Affordable Care Act Update
Wellness Incentives & Programs
Employee Communication

April 26, 2013
Your Presenters

- Bruce Davis: Principal, Leader of Findley Davies’ Health/Group Benefits Consulting Practice
- Carrie Alexander: Senior Consultant, Change Management Practice, Findley Davies
- Laura Hoag, Senior Consultant, Health & Group Benefits Practice
Agenda

• Update on the Affordable Care Act
  ▪ Overview of the Employer Shared Responsibility Rules
  ▪ Planning Considerations
• Practical Employee Communications
• Update on Wellness Rules
  ▪ Future Direction of Incentives
• Questions & Answers
Top Focus Areas of Employers’ Health Care Strategy-2013

Source: NBGH/TowersWatson

- Stay up to date and comply with the PPACA: 55%
- Educate employees to be more informed consumers of health care (e.g., price transparency, quality care information, treatment decision support): 36%
- Develop workplace culture where employees are accountable and supported for their health and well-being: 34%
- Adopt/expand use of financial incentives to encourage healthy behaviors: 25%
- Develop/expand healthy lifestyle activities: 22%
Update on the Affordable care Act (ACA)
ACA Highlights for 2013

• Hospitals will pay an excise tax to new Patient-Centered Outcomes Research Institute
  – Funds comparative effectiveness research
  – $1/member (employee/spouse/child) for 2012 plan year
    ✓ Due 7/31/2013
    ✓ If insured, your carrier will pay the tax and build the cost into your rates
    ✓ If self-funded, you will use IRS Form 720 to pay tax
  – $2/member for 2013 plan year
ACA Highlights for 2013

• Hospitals will need to notify all employees about the availability of a health insurance exchange (“marketplace”) in their state
  – Effective date delayed until “late summer or early fall”
  – Exchange will begin enrolling individuals and small groups (< 50 EEs) on 10/1/2013
  – Carrie will speak about proactive communications in advance of this required notice
ACA Highlights for 2014

• New Individual Mandate
  – Must be covered under employer’s plan; buy individual insurance (in or outside the exchange); or pay a tax (greater of $95 per person or 1% of household income)

• Employer Shared Responsibility Requirements for Large Employers under new IRC Section 4980H
  – Penalties for failing to offer coverage or for offering “unaffordable” coverage
  – New definition of “FTE”
  – Need to track hours of “variable hour employees”
  – Assume on-demand reports to exchange, substantiating employee eligibility for your plan (document waivers)

• New Wellness rules allow incentives to increase from 20% to 30% of cost of single coverage
ACA Highlights for 2014

- Hospitals will pay annual Transitional Reinsurance Program fee of $63/member
  - Established in each state to help stabilize premiums for individual exchange coverage
  - Fee assessed for three years & collected annually
  - Fee is tax deductible
  - If self-funded, TPA may remit fee on your behalf
  - If the Transitional Reinsurance Program is state-operated (and not by HHS) state can’t levy fee higher than $63/member on self-funded plan subject to ERISA
Employer Shared Responsibility Rules
4980H Employer Shared Responsibility Rules - 2014

Does your organization employ > 50 Full-time equivalent Employees (FTE)? 30 Hours/Week

Yes

Has at least 1 FTE received a federal subsidy to purchase coverage in a public insurance exchange?

Yes

Qualifying FTEs may choose to purchase coverage in a public exchange (“marketplace”) and receive a federal subsidy (if household income <400% of FPL)

No

Employer not subject to employer shared responsibility rules

Caution: Breaking up a company into smaller pieces will generally not avoid the 50 FTE threshold. Aggregation rules combine all related entities to determine if organization is an “Applicable Large Employer”

NO PENALTY

Yes

Does your organization offer qualified coverage to 95% of FTEs?

Yes

Does at least 1 plan offered cover a minimum 60% of allowed expenses?

Yes

Do any FTEs pay > 9.5% of W-2 (Box 1) wages for employee-only coverage under this minimum value plan?

