plan Descriptions (SPD).
Pre-existing Condition Exclusions Prohibited on Individuals under Age 19 (effective 1/1/11)	Health plans may not impose any preexisting condition exclusions on participants or beneficiaries under the age of 19	➢Confirm the health plans are in compliance.
Retroactive Termination of Coverage Prohibited (effective 1/1/11)	Health plans may not terminate coverage retroactively except under limited circumstances following advance notice	➢Ensure health plans are in compliance.

Completed Requirements: 2011

2011	Explanation	Implications
Extension of Child Coverage to Age 26 (effective 1/1/11)	Health plans that provide dependent coverage must cover children to age 26 regardless of student, marital, employment, residency or tax dependency status. Grandfathered health plans need not cover children who are eligible for employer-provided health coverage (expires 1/1/14)	➢Ensure compliance within eligibility guidelines and enrollment. ➢Evaluate cost benefit analysis of administering state specific guidelines covering dependents beyond age 26 (i.e. Florida to age 30).
Preventive Services Coverage (effective 1/1/11)	Non-grandfathered health plans must cover certain preventive services without cost-sharing except network plans may limit this to in-network providers	➢Ensure SPDs are up-to-date. ➢Account for impacts on claims in renewals. ➢Provide communications to employers/employees on difference between preventive and diagnostic (i.e. colonoscopies, mammograms)
Claim and Appeal Rules Modified (effective 1/1/11)	Non-grandfathered health plans must adhere to expanded claim and appeals requirements including right to external appeal of adverse determination.	➢Ensure compliance; ➢Communicate new processes to employees

Completed Requirements: 2011

2011	Explanation	Implications
Patient Protections (effective 1/1/11)	Non-grandfathered health plans that require designation of a primary care physician must allow pediatrician to be designated as child's PCP, must not restrict a woman's access to OB/GYN services, and must not restrict access to emergency services	➢Coordinate with medical vendor to ensure compliance; ➢Communicate to employees
Medical Loss Ratio Rebates for Insured Plans (effective 1/1/11)	Carriers that fail to meet medical loss ratio standard must rebate a portion of the premium to health plan and notify enrollees of this. Rebates must be paid by 8/1 of following year. Health plan fiduciaries must assess protocol for handling rebate.	➢Determine method of distribution; ➢Ensure method is fair, objective, and reasonable; ➢Distribute within 90 days of receipt ➢Applies to fully insured plans.

Delayed Compliance Requirements

2011	Explanation	Implications
Automatic Enrollment (effective 7/1/11) (**DELAYED**, pending issuance of guidance to be released no earlier than 2014)	Employers covered by the FLSA with more than 200 full-time employees must automatically enroll all new full-time employees in their health plan for which they are eligible, and continue the enrollment of current employees	➢Keep informed of regulatory updates
Nondiscrimination Requirements Applicable to Insured Plans (effective 7/1/11) (**DELAYED**, pending issuance of guidance)	Non-grandfathered insured health plans may not discriminate in favor of highly compensated individuals, and will be subject to similar nondiscrimination testing rules that currently apply to self-insured health plans	➢Keep informed of regulatory updates;
Employer Quality of Care Report (effective 3/23/12) (**DELAYED**, pending issuance of guidance)	Health plans must provide annual reports to HHS and participants regarding plan benefits that improve health outcomes	➢Keep informed of regulatory updates

Completed Requirements: 2012

2012	Explanation	Implications
Employer Reporting of Health Coverage on Form W-2 (effective 1/1/12)	Employers must include on annual Form W-2 the aggregate cost of health plan benefits provided to employees	➢Ensure compliance
Limit on Health Care FSA Contributions to $2,500 (effective 1/1/13)	Salary reduction contributions to any health care FSA are limited to $2,500 annually (indexed for inflation beginning in 2014) per employee	➢Ensure compliance

Completed Requirements: 2012-2013

2012	Explanation	Implications
Employer Distribution of Summary of Benefits and Coverage (effective annual enrollment periods on or after 9/23/12)	Sponsors of self-insured health plans and insurers must distribute a summary of benefits and coverage that includes certain standardized information at initial and annual enrollment	➢Distribute to employees during Open Enrollment. ➢Review SBCs from medical vendors for accuracy ➢Prepare for 2nd languages where appropriate ➢Post on-line with SPD or hand distribute where appropriate ➢If self-insured, employer will be required to draft from vendor template; If fully insured, medical carrier will provide.
Comparative Effectiveness Fee (effective 8/1/12)	Sponsors of a self-insured health plans and insurers for each plan year are assessed a federal tax of $2 ($1, for initial plan year) times the average number of covered lives. Fee expires after 7 years.	➢Fees are included in fully insured rates. ➢For self-insured health plans, fee to be remitted to IRS on Form 720 ➢Initial due by 7/31/14
Coverage Required without Cost-Sharing for Women's Preventive Health Services (effective 1/1/2013)	Non-grandfathered health plans must provide certain women's preventive care services without cost-sharing except network plans may limit this to in-network providers	➢Required to be implemented beginning plan year on or after 1/1/2013. ➢Ensure SPDs and benefit summaries are updated

