**Enfield Board of Selectmen**
**Whitney Hall**
**Enfield, New Hampshire**

**MINUTES of July 1, 2013**

**Board of Selectmen:** John W. Kluge, Chairman; Fred Cummings; Donald J. Crate, Sr.

**Administrative Staff:** Steven Schneider, Town Manager; Jim Taylor, Director of Public Works

**Others:** Dan Kiley, Mike Sampson, Canaan Town Administrator,

## BUSINESS MEETING

### I. CALL TO ORDER

Mr. Kluge called the meeting to order at 6:00 PM.

### II. APPROVAL OF MINUTES

Mr. Cummings moved to approve the minutes of June 3rd, 2013 as printed, Mr. Crate seconded, vote unanimous in favor of the motion.

### III. COMMUNICATIONS

**Shoreland Permit Application – Sanders, 496 Shaker Blvd.** This project involves patio renovations/addition, the rehabilitation of stone wall and the replacement of stairs.

**Wetlands Permit Application.** The Town has applied for this permit to repair a sagging sewer line.

**Comcast correspondence.** Comcast has indicated that they will be changing channel packages.

**Roads Scholar Program –** Town Employees Norman Ruel and Don Lashua have achieved Roads Scholar Level Two.

### IV. BOARD REPORTS

**Enfield Village Association (EVA):**
Kluge reported that EVA has received a grant from the Bryne Foundation to help with the rehabilitation of the Greely House.

### V. TOWN MANAGER'S REPORT

## VI. PUBLIC COMMENTS

**Dan Kiley –** Mr. Kiley informed the Board that the Mascoma School Board will be obtaining an appraisal for the land they own that is located behind the SAU office. The majority of that land is located in Canaan. Would it be possible to extend Enfield water/sewer lines to the Canaan portion of that land? The Town would need to check with the City of Lebanon to review any possible extension into Canaan and potential users.
The question was also raised about any potential boat parades. Inquiries should be forwarded to the various lake associations.

## VII. BUSINESS

**Mike Sampson – Canaan Town Administrator:**
Mr. Sampson made a detailed presentation that centered on Health Care. (the handout distributed by Mr. Sampson is included) The Town of Canaan Selectboard asked Mr. Sampson what could be done to address health care costs not only for the Town of Canaan organization, but also the community as well. Mr. Sampson was instrumental in establishing a community healthcare clinic in Plainfield Vt. That particular center serves six Vt. Towns, and has been in existence since 1975. Mr. Sampson has been focusing on what we can control locally; prescriptions, primary care, and insurance administration. If we can somehow combine our communities purchasing power the costs for prescriptions should be lower, as well as forming a larger pool to spread risk. Mr. Sampson's goal is to achieve 26% overall savings in what we currently spend on healthcare. He asked the Enfield Selectboard to assist engaging Enfield residents to be a part of the conversation to address rising health care costs. There will be a meeting in August that will describe in detail how the citizens of the five towns in the Mascoma Valley School District can work to achieve some stability with regard to health care costs.

**Nick Loupis – Lake Street Sewer Extension:**
Mr. Loupis approached the Town inquiring if the Town would be interested in extending the sewer lines on Lake St. Specifically Mr. Loupis would be willing to extend the lines at his own expense, if the Town would waive the connection fees. The Board was comfortable with that arrangement as long as the lines were built to Town specifications.

**Curbside Trash/Recycling:**
Mr. Schneider described a meeting that he and Mr. Taylor had with representatives from Casella, the solid waste contractor. Casella is planning on starting the new curbside program the week of August 5th. Residents will be receiving two mailings, one from the Town that generally explains the program and one from Casella that will provide in detail what can be recycled, where to place the new bins, when the pick-up day will be, and when the new bins will be delivered. The new zero-sort recycling program will accept all plastics, #1 - #7, metals, paper, cardboard, and glass.

**Affordable Health Care Act:**
Mr. Schneider described a meeting he attended recently with other NH municipal officials that addressed implementing the Affordable Health Care Act. The Town as an organization will need to comply with the new Act. (attached is the handout from that presentation) The Town is not considered a large employer, one that has more than 50 full-time employees and as such that

releases us from a few components of the Act. The Town currently complies with the employee notification and the affordability requirements. The biggest hurdle for the Town will be in 2018 when the 40% excise tax on high cost health plans goes into effect. The Act sets a dollar threshold in 2018 for both single and family plans that will difficult to be under. If we use a conservative medical inflation rate of 7% for the next 5 years, the plans we offer will be well over the threshold and will subject our employees to a tax of approximately $80 per month. Without serious cost reform, the only ways we can achieve any cost savings with our plans is reduce benefits and to raise the deductible levels, which makes it difficult to keep our plans affordable. There are several years before that part of the Act takes effect and we do expect there to be some change to the threshold levels.

**Vacation Policy:**
Mr. Schneider presented an update to the Enfield Personnel Policy regarding vacation leave. The new vacation leave policy will grant employees 80 hours of vacation leave after one year of employment. The previous policy granted 40 hours after one year and 80 hours after two years. Everything else regarding the vacation policy remained the same. The Board was supportive of the change to the vacation leave policy.

**Sewer Waiver Request: Colman**
Mrs. Colman on US Rt. 4 has requested a waiver from connecting to the sewer system. The Board would like it confirmed that Mrs. Colman has a State approved septic system. Mr. Crate felt that they could grant the waiver just for her, and when the property was sold, the new owner would need to connect. Any document that was produced that outlined this allowance should be recorded at the Grafton County Register of Deeds. The Board will review this at the next meeting in August.

**Community Building Schedule:**
Mr. Schneider presented a Community Building Schedule Policy. The policy would give existing users the ability to schedule their event up to a year in advance and opened up scheduling in October. The Board felt that Enfield Town Departments and Enfield based community groups should have the ability to schedule events up to one year in advance and have the first opportunity to schedule their time. All other groups will be allowed to schedule their events only one month in advance. One-time events such as a wedding reception of baby shower may schedule more than a year in advance.

**Jones Hill Road: Construction**
Mr. Taylor shared with the Board that work on Jones Hill Road will begin on July 8th. The contractor will start by grinding up existing pavement and sub-base. An emulsified layer will then be laid out and cured for a week. The final phase will be two separate layers of pavement. If the weather cooperates the project should take one month to complete.

**Administrative Items: 2nd Quarter Water/Sewer Billing**
Mr. Taylor informed the Board that 2nd quarter billing would be sent out soon. The Board discussed the billing and was in agreement with Mr. Taylors's request.

**Other Business:**
Mr. Cummings asked that the hydrant near Barely Used Books be mowed clear. He also asked about the heating/cooling system upgrade at the Community Building. Mr. Taylor replied that an energy consultant will be hired to determine if an improvement may be made to the existing system rather than replacing the entire system. Mr. Cummings wanted to know the status of the Community Building floor resurfacing. Mr. Taylor responded that we will need at least 10 days to do the work and we are looking at the building schedule to find an appropriate time. Mr. Cummings wanted to know when the Town will go out to bid for the smaller pavement projects and Mr. Taylor felt that it would be a late Fall timetable. Mr. Cummings wanted to know where we were with the Transfer Station Storage Shed, and Mr. Schneider replied that we would like to wait for a while to determine the impact of the new curbside recycling program on the transfer station. Mr. Crate wanted to know if we had ordered the lights on the Shaker Bridge. Mr. Schneider confirmed that we will be ordering three lights, one placed closer to Rt. 4A, and the other two placed on the causeway headed toward Enfield Village. All of the wiring for the lights has been completed so this should be an easier installation than last time. Mr. Crate wanted to know if the paving of the small section on Baltic St. had been scheduled. Mr. Taylor asked if Mr. Crate would be willing to mark the area he thought should be paved. Mr. Crate was agreeable and will mark the area.

Mr. Schneider asked that the Board inform payroll that his raise should be issued. The Board agreed to do that.

**Adjourn:**
The meeting adjourned at 8:20pm.

_____
John W. Kluge, Chairman

_____
B. Fred Cummings

_____
Donald J. Crate, Sr.
Enfield Board of Selectmen

# Health Insurance & Health Costs

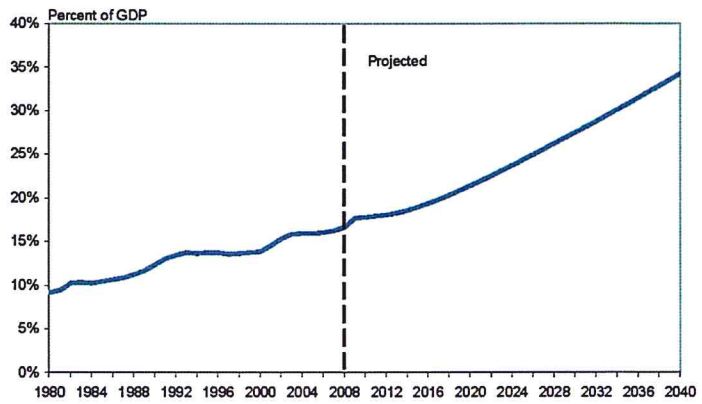
## How much? Who pays? Who uses it?

## How can we… towns, employers & patients … control costs?

Town of Canaan

# Health as % of GDP – The Future

**Figure 1: National Health Expenditures as a Share of GDP, 1980-2040**




Source: CEA calculations.

