Council Meeting: 10/15/2013
Agenda: Study Session
Item #: 3. a.

CITY OF KIRKLAND
Human Resources Department
505 Market Street, Suite B, Kirkland, WA 98033 425.587-3210
www.kirklandwa.gov

MEMORANDUM

To: Kurt Triplett, City Manager

From: James Lopez, Director of Human Resources and Performance Mgmt.

Date: October 3, 2013

Subject: Healthcare Update and 5 Year Benefits Framework

RECOMMENDATION

That the City Council receives an update on the results of Kirkland switching to self-insured healthcare benefits and a presentation on a 5 year benefits policy framework to improve employee health while mitigating the rising cost of healthcare to the City. Healthcare benefits are a complex topic and are also a key element of Kirkland's collective bargaining agreements. Several additional study sessions will likely be requested by staff in 2014 to keep the Council apprised of Kirkland's efforts on this issue.

BACKGROUND

Three years ago the Human Resources Department came to Council with a recommendation to move Kirkland's health coverage from the Association of Washington Cities (AWC) to a self-insured platform. Included in this packet for background purposes is Attachment A, a memorandum to Council dated February 23, 2010 titled "Medical Benefits Strategies." This 2010 memo describes the due diligence study that was undertaken to support the recommendation to Council to leave the AWC and become self-insured. The memo discusses marketplace options for providing insurance to employees, the City's obligations concerning the collective bargaining process, a high level overview of how to operate a self-insured plan, and the benefits of "controlling our destiny."

On October 5, 2010 Council approved Resolution R-4840, Approving a Self-Funded Medical Plan and Authorizing the City Manager to Execute Agreements with a Third Party Administrator and Other Providers Needed to Operate the Plan and the Fund to be Created to Finance the Plan. The link includes the staff memos and presentations made to the Council to support this decision. A major factor in making this decision was the ability to gather claims data to make informed decisions regarding our benefits. The City now has over two-and-a half years of data and is starting to get a good picture of our utilization. A claims analysis was done by Verisk Health (a third party Medical Intelligence vendor) and below is a high-level overview of some of the areas that stand out in our data compared to their norms with other organizations.

Demographics
The City has around 520 employees on the plan and 920 dependents and our average age on the plan is 33. This average age is below the norm of 36. Spouses make up 28% of our group, but account for 36% of our claims and 40% of our large claims.

Medical Spend
The City's gross medical spend in 2012 was $343.10 per employee per month; this number is 29% higher than the norm.

This high utilization can be seen through a couple of different statistics with professional services utilization being the largest driver at 27% above the Verisk Health norm ("norms"). Several of our office visit subcategories are above the norms, with behavioral health visits being one of the most significant at 173% above.

Another area where Kirkland is seeing above average utilization is in maternity visits which are 43% more than norms. We believed this to be a one-time 2012 phenomenon, but in 2013 we are seeing these trends continue, although they are stabilizing. This correlates to the large amount of new hires with young families due to annexation in 2011.

Emergency room utilization is usually one of the top focus areas for employers. Our ER utilization is actually below the norms, which is good news; however, the amount we are paying per visit is over $700 more than what is being seen in the marketplace.

Pharmacy Spend
Our pharmacy spend in 2012 averaged $52.98 per employee per month, which is 2.5% below the norms. With this good news also comes the inverse because our utilization patterns are 19% higher. Essentially Kirkland uses a higher volume of drugs than the norm, but pays less for them. This contrast can somewhat be explained by high generic drug usage which Kirkland promotes proactively. Our generic drug use is 2% higher than the norms.

Another area where we have room for improvement is in our mail order program. Through mail order employees can often get three months of medication for the cost of two months, yet we have very low participation in this program. Increased mail orders could not only lower the cost of pharmacy claims to our plan, but also reduce the amount employees spend out of pocket.

During this same two-and-a-half year period the federal government has passed the adoption, implementation, and interpretation of the Affordable Care Act. This legislation has and will have a major impact to our cost of providing benefits.

Attachment B, *Healthcare Reform Survival Guide for Employers*, is a guide that was published by our consultant Alliant. This guide provides an overview of how the Affordable Care Act has and will impact employers as well as the timing of when these impacts have been and will need to be implemented. This guide covers six topic areas including plan benefits, plan administration, plan finances and taxes, pay or play (requirements of employers providing coverage), communications, and participant issues.

During the upcoming Study Session the Council will be provided an overview of following:

- A discussion of key considerations that impact our health plan
- A discussion on the history and benefits of being self-insured
- A look at Kirkland's cost trends
- The impacts of the Affordable Care Act on Kirkland's health benefit plan

With all of these factors in mind, the Human Resources Department will present a five year framework to find strategies that improve the health of Kirkland employees while moderating the rising costs of providing quality health insurance.

One initiative in the 2013-2014 Work Plan is to *"Continue partnership initiatives with employees to achieve sustainability of wages and benefits."* In 2012 and 2013 the focus was on predictability of wages and HR implemented this through labor negotiations. In 2014 HR's work will focus on the second half of this initiative - finding healthcare strategies to achieve sustainability of benefits. We will continue to work with the now established Employee Benefits Advisory Committee (EBAC), our benefits consultant Alliant, and through negotiations with our union groups to implement plan designs that offer the City and its employee's quality healthcare that is compliant with legislation and is sustainable into the future. A strong component of success in achieving the 2014 health care work will be the education of our employees on all aspects of the ACA, Kirkland's health claims data, and potential changes to plan design to improve health and reduce costs. The Human Resources Department will be requesting one-time resources from the health benefits fund to provide the proactive 2014 education efforts necessary. More information about this request will be included in the mid-biennial budget process.

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MEMORANDUM

To: City Council

From: William R. Kenny, Human Resources Director

Date: February 23, 2010

Subject: Medical Benefits Strategies

As stated in previous Reading File and strategy updates, the City's medical benefits have been under review by the Human Resources Department, as well as our Medical Benefits Committee, with a cross-section of employee and Union representatives.

In keeping with this theme, we have spent the last couple of years completing a due diligence assessment or study of options, while closely watching the changes that are occurring with our current provider of medical benefits, the Association of Washington Cities (AWC).