Current Compliance Requirements: 2013

2013	Explanation	Implications
Medicare Tax on High Income Individuals (effective 1/1/13)	An additional employee Medicare tax of 0.9% (from 1.45% to 2.35%) applies to individuals with wages in excess of $200,000 annually ($250,000 joint return) An additional employee Medicare tax of 3.8% on net investment income applies to individuals with adjusted gross incomes above $200,000 annually ($250,000 joint return)	➢Process deductions for high earners
Notice to Inform Employees of Coverage Options in Exchange (effective 3/1/13)	Employers must provide employees with certain information related to available Exchange programs and subsidies. HHS indicates a model notice to be issued.	➢A draft of the model notice with verbiage/requirements from federal agencies was recently released. ➢Employer is required to provide notice to every employee prior to October 1.
Elimination of Deduction for Expenses Allocable to Retiree Drug Subsidy (effective 1/1/13)	The Part D subsidy to employers will no longer be tax-deductible.	➢No action required without sizable post-65 Retiree population.

Upcoming Compliance Requirements: 2014

2014	Explanation	Implications
State Insurance Exchanges (effective 1/1/14)	Each state will establish a health Exchange through which qualified individuals and businesses (100 or fewer employees) can purchase qualified health plan insurance that provides an essential health benefits package	➢Florida will not offer a state exchange in 2014 ➢Evaluate competitiveness of benefits and premium as federal exchange is developed. ➢Develop ancillary product/wellness programs to compete
Individual Mandate to Purchase Insurance or Pay Penalty (effective 1/1/14)	All individuals and their eligible dependents are required to maintain minimum essential coverage or pay certain tax penalties	➢Model payroll contributions vs. cost of mandate. ➢Communicate penalties at time of open enrollment. ➢Anticipate some migration into plan by employees currently waiving coverage or populations not currently eligible for benefits (e.g. long term substitutes).

Upcoming Compliance Requirements: 2014

2014	Explanation	Implications
Employer Responsibility to Provide Affordable Minimum Essential Health Coverage (effective 1/1/14) (transition rule for fiscal year plans may allow delay in effective date to 7/1/14)	Employers that employ an average of at least 50 FTE employees during the prior calendar year and do not offer **minimum essential coverage** to full-time employees are subject to a $166 nondeductible assessment for any month in which any full-time (30 hrs/wk) employee is enrolled in an Exchange and receives the federal premium tax credit or cost-sharing reduction (assessment imposed for <u>all</u> full-time employees less 30) Proposed regulations clarify the following: ➢ $2,000 penalty for failure to offer minimum essential coverage to full-time employees ▪ Will not be imposed if at least 95% of full-time employees have minimum essential coverage ▪ Must offer coverage to child dependents of full-time employees to avoid penalty; coverage need not be offered to spouse dependents	➢Evaluate current plans to ensure meeting essential minimum benefits. ➢Review current hours worked policy to ensure compliance.

Upcoming Compliance Requirements: 2014

2014	Explanation	Implications
Employer Responsibility to Provide Affordable Minimum Essential Health Coverage (effective 1/1/14) (transition rule for fiscal year plans may allow delay in effective date to 7/1/14)	Employers that employ an average of at least 50 FTE employees during the prior calendar year and offer minimum essential coverage are subject to a $250 nondeductible assessment for any month in which any full-time (30 hrs/wk) employee is enrolled in an Exchange and receives the federal premium tax credit or cost-sharing reduction (assessment imposed only for full-time employees receiving the credit or cost-sharing reduction less 30) Proposed regulations clarify the following: ➢$3,000 penalty for unaffordable/low value coverage ▪Does not apply to unaffordable dependent coverage ▪In addition to the W-2 wage safe harbor for determining affordability, employers may also use a rate of pay safe harbor or a Federal poverty line safe harbor	➢Evaluate current plans to ensure meeting essential minimum benefits. ➢Review current hours worked policy to ensure compliance.

Upcoming Compliance Requirements: 2014

2014	Explanation	Implications
Limit of 90-Day Waiting Period for Coverage in Plan (effective 8/1/14)	Waiting periods cannot exceed 90 days from date of hire or, if later, entry into job classification eligible for health plan	➢Review direct contracts to ensure compliance; ➢Potential impact on cost due to added members
Preexisting Condition Exclusions Prohibited (effective 7/1/14)	Health plans may not impose any preexisting condition exclusions	➢Evaluate financial implication on claims pre-renewal; ➢Review members who may have been denied in the past
Annual Limits Prohibited (effective 7/1/14)	Health plans may not impose any annual limits on the dollar value of essential health benefits for any participant or beneficiary	➢Ensure plans are in compliance

Upcoming Compliance Requirements: 2014

2014	Explanation	Implications
Coverage of Clinical Trials (effective 8/1/14)	Non-grandfathered health plans must cover costs associated with member's participation in a clinical trial.	➢Ensure SPDs/benefit summaries are updated
Contribution to Temporary Reinsurance Program (effective 8/15/14)	Health plans must pay a contribution toward cost of state-administered reinsurance programs from 2014-2016	➢Fee will be $63 times average covered lives in plan (included in fully insured rates) ➢Initial fee to be remitted in late-December, 2014/early January, 2015
Notices to Inform Employees and IRS of Certain Coverage and Related Data (effective 8/1/14)	Two notices to employees and IRS will provide details about minimum essential coverage, full-time employee coverage, waiting period, etc.	➢Monitor regulatory guidance on notice language and data requirements