No

NO PENALTY

EXCEPTION

If 1 or more FTEs who are not offered coverage receive subsidies when they enroll in a public exchange, then assessed the $3,000 penalty (as long as this # FTEs < 5% of total FTEs, the tax applies only to those FTEs who enroll in the exchange, not to all FTEs)

NON-DEDUCTIBLE EMPLOYER PENALTY OF $3,000 x Number FTEs Who Purchase Coverage in an Exchange

Cap = $2,000 x Total FTEs Less 30

NON-DEDUCTIBLE EMPLOYER PENALTY OF $2,000 x Total FTEs Less 30 (Ratably allocated among related entities)

Exceptional

NO PENALTY

* 2 other Safe Harbors for affordable coverage: 9.5% x Rate of Pay x 130 hours or 9.5% x Individual Federal Poverty Level ($11,490 in 2013)
Planning Considerations for 2014

• Opportunity to evaluate dependent subsidies and re-establish cost-sharing objectives
  – Not required to offer coverage to spouses
  – Not required to contribute towards cost of covering spouses or children
  – Affordability requirements apply only to Single FTEs-not to FTE-Families or to PTEs

• Opportunity to harmonize dependent eligibility provisions for free-standing Dental and Vision benefits
Special Considerations for Hospitals

• Many hospitals use per diem or as-needed nurses and other personnel to work difficult-to-fill shifts or to help in peak occupancy situations

• In most cases, benefits are not extended to these per diem employees, even though some may average more than 30 hours/week
Special Considerations for Hospitals

- Hospitals may use 5% safe harbor for the 1st penalty tax to identify small core group of per diem employees to continue working their shifts as before
  - Failure to offer coverage is not required to be inadvertent; strategic exclusions may be considered
  - Their hours are not reduced; staffing needs are met and patient satisfaction upheld
  - Health benefits are not offered
  - If one or more of these per diem employees goes to the exchange and receives a subsidy, the penalty is limited to $3,000/person
ACA Highlights for 2015-2018

• 2015: Hospitals subject to new reporting requirements under IRC Section 6056
  – No proposed rules issued yet
  – For periods beginning after 12/31/2013 must file an annual information return to:
    ✓ Disclose #FTEs each month
    ✓ Certify coverage:
      ✓ offered to 95% or more FTEs; and
      ✓ at least 1 plan offered meets minimum value test
    ✓ Disclose monthly premiums for lowest cost option (i.e. employee contributions are affordable)
  – No later than 1/31 of each year, furnish each FTE written statement containing information similar to that reported on the Code Section 6056 return
ACA Highlights for 2015-2018

- 2018: 40% excise tax on “Cadillac Plans”
  - Assessed on value exceeding $10,200 Single or $27,500 Family
Best Practices for Employee Communications
The Basics

- Tell what you know, when you know it
- Take credit
- Avoid the blame game
- Don’t make promises you can’t keep
- Call employees to action
- Keep it simple!
Special Considerations for 2014

• Expect employees to get information overload
  – Exchanges
  – Friends, family, the media
• Make sure they read your messages
  – Create a strategy to articulate:
    ✓ What you want your campaign to accomplish (objectives)
    ✓ What to say and have people do (key messages)
    ✓ To whom (audiences)
    ✓ How (channels)
    ✓ When (timeline & deliverables)

Be prepared to answer questions about:
• What’s happening with Health Care Reform, and when
• Benefits for part-time, per-diem, and seasonal employees
• Exchanges – whether employees are eligible and what they need to do
• What it all means for employer-sponsored benefits
Open Enrollment – Start Early

• Do your homework to determine:
  – Whether plans cover 60% of essential health benefits
  – If any employees qualify for a premium subsidy
  – What to say about state exchanges
  – Your part-time employee strategy

• Prepare the communication strategy and develop a project plan to meet OE deadlines
  – Make sure you incorporate required messages and deliverables

• Give advance notice to employees that materials are on their way so materials aren’t lost in the mix
Provide Advance Info to Leaders

- Help them understand the impact on the organization
  - Overview of the provisions
  - How employees are impacted
  - Communication plans
- Provide key messages and talking points
Key Messages

- Basic information about how health care reform
  - Timing
  - How it affects their benefits
    - Who will be impacted by part-time rule – and how
    - What exchanges will mean for their benefits
  - Required announcements/deliverables
    - State exchange basics (Model Notice)
    - Your plan value
    - Tax implications
Health Care Reform – Give a Simple Update

- **No limits on pre-existing conditions:** “No matter your health, you can’t be denied coverage”
- **Pay or Play:** “Organizations with at least 50 eligible employees must offer affordable insurance or pay a penalty”
- **Exchanges:** “Health insurance exchanges will be set up in each state, so you can compare plan options based on price, benefits and services, and quality. States have lots of options on how they can do this. This may get complicated.”
Key Messages

• Your value proposition
• Say very clearly what employees need to do, and when
• Explain how to learn more when information becomes available
• Direct employee questions
Develop a “Brand”

- Develop a consistent **look and feel**
- Help employees identify that messages are coming from their employer
- Take credit for providing benefits
Emphasize the Value of your Organization’s Benefits

Use as teaching moment

- How much health care costs
- How the company and employees share that cost
Present a timeline of events to help employees understand how it will affect them and know what they will need to do.