**Dartmouth Institute estimates that health care costs in the Upper Valley will equal 25% of all expense in 2017**

Town of Canaan

# Population that is Insured

## Percent of population that is insured 84%

## Who pays?

### Employers 59%

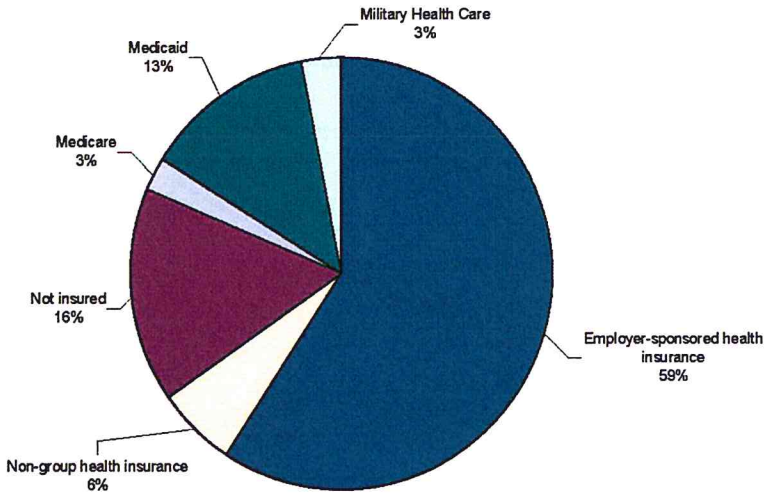
### Government 28%

### Individual 9%

Town of Canaan

# Who's Insured – By Whom?

Health Insurance Status of Non-Elderly Individuals in the United States, 2007




Source: U.S. Census Bureau. Income, Poverty, and Health Insurance Coverage in the United States: 2007.

Town of Canaan

# Smaller employers are dropping health coverage

In the United States, almost 96% of firms with 50 or more employees offer health insurance as compared with 43% of firms that have fewer than 50 workers. Among small firms, the percentage offering health insurance peaked in 2001 and has been gradually declining since then.

Assuming that real growth in the cost of employer-sponsored insurance premiums does not slow from current rates, the Council of Economic Advisors project that less than 20 percent of small employers will offer coverage by 2040.

Town of Canaan

# How have Deductibles Changed?

| Total Plan Premium Costs | Percentage Increase | Average Cost per Employee | Average Employee Premium Contribution | Average Employee Out-of-Pocket Cost |
|---|---|---|---|---|
| 2013 (projected) | 6.3% | $11,188 | $2,385 | $2,429 |
| **2012** | 4.9% | $10,522 | $2,204 | $2,200 |
| **2011** | 8.5% | $10,034 | $2,090 | $2,072 |
| **2010** | 6.2% | $9,246 | $1,927 | $1,761 |
| **2009** | 5.0% | $8,703 | $1,797 | $1,580 |
| **2008** | 5.3% | $8,290 | $1,691 | $1,508 |
| **2007** | 5.3% | $7,874 | $1,567 | $1,364 |

*Source: Aon Hewitt Health Value Initiative database of large U.S. employers' health care costs.*

Town of Canaan

# Growth Rates Over 10 Years

## 2002 – 2012 Inflation increased 26%

## Drug Price Growth – 89%

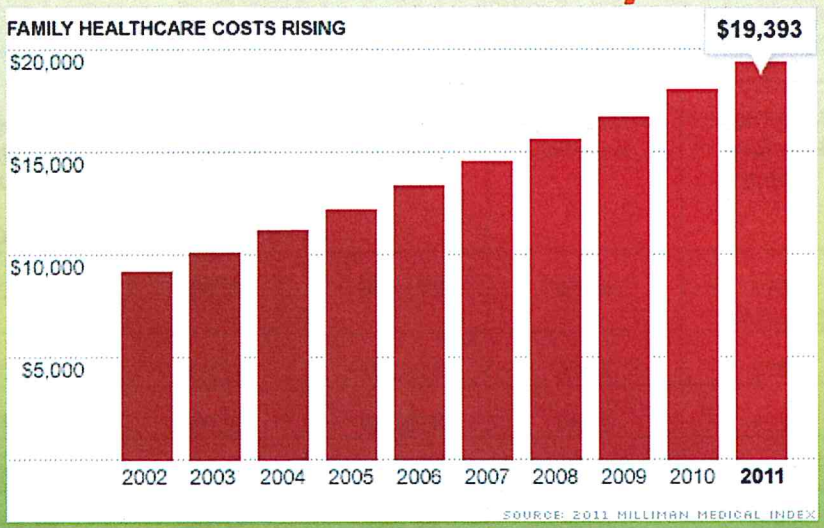
## Hospitalization – 67%

## Physicians – 66%

**Insurance premium growth rate during same period was 113%**

Town of Canaan

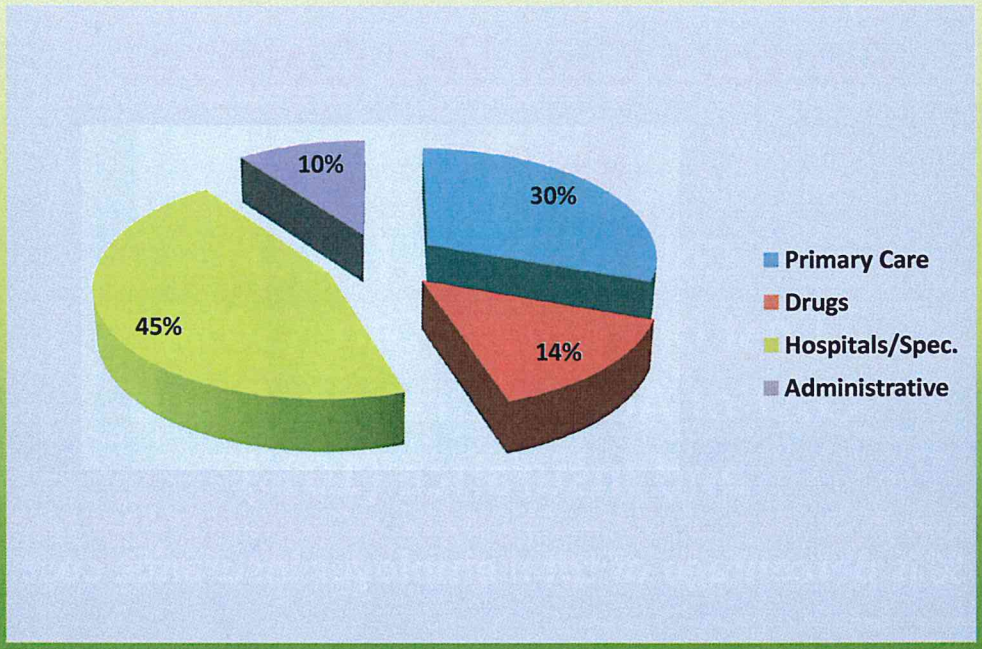
# The Growth in Family Costs




**The health care costs for a family of four have doubled in less than a decade from $9,235 in 2002 to over $19,000 in 2011 and $23,000 in 2013.**

Town of Canaan

# What makes up Health Care Cost?




Town of Canaan

# We Don't Manage Health Care Costs - Employers Shift Costs to Others

- We look for competition between insurance pools – making the insurance companies provide a leaner service
- We restrict the people we cover and reduce the pool whenever our costs get excessive – shifting the costs of care to our employees
- We make the employees pay a larger part of the premium cost – again shifting the cost to the employee
- We increase deductibles and co-pays – again shifting the cost
- We DO NOT manage actual health care costs

Town of Canaan

# What Health Care Cost Factors Can We Control locally?

Cost of Drugs (14%)
Cost of Primary Care (30%)
Cost of Administration, Fraud and Insurance (10%)

% is percentage of total employer insurance cost

Town of Canaan

# How do we control pharmaceutical cost?

Purchasing drugs at the lowest brokerage level, we can save 75-90% of the cost.

Typically, we pay an average of $800 per patient for drug coverage per year.

The potential savings would be at least $600 per patient per year

Town of Canaan

# How can we control primary care physician cost?

Create comprehensive, quality primary care centers that are cost effective and make incentives for people to use them – ownership, lower costs, convenience & quality

**Potential Savings - Half of Primary Care – about $1,500 per patient per year**

Town of Canaan

# How can we control insurance cost?

Spread risk over a longer period – 3-5 years and bigger community pool.

Keep savings

Local management of fraud

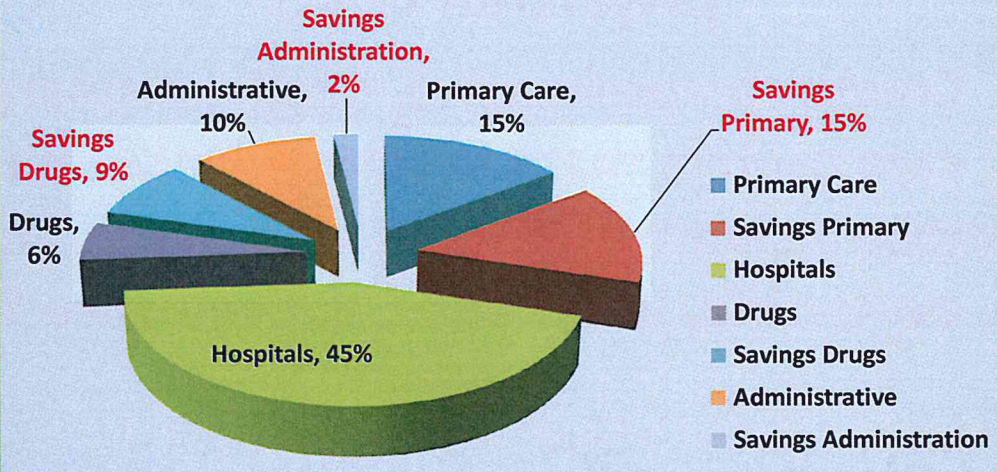
Voluntary tort limitation on non-intentional negligence

Offer our efforts to reduce costs through consumer participation/responsibility creating consumer based management of costs and better utilization