Upcoming Compliance Requirements: 2014

2014	Explanation	Implications
Increased Cap on Rewards for Participation in Wellness Program (effective 8/1/14)	For non-grandfathered health plans, the maximum employer wellness program incentive based on an individual's satisfying a standard related to a heath status factor is increased from 20% to 30% of employer plus employee plan cost	➢Utilize to promote wellness; ➢Utilize as an opportunity to lower employee contributions
Annual OOP Limits and Deductibles Capped (effective 8/1/14)	For all non-grandfathered health plans, the annual out-of-pocket limits (indexed for inflation) may not exceed the limits that apply to HSAs (in 2014, $6,350 for individual; $12,700 for other than individual) For non-grandfathered small group insured health plans, the deductibles cannot exceed $2,000 for individual and $4,000 for other than individual (both indexed for inflation)	➢Assess current plan designs to ensure compliance; ➢Need to determine potential financial impact for reducing deductibles and out of pocket maximums where necessary
Employer Reporting of Health Insurance Information to Government and Participants (effective 1/1/14)	Health plans and insurers must provide certain disclosures to HHS and participants regarding claims procedures, enrollment information, minimum essential coverage, financial information, etc.	➢Awaiting upcoming guidance ➢Communicate to employees as required

Long Term Compliance Requirements: 2017/2018

2017/2018	Explanation	Implications
Large Employers May Access State Insurance Exchanges (effective 1/1/17)	Large employers (>100 employees) are able to access an Exchange, if permitted by state.	➢Assess exchange landscape compared to benefits in place
Excise Tax on High-Cost Coverage (effective 1/1/18)	A 40% excise tax is imposed on health plans whose annual cost exceeds $10,200 (individual) and $27,500 (family) (as indexed) Threshold is increased to $11,850 (individual) and $30,950 (family) for retirees 55-64 and selected high risk occupations; also, age and gender adjustments permitted	➢Review current premiums and apply trend to determine potential exposure; ➢Evaluate potential benefit change impacts to mitigate trend

Health Care Reform—Paradigm Shift for Employers and Employees

Employer Plan

- If offered, generally the best choice for employees who do not receive a federal subsidy in the exchanges
- Insurance plan familiar to most employees

State Exchanges

- Employees with low family incomes may receive better benefits at a lower cost in a state exchange
- These individuals can only receive federal subsidies if employer does not offer an affordable plan

Medicaid

- Only available in states that choose to expand Medicaid coverage
- Employees receive nearly full coverage, although provider access is limited

Opt-Out Self Insure

- Employees may opt-out for many reasons including a spouse with a better/cheaper plan, TriCare coverage, or simply not wanting to own health insurance

Shared Responsibility Payments Effective 2014

Employer Plan

The Shared Responsibility Payment can affect a group if:

1. Employer fails to "offer" coverage to its full-time employees (and their dependents)

   or

2. Employer "offers" coverage but it is unaffordable or does not provide minimum value

Employer could be subject to an assessable payment in one of two situations:

1. "Failure to Offer" Penalty –

- Employer fails to offer its full-time employees (FTE), and their dependents, the opportunity to enroll in minimum essential coverage (MEC) under an eligible employer sponsored plan;
- One or more FTEs enrolls in an Exchange and receives a federal subsidy;
- Employer subject to a monthly penalty

  1/12 of $2,000 times the total number of FTEs minus the first 30 FTEs

2. Targeted Penalty –

- Employer offers its FTEs (and their dependents) the opportunity to enroll in MEC but the coverage is either unaffordable or does not provide minimum value;
- One or more FTEs enrolls in an Exchange and receives a federal subsidy;
- Employer subject to monthly penalty

  1/12 of $3,000 times the total number of FTEs that receive the subsidy

- Penalty may not exceed the amount of the "Failure to Offer" penalty
- Also triggered if an employer offers MEC to at least 95% of FTEs, and their dependents, and any one or more of the 5% who is not offered coverage is certified to the employer as receiving a federal subsidy

Definitions

Employer Plan

- Dependents
  - Employers must offer coverage to dependents
  - Includes an employee's child who is under 26 years of age
  - Does not include an employee's spouse
  - Coverage offered to dependents is not required to be affordable
- Minimum Essential Coverage (MEC)
  - Plan must cover 10 key essential health categories
  - Emergency/ambulatory services, hospitalizations, maternity, mental health/substance abuse, prescription drugs, rehabilitative services and devices, lab services, preventive/wellness services, chronic disease management and pediatric services
- Minimum Value
  - Plan's share of the total allowed costs of benefits must be at least 60%
  - HHS provided guidance on methodologies to determine minimum value and intend to provide additional guidance
- Affordability
  - Employer-sponsored plan is affordable if the employee's required contribution for self-only coverage does not exceed 9.5% of the employee's income for the taxable year
  - Safe harbor includes an employee's W-2

