Title: The Latest on the Health Care Reform Debate and ACA Implementation

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Health Care Reform
A federal legislative update

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GFOA
2017 GFOA Annual Conference
Where are we coming from?
- GFOA Policy
- The plan to repeal and replace Affordable Care Act

Where are we now?
- AHCA passage
- What does it do?

Where are we going?
- The Senate
Where are we coming from?
The Government Finance Officers Association (GFOA) urges the Administration and Congress to work together with state and local governments on initiatives to reform the nation’s health care delivery system in order to contain the growth of health care costs and expand access to health care for all. GFOA encourages a federal approach that includes:

- Expanded Health Care Coverage
- Equal Consideration for All
- Adequate Federal Funding
- Transparency within the Health Care System
- Health Care Education
GFOA Policy Statement

40% Excise Tax on Health Care Premiums (2015)

GFOA is committed to working with federal policy makers to develop and support the health care reform initiatives in order to expand access to quality care and control the growth of health care costs. GFOA continues to support expanded health care coverage resulting from the Affordable Care Act and acknowledges that implementation of the policy requires adequate federal funding supporting its sustainability. However, GFOA opposes efforts by the federal government to impose unfunded mandates that will further escalate the cost of employer-provided health care insurance on state and local governments. In so doing, GFOA supports legislative efforts to repeal the 40% Excise Tax on Health Plan Premiums, as well as alternative approaches that would mitigate the effect of the excise tax on state and local governments.

The means for funding the implementation of the Affordable Care Act should preserve the authority of state and local governments to design and maintain health insurance arrangements that are tailored to the specific needs of the employers. These arrangements should:

(a) provide flexibility for the significant regional variations in health care costs;
(b) support initiatives to reduce the rising costs of healthcare in order to ensure adequate health care benefits to employees, including programs designed to mitigate total health care costs such as wellness programs, on-site medical clinics and tele-medicine; and
(c) be affordable, financially prudent, and meet the sponsor’s workforce management goals.
The GOP Plan to Repeal and Replace

- Budget Reconciliation
- Executive Actions
- Legislation
Budget Reconciliation – Quick Notes

- Process created under Congressional Budget and Impoundment Control Act of 1974
- Process can only direct one (or more) committee to change legislation on an issue that involves the federal debt limit, revenue, or spending
- Can only be used to repeal portions of the ACA, not outright repeal
- Why use it?
Budget Reconciliation

START
House/Senate Budget Committees

Budget Resolution with Reconciliation Instructions

Full House/Senate

Budget Resolution with Reconciliation Instructions is amended (or not) and passed out of House/Senate

Budget Conference Committee

Irons out differences in budget resolutions

Full House/Senate

Passes Congressional Budget Resolution, Sends Instructions to Committee

Single Committee

Sends instructions to one OR multiple committees

Full House/Senate

Budget Committee

Recommends policies that save at least as much as the instructions

Compiles into a single bill

Ways and Means*

Energy & Commerce*

Agriculture*

Resolve Differences (if needed)

Each body considers the reconciliation bill on a “fast track,” with strict limits on time and amendments, and a 50-vote threshold in the Senate

President’s Desk

END
Executive Action

Executive Order Minimizing the Economic Burden of the Patient Protection and Affordable Care Act Pending Repeal (Jan. 20, 2017)

- “…easing the burden of the Affordable Care Act.”

- Individuals, insurance companies, hospitals, doctors, medical device manufacturers, i.e. the health care industry

- For example, Health and Human Services (HHS) could change through rule-making, the minimum requirements for coverage
Executive Action

What else can POTUS do?

- Withhold subsidy payments to insurance companies
- Not enforce individual mandate
- Make tax credits to middle-income households less generous
- Impose Work Requirements for Medicaid
Legislation

- **S. 191 – Patient Freedom Act of 2017**  
  *Sens. Cassidy (R-LA) and Capito (R-WV)*  
  - Selectively repeals parts of ACA, only addresses Title I  
  - Gives states option to continue ACA implementation, utilize Roth HSAs, no reform  
  - Keeps state innovation waivers, ban on annual limits, prohibition against health status discrimination

- **S. 222 – Obamacare Replacement Act**  
  *Sen. Rand Paul (R-KY)*  
  - Repeals individual mandate and essential health benefits that insurance plans must cover  
  - Changes rules for patients with pre-existing conditions, i.e. two-year open enrollment, requirement to maintain continuous coverage
H.R. 1628 – American Health Care Act of 2017

Rep. Diane Black (R-TN)

- Introduced 3/20/2017
- Followed weeks of some negotiations among GOP members, no hearings held, changes to the bill were ongoing
- Initial Congressional Budget Office score – mixed bag for Republicans – approx. 24M more would lose coverage under the new plan, but would result in some deficit reduction
- Concerns among GOP caucus – mixed bag as well, i.e. AHCA went too far v. did not go far enough
- Vote originally scheduled for 3/24/2017 – Speaker Ryan pulled the bill at the last moment

After waiting seven years this should be easy, right???
*Gray dots are vacancies*
Where are we now?
H.R. 1628 – American Health Care Act of 2017

- House passes – after several changes to try and sway members from No to Yes, slimmest of margins 217-213 on 5/4/2017***
- Ends penalty for no coverage – replaces with 30% surcharge to regain insurance if you let coverage lapse for more than 63 days in a year
- Ends funding for Medicaid expansion funding
- Changes Medicaid from an open-ended program to one that gives states fixed amounts of money per person
- ACA cost sharing subsidies based on incomes and premium costs replaced with tax credits based on age
- Repeals taxes* on wealthy, insurers, drug and medical device makers
- State waivers that could allow insurers to charge older customers higher premiums
- $8 billion over 5 years to states to finance high-risk pools to cover those with pre-existing conditions
- States get $130 billion over a decade to help people afford coverage
Where are we going?
Senate Outlook – A challenge for both parties

2017:
Democrats: 46
Republicans: 52

*2 Independents that caucus with Democrats
Senate Outlook – Working Group

McConnell (KY)
Hatch (UT)
Alexander (TN)
Enzi (WY)
Thune (SD)
Barrasso (WY)
Cornyn (TX)
Cruz (TX)
Lee (UT)
Cotton (AR)
Gardner (CO)
Portman (OH)
Toomey (PA)
Senate Outlook

- CBO Score – week of May 22

- Weekly policy lunches
  - Presentations from members
  - Ideas but no specifics

- Democrats?
  - Not expected to provide help – unless repeal is off the table
Questions?