## Health Care Reform

### A Look Ahead at Health Care Reform

Some portions of health care reform will not be implemented for several years. Below is a timeline of some of the health care reform provisions over the next several years.

<table>
<thead>
<tr>
<th>Year</th>
<th>Events</th>
</tr>
</thead>
</table>
| 2012 | - Employers will report aggregate cost of employer's health coverage on W-2 for 2011 tax year. (Note: this does not mean you will be taxed on the value of your health care benefits. The amount is simply being reported to the federal government.)
- Uniform Summary of Benefits will be distributed to all benefits-eligible employees. |
| 2014 | - Most U.S. citizens and residents will be required to purchase health coverage or pay an annual penalty.
- Employers with over 200 employees will be required to enroll employees in their health care plans automatically, unless the employee opts out.
- To purchase insurance, subsidies will be provided for families earning up to 400% of the federal poverty level (approximately $88,000 per year for a family of four in 2010).
- Employers must offer "minimum essential coverage" or pay annual penalties to the government.
- Employers cannot restrict or deny coverage to adults for pre-existing conditions.
- The waiting period for group health care coverage cannot exceed 90 days. |
| Beyond 2014 | - A 40% excise tax will be imposed on high-value or "Cadillac" insurance plans.
  - For active employees, the tax will apply when the total premium (which includes both the employer and the employee's share) exceeds $10,200 for single coverage, or $27,500 for family coverage.
  - For retirees, the tax will apply when the total premium (which includes both the employer and the employee's share) exceeds $11,650 for single coverage, or $30,950 for family coverage. |
Make information readily available

Make it easy to **read**
- List of terminology with simple, plain English definitions for common PPACA terms
- FAQs so employees can find the information they need quickly and reduce message clutter

Make it easy to **find**
- Central location (such as HR office, intranet page, or microsite) to post updated info
- Provide a mechanism for feedback
- Educate managers, supervisors, and leaders to answer questions
### Health Care Reform Provisions Effective January 1, 2011

#### What’s Changing

Here are the benefit plan changes that begin on January 1, 2011 as required by health care reform.

<table>
<thead>
<tr>
<th>Health Care Reform Requirements</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employers must allow employees to cover children on health care plans until age 26.</td>
<td>We are changing the eligibility requirements for our medical plan. You may cover natural, adopted, or step children until their 26th birthday, regardless of:</td>
</tr>
<tr>
<td></td>
<td>- Your child’s student status,</td>
</tr>
<tr>
<td></td>
<td>- Whether you claim your child as a dependent on your tax return,</td>
</tr>
<tr>
<td></td>
<td>- Your child’s marital status, and/or</td>
</tr>
<tr>
<td></td>
<td>- Whether your child is eligible for coverage under other medical plans (such as through their own employer).</td>
</tr>
<tr>
<td></td>
<td>You may enroll your child during open enrollment. If you are enrolling a child for the first time, you must provide the child’s birth certificate, adoption certificate, legal order, or other documentation to prove eligibility.</td>
</tr>
<tr>
<td>Employers may not place lifetime or annual dollar limits on essential benefits.</td>
<td>We are removing the $2,000,000 lifetime maximum. We will also eliminate annual dollar limits on benefits. (Note: Number of annual visits may still be limited for certain treatments.) That means essential medical coverage – such as doctor visits, hospitalizations, and prescriptions – will continue regardless of how much care you may need while you are enrolled in medical plan.</td>
</tr>
<tr>
<td>Employees may not use their Health Care FSA to pay for over-the-counter drugs, with a couple exceptions.</td>
<td>You may no longer use your Health Care Flexible Spending Account to reimburse yourself for over-the-counter drugs. However, you may reimburse yourself for over-the-counter drugs if they are prescribed by your doctor, and you may continue to use your FSA to pay for insulin.</td>
</tr>
<tr>
<td>Employers may not deny coverage to children who have pre-existing conditions.</td>
<td>If your child has a pre-existing condition that excluded him or her from coverage in the past, you may enroll your child in the medical plan during open enrollment.</td>
</tr>
</tbody>
</table>

#### What’s Not Changing

Medical plan will stay the same in a lot of ways for 2011. Here’s what won’t change:

- We are not making any changes to the medical plan design. Your deductibles, co-insurance amounts, and covered benefits will remain the same.
- Medical plan will still be a Participating Provider Option (PPO) – so you can go to any physician you choose. You save money and receive better benefits by choosing providers in the BlueCross network.
- We will continue covering in-network preventative procedures – such as annual physicals, vaccines, mammograms, and colonoscopies – at 100% with no annual dollar limit.
Make information readily available

2013 Open Enrollment: October 29 to November 16

Open Enrollment is the designated period of time when you can enroll in or make changes to your benefit options. This year’s Open Enrollment will take place between October 29 and November 16, 2012.