Definitions

Employer Plan

- Determining FTEs
  - Employee employed on average at least 30 hours of service per week, with respect to any month
  - Employers need to establish length of time for:
    - Measurement Period: 3 to 12 months and can vary by certain groups – different groups of collectively bargained employees under separate collective bargaining agreements, union/non-union, salary/non-salaried, employees who's primary places of employment are in different states
    - Administrative Period (optional): Up to 90 days to enroll
    - Stability Period: Equal to Measurement Period but not less than 6 months
  - Administrative issues
    - Most employers already have hours of service for hourly employees in payroll system
    - Employers will need to document hours for part-time salaried employees and FTEs not offered health care coverage
      - Variable hour employees
      - Any other employees not offered health care coverage (e.g. those who consistently work less than 30 hours per week)
- 95% Standard
  - Margin of error to recognize potential inadvertent errors in the offer of coverage
  - Employer will be treated as offering coverage to its FTEs for a calendar month if, for that month, it offers coverage to 95% of its FTEs (and their dependents)
  - This "margin of error" is permitted regardless of whether the failure to offer is inadvertent

Definitions

Employer Plan

- New FTEs
  - If a new hire is reasonably expected to work full-time, then the employer must offer coverage before the expiration of the employee's initial 3 full calendar months of employment
  - Eliminates risk for an assessable payment
- Educational Organizations
  - IRS weighed in on unique circumstances presented by educational organizations
    - Function on the basis of an academic year
    - Includes extended periods with limited classroom activity or not in session
    - Often employ adjunct faculty
  - During traditional breaks (winter or spring) that are paid leave periods, an employer must credit employees pursuant to the hours of service rules
  - Adjunct faculty members
    - Further guidance required
    - Until then, employers must use a reasonable method of crediting hours of service, including:
      - Classroom or other instruction time
      - Class preparation

Plan Year Timeline - Measurement, Administration and Stability Periods

Employer Plan

Measurement period

- Period of time over which employer tracks employee's hours of service
  - Cannot be less than 3 months or more than 12 months in duration
- *Initial* measurement period for new employees will be based on each employee's start date
- *Standard* measurement period for ongoing employees will be uniform period of time set by employer

Administrative period—optional (up to 90 days in duration)

- Employer looks back at employee's hours of service in measurement period
  - Did employee work an average of 30 hours per week during measurement period
    - If yes, then employee is a FTE
    - If no, then employee is not a FTE and employer has to keep tracking hours of service in next measurement period