Key Messages:
o AWC Regence Plans A&B not offered after December 31, 2011 (except LEOFF 1) o AWC PPO plans (three) will replace Plans A&B, with a well city discount o Unions have been provided notice and the Medical Benefits Committee was re-convened o "Substantially Equivalent Benefits" (plan design and network) required per Union CBAs o Due Diligence Study of options completed and recommendations developing

Council Direction Requested:
o Best option would seem to be going to a (Limited Risk) Self Funded Medical Program o Change could be as early as July 1, 2010 and recommended not later than January 1, 2011 o Cost containment and "Control Own Destiny" goals are greater with Self Funded Program o Alternative would be to stay with AWC and convert to PPO for 2011 (or 2012 latest)

Background
Kirkland has made a concerted effort over the past few years to move the majority of City employee's medical coverage from Regence Plan A to Plan B. This was a strategy to help contain the City's benefit costs in an environment of spiraling medical premium rates.

We were also able to get language in our negotiated collective bargaining agreements (CBAs) that provides, even mid-term of the agreements, for a due diligence study of the medical programs, associated costs and identification of other health options available to the City of Kirkland. Obviously, the Unions were hesitant to "pre-agree" to potential unknown changes but did agree to language that provides for exploring options toward "substantially equivalent benefits" and allowing for future changes. The CBAs also provides for (impacts) bargaining of any major changes.

In 2008 we received notice from AWC that they would be eliminating Regence Plan A and Regence Plan B and converting to three PPO plans effective at the end of 2011. The stated reason for the elimination is that the plans are no longer actuarially efficient for the Trust to continue to offer. It is noted that most other multi-employer trusts and medical plans have made or are making similar decisions and are or have moved to a PPO platform.

It might first be helpful to clarify what a PPO is - in contrast to our current Regence Plan A and B (known as a fully funded or POS / Point of Service medical program):

> PPO –"… a managed care organization of medical doctors, hospitals, and other health care providers who have covenanted with an insurer or a third-party administrator to provide health care at reduced rates to the insurer's or administrator's clients….
>
> A preferred provider organization is a subscription-based medical care arrangement. A membership allows a substantial discount below their regularly charged rates from the designated professionals partnered with the organization. Preferred provider organizations themselves earn money by charging an access fee to the insurance company for the use of their network (unlike the usual insurance with premiums and corresponding payments paid either in full or partially by the insurance provider to the medical doctor). They negotiate with providers to set fee schedules, and handle disputes between insurers and providers….
>
> Other features of a preferred provider organization generally include utilization review, where representatives of the insurer or administrator review the records of treatments provided to verify that they are appropriate for the condition being treated rather than largely or solely being performed to increase the amount of reimbursement due…." [Wikipedia]

To employees and their families, the key to the quality of care is the provider network – i.e. how inclusive the provider network is and, specifically, if their individual health care providers are members.

Due Diligence Study

In order to assure a prudent due diligence study, the Benefits Committee utilized the services of Alliant / ClearPoint to analyze options for the city within the medical benefits marketplace.

There are four options that are generally available to an employer. We reviewed each of these as part of the due diligence study. Those four options are:

1) contracting directly with insurance carriers,
2) moving to another multi-employer trust,
3) staying with AWC
4) initiating a Self Funded medical program

Previous Council Reading Files have provided more detailed discussion of these options and the pros and cons for each.

A lack of specific City of Kirkland claims data has represented a significant problem in looking at options. AWC does not provide access to the claims experience data to individual participating members. Because of this, we have been unable to provide exact claims data to potential carriers in order to secure quotes.

Rates are typically set through a combination of factors including employee population size, employee and family demographics and previous claim experience (actual costs). With our small employee population and lack of specific claims experience information, potential carriers initially either declined to quote or have come up with quotes significantly higher than our current costs.

As discussed further in the "Risk Management" section below, working with Aliant / ClearPoint, we were able to creatively mitigate this lack of Kirkland specific claims data by providing carriers with reasonable experience information utilizing known claims data from comparable jurisdictions and our own demographics. Even with this, carriers have tended to quote rates higher than current AWC rates (…Premera quoted, for example, 50% higher than current premium costs).

With the remaining options of either staying with AWC or moving to another multi-employer trust, both approaches result in a conversion to a PPO plan design. (It is noted that many of the other large multi-employer trusts, such as the PEBB state program or Union trusts, such as the Teamsters, are already in a PPO format). Therefore, coupled with a continuing increase in costs (…either through an immediately higher premium or as a result of a lack of ability to affect or control "trend" regarding escalating premium costs), it is not really a question of if Kirkland should move to a PPO platform but rather "when?" and "which one…?"

Competing Interests

Reconciling competing interests has been a challenging endeavor in this approach. All employers today are critically concerned in regard to the escalating costs associated with medical benefit programs. This is balanced with the needs of employees and their families, who are most interested in the benefit plan design and the provider network which is available to them. This has proven to be even more-so true for City of Kirkland employees. The Unions are concerned about change from current benefit levels and any efforts toward increasing their members' out-of-pocket expenses (cost-sharing) – hence the emphasis on assuring substantially equivalent benefits.

In order to attempt to balance these competing interests, and provide an "apples to apples" comparison to AWC's current (Plans A&B) and AWC's future (PPO) programs, the study of options was initiated with some clear initial parameters:

1) Plan design within a PPO framework
2) Substantially similar benefit levels
3) Substantially similar provider network
4) Preventative benefit component
5) Deductible and out-of pocket similar to the AWC PPO
6) Ability to manage costs and reduce "trend"
7) Ability to "control our own destiny"

Given all considerations, a "limited risk" Self Funded medical program would seem to provide the best prospect of meeting Kirkland's interests and reconciling these competing interests.

What Is Self Funding?

An employer who operates a Self Funded health plan assumes the financial risk for providing health care benefits for its employees. Self Funded plans differ from fully insured plans in that employers do not pay monthly premiums for health care, however they do pay the claims cost for the services that employees actually receive and the costs to administer the program.

The basic components of a well-established Self-Funded Plan would include:

1) Third Party Administrator (Eligibility & Claims Processing)
2) Plan Design (Actuarially prudent – note: "substantially equivalent" requirement)
3) Provider Network (Health care services and provider discounts)
4) Stop Loss Insurance (Risk Limitation or Cap)
5) Reserves and Rate Stabilization Fund (Assure adequate funding and cost containment)

To limit their liability most employers purchase Stop Loss insurance. The Stop Loss insurer agrees to reimburse the employer for health care costs that reaches certain individual and/or aggregate thresholds (for example, $100,000 monthly per individual and $3.8 mm annual aggregate) in exchange for premium payments on the Stop Loss coverage. Generally, the lower the threshold amount, the higher the premium.