Pay for quality of Care, not number of visits or procedures

Town of Canaan

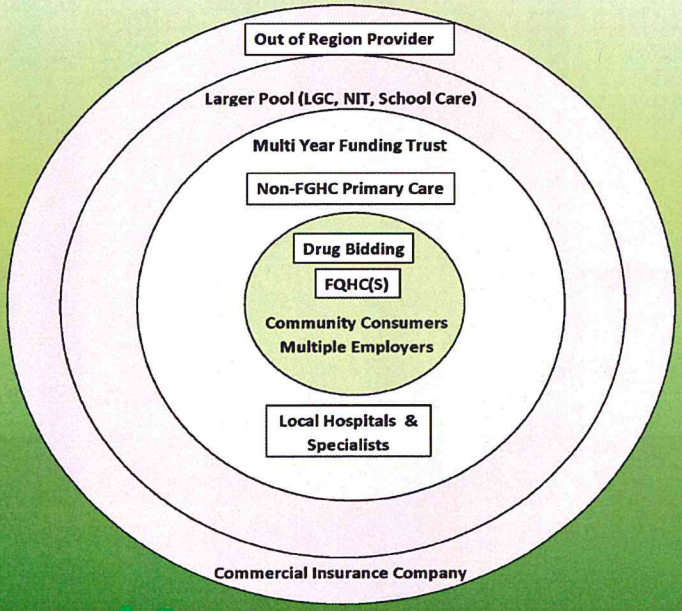
# Total System Cost Savings Goals




**Total Savings Goal 26%** and continuing

Town of Canaan

# How do we make it work?
# Create a Health Partnership
# Leverage our Premiums




**Pink is paid & managed through a traditional insurance company.**

**Green is paid through a traditional insurance company but is consumer managed with reduced primary care and drug costs and savings held by rate payers**

Town of Canaan

# Who Do We Need To Work With?

Employees/Patients
Premium Payers
Employee Unions
Employers
Local Primary Care Providers
Local Hospitals
Specialists
Local Non-Profits
Insurance Pools
Insurance Companies
State & Federal Governments

Town of Canaan

# What our Long Term Goals should be ...

Quality
Long term cost stability
Cost containment & full utilization, coordination and collaboration role with providers
Cost increases at rates no more than Inflation or 2x Inflation
Multiple plan levels for co-pay & deductibles
Consumer responsibility
Consumer choice and obligation for higher cost primary care alternatives
Competitive customer service
Reduced defensive medicine costs
Lower malpractice insurance costs

Town of Canaan

# Success So Far

- 25 Towns and Schools have joined by indicating a willingness to explore this option
- Alice Peck Day's Board and Management embraced the concept in June 0f 2012
- ReThink Health, an effort of 75 medical professional including DH and APD management as well as independent doctors, most regional non-profits, public and private employers insuring 10,000 UV employees, finance people, HR people and entrepreneurs pledged to work together in April of 2013 to make the system better – quality, cost containment, & access
- We started a Mascoma discussion to improve our communities in May of 2013

# Examples of Community Based Primary Care that offers quality and is accountable, convenient and affordable

**The Health Center – Plainfield, VT**
**Ammonoosuc Community Health Services**
**Mid-State Health Center**

# The Health Center - Plainfield, VT

**6 Rural Vermont Towns - Community Board**

**Comprehensive Community Health**

**Includes all income levels – sliding payment scale – Medicare & Medicaid**

**Quality Service**

**Created in 1975**

**14,000 registered Patients &**

**9,000 Patients Using Annually**

## Medical Primary Health Care

Four Physicians and four Physician Assistants provide a full range of primary health care services including:

- Family Medicine
- Internal Medicine
- Immunizations
- Gynecology
- Preventive Health Care
- Pediatric and Newborn Care*
- Specialist Referrals
- In Hospital Admissions and Care
- Nursing Home Care

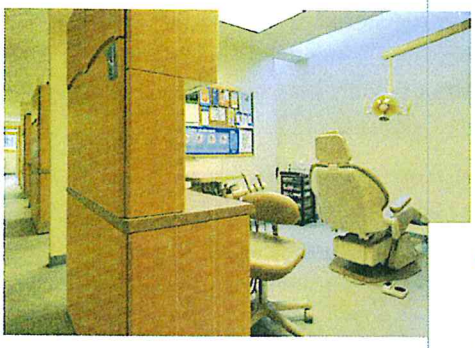
* We do not provide pre-natal care. We diagnose pregnancy and make referrals to area obstetrical practices.

## Community Health Pharmacy

The Community Health Pharmacy is a mail order retail pharmacy operated exclusively for Health Center patients. An automated dispensing unit is located in our Center to supply patients, at the time of their visit, with prescription medications for short term acute illnesses and with starter packages of longer term medications.


## Lab/Testing Services

A CLIA certified Category 1, COLA accredited medical laboratory is located at The Health Center, which can process many laboratory tests on site.



## Oral Health Care

Our staff of 3 dentists and 5 dental hygienists provide a wide range of primary general dental services for all ages including

- Hygiene (cleanings)
- Sealants
- Reconstructive dental care
- Root canals
- Crowns
- Surgical Extractions
- Bridges and Dentures

### Community Outreach

Two Social Workers assist our patients with applications for benefits such as VHAP, Catamount Insurance, and Medicaid; referrals to programs to help meet food, heating and housing needs; workshops, classes, and discussion groups: Healthier Living, Smoking Cessation, Nurturing Parenting, Cooking and Nutrition, and other classes scheduled by The Health Center.

They also help to coordinate Community Health Team services through the Vermont Chronic Care Initiative (formerly called the Blueprint for Health) and gather data for statewide health registries and programs.

### Physical Therapy

Essential Physical Therapy is located on the lower level of The Health Center. Referrals for physical therapy are made by Health Center staff.

### Nutrition

Our registered dietitian and Certified Diabetes Educator provides our patients with instruction for the dietary management of

- Hypertension
- Diabetes
- Elevated Cholesterol
- Weight Control

The Health Center has been designated as a Patient Centered Medical Home, Level 1, by the National Committee for Quality Assurance.

A Patient Centered Medical Home provides health care that helps to form partnerships between patients, their health care providers, and, when appropriate, the patient's family. Using established protocols of care, we model and measure health outcomes. The Health Center's team of providers and staff work with a community care team who assist patients with services that cannot be met by The Health Center staff. This designation further enhances the collaboration and teamwork that The Health Center has always strived to provide.

# Certified Patient Centered Medical Home

## 2013 BUDGET

| REVENUE | | |
|---|---|---|
| Misc . Revenue | $ 311,250 | |
| Patient Fees | $7,194,214 | FQHC $ 722,310 - Private $6,471,904 |
| Total Revenue | $7,505,364 | |

| EXPENSES | |
|---|---|
| Personnel | $4,490,923 |
| Fringe Benefits | $1,320,403 |
| Travel | $ 49,000 |
| Equipment | $ 63,000 |
| Supplies | $ 435,250 |
| Contractual | $ 247,000 |
| Repairs | $ 18,000 |
| Interest | $ 189,596 |
| Buildings & Grounds | $ 64,000 |
| Utilities | $ 47,000 |
| Fees / Licenses | $ 49,850 |
| Malpractice & Prop. Insur. | $ 100,500 |
| Continuing Education | $ 40,952 |
| Depreciation | $ 329,890 |
| Outreach | $ 19,750 |
| Misc. | $ 40,250 |
| Total Expense | $7,505,364 |

Full time staff Equivalent - 70
Patients – 14,000
Patients Using – 8,947
Visits 34,176
3.82 visits per user
Cost per Patient - $801.95
INCLUDES DENTAL
Add $200 for drugs
Total $1,001.95

Town of Canaan

# Summary - Cost Per Patient

**2013 Costs – Per Patient** **$801.95**

14,000 patients – 9,000 typically using the clinic

(Facility and Equipment cost included $3,000,000)

| | |
|---|---|
| **INCLUDES DENTAL** | **$0** |
| **Drugs would add** | **$200** |
| **Total** | **$1,001.95** |

TYPICALLY, WE SPEND ABOUT $2,800 PER YEAR ON INSURANCE PREMIUMS FOR PRIMARY CARE AND DRUGS –

POSSIBLE SAVINGS OF $1,800 PER PERSON PER YEAR

Town of Canaan

ACHS

# Ammonoosuc Community Health Services

ACHS - Littleton (Main/Admin. Offices)

ACHS - Franconia

ACHS - Warren

ACHS - Whitefield

ACHS - Woodsville

# Services

Comprehensive Primary Preventive Medical Care - Wellness Screening, Pediatrics, Chronic Disease Management, Geriatrics, Acute Illness Care, Nutrition

- Prenatal Care - Childbirth Education, Nurse/Midwife Service and Newborn Care
- Family Planning - Birth Control, STD and HIV Testing and Counseling
- Breast & Cervical Cancer Screening Program
- Behavioral Health - Counseling
- Partners in Health - Support for Families with Children with Chronic Health Conditions
- Oral Health Referrals and Voucher Program
- Pharmacy Services - In-house Pharmacy, Medication Management , Low-Cost Drug Program
- Financial Services - Sliding Fee Scale for eligible patients

# Staffing

ACHS-WARREN
Route 25, Main Street
603.764.5704

**9 Family Practice Physicians,**

**1 Pediatrician,**

**5 Advanced Practice Registered Nurses and 2 Physician Assistants.**

**2 of our Family Practice Physicians also practice obstetrics at Cottage Hospital.**

**We also contract with 2 Ob/Gyn Physicians in Littleton**

**1 NH Licensed Social Worker, a Clinical Psychologist and a Psychiatric Nurse Practitioner**

**We also employ Registered and Licensed Practical Nurses, Social Workers, Patient Navigators, and other support staff.**