Note: This is a passive enrollment period, meaning that if you do not enroll, your benefits from last year will automatically carry forward. You only need to enroll if you wish to make changes to your benefits or contribute to a Health Care or Dependent Care Flexible Spending Account. Your choices remain in effect January 1 - December 31, 2013 unless you have a qualified change in status.

Choosing the right health plan for you and your family can seem complicated, but it's manageable if you follow the few simple steps below.

Before you begin, it's good to have some information on hand including:

- A list of the doctors and providers your family sees for care
- A list of the medications your family regularly takes
- An idea of what care your family received in the past year

1. Review your Enrollment Materials
   - Why? So you can see your plan options and calculate costs so you can choose the right plan for you and your family.
   - Action Step: Review your 2013 enrollment guide and visit the HolChoice or AppChoice page to

2. Check Your Doctors and Other Health Care Providers
   - Why? If your doctors are in-network, you'll get the best level of benefits and pay the lowest costs.
   - Action Step: Visit Find A Doctor tool and search for your doctors and hospitals.

3. Check Your Medications
   - Why? You can estimate what you'll pay by knowing how they are covered. You can also see if there will be opportunities to switch to a lower cost medication as part of your coverage.
   - Action Step:

4. Enroll in a Plan
   - Why? Review your options for 2013 to be sure you enroll in the best coverage for your family during Open Enrollment. (If you do not enroll, last year’s benefits carry forward.)
   - Action Step:
Wellness Incentives and Programs
## Wellness Incentives Benchmarks

<table>
<thead>
<tr>
<th></th>
<th>2011</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use financial rewards for individuals who participate in health management programs/activities (i.e., positive incentives)</td>
<td>54%</td>
<td>81%</td>
</tr>
<tr>
<td>Use penalties (e.g., increase premiums and/or deductibles) for individuals not completing requirements of health management programs/activities</td>
<td>19%</td>
<td>36%</td>
</tr>
<tr>
<td>Require employees to complete a health risk appraisal and/or biometric screening to be eligible for other financial incentives</td>
<td>35%</td>
<td>75%</td>
</tr>
<tr>
<td>Require employees to validate participation in healthy lifestyle activities in order to receive a reward or avoid a penalty</td>
<td>–</td>
<td>59%</td>
</tr>
<tr>
<td>Reward or penalize based on smoker, tobacco-use status</td>
<td>30%</td>
<td>62%</td>
</tr>
<tr>
<td>Reward or penalize based on biometric outcomes other than smoker, tobacco-use status (e.g., achievement of weight control or target cholesterol levels)</td>
<td>12%</td>
<td>47%</td>
</tr>
<tr>
<td>Apply rewards or penalties and/or requirements under your health management programs/activities to employees and spouses alike</td>
<td>19%</td>
<td>59%</td>
</tr>
</tbody>
</table>

Proposed Wellness Rules

- Proposed Rule document was issued by the **Employee Benefits Security Administration (EBSA)** November 26, 2012
- Proposes amendments, consistent with ACA, for nondiscriminatory wellness programs in group health coverage
- Clarifies elements of the 2006 HIPAA nondiscrimination and wellness provisions
- Public comments were due January 25, 2013
- Proposed to apply to both grandfathered and non-grandfathered plans
## Five Wellness Requirements

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Original</th>
<th>Proposed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency of opportunity to qualify</td>
<td>Once per year</td>
<td>Same</td>
</tr>
<tr>
<td>Size of reward</td>
<td>20%</td>
<td>30%/50% for tobacco</td>
</tr>
<tr>
<td>Uniform availability and reasonable alternative standards</td>
<td>Same full award must be available</td>
<td>Same with clarification</td>
</tr>
<tr>
<td>Reasonable design</td>
<td>Promote health or prevent disease</td>
<td>Same with clarification</td>
</tr>
<tr>
<td>Notice of other means of qualification</td>
<td>Disclosure of availability</td>
<td>Same with new sample language</td>
</tr>
</tbody>
</table>
Two categories of Wellness programs

• Participatory – not required to meet the requirements
  – Complete biometric screening and HRA
  – Fitness center reimbursement
  – Rewards for health challenges

• Health contingent – required to meet the five requirements
  – Premium surcharge based on tobacco use
  – Rewards for meeting specific BMI, cholesterol, blood pressure and glucose levels
  – Requiring those who don’t meet standards to complete a program
Health Contingent Incentives

- Also known as “outcomes-based” or “health standards”
- Purpose of these proposed regulations is to clarify the design of health-contingent wellness programs

How many of you currently have a health-contingent wellness program?