Risk Management

Self-Funded programs are not totally without risk, but the risks can be minimized. As noted, having good Stop Loss coverage in place, with appropriate limits, is a key component of managing the risk.

As part of the due diligence study, we were able to do an actuarial analysis to predict our "Expected Liability" utilizing known claims data from comparable jurisdictions, coupled with a cross reference to our own demographics. This helps to overcome the issue of a lack of claims data from AWC and is best thought of as a base line average of anticipated claims.

To alleviate the volatility of claims, the Expected Liability average was then converted into a "Maximum Liability" (98% reliability factor). Stop Loss coverage would be put into place at this level.

Reserves and Rate Stabilization are tools to assure the adequate dollars are in place to pay both fixed costs and claims.

"Reserves" are built during the first year and do not necessitate a cash infusion. Typically, employers are in a position to "save" money in the first 12 months while self-funding. This occurs because claims payments for services in one month are not processed until the second or third month. For example, should Kirkland go to a Self Funded program, in the early months of the transition period, medical claims and provider billings "run-in" subsequent to when the service is actually delivered. Additionally, AWC would remain liable for services prior to the transition period, regardless of when paid. This allows reserves to build. (Please see Illustrative Example – Attachment 1)

The "Rate Stabilization" fund provides that anticipated costs remain constant for say a two year period, while providing a actuarially prudent hedge against "trend" in the second year. This is important, especially with a biennium budget. This helps to assure that overall costs are predictable and new cash infusions are not necessary.

"Control your own Destiny"

Performance measurement and management by information are powerful tools. With a Self Funded Program, cost containment options are different than with a fully funded program, such as AWC or direct contracting with a carrier. With Fully Funded programs, premium cost-sharing with employees is the only viable option toward cost containment and consumer managed care. Within Self Funded models, utilization and severity analysis are possible on an ongoing basis, and such elements as plan design, deductibles and out-of-pocket are variables within one's own control. Both the employer and the employees are in a greater position to influence and drive the type of care and the cost of it.

Typically, an employer would put into place a "Benefits Committee" (much like our current MEBT model) with both employee and management representation. If costs on a specific item are growing at an actuarially inappropriate rate, they can be specifically addressed. For example, if employees are over-utilizing Emergency Rooms, an alternative clinic or health care approach, or even a higher deductable, can be applied to that specific benefit to reduce utilization and to control cost.

Additionally, over-time, the employer can gather and analyze claims data to be responsive with provider or plan design changes or other modifications to meet utilization.

Further, the Self Funded model currently being used as a base line has a significant "preventive" component (annual physical, well-child, etc). This can be leveraged with the City's current wellness and health risk assessment efforts.

Questions deserving consideration

How would this be funded – won't it cost more?

When a conversion / transition is made to Self Funded, the employer is able to build reserves. Because fixed costs can be anticipated and claims costs have a gradual run-in, the additional cash can be retained as reserves against future claim costs. This alleviates the need for up-front cash.

By contributing even at current levels of cost (i.e. the amount that AWC premiums currently cost the City of Kirkland, which is approximately $5.1 mm), nearly $1.3 mm in reserves and rate stabilization could be achieved by the end of the first year. While no-one can assure claims cost, this assessment is based upon reasonably prudent actuarial analysis and risk factors.

Even with "trend" increases, this should assure that sufficient monies are being reserved to meet claims costs for a biennium budget, without additional annual adjustment. (Please see Illustrative Example – Attachment #1)

What is "trend?

Each year medical services cost more. Premium increases are correspondingly increased even more. However, depending upon an employer's approach, there can be a big difference in how much more. For example, in recent years, AWC has averaged 10% premium increases (and even more than that in prior years.) Contrast that with some of our neighbors such as Bellevue and Redmond, who are Self-Funded, and have averaged closer to 6% cost increases. In some years they have had 0% increases in cost (Redmond – 2009, Bellevue – 2008) and Everett, Renton and others have enjoyed similar successes.

Additionally, each year the Stop Loss premium may also increase. Again that is driven by the number of times that claims exceed maximum liability, either based upon unusual individual or aggregate experience. While there is only a 2% prospect of this occurring, the Rate Stabilization fund would provide adequate safeguard against the need for additional cash infusion, cover any trend increases, as well as provide predictability as to the total cost of a medical program.

What are factors that would jeopardize a Self Funded Plan?

Most Self Funded programs are successful. Very occasionally, you may hear about one that is not successful and that organization would then go back to a different medical program. While rare, there are some "lessons learned" in those instances. Generally, one or more of the following have occurred, when there are problems with Self Funded medical programs:

1) Inadequate Stop Loss Coverage
2) Too small of a group or "high cost / high risk" demographics
3) Incomplete or improper actuarial analysis
4) Too rich plan design
5) Not managing by information / adjusting to utilization
6) Reserves or Rate Stabilization set too thin
7) Treating Reserves or Rate Stabilization as "cash"

How will we know if we are reserving enough / too much?

First Choice Health would provide Third Party Administrative services. This will provide ongoing claims and experience data. Alliant / ClearPoint will then provide analytical, underwriting, key metrics analysis, risk measures and severity reports based upon actual Kirkland data.

Externally, the State of Washington provides an annual audit and detailed actuarial assessment of reserve levels and the adequacy of those reserves. Internally, a Benefits Committee will also provide a consumer-driven approach to managed health care, based upon composite information.

What about Group Health and other Insurances?

Group Health is an HMO and, by law, we would continue to offer Group Health as an option under this scenario. The Self Funded program basically replaces Regence Plans A and B. Other insurances such as Vision and Dental, as well as our FSA/125 Plan, etc. would continue to be offered at current levels, and would be generally unaffected.

It should also be identified that we would also have very significant opportunities as to Prescription Drugs access and cost. This approach allows for greater volume purchasing, pricing transparency and formulary management, resulting in lower costs.

What about employee cost-sharing?

Each of our Collective Bargaining Agreements has language that provide for the ability to change medical programs, with certain requirements. The basic tenant is "substantially equivalent." The language of the AFSCME Agreement serves as an example:

ARTICLE 15 – HEALTH & WELFARE

15.1 MAINTENANCE OF BENEFITS

Medical and Dental Insurance - The Employer may self-insure medical and/or dental insurance coverage or select a new medical and/or dental insurance plan and shall make every possible effort to maintain substantially equivalent benefits. The Employer and the Union shall meet to explore alternative insurance coverage prior to selecting any new medical and/or dental insurance plan in order to maintain substantially equivalent benefits at a reasonable cost. The Employer recognizes its responsibility to bargain with the union the impact of those decisions…..