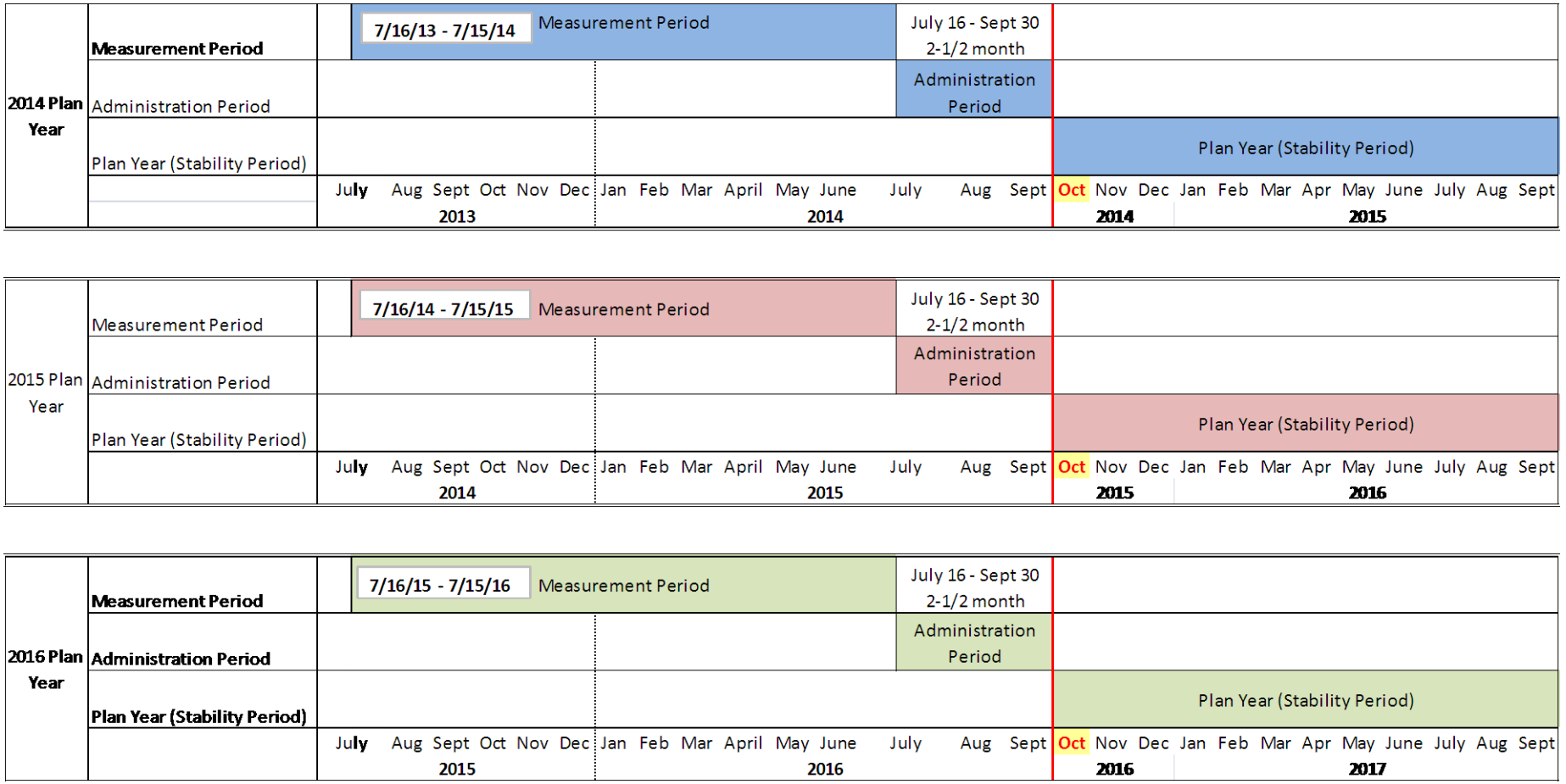
Stability period

- Period of time employer must offer coverage to FTE to avoid ACA penalties
  - Stability period must at least equal measurement period, but not less than six months
- If not an FTE in measurement period, stability period cannot exceed measurement period

Plan Year Timeline - Measurement, Administration and Stability Periods

Employer Plan

Effective Date: October 1



1. All measurement periods are illustrated to end on July 15 of the preceding year

2. Beginning with the 2015 plan year, and for all subsequent years, employers generally will use a measurement period of 12 months, which must coincide with the administration period, to match the 12 month plan contract year (Stability Period). This eases the administrative burden for tracking hours.

3. There is an option to utilize a 6-month Measurement Period, however, this would require the Stability Period to be 6 months.

Other Affordable Care Act Considerations

Employer Plan

- No waiting periods over 90 days
- No pre-existing condition exclusions or annual/lifetime limits
- New accumulation rules to out-of-pocket (OOP) maximum
  - OOP maximums cannot be greater than HSAs ($6,350 single / $12,700 family for 2014)
  - Deductibles, coinsurance, and copays, including Rx, must accumulate to the OOP maximum
  - Transition rules give flexibility for “separate service providers” for one year
  - Does not apply to out-of-network benefits
- Auto-enrollment delayed (until 2015 at the earliest)
- Required notices/communications to employees about exchanges and eligibility

Employer—Population Overview and Observations – *Illustrative Client A*

Employer Plan

- Benefit eligibles based on the census file provided by Client A:
  - 10,995 total benefit eligible employees
    - 10,901 currently eligible
    - 94 newly eligible
- Affordability
  - All plans passed the affordability test because employee only coverage is offered at no cost for at least one plan
- Employees predicted to enroll in Medicaid, with Client A plans at current = 2
  - In states that do not expand Medicaid, employees between 100% and 138% would be eligible for subsidies in the exchange (if employer's plan is unaffordable)
- 13.89% of employees do not have coverage through Client A
  - This group currently includes 1,889 ineligible employees
  - Our evaluation predicts that a portion of those who waive coverage have no insurance
- 3,997 (36.67%) under the 250% poverty level
  - This group would be most likely to benefit from enrolling in the exchange if there was a change to contributions to make coverage unaffordable for this group

Analysis of Substitute Workforce – *ILLUSTRATIVE*

Employer Plan

Population Overview	
Current Full-Time Employees	10,901
Current Benefit Ineligible/Substitute Employees	1,889
Benefit Ineligible/Substitute Employees Working 30+ Hours/Week	94
2014 Benefit Eligible Employees (10,901 + 94)	**10,995**
% of Benefit Ineligibles/Substitutes out of 2014 Total Benefit Eligible (94 / 10,995)	**0.85%**
% of 2014 Benefit Eligible Covered	**99.15%**

- Substitutes working over 30 hours per week **make up less then 1%** of the total population that works over 30 hours per week, assuming all full time employees work 30+ hours per week
  - School District **will not** be subject to the $2,000 per employee penalty
- The District can chose to make these substitutes benefit eligible or pay a $3,000 penalty per substitute that goes to the Federal Exchange and receives a subsidy, below is an exhibit showing the financial impact of each:

% Enrollment	Low Plan	Federal Exchange (PPACA Penalty $3,000 per EE)*	Net Difference
100% (94 EEs)	$577,446	$282,000	$295,446
50% (47 EEs)	$288,723	$141,000	$147,723

Notes:

1. Does not include any possible tax implications
2. Assumes substitutes receive same Board contributions as current, and are enrolled in lowest cost plan