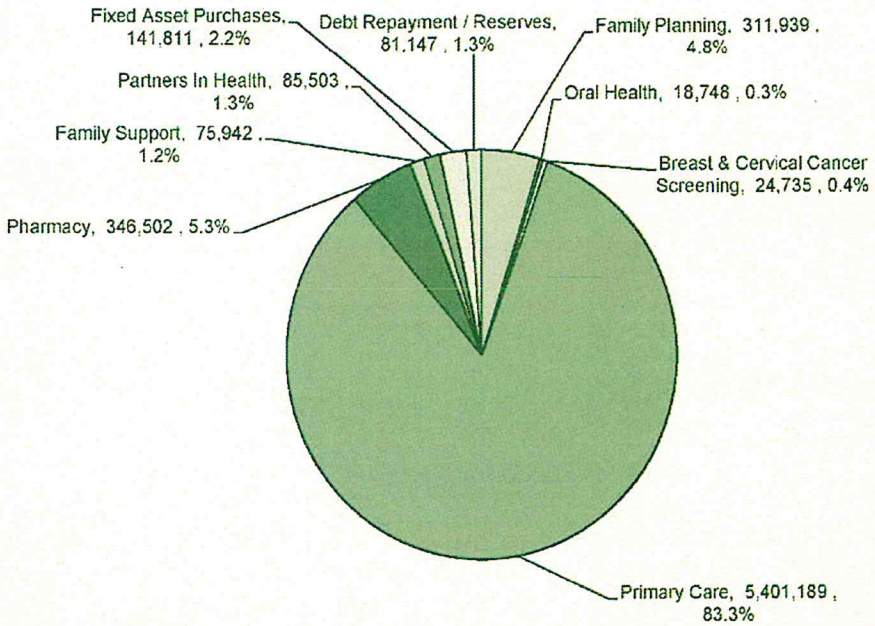
# FY2011-2012 Statistics

- Number of Unduplicated Medical Clients Served – 8,566
- Number of Medical Visits – 32,008
- Client/Payor Mix: 15.4 % Medicaid, 19.1% Medicare, 17.7% Uninsured, 46.5% Insured
- Value of free medications provided to our patients - $909,786
- Value of discounted health care services provided to our patients – $643,309 - (Sliding Fee Scale)

**Cost per Patient Served - $757.35**
**Dental & Drugs est. $350**
**Total $1,107.35**

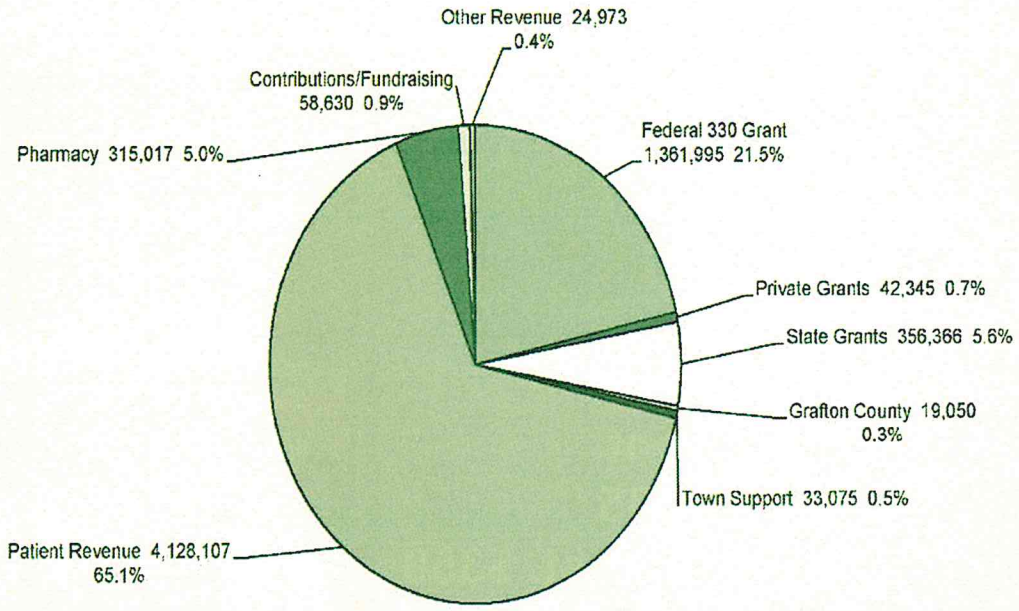

# ACHS Program Expenses

Fiscal year ending 6.30.2012



# ACHS Sources of Revenue

Fiscal year ending 6.30.2012




# Mid-State Health Center

MID-STATE HEALTH CENTER

*Where your care comes together.*

Mid-State employs a staff of more than 85 health care professionals delivering health care services to more than 10,000 patients annually in our Plymouth and Bristol offices.

With a team approach to health care, we create a personalized care experience for each patient.

## Staff Includes:


- 9 Physicians
- 4 Advanced Practice Registered Nurses
- 4 Registered Nurses
- 2 Licensed Practical Nurses
- 3 Clinical Psychologists
- 1 Health Coach (Registered Nurse)
- 1 Patient Support Specialist
- 14 Medical Assistants
- 1 Licensed Nursing Assistant
- 2 Pharmacy Assistants
- 1 Laboratory Technician
- 12 Patient Services Representatives

## Primary care services for the entire family:

- Urgent Visits
  (Same-day or next-day appointments are often available)
- Wellness and Preventive Care
- Management of Chronic Disease
- Health care for Infants and Children
- Women's Health (Gynecological)
- Immunizations for Infants, Children, and Adults
- Skin Evaluations
- Behavioral Health Services and Counseling
- Lab Services

## Finances

Net Revenue.....$6,121,645

Total Expenses
(Less Depr and BD).....$6,128,935
Depreciation Exp .....$ 95,394
Bad Debt Exp.....$ 182,170
Other Income .....$ 20,856
Net Income Before Grants.....$(263,998)

Grant Income .....$ 500,735
Net Income after Grants.....$ 236,737

**Cost Per Patient Served - $ 612.89**
**Dental & Drugs est. $ 400.00**
**Total $1,157.35**

## What's Been Planned Locally
## 105 Residents
## 2% from each of 4 towns

- First Meeting – 90 attendees - Defined the problem
  - Cost Increases
  - Access – location – time – coordinated service
  - Quality - coordination of providers – communication – cooperation in decision making – understanding – sufficient visit time
  - What do we like and dislike in local health care
- Second Meeting – added 15 new people
  - Prioritized what should be provided locally