Participation in benefits shall be consistent with Article 15.2 of this Agreement and the trusts and Plans described below.

15.2 HEALTH AND LIFE INSURANCE

Medical Insurance - the Employer shall pay each month one hundred percent (100%) of the premium necessary for the purchase of employee coverage and one hundred percent (100%) of the premium necessary for the purchase of dependent coverage under the Association of Washington Cities Regence Medical Plan B or Group Health Plan 2 for each employee of the bargaining unit.

Changes in insurance carrier shall be subject to Article 15.1….

Obviously, a change to a Self Funded Program will represent a significant "leap of faith" for our employees and their families. Additionally, to the Unions, it is their perspective that the components of benefit plan design, provider network and member cost are all elements of "substantially equivalent benefits."

It is a very significant question as to Union receptivity if this type of a change in programs (Self Funded) could be accomplished if employee cost-sharing was concurrently proposed.

Again, it is believed and recommended that the cost containment potential for the City of Kirkland is in the greater ability to "Control our own Destiny."

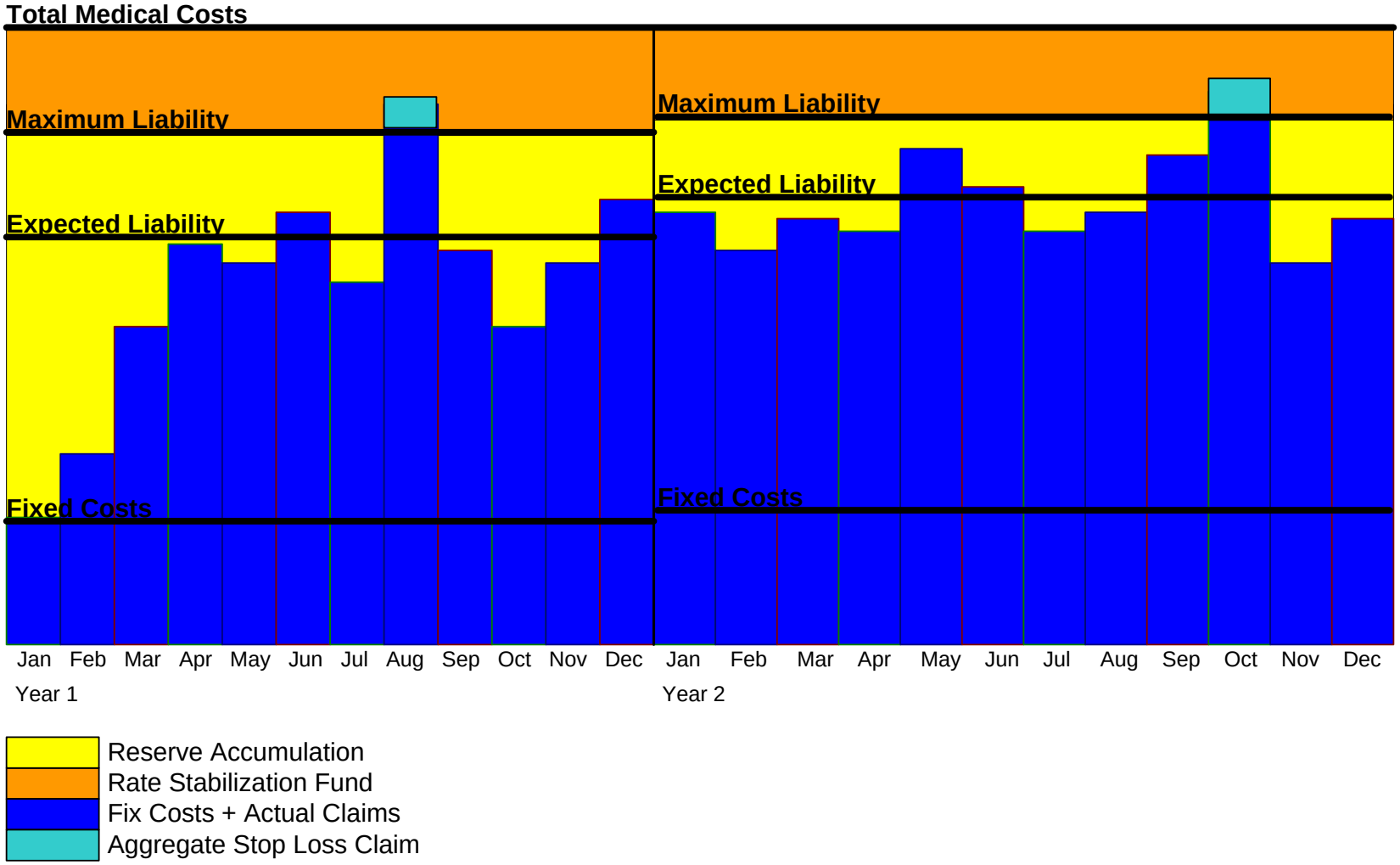
Conclusion

The opportunity to realize a positive change in medical programs (at a time when change is necessitated) is important for a variety of reasons. It is also noteworthy that the options available to the City of Kirkland become less with the passage of time.

This Reading File presents Self Funded as an option for Council's consideration, and one that does reconcile multiple competing interests. It also meets many of the goals necessitated by the City of Kirkland's understandable budget and financial concerns.

It is hoped that this Reading File represents an opportunity for Council discussion and direction, on a matter that is critical to our City as well as to its employees and their families.

How do we build reserves? -Illustrative Example



HEALTHCARE REFORM SURVIVAL GUIDE

FOR EMPLOYERS

Alliant
EMPLOYEE BENEFITS

PATIENT PROTECTION AND AFFORDABLE CARE ACT
HEALTHCARE REFORM
OBAMACARE

They're all different names for the same thing.
But what does it mean to you as an employer?

It means changes.
Lots of changes.

Changes to your…

- Plan design
- Plan administration
- Eligibility rules
- Plan finances
- Employee communication

And it also means changes for your employees and their dependents. In fact, there probably isn't a person in America who isn't affected by Healthcare Reform in some way.

We at Alliant know that it's hard to keep straight all of the changes that have already come, that are around the corner, and that are still a ways down the road. That's why we're providing you this Healthcare Reform Survival Guide.

Now, keep in mind, while we do **have** lawyers, we're not **your** lawyers. So you'll need to be in close touch with your plan's attorneys to be sure that you're doing what you're supposed to. But we hope that the Guide will help you survive all of the changes due to Healthcare Reform.