Strategic Implications - *ILLUSTRATIVE*

Employer Plan

- 2014 Health Care Reform fees/taxes impact to medical premiums = $709,440 to $720,525
  - PPACA Reinsurance Fee and PCORI Fee
- Additional increase for benefit enhancements – OOP Maximums
    - Maintain current plan designs; or
    - Increase OOP maximums to be cost neutral
- Substitutes/non-permanent employees
  - Newly benefit eligible
    - Assume majority take District coverage as long as one plan is available at no cost
    - Estimated $577,446 added to medical premium
  - Remain as non-benefit eligible
    - Assume portion receive subsidy
    - Risk penalties up to an estimated $282,000 to be paid outside of the medical plan

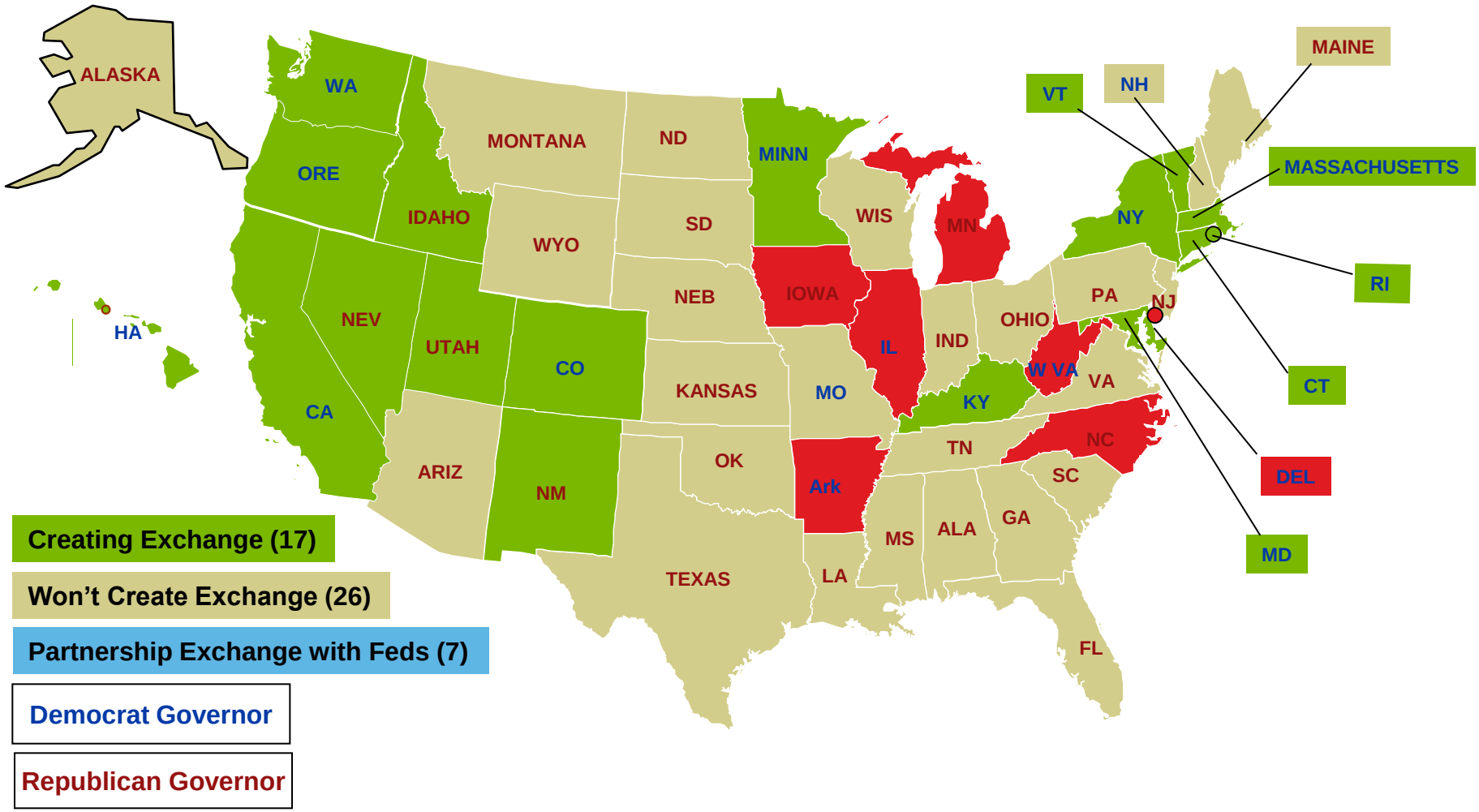
Evolving Exchange Landscape

State Exchanges

- State Exchanges open in 2014
  - Metallic plans - Bronze, Bronze Plus, Silver, Gold, Platinum
  - “Young invincible” plan for individuals under 30 years old
- Federal subsidies are available in Exchanges to individuals with household incomes between 138% and 400% of federal poverty level (FPL) who do not have access to qualifying, affordable employer coverage
  - For States that do not expand Medicaid, federal subsidies will be available to individuals with household incomes between 100% and 400% of FPL
  - Employees at or below 250% of FPL will be enrolled in a Silver plan with ***lower*** cost sharing
- Federal subsidies will be based on Silver plan, even if individual chooses Bronze or higher metallic plan
  - Individuals do not get the excess subsidy if a lower cost plan is selected or a higher subsidy if a higher cost plan is selected
- Less than half of states will have an Exchange up and running in 2014
  - Federal Exchange will be the fall-back but debate over whether there will be a subsidy
  - Florida will use the Federal Exchange