## THE RESULTS

**Blue Box means unanimous agreement**

**Green Box means almost unanimous agreement**

**Red Stars mean 80% want to have**

**Green Stars means that 75% want to have**

| Area | Need | A | B | C | D | TOTAL SCORE | TOP 80% >16 | TOP 75% >14 |
|---|---|---|---|---|---|---|---|---|
| ACCESS | Referrals | 5 | 5 | 4 | 5 | 19 | ★ | |
| | Health/wellness visits | 5 | 5 | 3 | 5 | 18 | ★ | |
| | Choice - docs, drugs, insur. Etc | 4 | 5 | 5 | 4 | 18 | ★ | |
| | Availability of appointments | 5 | 5 | 4 | 4 | 18 | ★ | |
| | Serves whole family | 4 | 5 | 4 | 4 | 17 | ★ | |
| | In community | 4 | 5 | 4 | 3 | 16 | | ★ |
| | Enough time in visit | 3 | 5 | 4 | 4 | 16 | | ★ |
| | Insurance regardless of employer | 5 | 5 | 2 | 4 | 16 | | ★ |
| | Evening hours | 4 | 5 | 3 | 3 | 15 | | ★ |
| | Home health/visits | 5 | 5 | 3 | 2 | 15 | | ★ |
| | 7 days a week | 2 | 5 | 3 | 4 | 14 | | |
| | Fast rescue | 3 | 5 | 4 | 2 | 14 | | |
| | Transportation | 5 | 4 | 3 | 2 | 14 | | |
| | Combined svcs in 1 visit | 3 | 3 | 4 | 3 | 13 | | |
| | No wait | 3 | 3 | 3 | 3 | 12 | | |
| AFFORDABLE | Lower price for testing | 5 | 5 | 5 | 5 | 20 | ★ | |
| | No wasted services | 5 | 5 | 5 | 4 | 19 | ★ | |
| | No unnecessary services | 5 | 5 | 5 | 4 | 19 | ★ | |
| | Fair / consistant charges | 5 | 5 | 5 | 4 | 19 | ★ | |
| | Insurance costs vs private pay | 5 | 5 | 4 | 5 | 19 | ★ | |
| | Low co-pays | 4 | 5 | 5 | | 18.667 | ★ | |
| | Low deduct. | 4 | 5 | 5 | | 18.667 | ★ | |
| | Sliding scale | 5 | 5 | 4 | 4 | 18 | ★ | |
| | Community insur. | 5 | 5 | 4 | 4 | 18 | ★ | |
| | Min. Prime. Care | 4 | 5 | 4 | | 17.333 | ★ | |
| | Low premium share | | 5 | 4 | | 12 | | |
| EDUCATION COUNSELING | Community education | 4 | 5 | 4 | 2 | 15 | | |
| | School education | 1 | 5 | 4 | 2 | 12 | | |
| HEALTH SVCS TYPES | Immunizations | 5 | 5 | 5 | 4 | 19 | ★ | |
| | Chronic Disease | 5 | 5 | 4 | | 18.667 | ★ | |
| | Dental care | 5 | 5 | 4 | 4 | 18 | ★ | |
| | Pre-natal | 5 | 5 | 4 | 4 | 18 | ★ | |
| | Wellness | 5 | 5 | 4 | 4 | 18 | ★ | |
| | Mental health | 5 | 5 | 3 | 4 | 17 | ★ | |
| | Mid-wife | 5 | 4 | 4 | 4 | 17 | ★ | |
| | Nutrition | 4 | 5 | 4 | 3 | 16 | | ★ |
| | Auditory | 3 | 5 | 4 | 3 | 15 | | ★ |
| | Physical therapy | 3 | 5 | 4 | 3 | 15 | | ★ |
| | Hospice | 2 | 5 | 4 | | 14.667 | | ★ |
| | Dermatology | | 5 | 4 | 2 | 14.667 | | ★ |
| | Eye care | 3 | 4 | 4 | 3 | 14 | | |
| | Alternative meds | 4 | 5 | 3 | 1 | 13 | | |
| | Rehab | 1 | 5 | 3 | 3 | 12 | | |
| | Exercise | 1 | 5 | 3 | 1 | 10 | | |
| | Chiropractic | 1 | 3 | 3 | 2 | 9 | | |
| HEALTH PROCEDURES | Birth control | 5 | 5 | 4 | 5 | 19 | ★ | |
| | Acute care | 5 | 5 | 4 | 5 | 19 | ★ | |
| | Lab | 5 | 3 | 5 | 5 | 18 | ★ | |
| | Screening | 5 | 5 | 3 | 5 | 18 | ★ | |
| | X-Ray | 5 | 3 | 4 | 5 | 17 | ★ | |
| | Nutrition | 4 | 5 | 4 | 4 | 17 | ★ | |
| | Specialists | | 3 | 3 | 5 | 14.667 | | ★ |
| PHARMACY | Low cost | 5 | 5 | 5 | 4 | 19 | ★ | |
| | No mistakes | 5 | 5 | 5 | 4 | 19 | ★ | |
| | Drug counseling | 5 | 5 | 5 | 4 | 19 | ★ | |
| | Available immediately | 5 | 5 | 4 | 4 | 18 | ★ | |
| | Alternative drugs | 3 | 5 | 4 | 4 | 16 | | ★ |
| QUALITY | Listens | 5 | 5 | 5 | 5 | 20 | ★ | |
| | Works cooperatively with me | 5 | 5 | 5 | 5 | 20 | ★ | |
| | Clear communications | 5 | 5 | 5 | 5 | 20 | ★ | |
| | Shared decision making | 5 | 5 | 5 | 5 | 20 | ★ | |
| | Low infection | 5 | 5 | 5 | 5 | 20 | ★ | |
| | Accurate records | 5 | 5 | 5 | 5 | 20 | ★ | |
| | No mis-diagnosis | 5 | 5 | 5 | 5 | 20 | ★ | |
| | Help me understand | 5 | 5 | 5 | 5 | 20 | ★ | |
| | Insur. Co. should not overly restrict care | 5 | 5 | 5 | 5 | 20 | ★ | |
| | Coordinated care | 5 | 5 | 4 | 5 | 19 | ★ | |
| | Compatible records | 5 | 5 | 4 | 5 | 19 | ★ | |
| | Patient cooperates with doctor | 5 | 5 | 4 | 5 | 19 | ★ | |
| | Access to sophisticated procedures | 5 | 5 | 4 | 5 | 19 | ★ | |
| | Personal relationship | 5 | 5 | 4 | 2 | 16 | | ★ |
| PSYCHSOC SVCS | Smoking | 5 | 5 | 4 | 3 | 17 | ★ | |
| | Nutrition / Obesity | 5 | 5 | 4 | 3 | 17 | ★ | |
| | Drug / Alcohol | 5 | 5 | 3 | 3 | 16 | | ★ |
| | Support groups | 5 | 5 | 3 | 3 | 16 | | ★ |
| | Grief Counseling | 4 | 5 | 3 | 3 | 15 | | ★ |
| | Adult day care | 5 | 1 | 4 | 3 | 13 | | |
| | Mental health facility | 1 | 5 | 4 | 3 | 13 | | |
| | Nothing unnecessary | 5 | 1 | 3 | 3 | 12 | | |
| LONG TERM | Respite | 5 | 5 | 4 | 1 | 15 | | |
| | Adult day care | 4 | 4 | 3 | 1 | 12 | | |
| STAFF | General practitioner | 5 | 5 | 5 | 5 | 20 | ★ | |
| | Qualified practitioners | 5 | 5 | 5 | 5 | 20 | ★ | |
| | Team approach | 5 | 5 | 5 | 5 | 20 | ★ | |
| | Low turn-over | 5 | 5 | 4 | 5 | 19 | ★ | |
| | APRN (Nurse Practitioners) | 5 | 5 | 4 | 5 | 19 | ★ | |
| | OB/GYN | 5 | 5 | 4 | 5 | 19 | ★ | |
| | Pediatrician | 5 | 5 | 4 | 4 | 18 | ★ | |
| | Dentist | 5 | 5 | 5 | 3 | 18 | ★ | |
| | Dental hygenist | 5 | 5 | 5 | 3 | 18 | ★ | |
| | Dedicated school nurses | 5 | 3 | 5 | | 17.333 | ★ | |
| | Qualified emergency response | 5 | 4 | 4 | 4 | 17 | ★ | |
| | Caring practitioners | 5 | 5 | 4 | 3 | 17 | ★ | |
| | Pharmacist | 5 | 5 | 4 | 3 | 17 | ★ | |
| | Pharmacy Assistant | 5 | 5 | 4 | 3 | 17 | ★ | |
| | Laboratory technician | 5 | 5 | 4 | 3 | 17 | ★ | |
| | X-Ray tech | 5 | 5 | 4 | 3 | 17 | ★ | |
| | Psychiatric nurse practitioner | 5 | 5 | 4 | 2 | 16 | | ★ |
| | Patient advocate(s) | 5 | 5 | 4 | 1 | 15 | | ★ |
| | Psychologist | 4 | 5 | 3 | 3 | 15 | | ★ |
| | Dietician | 5 | 4 | 3 | 3 | 15 | | ★ |
| | Holistic care providers | 4 | 5 | 4 | 1 | 14 | | |
| | Health coach | 3 | 5 | 2 | 4 | 14 | | |
| HARDWARE | Medical equipment providers | 5 | 5 | 4 | 4 | 18 | ★ | |
| | Low cost medical equipment | 5 | 5 | 4 | 4 | 18 | ★ | |
| | Long life equipment | | | | | 0 | | |
| | Perfect Consensus | | | | | | | |
| | Nearly Perfect Consensus | | | | | | | |

## The Nature of Good Health Care

- Good Health Care offers several local general practitioners who are teamed with a specific nurse practitioner to give every patient more depth in their care and coverage and at least two care providers that the patient knows personally and feels comfortable with. The health care providers work as a team with other services of the clinic like lab services.
- Medical care should include pediatrics, pre-natal and professional mid-wives
- Dental care including a dentist and dental hygienists should be included.
- Laboratory services, Physical Therapy, Pharmacy, Nutrition, Therapy, Hospice, Home Visits, Mental Health and minor X-Ray services should be available.
- Medical care should be coordinated with hospitals, specialists, local schools, daycares, senior programs, government programs, Veterans Administration, public housing and community assistance programs.
- Assistance in getting insurance and maintaining insurance that is affordable should be provided.


## Access to Good Health Care

Good health care should be local. It should serve the entire community and entire families.
Care should be a matter of choice. There should be no requirements for use.
Appointments should be readily available and happen in a timely manner. Evening and weekend appointments need to be available. Appointments should allow enough time with the professionals to truly understand and manage health problems.
We should try to include current primary care doctors if possible.
All patients should have access to local hospitals and specialists as needed.

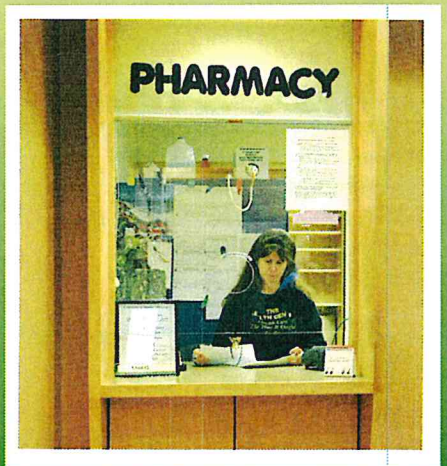
## Good Health Care has built in quality control. It assures:

- an organized health team that integrates patient, doctor, nurse practitioner, lab services, rehab, social services, mental health counseling, pharmaceuticals, nutrition, and dental care
- close communication between the patient, the providers and between providers
- that the team coordinates external services
- full communication with the patient regarding plans, procedures, results and revisions
- that the patient shares in the decision making with understanding, cooperation and agreement
- that there is sufficient time available for the communication and coordination
- that there is independent quality control using a patient advocate to review records and patient history to assure that the goals for communication, understanding, decision sharing and coordination with external services is achieved
- that integrates team health care around a patient that include the doctor, a nurse practitioner, lab services, rehab, social services, mental health counseling, pharmaceuticals, nutrition, and dental care

## Financing Good Health Care

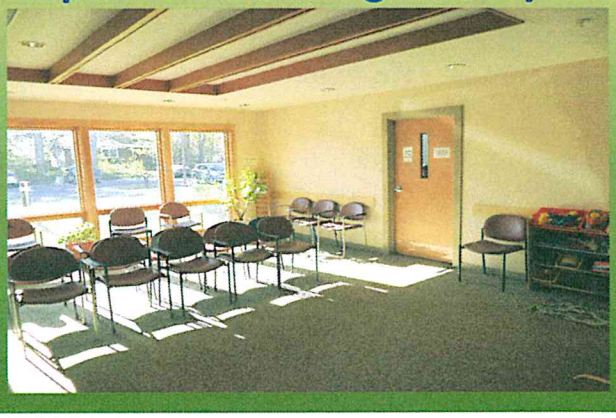
- Cost Care that is affordable assures that the cost of professionals, drugs, tests, procedures and rehab are as reasonable as possible, fair for all and the same for insured and uninsured patients.
- It should adopt a sliding scale system for those who can't afford insurance or full payment for service based on what they can afford.
- Develop a community insurance policy that is affordable.
- Reduce waste and duplication of service and offer service in the lowest cost environment (not an emergency room).
- The goal is to cut primary care costs by 50% and drug costs by at least 75% and reduce or stabilize insurance premiums to keep insurance affordable.