Alliant
EMPLOYEE BENEFITS

About this Guide

This guide is divided into six sections:

1. Plan Benefits
2. Plan Administration
3. Plan Finances and Taxes
4. Pay or Play
5. Communications
6. Participant Issues

Within each section, the specific provisions of Healthcare Reform are separated into provisions that are:

- Already in Effect
- Coming Up
  (Scheduled for implementation in the next year or so)
- Way Out There
  (Either not scheduled for implementation soon or likely to be delayed because of lack of guidance or proper infrastructure)

Also note that the following codes are used throughout the Guide:

ALL	This provision applies to all plans, regardless of grandfathered status
GF	This provision applies to grandfathered plans only
NOT GF	This provision does not apply to grandfathered plans
S	Applies only to small employers (fewer than 50 employees)
L	Applies only to large employers (50 or more employees)
XL	Applies only to large employers with more than 200 employees

Alliant EMPLOYEE BENEFITS

Getting Started: A Vocabulary Lesson

Every time the government makes a new rule, they generally come up with new terms that need to be defined. Here are a few definitions to get you started. You'll be seeing these terms throughout the Guide, so we thought we'd put their meanings up front and center.

DEPENDENT CHILD

Healthcare Reform regulations don't define the term "child" for the purposes of deciding which children need to be offered dependent coverage. But as a rule the following categories of children would be covered:

- Biological children
- Adopted children
- Stepchildren
- Eligible foster children

They are considered children under the plan for at least as long as the relationship lasts. For example, a stepchild is considered a dependent child by the plan as long as the stepparent and biological parent are married. Children of a domestic partner could be covered if the child is considered a stepchild under state law (for example, in states that recognize same sex marriage).

If you're not sure about the rules that apply to your plan, talk to your carrier or TPA for specifics.

ESSENTIAL HEALTH BENEFIT

The federal government hasn't officially defined what an essential health benefit is. However, we know that it will include benefits in the following 10 categories:

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

Work with your carrier or TPA to decide which items and services are essential health benefits. Agencies will take into account a plan's good faith efforts to comply with these rules.

EXCEPTED BENEFIT

Excepted benefits are benefits that are not affected by some of the new Healthcare Reform rules. These include:

- **Fully-insured** dental and vision plans if the benefits are provided through separate insurance contracts.
- **Self-insured** dental and vision plans if the participant elects the coverage separately from the medical plan and pays a separate premium for the coverage. (100% employer-paid plans wouldn't qualify.)

GRANDFATHERED PLAN

A grandfathered plan is one that existed on March 23, 2010, otherwise known as the date Healthcare Reform was passed. The plan has also continued since that date without any major changes. Changes that trigger a loss of grandfathered status are generally those that are negative for the participant, such as increases in cost-sharing, limits on benefits, etc.

Grandfathered status affects compliance with various different rules.

ALREADY IN EFFECT

DOLLAR LIMITS ON ESSENTIAL HEALTH BENEFITS ALL

Currently, plans cannot have lifetime dollar limits on essential health benefits (see page 6). In addition, annual dollar limits on essential benefits cannot be less than $2 million for plan years starting between now and December 31, 2013. For plan years starting on or after January 1, 2014, plans cannot place annual limits on essential health benefits.

- **These rules apply to all plans regardless of grandfathered status.**
- **Make sure these rules are reflected in your plan document.**
- **You may want to consider using treatment-based limits (such as a limit on the number of office visits) as an alternative.**
- **Discuss your options with your carrier or TPA.**

DEPENDENT COVERAGE TO AGE 26 ALL

Plans that offer coverage for children must make that coverage available until the child reaches age 26 (through age 25). The plan can't deny coverage based on the child's employment, income level, ability to self-support, student status, or marital status. However, until 2014, grandfathered plans can exclude dependents who have access to coverage through their own employers. Coverage will generally be tax-free until the tax year when the child turns 27.

Make sure these rules are reflected in your plan document.

PATIENT PROTECTIONS NOT GF

Healthcare Reform added the following new rules. All of them took effect in plan years that began on or after September 23, 2010.

- **Participants must be allowed to choose any participating primary care provider (a pediatrician can be named as a child's primary care provider).**
- **Plans can't require pre-authorization or referral for care by a doctor of obstetrics or gynecology.**
- **Plans that provide benefits for emergency services can't do the following:**
  - Require pre-authorization for emergency care at in-network or out-of-network facilities.
  - Deny coverage because the facility is outside the network.
  - Impose administrative requirements or limits on coverage that are more restrictive in an out-of-network facility than they are at an in-network facility.
  - Require the patient to pay more than is allowable under cost-sharing rules.
- **Certain preventive health services must be covered with no cost sharing.**

- **Make sure your plan document reflects these changes.**
- **Talk to your carrier or TPA if you have questions about which preventive care items must be covered with no cost sharing.**

COMING UP

DOLLAR LIMITS ON ESSENTIAL HEALTH BENEFITS ALL

For plan years starting on or after January 1, 2014, plans cannot place annual limits on essential health benefits.

- **These rules apply to all plans regardless of grandfathered status.**
- **Make sure these rules are reflected in your plan document.**
- **You may want to consider using treatment-based limits (such as a limit on the number of office visits) as an alternative.**
- **Discuss your options with your carrier or TPA.**

REQUIRED COVERAGE OF CLINICAL TRIALS NOT GF

Starting on January 1, 2014, health plans must allow participation in an approved clinical trial and cannot discriminate against an individual participating in a clinical trial. Plans also can't limit or place conditions on coverage for routine patient care provided in the clinical trial.

If your plan is not grandfathered, make sure it is updated to reflect this change.

COST-SHARING LIMITATIONS APPLY

Out-of-Pocket Maximum Limits NOT GF

For plan years starting in 2014, out-of-pocket limits for self-only and family coverage can't be more than the limits for HSA-compatible HDHPs. These limits are indexed each year. In 2013, these limits are:

- **$6,250 (individual coverage)**
- **$12,500 (family coverage)**

Deductible Limits S

For small, insured health plans, there will be limits on deductibles. Deductibles cannot exceed:

- **$2,000 (individual coverage)**
- **$4,000 (family coverage)**

- **If your plan is not grandfathered, make sure it is updated to reflect this change.**
- **If you are considered a small employer, make sure that your plan deductibles are in line with these limits.**

WAY OUT THERE

None.