Less Than Half of States Setting Up Exchanges

State Exchanges



How The Exchange Works

State Exchanges

State Medicaid Expansion Possibilities

Medicaid

- States can expand Medicaid entitlement to individuals with incomes up to 138% of FPL, covering up to 17 to 22 million new Medicaid beneficiaries
- Less than half of states are expanding Medicaid in 2014
- If a state sets up an exchange but does not expand Medicaid, individuals with incomes between 100% and 138% of FPL would be eligible for federal subsidies to purchase insurance in the exchange
  - Without Medicaid expansion, individuals below 100% of FPL but not currently eligible for Medicaid (approximately 11.5 million individuals*) would remain uninsured
- Impact to employers would result from
  - Cost-shifting due to uninsured
  - Potentially higher Shared Responsibility Payments if do not offer minimum essential benefits or minimum affordable coverage to full-time employees between 100% and 138% of the FPL

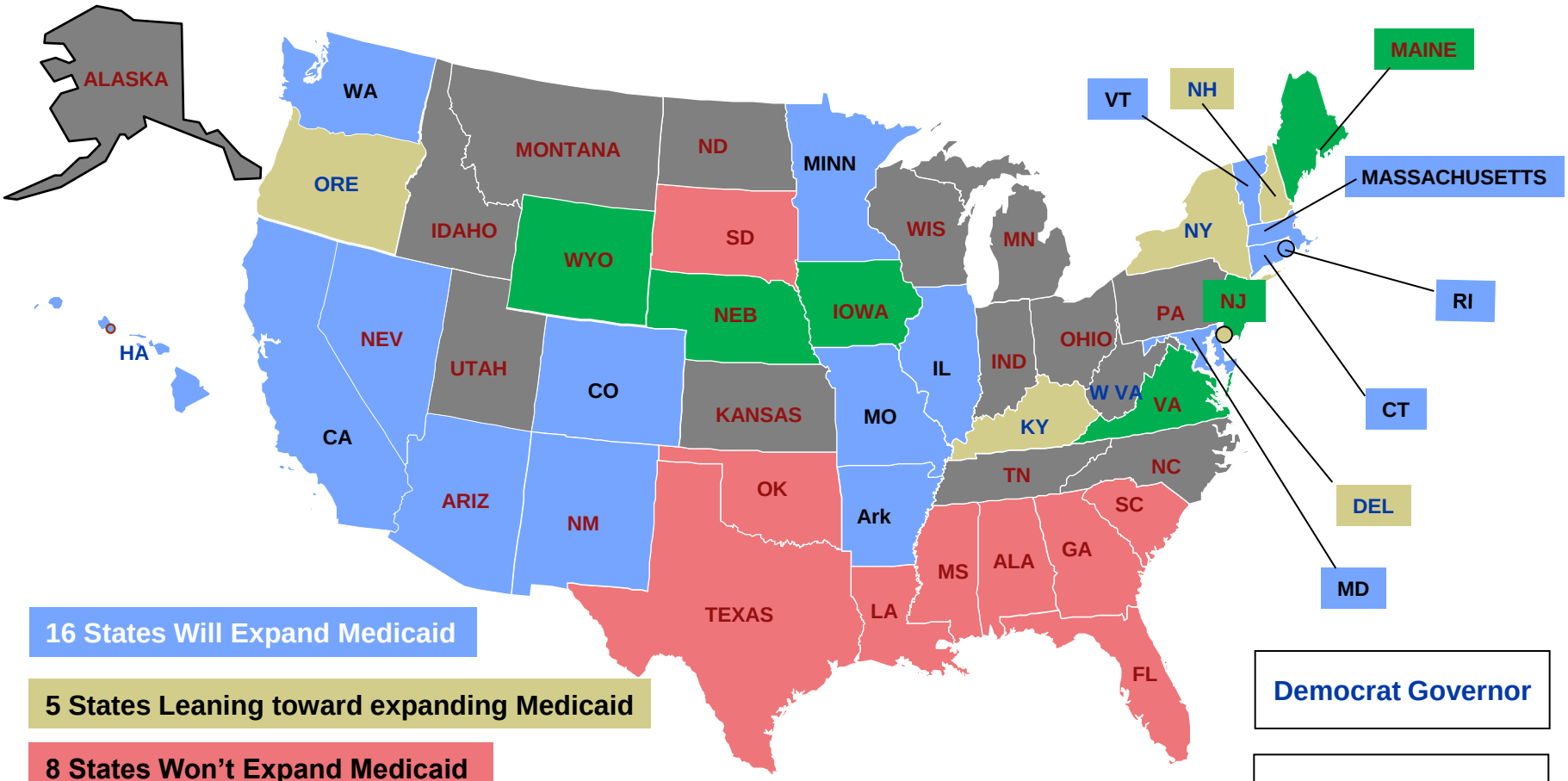
2013 HHS Poverty Guidelines (Annual Income, 48 continguous states)