*New money isn't needed – there is enough existing money to fund the change.*



## Accountability in Good Health Care

**This clinic would be *controlled by the users in the community*, not by a hospital or the State or federal government or a town government. It would be funded by the users with a shared sense of responsibility and shared expense but with generally much lower expense.**



## NEXT STEPS

- **Prepare a specific draft plan using existing resources whenever possible but with local control through collaborative effort**
- **Community looks at a draft plan**
- **Community modifies the draft plan**
- **Get a community commitment to use the plan**
- **Facilitate the implementation of the plan using existing resources**

LGC
NEW HAMPSHIRE
Local Government Center
HealthTrust

# LGC HealthTrust Healthcare Reform Update

June 2013

**Presented by:**
**David Law, Benefits and Coverage Counsel**
**Melisa Briggs, Assistant Manager, Benefits**
**Darlene Simmons, Risk Pool Services Advisor**

## Disclaimer

**This healthcare reform presentation and slides are provided for general informational purposes. They are not intended as and do not constitute legal or tax advice. Questions regarding your specific circumstances should be addressed to your legal, tax or other professional advisers.**

2

# Agenda

- Overview
- 2011-2013 Provisions
  - **2011 Reforms**
  - **Preventive Health Services (2011 Plan Year)**
    - **Women's Preventive Services (2013 Plan Year)**
  - **W-2 Reporting (beginning CY 2012)**
  - **Summary of Benefits and Coverage (SBC) Requirements (2013 Plan Year)**
  - **Healthcare FSA Contribution Limits (2013 Plan Year)**
- Preparing for the Big Year - 2014
  - **Notice of Exchanges (by 10/1/2013)**
  - **Exchanges ("Health Insurance Marketplaces")**
  - **Employer Shared Responsibility Penalties**
  - **Employer Reporting Requirements**
  - **90-Day Maximum Waiting Period (2014 Plan Year)**
- Funding Sources Impacting HealthTrust Plans
  - **Comparative Effectiveness Research (PCORI) Fees (2012-2018 Plan Years)**
  - **Transitional Reinsurance Program Fee (CY2014-CY2016)**
  - **Excise ("Cadillac") Tax on Certain High-Cost Plans (2018)**

3

# Healthcare Reform Law and Effective Dates

- The Patient Protection and Affordable Care Act of 2010 as amended by the Health Care and Education Reconciliation Act (PPACA or ACA); came into effect after 9/23/2010
- US Supreme Court ruled PPACA constitutional on 6/28/2012
  - Individual coverage mandate upheld because penalties = taxes
  - States can opt out of new Medicaid expanded coverage
- Many provisions of the law apply on plan's anniversary, but certain provisions have CY effective dates:
  - W-2 Reporting Requirements (1/2013 for CY 2012)
  - Employer Shared Responsibility Penalties (1/1/2014)
  - Employer reporting to IRS and Employees (1/2015 for CY 2014)

4

## What We Understand Today

- Regulations and rules continue to be issued by federal agencies
- Some still have to be finalized
  - Proposed → Interim → Final
- Remember: PPACA generally does not impact retiree-only plans (Medicomp)
- This presentation is based on what we understand TODAY

5

## 2011 Reforms

- Grandfathered Plans
- Coverage for Dependent Children to Age 26
- Preventive Services without Patient Cost Sharing
  - Women's Preventive Health Care (2013 Plan Year)
- No Annual and Lifetime Dollar Limits for "Essential Health Benefits" (with limited exceptions until 2014)
- Other Enacted Provisions
  - No rescissions, expanded appeals processes, out-of-network emergency care, and designating PCPs and OB/GYNs
- Health FSA Over-the-Counter Product Reimbursement Rules
- Early Retiree Reimbursement Program (ERRP)

6

## Preventive Services (2011 Plan Year)

- 100% coverage for in-network preventive services
  - No cost to patient
- Preventive services include:
  - Routine physical exams, routine vision and hearing exams
  - Screenings (mammograms, colonoscopies, lab work)
  - Immunizations
  - Smoking cessation counseling
  - Various other services described in the U.S. Preventive Services Task Force A and B recommendations, and certain other federal guidelines.

7

## Women's Preventive Health Services (2013 Plan Year)

- Effective 2013 plan years, 100% coverage with no patient cost-share; PPACA FAQs (Part XII) 2/20/2013 new details
- FDA-approved contraceptive methods, contraceptive education and counseling
  - Brand name medications with direct generic equivalents may have cost-share
- Screenings and/or counseling (e.g. gestational diabetes, human papilloma virus (HPV), sexually transmitted infections)
- Breastfeeding support, supplies and counseling
- Women's sterilization procedures and counseling
- Domestic violence screening and counseling

8

## W-2 Reporting (by 1/31/13 for CY 2012 )

- Required for 2012 (1/2013 W-2s) for employers that filed 250 or more W-2s in 2011 and annually thereafter
  - See IRS Notice 2012-9 for details
- Optional until further IRS guidance for employers that file fewer than 250 W-2s in 2011 or subsequent years
- Must report full value of employee's health plan coverage on employee's W-2 on Form W-2 Box 12 (Code DD)
- Not taxed, only reported for tracking of coverage values
- Only required to report if a W-2 is issued (generally not Retirees and COBRA beneficiaries)
- Upon request, HealthTrust can provide groups with calendar year invoice reports in December

9

## Summary of Benefits and Coverage (SBC) Notice Requirements (2012/2013)

- Uniform Summary of Benefits and Coverage (SBC)
  - Describes benefits and limitations of coverage under each group health plan option
  - Strict requirements for SBC content and distribution
- All employers/groups (regardless of size) must provide SBCs to "eligible individuals"
  - Includes eligible and enrolled employees, early (pre-65) retirees and COBRA beneficiaries
- LGC HealthTrust and group both have responsibilities
  - SBC procedures and FAQs are at http://www.nhlgc.org/coverage/healthcare_reform.asp
  - October 2012 Webinar http://www.nhlgc.org/ni/webinars.asp

10

## SBC Notice Requirements

- Effective Dates:
  - Annual renewal/open enrollment
    - First day of annual renewal/open enrollment period for January 2013 or July 2013 Renewal (and annually thereafter)
  - New hires or newly eligible employees
    - New enrollments after 1/1/2013 (January groups) or 7/1/2013 (July groups)
  - SBC Form will be modified for 2014 Plan Years
    - Adds statement of whether plan coverage is "minimum essential coverage" and whether it meets "minimum value" (60% of covered costs of benefits)

11

## SBC Notice Requirements

- Must be distributed in paper or electronic form, and free of charge
- Electronic distribution requirements:
  - Special ERISA and PPACA rules apply
  - Can post on employer's internet/intranet if all notified
  - By email if individual agrees and site is readily accessible
  - Must notify that paper copy is available upon request

12

## SBC Notice Requirements

- HealthTrust will provide groups with SBCs for each medical plan option (including RX) before annual open enrollment and within 7 business days of group's written request

  *NOTE: HealthTrust will continue to provide Cost Sharing Schedules and Prescription Drug Benefit Summaries*

- Groups must distribute SBCs:
  - To eligible individuals at annual/renewal open enrollment
  - To new employee upon initial eligibility/enrollment
  - Within 7 business days of request
- For changes during a plan year, must give "Notice" or new SBC 60 days in advance of "material changes" to plan

13

## Group SBC Distribution Requirements

**Annual Renewal/Open Enrollment**

- If Group offers multiple plan options
  - Currently enrolled individuals must automatically receive SBC for plan option in which they are enrolled; but also must receive SBCs for other plan options upon request
  - Eligible but not enrolled employees must receive SBCs for all plan options for which they are eligible (e.g., employees who have "opted out" of group's plan)
  - If Group replaces existing plan with new plan option, new SBC must be provided to all eligible individuals

14

## Group SBC Distribution Requirements

- If Group offers Health Savings Account (HSA)
  - HSAs ***are not*** considered separate group health plans and therefore generally ***are not*** subject to SBC requirements. **However, employers who offer a High Deductible Health Plan that includes an HSA should supplement the SBC for that plan with information describing the HSA component.**
- If Group offers Health Reimbursement Arrangement (HRA)
  - HRAs ***are*** considered separate group health plans and therefore generally ***are*** subject to SBC requirements.
  - Separate SBC is **not required** if HRA is **"integrated"** with employer group medical plan (meaning HRA only funds deductibles, copays, etc., under medical plan). **Instead, employer should supplement the medical plan SBC with information describing the HRA funding component.**
  - A separate SBC must be provided for stand-alone **"non-integrated"** HRAs (meaning HRA funds may be used for any eligible medical expense).

15

## Group SBC Distribution Requirements

- If Group offers Healthcare Flexible Spending Account (Health FSA)
  - Separate SBC is ***not*** required for Health FSA that is an "excepted benefit" under HIPAA rules.
    - Example - If Health FSA is solely funded with employee salary reduction contributions **and** offered to all employees who are eligible for employer's group medical plan.
  - Separate SBC ***is*** required for Health FSA that is **not** HIPAA "excepted benefit".
    - Example - Separate SBC may be required if Health FSA is either (i) funded with employer contributions (non-salary reduction) in excess of $500 or (ii) offered to class of employees who are not eligible for employer's group medical plan.
  - HealthTrust will provide SBC template for Health FSA administered by HealthTrust.

16

## SBC Notice Requirements - Penalties

- Penalties for non-compliance
  - During first year and second year (2014 Plan Year), no penalties if working diligently and in good faith to comply
  - Law provides for fines of up to $1,000 per failure for willful failure to provide SBC
  - Employer should establish written procedures and keep records of SBC compliance
- Safe Harbors and other enforcement relief has been extended for 2014 plan year compliance.
- See PPACA FAQs Part XIV (4/23/2013) regarding SBC updated guidance for 2014 Plan Year

17

## Health FSA Contribution Limit (2013 Plan Year)

- Effective for 2013 plan years, maximum employee salary reduction contribution **cannot exceed $2,500 for plan year**
- Does not affect employer contributions to a Healthcare FSA
- Plan documents may need to be revised (by 12/31/2014 if plan allowed higher maximum employee contribution)
- See IRS Notice 2012-40 for details

18

# Healthcare Reform

## Preparing for the Big Year - 2014

## Notice of Exchanges by October 1, 2013 ("Health Insurance Marketplaces")

- Employer must provide one-time notice to all current employees by October 1, 2013 regarding 2014 Exchange availability, subsidies and related items
  - **Model notice** has been provided by DOL at http://www.dol.gov/ebsa/pdf/FLSAwithplans.pdf
  - See Technical Release 2013-02 May 8, 2013 at http://www.dol.gov/ebsa/newsroom/tr13-02.html
  - DOL also updated model COBRA election notice language to include reference to Exchange coverage

20

## Notice of Exchanges (Marketplaces)

- **Timing of Notice**
  - No later than **October 1, 2013** for all current employees
  - Within **14 days** of employee start date for new hires on or after **October 1, 2013**
- **Recipients**
  - All current full-time and part-time employees (and new hires) regardless of medical plan eligibility or enrollment
  - Does not need to be provided to dependents, retirees or COBRA beneficiaries
- **Form of Delivery**
  - Free of charge and in writing. May be by first class mail, hand delivery or electronically if **ERISA electronic disclosure** rules are satisfied.