ALREADY IN EFFECT

NEW STANDARDS FOR APPEALS NOT GF

The rules have the following effects:

- Expand the definition of adverse benefit determination.
- Clarify procedures regarding full and fair review of claims.
- Provide guidance on conflicts of interest.
- Provide new content requirements for notices, and that they be provided in a non-English language in some cases.
- Change the compliance standards and rules about exhausting other avenues of appeal.
- Require continued coverage while an appeal is in process.

Make sure the new claims appeal rules are reflected in your plan document.

LIMITS ON CANCELING COVERAGE RETROACTIVELY ALL

Except in cases of fraud or intentional misrepresentation (lying), plans can't retroactively cancel coverage (called "rescission of coverage"). And even when there is fraud or lying, the plan document must state that it has the right to retroactively terminate coverage in these circumstances. Retroactive cancelation because of a failure to pay premiums is not considered a rescission and is, therefore, allowed.

Update your plan document to ensure that you can retroactively cancel coverage in the event of fraud or lying. Discuss with your carrier or TPA.

LIMITS ON PRE-EXISTING CONDITION EXCLUSIONS ALL

Any plan limits on pre-existing conditions cannot apply to children under age 19. Starting in 2014, plans can't apply pre-existing condition exclusions to any participant.

Make sure these changes have been included in your plan document.

REPORTING THE COST OF EMPLOYER-SPONSORED COVERAGE ON FORM W-2 ALL

Employers must report the aggregate cost of employer-sponsored coverage on Form W-2.

- For a **fully-insured** plan, the aggregate cost of coverage is the combined employer and employee contribution to premium.
- For a **self-insured** plan, aggregate cost of coverage is usually the COBRA applicable premium minus the 2% administration fee.

Excepted benefits (see page 4) do not have to be reported. Employers who issued fewer than 250 W-2s in the previous calendar year are currently not required to report. However, note that after you cross the 250 W-2 threshold, you will be required to report in the following year.

- **Make sure your payroll teams are prepared for this new reporting requirement.**
- **Ask your Alliant representative for a copy of our comprehensive W-2 reporting guide for additional support.**

ALREADY IN EFFECT

HEALTHCARE FSA CONTRIBUTIONS CAPPED AT $2,500 ALL

Employee contributions are limited to $2,500 (indexed for inflation starting in 2014). Employer contributions generally don't count toward the limit unless an employee could elect cash instead of the employer contribution. Please note that:

- **The $2,500 limit applies on an employee-by-employee basis. This means that two spouses employed by the same employer could each contribute $2,500.**
- **The $2,500 limit also applies on an employer-by-employer basis. This means that employees with more than one employer could contribute $2,500 under each employer's FSA.**

There has been no change to the allowable contribution for Dependent Care FSAs.

- **Make sure your cafeteria plan document includes this change.**
- **Communicate the new limit to employees.**

COMING UP

NON-DISCRIMINATION RULES

Healthcare Reform rules state that non-grandfathered fully-insured plans will now have to comply with the same non-discrimination rules that already apply to self-insured plans. In short, these rules prohibit discrimination in favor of highly compensated individuals. Technically, this rule is already in effect for self-funded plans. It is not yet being enforced against fully-insured plans.

So, here's what you need to know:

- **If you plan is fully-insured and non-grandfathered, your plan will need to comply once guidance is released.**
- **If your plan is self-insured, carry on and don't discriminate.**

- **Be on the lookout for new guidance as we approach 2014.**
- **If you have any plan terms that are a concern (for example, a plan that provides better coverage for certain classes of employees), know that these will probably need to be changed once regulations are released. Discuss any concerns with your carrier/TPA or legal counsel.**

Important Note!
The following designs tend to raise "red flags" for discrimination purposes. These features won't necessarily cause a testing failure, but should be looked at to make sure they don't violate the discrimination rules.

- **Excluding part-time, seasonal, or temporary employees from participation**
- **Having different plans available only to certain classes of employees**
- **Different eligibility provisions such as waiting periods for different classes of employees**
- **Employer contributions that increase with an employee's tenure or a percentage of the employee's compensation**
- **Different employer contributions for different classes of employees**

AUTOMATIC ENROLLMENT FOR LARGE EMPLOYERS ONLY ALL XL

Healthcare Reform rules are designed to ensure that everyone has healthcare insurance coverage. Therefore, large employers (200+ counted employees) must ensure coverage for benefits-eligible employees by:

- **Automatically enrolling new full-time employees in one of the employer's benefit plans**
- **Automatically continuing the enrollment of current employees from one plan year to the next (called "passive enrollment").**

COMING UP

If you're a large employer, watch for guidance on this and let your human resources/benefits administration teams know this is coming.

NO PRE-EXISTING CONDITION EXCLUSIONS ALL

Starting in 2014, plans can't apply pre-existing condition exclusions to any participant.

Make sure these changes have been included in your plan document.

EXCESSIVE WAITING PERIODS PROHIBITED ALL

Starting with the first plan year on or after January 1, 2014, plans can't apply a waiting period that is longer than 90 days. If your plan currently extends eligibility on the first of the month after 90 days, the plan will not be compliant. Coverage must begin no later than day 91. This is a true "days passed" standard and includes weekends and holidays.

EXAMPLE:

ABC Company has always allowed employees to participate in its health plan starting the first of the month after the employee has worked 90 days. Will this "first of the month after 90 days" standard be acceptable under the new Healthcare Reform rules?

No. Suppose ABC Company hires Danny as a full-time employee on June 1, 2014. Ninety days from Danny's first day of employment (June 1, 2014) is August 29, 2014. Waiting until September 1 to enroll Danny would violate the Healthcare Reform rules because this would result in a waiting period longer than 90 days.

Additional guidance on how waiting periods are applied in connection with the "Pay or Play" rules may be issued. Please see page 11 for more information on Pay or Play.

Make sure this change is included in your plan document.

REPORTING HEALTH INSURANCE STATUS TO IRS ALL L

Employers with 50 or more full-time employees who offer employer-sponsored coverage must report coverage status to the government. A summary of the reported information must be given to employees.

EMPLOYER ACTION ITEM

- **Watch for additional guidance.**
- **Make sure your payroll teams (or teams who will be responsible for this reporting) are prepared for this new reporting requirement.**

WAY OUT THERE

None.

ALREADY IN EFFECT

INSURANCE CARRIERS MUST ISSUE REFUNDS TO CERTAIN FULLY-INSURED PLANS ALL

Carriers must refund a portion of your plan's premiums if the carrier does not spend a minimum amount of your premiums on paying plan claims.