Household Size	100% of poverty	138% of poverty
1	$11,490	$15,856
2	$15,510	$21,404
3	$19,530	$26,951
4	$23,550	$32,499
5	$27,570	$38,047
6	$31,590	$43,594
7	$35,610	$49,142
8	$39,630	$54,689
add for each additional person	$4,020	$5,548

Source: The Urban Institute

Less than Half of States Expanding Medicaid in 2014

Medicaid



Individual Responsibilities

- Individual must maintain minimal essential coverage or pay a penalty that is “generally” based on taxable income
  - Payable on tax return for the year in which the penalty was incurred
  - 2014: $95 or 1% of household income whichever is greater
  - 2015: $325 or 2% of household income whichever is greater
  - 2016: $695 or 2.5% of household income whichever is greater

- Medicare Contribution Tax (Effective 01/01/2013)
  - Additional FICA tax of 0.9% applicable to wages in excess of $200,000 annually ($250,000 joint return)
  - Applies only to employee portion of FICA; no matching employer payment
  - Additional tax of 3.8% on unearned, net investment income for individuals with annual gross income above $200,000 annually ($250,000 joint return)

How Will a Person Get Coverage in 2014?

Family Income less than 138% of Poverty

- Family is eligible for Medicaid
- If employer coverage is available
- Family may choose the employer plan or Medicaid

Family Income less than 400% of Poverty

- Family is eligible for subsidy in Exchange
- If employer coverage is available, but either inadequate (<60% benefit) or unaffordable (premiums >9.5%)
- Family may choose the employer plan or subsidized coverage in Exchange
- If employer coverage is available and adequate and premiums are affordable
- Family may choose the employer plan or *unsubsidized* coverage in Exchange

Family Income greater than 400% of Poverty

- Family may purchase *unsubsidized* coverage in Exchange
- If employer coverage is available
- Family may choose the employer plan or *unsubsidized* coverage in Exchange

2013 FPL	Single Individual	Family of 4
100%	$11,490	$23,550
133%	$15,282	$31,322
400%	$45,960	$94,200

Appendix

AON Hewitt

Health Care Reform Timeline

2011 Plan Year	2011	2012	2013	2014	2018
▪ **Lifetime dollar limits on Essential Health Benefits (EHB) prohibited*** ▪ **Preexisting Condition Exclusions Prohibited for Children under 19*** ▪ **Overly restrictive annual dollar limits on EHB prohibited*** ▪ **Extension of Adult Child Coverage to Age 26*** ▪ **Prohibition on Rescissions*** ▪ **No Cost Sharing and Coverage for Certain In-Network Preventive Health Services**** ▪ **Effective Appeals Process**** ▪ **Consumer/patient protections**** ▪ **Nondiscrimination requirements on fully insured plans** (*DELAYED*)** ▪ **Certain Retiree Medical Claims Reimbursable (ERRP)** ▪ **Retiree Drug Plan FAS Liability Recognition**	▪ **Over-the-Counter Medicines Not Reimbursable Under Health FSA, HRAs, or from HSAs Without a Prescription, Except Insulin** ▪ **HSA Excise Tax Increase** ▪ **Public Long-Term Care Option (CLASS Act) –*No Longer Supported by HHS*** ▪ **Medicare Part D Discounts for Certain Drugs in "Donut Hole"**	▪ **Employer Distribution of Summary of Benefits and Coverage to Participants*** ▪ **Comparative Effectiveness Fee** ▪ **Employer Quality of Care Report**** ▪ **Medical Loss Ratio rebates (insured plans only)*** ▪ **Employer Reporting of Health Coverage on Form W-2 (*due January 31, 2013*)**	▪ **Notice to Inform Employees of Coverage Options in Exchange** ▪ **Limit of Health Care FSA Contributions to $2,500 (Indexed)** ▪ **Elimination of Deduction for Expenses Allocable to Retiree Drug Subsidy (RDS)** ▪ **Medicare Tax on High Income** ▪ **Addition of women's preventive health requirements to No Cost Sharing and Coverage for Certain In-Network Preventive Health Services **** ▪ **PCORI fee**	▪ **Individual Mandate to Purchase Insurance or Pay Penalty** ▪ **State Insurance Exchanges** ▪ **Employer Responsibility to Provide Affordable Minimum Essential Health Coverage***** ▪ **Preexisting Conditions Exclusions Prohibited*** ▪ **Annual Dollar Limits on EHB Prohibited*** ▪ **Automatic Enrollment (*DELAYED*)** ▪ **Limit of 90-Day Waiting Period for Coverage*** ▪ **Employer Reporting of Health Insurance Information to Government and Participants** ▪ **Increased Cap on Rewards for Health-Based Wellness Program**** ▪ **Cost-sharing limits for all group health plans, not just HDHPs/HSA (deductibles and OOP maximum)**** ▪ **Transitional reinsurance fee**	▪ **Excise Tax on High-Cost Coverage**

*Denotes group/insurance market reforms applicable to all group health plans.
Denotes group/insurance market reforms **not applicable to grandfathered health plans.
*** This requirement applies to full time employees (e.g., 30 hours per week) and will require coverage that is affordable and satisfies a certain actuarial value to avoid the penalty. Guidance forthcoming.