21

## Notice of Exchanges

Required content

- Existence of Exchange (Marketplace), services offered, and how employees can contact the Exchange for assistance
- Employer name, address, EIN, contact person
- Health plan information including if plan meets ***minimum value*** requirement and whether it is intended to be ***affordable***
- Employee may be eligible for premium tax credit on Exchange if employer plan is not minimum value or affordable
- If employee obtains coverage through the Exchange, the employee will lose the employer's contribution toward health benefits (if any) and the corresponding tax-favored treatment of that employer contribution

22

## What are Exchanges/Marketplaces? (2014)

- Available on 1/1/2014, new marketplace for qualified individuals (Individual Exchange) and small employer groups (SHOP Exchange) to purchase private health insurance plans
  - Small employer = 50 (possibly 100) or fewer employees
  - Larger employers may be eligible beginning in 2017
- "Low and moderate income" individuals may qualify for premium tax credit or cost sharing subsidy (100%-400% of Federal Poverty Level)
- New Hampshire has opted out of establishing a State Exchange, but has elected to pursue a Federal/State Partnership Exchange (February 2013 Decision)
- Federal HHS will establish and operate the 2014 Exchange in NH with NH State Insurance Department participating in Plan Management and Consumer Assistance Program (CAP)

23

## Healthcare Exchange Functions

- Certifies insurer's plans as qualified or not
- Approves premium rates for qualified health plans
- Makes eligibility determinations for individual and small employer participation
- Certifies exemptions from individual mandate penalties for applicable individuals
- Coordinates with employers regarding participating employees and enrollment
- Determination and administration of subsidy and premium credit eligibility for qualified individuals
- Education and outreach programs providing consumer assistance to qualified individuals and small employers

24

## Individual Mandate (2014)

- Exchanges are necessary due to the "Individual Mandate" to have "minimum essential" health insurance coverage beginning 1/1/2014
  - Individual non-compliance penalties
  - Penalty of $95, or up to 1% of income, whichever is greater, on individuals who do not secure insurance (for 2014)
  - Penalty rises to $695, or 2.5% of income, by 2016

25

## Premium Assistance Tax Credits

- Premium tax credits available to individuals with household income between 100% and 400% of Federal Poverty Line (FPL)
- Cost sharing subsidies available to individuals with household income between 100% and 250% of FPL
- Only available for individual market coverage (not Small Employer "SHOP" coverage) on the Exchanges
- Tax credits and subsidies phased out as household income increases
- Individuals generally will pay between 2% and 9.5% of household income for coverage on Exchanges

26

## Premium Assistance Tax Credits

The Premium Assistance Tax Credit is calculated based on:

- The premium cost of the second lowest cost Silver Plan offered through Exchange, and
- The household income level of the applicant

| Household Income Level (% above FPL) | Maximum Premium as Percentage of Income |
|---|---|
| Up to 133% | 2.0% |
| 133% - 150% | 3.0% - 4.0% |
| 150% - 200% | 4.0% - 6.3% |
| 200% - 250% | 6.3% - 8.05% |
| 250% - 300% | 8.05% - 9.5% |
| 300% - 400% | 9.5% |

27

## Premium Assistance Tax Credits

**2013 Federal Poverty Level Guidelines**

| Household Size | 100% FPL | 133% FPL | 400% FPL |
|---|---|---|---|
| 1 | $11,490 | $15,282 | $45,960 |
| 2 | $15,510 | 20,628 | $62,040 |
| 3 | $19,530 | 25,975 | $78,120 |
| 4 | $23,550 | 31,322 | $94,200 |
| 5 | $27,570 | 36,668 | $110,280 |
| 6 | $31,590 | 42,015 | $126,360 |

Source: Department of Health and Human Services

28

## Employer Shared Responsibility Penalties (1/1/2014)

- **Effective 1/1/2014 (regardless of plan year*),** "Large employers" (**50 or more FTE employees**) may be subject to penalties if:
  (1) the employer does not offer group health plan coverage to at least 95% of its "full-time employees" (and dependents) or;
  (2) if the cost of premiums is "unaffordable" for any full-time employees
  *Under IRS Proposed Regulations, delayed effective date (7/1/2014) for some July year plans in limited circumstances
- Penalties could apply if at least one affected full-time employee **purchases coverage** through an Exchange **and qualifies for a premium tax credit or subsidy**
  *First potential penalty is not due until 2015 for CY2014

29

## Employer Shared Responsibility Penalties

- **"Large Employer" Test**
  - PPACA defines "large employer" as an employer that employed 50 or more full-time equivalent (FTE) employees during the prior calendar year.
  - To determine status: Add
    - Number of full-time employees (30 hours or more), plus
    - FTEs - For part-time employees, calculate total number of hours that ***all*** part-time employees work in a month and divide by 120. This is the number of FTEs.
  - If total is 50 or greater, then you are a "Large Employer"

30

## Employer Shared Responsibility Penalties

- **Special Aggregation Rules for "Large Employer" Test**
  - Related employers (those in "controlled group" or "affiliated service group" under IRC Section 414) will be treated as a single employer
  - Proposed regulations state that until further guidance government entities may rely on reasonable, good faith interpretation of IRC Section 414 (b), (c), (m), (o) rules

31

## Employer Shared Responsibility Penalties

- **Special Aggregation Rules for "Large Employer" Test (cont'd)**
  - Although test likely to be completed at EIN level, towns/cities with libraries or special districts with separate EINs and multi-district SAUs should contact their attorney or tax advisor for guidance
  - Under proposed regulations, even if group of employers is aggregated for large employer status, penalties will be determined and apply separately for each entity within group

32

## Employer Shared Responsibility Penalties

- **"Full-Time Employee" (cont'd)**
  - Special rules for variable hour (and seasonal) employees
    - On-call fire
    - Parks & rec employees
    - Coaches
    - Substitutes
    - Shift swap employees
    - Per diems
  - Other special rules for changes in employment status during an initial measurement period and rehired employees

35

## Employer Shared Responsibility Penalties

- **"Full-Time Employee" (cont'd)**
  - Proposed regulations contain special rules for school employees
    - Must either ignore or credit "employment break periods" (e.g. summer) in determining average weekly hours
  - Proposed regulations contain anti-abuse rules, but also request additional comments on special issues for school employees

36

## Employer Shared Responsibility Penalties

➢ **"Full-Time Employee"**

- PPACA defines full-time as an employee who works on average 30 hours or more per week.
- Detailed guidance (IRS Notices 2012-17, 2012-58 and new 1/2/2013 IRS Proposed Regulations)
- Different rules for "Ongoing Employees" and "New Employees" (new full-time vs. new variable hour)
- New Full-time Employees: If reasonably expected to work full-time (30 hours or more), must be offered coverage within 90 days.
- New Variable Hour Employees: If not reasonably known at date of hire whether employee will average 30 hours or more, can use measurement/stability period look-back method.

33

## Employer Shared Responsibility Penalties

➢ **"Full-Time Employee" – Measurement/Stability Period**

"Initial or Standard Measurement Period" and "Stability Period" for Variable Hour (or Seasonal) Employees

- Employer will establish 3 to 12 consecutive calendar month Measurement Period
  - Short 2013 Measurement Period option
- Did employee average 30 hours per week during look-back Measurement Period?
- If employee meets "Full-Time" standard during measurement period, employee will be considered "Full-Time" for a set "Stability Period" established by employer
  - Must be at least 6 months and at least as long as the Standard Measurement Period

34

## Employer Shared Responsibility Penalties

1. **Penalty for Not *Offering* Coverage ("Pay or Play")**
   - If coverage is not offered to at least 95% of all* full-time employees (and their dependents**) and one full-time employee obtains Exchange coverage and qualifies for a tax credit,
   - Employer will owe a penalty of $2,000 per year (assessed on a monthly basis = $167/ month) times total number of full-time employees (minus 30)

*Under Proposed Regulations, 95% standard replaces "all" standard and will be met if coverage is offered to all but 5% of (or if greater 5) full-time employees

**Dependent means employee's child under age 26; not spouses or domestic partners

37

## Employer Shared Responsibility Penalties

1. **Penalty for Not *Offering* Coverage ("Pay or Play")** – (cont'd)
   - Health Plan options offered should be "*minimum value*"
     - Plan expected to pay 60% or more of the costs of covered medical services; employee non-premium cost sharing (copays, deductibles etc.) not to exceed 40%
     - All HealthTrust plan options tested to date meet minimum value requirements
   - Employer not required to pay premium, only to offer coverage to all full-time employees (and dependents)
   - Employer not required to offer coverage to part-time (less than 30 hours per week) employees

38

## Employer Shared Responsibility Penalties

2. **Penalty for not offering *Affordable* Coverage**
   - If large employer offers "minimum value" coverage to 95% of full-time employees, but the employee premium is "unaffordable" **and** a full-time employee obtains Exchange coverage and qualifies for a tax credit, then
   - **Employer will owe a penalty of $3,000 per year (assessed on a monthly basis = $250/month) for each such full-time employee**
     - This penalty is assessed **only** with respect to each full-time employee who obtains subsidized Exchange coverage (not all full-time employees)

39

## Employer Shared Responsibility Penalties

2. **Penalty for not offering *Affordable* Coverage** (cont'd)
   - **Unaffordable** = the employee's **contribution** for the employer's lowest cost coverage **(self-only coverage) exceeds 9.5% of the employee's household income**
   - Proposed regulations allow use of **three safe harbors** (instead of family income) in determining the affordability of employer coverage; employer can use 9.5% of
     - Employee's W-2: (Box 1 for year)
     - Employee's Rate of Pay: (Monthly salary or hourly rate times 130 hours), or
     - Federal Poverty Line: (For single individual= $11,170 in 2012; Eg. 9.5% of $11,170=$1,061 ÷ 12=$88.43 /month)