- **In large groups, the minimum is 85%**
- **In small groups, the minimum is 80%**

There are special rules about how refunds can be used. It will depend on:

- **The terms of your plan**
- **Whether it's an ERISA, non-ERISA, or church plan**
- **Whether the refund is considered a plan asset**

This rule does not affect self-insured plans.

Review your plan and talk to your carrier.

PATIENT-CENTERED OUTCOMES RESEARCH FEE ALL

This is also called the "clinical effectiveness fee." Fees are based on the number of employees and dependents covered by the plan. If an employer has more than one self-insured plan and if the self-insured plans have the same plan year, participants of both plans will usually be counted only once for the fee.

The fee is $1 per person per year for plan years that end before October 1, 2013, then $2 per person per year.

Get familiar with the different methods for taking a "headcount" and submit the fees by the date due (generally July 31).

COMING UP

ANNUAL FEES FOR INSURANCE CARRIERS OF FULLY-INSURED PLANS

Carriers will probably pass the fees along to plans. Plans could feel the impact of this as early as 2013 if carriers collect the fee in advance in order to have "cash on hand" when the fees are payable to the government in 2014.

If your plan is fully-insured, talk to your carrier about how much the fee will be and when it will be collected.

REINSURANCE FEES FOR INSURANCE CARRIERS AND TPAS

Insurance carriers and TPAs must contribute to a temporary reinsurance program. The fee is estimated at $63 per covered life, and lasts for three benefit years (2014–2016). Again, these fees are likely to be passed along to policyholders.

Talk to your carrier or TPA for information about how the fees will apply to your plan.

SECTION 4 PAY OR PLAY ALL L (SHARED RESPONSIBILITY TAX)

Because "Pay or Play" is such a big part of Healthcare Reform, we're devoting a whole section of the Guide to it. In this section, you'll get a good overview of how Pay or Play works, and how it will affect your organization.

OVERVIEW

The Pay or Play rules require that large employers offer minimum essential coverage to their full-time employees or pay a penalty. If an employer doesn't provide minimum essential coverage, it must pay an annual tax of $2,000 per employee starting with employee number 31. (There is no penalty for the first 30 employees.)

If an employer provides minimum essential coverage but the coverage is unaffordable or doesn't provide minimum value, the employer must pay an annual tax of $3,000 for each employee who gets subsidized coverage through an Exchange.

WHAT IS A LARGE EMPLOYER?

A large employer has at least 50 full-time or full-time equivalent employees. Add together the number of actual full-time employees and the number of full-time equivalent employees to see if there are at least 50 employees.

Ask your Alliant representative if you need assistance determining if your company is considered a "large employer."

LARGE EMPLOYER

50+ FULL-TIME EMPLOYEES AND FULL-TIME EQUIVALENT EMPLOYEES

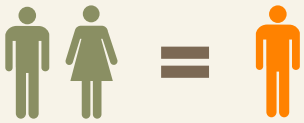
WHAT MAKES AN EMPLOYEE FULL-TIME?

Full-time is defined as 130 hours per month. This includes:

- **Actual hours worked**
- **Hours paid, but not worked (for example, paid sick time or vacation time)**

WHAT IS A FULL-TIME EQUIVALENT EMPLOYEE?

Multiple part-time employees can be "added together" to make one full-time equivalent employee. For example, two employees working 65 hours per month (approximately 15 hours per week) add up to one full-time employee working 130 hours per month.



2 part-time employees 65 hrs./mo. = **1 full-time employee 130 hrs./mo.**

Alliant EMPLOYEE BENEFITS

PAY OR PLAY REQUIREMENTS

1. PLANS MUST PROVIDE MINIMUM ESSENTIAL COVERAGE

Although regulatory guidance has not yet been issued, most employer-sponsored major medical plans will be considered minimum essential coverage.

2. PLANS MUST PROVIDE MINIMUM VALUE

In order to provide minimum value, a plan's share of the cost of benefits must be at least 60%. Employers will have different options to make sure their plans meet this threshold.

- HHS and the IRS have created an Excel-based calculator
- A safe harbor or checklist method will also be available
- An actuarial analysis could be done (probably the least appealing option due to the expense)

3. COVERAGE MUST BE AFFORDABLE TO EMPLOYEES

Under Healthcare Reform, coverage that costs more than 9.5% of the employee's household income will not be considered affordable. Because employers will usually not know an employee's household income, the rules allow employers to use the following methods to calculate affordability. Calculations are based on employee-only coverage for the lowest cost plan offered that provides minimum value:

- **W-2 wages method:** The employee's annual premium contribution does not exceed 9.5% of W-2 wages.
- **Rate of pay method:** The employee's cost does not exceed 9.5% of the employee's hourly wage X 130 per month. (Note: 130 hours per month is used for the calculation even if an employee works more hours than 130.)
- **Federal Poverty Line (FPL) method:** The employee's cost does not exceed 9.5% of the federal poverty line for a single individual.

EXAMPLES

W-2 WAGES METHOD

Kathy earns $50,000 per year and pays $300 per month for single coverage on her employer's lowest cost plan. Kathy's annual contribution to coverage is affordable because it does not exceed 9.5% of her W-2 wages. (50,000 X .095 = 4,750, the maximum contribution that could be charged annually and still be considered affordable.) Kathy's contribution is below this threshold—she pays $3,600 in premiums annually.

RATE OF PAY METHOD

John makes $15.00 per hour and works 40 hours per week. He pays $150 per month for single coverage on his employer's lowest cost plan. John's contribution to coverage is affordable under the rate of pay method because it does not exceed 9.5% of his hourly wage multiplied by 130 hours (15 x 130 = 1950; 1950 x .095 = 185.25, the maximum contribution that could be charged and still be considered affordable).

FEDERAL POVERTY LINE METHOD

Using John from the previous example, would his $150 monthly contribution still be considered affordable using this method? No. If John lives in the continental U.S., the federal poverty level for a single individual is $11,490. 11,490 X .095 is $1,091.55 per year, or $90.96 per month (the maximum contribution that could be charged and still be considered affordable). John's $150 monthly contribution exceeds this threshold.

DETERMINING ELIGIBILITY FOR COVERAGE

Coverage must be available to all full-time employees. So the first thing employers need to do is determine which employees—in the eyes of the federal government—are considered "full-time."

WHO IS FULL-TIME?