How many of you are considering it?
Size of Reward

• Health-contingent wellness rewards increase to 30 percent of the cost of health coverage
• 50 percent for programs designed to prevent or reduce tobacco use
• Total cost of employee-only coverage or,
• If spouse of dependents may participate, the total cost of the respective coverage
Notice of Other Means to Qualify

• Disclose availability of other means of qualifying for the reward or possibility of waiver of standard in all plan materials describing the wellness program

• New sample text and examples intended to be simpler for individuals to understand and to increase likelihood that those who qualify will take advantage of the alternative
Notice – Sample Language

“Your health plan is committed to helping you achieve your best health status. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact us at [insert contact information] and we will work with you to find a wellness program with the same reward that is right for you in light of your health status.”
Reasonable Alternative Standards

• Or the standard can be waived for an entire class or on an individual basis

• Purpose of the proposed regulations is to clarify the definition of reasonable alternative to avoid “prohibited discrimination”

• Intent that these clarifications help ensure that the program is reasonably designed to improve health and not a subterfuge for reducing benefits based on health status

• Available to all similarly situated individuals
Reasonable Alternative Standards

• Provided if:
  – It is unreasonably difficult due to a medical condition
  – It is medically inadvisable to attempt to satisfy the standard

• The same, full reward must be available to those who satisfy the alternative
Reasonable Alternatives

• Physician verification for claims that require medical judgment

• Under proposed rules, individuals would not have to improve their health to earn a reward, even if achieving the goal would not be unreasonably difficult
Reasonable Alternative Comments

• Focused on the definition of a reasonable alternative for health-contingent incentives

• If an individual has a medical condition, the standard should be set by the individual’s health care provider

• Individuals who do not meet the health standard and do not have a medical condition may qualify if they are improving toward the health standard
Reasonable Design

• Programs must be reasonably designed to promote health or prevent disease
• Not be overly burdensome
• Not be a subterfuge for discrimination based on a health factor
• Not be highly suspect in method
• Comments invited on how to effectively target wellness programs so not a one-size-fits-all approach
Reasonable Design

- Commentary by various groups supports employers taking a comprehensive approach.
- For example, if you just offer a walking program and then implement health contingent incentives, you are probably not providing enough support for participants to achieve the health standards.
- A reasonably designed wellness program should be comprehensive and address Wellness Core Success Factors.
Wellness Core Success Factors

1. Strategic Planning
2. Culture and Environment
3. Program Administration
4. Programs
5. Engagement
6. Measurement and Evaluation
Effective Incentives

“The effectiveness of incentive programs depends critically on how the incentives are timed, distributed, and framed, and several factors might make insurance-premium adjustments, the most common implementation mechanism, less effective dollar for dollar than other approaches.”

Effective Incentives

• Incentives should provide **immediate** and **frequent** positive feedback or reward. People are more attracted to immediate benefits than delayed benefits and more deterred by immediate than delayed costs.

• Mental accounting - the **effect of rewards diminishes when bundled** into larger sums of money: a $100 discount on premiums may go unnoticed, whereas a $100 check in the mail may register as an unexpected windfall.

Wellness Program Design

• Even if your health-contingent wellness program meets the criteria outlined by the Affordable Care Act Wellness Guidelines, consider other implications
  – GINA
  – ADA
  – Organizational culture

• Just because you can, and everyone else is doing it, doesn’t mean it’s the right thing to do
Questions & Answers

• Presentation slides, an audio recording and Q&A transcript can be found on the Findley Davies website, www.findleydavies.com (Resource Center, Webinars)

• Our next Webinar is scheduled for May 22\textsuperscript{nd}
  – Proposed Wellness Rules
  – IRC 6056 Reporting Requirements
  – Eligibility Definitions for HIPAA-excepted Benefits
     ▪ Dental
     ▪ Vision
  – Other Ancillary ACA issues
Thank You

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