40

## Employer Shared Responsibility Penalties

**PLANNING CONSIDERATIONS for Employers:**

1. Determine Large Employer Status (50 or more FTEs)
   - Multiple related entities EIN issue
2. Identify all full-time employees (30 hours or more) who are ***not*** currently eligible for your group health plan coverage - use new Proposed Regulations
   - May consider reducing hours of an employee or class of employees to less than 30 hours per week, subject to CBAs
3. Decide whether to offer coverage to ***"all"*** (95%) of such full-time employees (and their dependents), or can be subject to $2,000 "pay or play" penalty
   - "Offer" does not require employer contribution

41

## Employer Shared Responsibility Penalties

**PLANNING CONSIDERATIONS for Employers:**

4. If coverage offered to all full-time employees, determine whether employer/employee premium share is "Affordable". If not, consider:
   - Increasing the employer paid premium to "affordable" level for all full-time employees, or
   - Paying $3,000 penalty for those employees who purchase subsidized Exchange coverage.
   - Offering lower cost benefit plan options to make employee premium more affordable.
5. Uncertain impact of **Nondiscrimination Rules** if coverage or contributions vary for different classes of employees or employees within same class

42

## Employer Shared Responsibility Penalties

**PLANNING CONSIDERATIONS for Employers:**

6. If employer currently offers a "buyout," should obtain proof of other employer group coverage from employee
7. Note: **Waiting periods** cannot exceed 90 days (from date of hire) for plan years beginning in 2014
8. Existing CBAs should be updated as necessary to reflect PPACA decisions and compliance

***Employers should evaluate options with legal or tax advisers since these PPACA penalties and guidance are still evolving.***

43

## Employer IRS Reporting Requirements (2014/2015)

- Still awaiting further IRS guidance
- Applies primarily to large employers (>50 FTEs)
  - May also apply, on a limited basis, to small employers
- Report to IRS and employees on plan coverage
  - Due by 1/31/2015 for coverage provided in 2014, regardless of plan year
  - Name of each employee, SSN and dependents covered, portion of premium paid by employer, and other items
  - Penalty of $50 per return for all returns in a calendar year that are not filed with IRS

44

## 90-Day Maximum Waiting Period (2014 Plan Year)

- Effective on 1/1/2014 for January Groups or 7/1/2014 for July Groups
- Plan cannot impose any waiting period (probationary period) that exceeds 90 days from date of hire or date otherwise eligible for coverage
  - "First of the month following..." rule will create non-compliance for current 90-day waiting period
  - Groups will need to adjust length of waiting period (e.g., reduce to 60 days) to comply
  - If employee is in waiting period on first day of 2014 plan year (1/1/14 or 7/1/14), must be enrolled within 90 days of date of hire or date otherwise eligible
- CBA bargaining considerations
- Example: 60 day waiting (probationary) period with enrollment first day of the month following –

  Employee is hired on 4/2/2013 → Employee would be eligible for enrollment on 7/1/2013

45

## Healthcare Reform

Funding Sources Impacting HealthTrust Plans

## Comparative Effectiveness Research (PCORI) Fees (2012-2018 Plan Years)

- To pay for research by Patient-Centered Outcomes Research Institute (PCORI) to evaluate medical treatments and reduce healthcare expenditures
- Group Health Plans (including retiree-only Medicomp plans) must pay annual fees of $1 (first year) and $2 (second year and indexed thereafter) per covered life (employee/retiree, spouse and dependents)
- Applies to plan years ending after 10/1/2012 and before 10/1/2019 (2012-2018 Plan Years)
- First reporting for January plans by 7/31/2013 (for CY2012) and for July plans by 7/31/2014 (for plan year ending 6/30/13)

47

## Comparative Effectiveness Research (PCORI) Fees (2012-2018 Plan Years)

- **IRS Final Regulations (12/2012)** state that fees will be reported and paid by "plan sponsor" of self-insured group health plans
  - **For this purpose, HealthTrust is considered the plan sponsor and *will report and pay PCORI fees* for HealthTrust medical plan options offered by member groups**
  - **Small expected impact on rates**
- **Employer has reporting and payment obligation as "plan sponsor" with respect to employees covered by:**
  - Health Reimbursement Arrangements (HRAs); and
  - Healthcare FSAs if not "HIPAA excepted benefit":
    - Employer contribution > $500 or
    - Offered to class of employees not eligible for group medical plan

48

## Comparative Effectiveness Research (PCORI) Fees (2012-2018 Plan Years)

- PCORI Fee is reported annually on IRS Form 720, "Quarterly Federal Excise Tax Return" by 7/31 of the calendar year following the last day of the plan year.
- Updated IRS Form 720 and instructions can be found at www.irs.gov/form720.
- More information in IRS Final Regulations at http://www.gpo.gov/fdsys/pkg/FR-2012-12-06/pdf/2012-29325.pdf

49

## Transitional Reinsurance Program Fee (CY2014-CY2016)

- To reduce risk of adverse selection and stabilize costs and premiums of individual coverage offered by insurers on Exchanges
- Insurers and self-insured group health plans must pay annual per covered life reinsurance contributions for calendar years (not plan years) 2014-2016
- Fee for 2014 is estimated at **$5.25 per month ($63 per year) per covered life**, expected to be lower in subsequent years
  - **To be included in HealthTrust Rates for July 2013 plan year (6 months of 2014) and future January and July plan years (through 2016)**

50

## Transitional Reinsurance Program Fee (cont'd) (CY2014-CY2016)

- **Under HHS Final Regulations (March 2013),** fee will be reported and paid over to HHS **in early Jan 2015 for CY 2014** by either HealthTrust or Anthem (as TPA) on behalf of HealthTrust self-insured pooled plans.
- Reinsurance fee does not apply to Medicomp retiree-only plans or non-major medical coverage, including dental, vision, Healthcare FSAs, HSAs and most HRAs
- Fee will apply to Active Employees, Non-Medicare eligible retirees and COBRA beneficiaries participating in group's major medical health plan

51

## Excise Tax on Certain High-cost Plans (2018)

- aka "Cadillac Tax"; no regulations or other guidance to date
- 40% excise tax on excess benefit of high-cost employer sponsored plan offered to employees and former employees
- Limit based on $10,200 for single coverage and $27,500 for other than single coverage
- Higher limit for early retirees (age 55-65) and plans with majority of employees in high-risk occupations (police and fire)
- Employer's will be responsible to calculate excess benefit subject to tax for each covered employee or retiree
- Expected to bring in $32 Billion in tax revenue

***Much uncertainty remains; awaiting guidance***

52

## Excise Tax on Certain High-cost Plans (2018)

If the 2018 premium is greater than the numbers below, there will be a 40% excise tax on the excess* for each affected employee

| Contract Type | Annual Premium Threshold | Monthly Premium Threshold |
|---|---|---|
| 1-Person Contract | $10,200.00 | $850.00 |
| Family Contract | $27,500.00 | $2,291.67 |

** 40% excise tax calculated only on the amount exceeding the threshold. (e.g. Dollar Difference x .40)*

Notes: Police and firefighters, as well as retirees over 55, have higher 2018 annual thresholds of $11,850.00 and $30,950.00.

"Premium" is the amount that both the employer and employee pay for coverage. May also include amounts for flexible spending, health reimbursement or health savings accounts.

53

## Excise Tax on Certain High-cost Plans (2018)

Projecting 2013 monthly rates that might invoke the excise tax in 2018

| | Projected Monthly Rates | | | | | | Monthy Tax Owed |
|---|---|---|---|---|---|---|---|
| Renewal Year | 2013 | 2014 | 2015 | 2016 | 2017 | 2018** | per Employee** |
| 1-Person | $650.00 | $694.20 | $741.41 | $791.82 | $845.67 | $903.17 | $21.27 |
| Family | $1,800.00 | $1,922.40 | $2,053.12 | $2,192.74 | $2,341.84 | $2,501.09 | $83.77 |
| Medical Trend = | 6.80% | | | | | | |

*** Final figures may vary slightly due to compounding within formulas.*

***1-Person Contract Threshold: $10,200 Annually; $850 Monthly***
***2-Person Contract Threshold: $27,500 Annually; $2,291.67 Monthly***

Note: You can enter your current rates and presumed medical trend above in the yellow boxes to see if you will be subject to the 40% Excise Tax in 2018. If the boxes and the numerals turn to RED you will have exceeded the 2018 threshold and will have to pay the tax.

54

## Excise Tax on Certain High-cost Plans (2018)

Example of lowest 2013 rates that will let you avoid the excise tax in 2018

| | Projected Monthly Rates | | | | | | Monthy Tax Owed per Employee** |
|---|---|---|---|---|---|---|---|
| Renewal Year | 2013 | 2014 | 2015 | 2016 | 2017 | 2018** | |
| 1-Person | $612.69 | $654.15 | $698.41 | $745.67 | $796.12 | $849.99 | *No Tax* |
| Family | $1,651.87 | $1,763.65 | $1,882.98 | $2,010.39 | $2,146.42 | $2,291.66 | *No Tax* |
| Medical Trend = | 6.80% | | | | | | |

** *Final figures may vary slightly due to compounding within formulas.*

***1-Person Contract Threshold: $10,200 Annually; $850 Monthly***
***2-Person Contract Threshold: $27,500 Annually; $2,291.67 Monthly***

55

## Healthcare Reform

Information/Resources

# Disclaimer

**This healthcare reform presentation and slides are provided for general informational purposes. They are not intended as and do not constitute legal or tax advice. Questions regarding your specific circumstances should be addressed to your legal, tax or other professional advisers.**

59

## Healthcare Reform
## HealthTrust Information/Resources

- HealthTrust maintains Healthcare Reform website at http://www.nhlgc.org/coverage/healthcare_reform.asp which contains updates and links to government agency regulations and guidance, HealthTrust presentations, articles and summaries of key provisions; information also may be accessed by topic name
- Official government web sites:
  - www.healthcare.gov
  - http://cciio.cms.gov/
  - http://www.dol.gov/ebsa/
  - http://www.irs.gov/newsroom/

57

## QUESTIONS?

58