The rules here are fairly complex. In short, employers must put employees into different categories. Employees who are working full-time (130 hours per month) generally must be offered coverage to avoid a penalty. Other employees whose hours are unpredictable will have their full-time status determined by looking back over a period of time called a measurement period.

HOW LONG IS THE MEASUREMENT PERIOD?

The measurement period is set by the employer, but can't be longer than 12 months. Most employers will have an initial measurement period for new and variable hour employees and a standard measurement period for ongoing employees. If, at the end of the measurement period, the employee has met the threshold for full-time status, he or she must be offered coverage to avoid a penalty.

WHAT IS A STABILITY PERIOD?

At the end of the measurement period, the employee usually enters what's called a stability period. The stability period has to be at least as long as the measurement period was, and during the stability period, employees are vested in their benefits coverage regardless of how many hours they actually work.

WHAT IS AN ADMINISTRATIVE PERIOD?

The rules allow an employer to use an administrative period—a time when the employer can:

- Collect paperwork
- Answer questions from employees
- Take care of other administrative tasks

The administrative period can't be longer than 90 days. The administrative period and measurement period together cannot last past the last day of the first month following the one-year anniversary of an employee's start-date.

- For example, if the employee is hired February 15, the combined measurement period and administrative period must end on or before March 31 of the following year.

PRACTICAL APPLICATION

Since most employers administer their plans on a monthly basis, the most common arrangement will be for an employer to have 13 distinct measurement periods:

- 12 "initial" measurement periods starting on the first day of each month for new employees. For example, if an employee starts work on March 13, his initial measurement period would start April 1.
- One "standard" measurement period for ongoing employees. Employers will likely want the standard measurement period to end close to their annual benefits enrollment so that eligibility for benefits is determined prior to annual enrollment beginning.

Most employers will probably use a split administrative period, with some administrative time before the measurement period starts (to answer questions and do initial paperwork) and after it ends (to calculate hours and complete enrollment). It would look like this:

EXAMPLE

Jane Doe is hired February 15 and is expected to have variable hours.

- Administrative Period #1 (February 15–February 28): She will enter the front end of an administrative period on February 15, which will last until the employer's next initial measurement period starts (March 1).
- Initial Measurement Period (March 1–January 31): Let's say the employer has an 11-month initial measurement period in order to have a longer administrative period. In this case, Jane finishes the initial measurement period on January 31.
- Administrative Period #2 (February 1–March 31): On February 1, she enters the back end of the administrative period, which will last until the end of the following month, or March 31.
- Eligibility Begins (April 1): If she is a full-time employee based on the measurement of her hours, she would be treated as full-time beginning April 1.

WHO IS FULL-TIME? (continued)

What happens if an employee does not meet the full-time threshold in the initial measurement period?

In this case, the employee enters what's called a "limited" stability period. It's considered limited because it will not necessarily last the same number of months as the measurement period—it will only last until the employer's standard measurement period for ongoing employees ends.

At the end of the limited stability period, the employer would take a second measurement of the employee's hours based on the standard measurement period—the one that started on or after the employee's hire date and generally ends just prior to annual enrollment. If the employee is full-time using this method, he or she will need to be offered coverage to avoid a penalty.

What if an employer misses someone?

It is possible to mistakenly determine that an employee is not full-time (and therefore not benefits-eligible) when in fact he or she is eligible. The rules provide some relief here. An employer who fails to offer coverage to a small number of full-time employees (5% or less) will not face the full pay or play penalty that would otherwise apply. This is known as the de minimis rule.

- **Familiarize yourself with these basic rules.**
- **Consider what groups within your organization will need training. For example, human resources and payroll teams will likely need training.**
- **Please contact your Alliant representative with specific questions on how the rules apply to you. The rules are complicated and represent a major change for most employers. Don't hesitate to reach out for assistance.**

WAY OUT THERE

CADILLAC TAX: TAX ON THE EXCESS BENEFIT OF HIGH COST HEALTH COVERAGE (2018)

A plan is considered a "Cadillac" plan if it provides a level of benefits that results in an annual premium of:

- **$10,200 for individual coverage**
- **$27,500 for family coverage**

Generally, these plans require little or no out-of-pocket cost for the participant, which tends to encourage overuse of medical care.

These plans will incur a 40% excise tax on the excess benefit (meaning, premiums that exceed these thresholds). There are many exceptions based on location and job classification.

- **Watch for guidance as the effective date approaches.**
- **Keep an eye on whether plans are trending toward the premium level, which would trigger the Cadillac tax.**

ALREADY IN EFFECT

PLANS MUST PROVIDE A SUMMARY OF BENEFITS AND COVERAGE (SBC)

Summary information using a template SBC must be provided to participants. The template allows for four double-sided, letter-size pages. Aside from adding the plan's specific information, the template cannot be changed.

- **Work with your carrier/TPA to ensure the SBC is written accurately and distributed to all individuals who should receive them.**
- **Determine if your dental and/or vision plans are required to provide SBCs. (See page 4 for information on excepted benefits.)**

COMING UP

EMPLOYERS MUST PROVIDE NOTICE OF EXCHANGES

Employers must provide employees with a written notice about the Exchange and the effect of buying Exchange coverage instead of employer-sponsored coverage. Regulators have issued a model notice. A pared down Alliant version of the notice is also available and will simplify the process for employers.

Distribute notice according to regulatory deadlines: October 1, 2013 (for employees hired on or after October 1, within 14 days of the employee's start date).

WAY OUT THERE

None.

ALREADY IN EFFECT

HSA PENALTIES INCREASE

If a participant uses HSA money for non-qualifying medical expenses, they are liable for a 20% penalty on the non-qualifying distribution. This is in addition to the regular income tax which would be due.

EMPLOYER ACTION ITEM

Even though it's not required, you may wish to communicate this change to employees in high deductible plans with HSAs.

RESTRICTIONS ON REIMBURSEMENTS FOR OVER-THE-COUNTER DRUGS

Over-the-counter medicines (other than insulin) cannot be reimbursed from an FSA, HSA or HRA unless prescribed by a doctor.

- **Make sure your cafeteria plan document has been updated to reflect this change.**
- **You will want to communicate this change to employees during annual enrollment if you offer a Healthcare FSA, an HRA or a high-deductible plan with an HSA.**

COMING UP

Exchanges become available.

Watch for additional guidance as we get closer to the effective date.

WAY OUT THERE

None.

QUESTIONS?

Contact your Alliant Employee Benefits representative if you'd like more information on Healthcare Reform and what it means to your company.