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The Current State of the ACA and the Future of Employer-Provided Health Plans

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General Outline of ACA Provisions Affecting Employers and Health Care Providers

- Employer mandate
- Individual mandate
- Market reforms
- ACA reporting
- Additional taxes
- Medicaid expansion
Current ACA Challenges
Employer Mandate

- Employer Mandate began in 2015
- Administrative complexity with determining full-time employees
- Complex reporting under Code Sections 6055 and 6056
Employer Mandate Penalty and Affordability Increases

- ACA Employer Shared Responsibility penalties increase for 2015 and 2016:
  - “A” penalty
  - “B” penalty
    - 2015: $3,120 / 2016: $3,240 / 2017: $3,390
- ACA “affordability” threshold increases from 9.5% of household income:
  - 9.56% in 2015
  - 9.66% in 2016
  - 9.69% in 2017
  - Affects the ACA affordability “safe harbors”
**Employer Mandate – April 2017 Treasury IG Report on 2015 Shared Responsibility Reporting**

- IRS processed 439,201 Forms 1094-C by 10/28/16
- IRS processed nearly 110 million Forms 1095-C by 10/28/16
- TIGTA review found some processes did not function properly resulting in IRS not having accurate and complete data for use in its compliance strategy
- Paper returns not processed timely and accurately
  - 16,000 paper Forms 1094-C not processed by 10/28/16
  - 1.4 million paper Forms 1095-C not processed by 10/28/16
Criteria used to identify validation errors did not always work

Error codes generated when no errors and vice versa because IRS did not sufficiently test error code programming

Development and implementation of systems to identify noncompliant employers subject to penalty have been delayed, not initiated, or cancelled

IRS’s implementation of post-filing compliance validation system delayed from January 2017 to May 2017
Health Insurance Exchanges

- Aetna and Humana completely exit exchanges in 2018
  - Leaves Medica as only carrier on Nebraska exchange and Highmark BCBS as only carrier on Delaware exchange
  - United and Blues downsizing participation
  - Many insurers seeking large rate hikes for 2018 – some up to 50% or more

- Uncertainty about what is happening in Washington, D.C.
- Continued uncertainty about the availability of cost sharing reduction payments
  - Payments to assist individuals under 250% of federal poverty level with cost-sharing in exchange plans
  - 15 State attorneys general intervening in House lawsuit since Trump administration does not appear to be defending it
Health Insurance Exchanges (cont’d)

- Trump Administration finalizes rule to shore up insurance companies and exchanges
- Allows sale of less generous policies that may feature lower premiums and higher cost sharing by loosening “metal” levels for exchange policies
- Shortens exchange open enrollment period for 2018 to November 1 to December 15 (used to go to January 31)
- Requires pre-enrollment verification for mid-year special enrollment events on exchange
- Insurers may apply premium payments for new coverage to unpaid premiums for last 12 months when consumers re-enroll with the same insurer
- Federal government will defer to states’ network adequacy standards
Why Does Exchange Viability Matter to Employers?

- Loss of cost sharing reduction payments undermines ability of insurers to remain on exchanges
- More people will become uninsured without cost-sharing assistance or because of reduced options
  - This results in more uncompensated care at health care providers and more underutilization of services
  - Costs for uncompensated care and underutilized services get shifted to employer group health plans
- Reduces options for former employees, so more will choose to stay on employer’s plan through COBRA increasing employer costs
- Employers that provide pre-65 retiree coverage through private exchange models could have fewer individual market options for retirees
Nondiscrimination in Health Programs and Activities – Final Rule
New ACA Section 1557

An individual may not be discriminated against on the basis of race, color, national origin, sex, age, or disability in health programs and activities that:

- receive financial assistance from the federal government;
- that are administered by a federal executive agency; or
- that are health insurance marketplaces.
HHS Final Rule

- Effective July 18, 2016
- Applies to health programs or activities that are "recipients" of federal financial assistance from HHS.
- Recipient is:
  - State or political subdivision (or any instrumentality of a State) or any public or private agency, institution, or organization, or other entity, or any individual;
  - To whom federal financial assistance is extended from Dept. of Health and Human Services directly or through another recipient; and
  - Which operates a health program or activity.
To Whom Does 1557 Apply?

- A covered entity that provides an employee health benefit program to its employees is subject to 1557 with respect to that benefit program in only three circumstances:
  - the entity is principally engaged in providing or administering health services, health insurance coverage, or other health coverage
  - the entity receives Federal financial assistance a primary objective of which is to fund the entity’s employee health benefits program
  - the entity operates a health program or activity that is not an employee health benefit program and that receives Federal financial assistance.

- For example, a hospital that takes Medicare or Medicaid funds is subject to 1557 with respect to services provided to patients and with respect to the group health plan provided to its employees.
To Whom Does 1557 Apply? (cont’d)

- One example in the preamble states that if a State receives Medicaid funding, 1557 applies to the Medicaid program and the group health plan offered to the Medicaid agency's employees, but would not apply to a group health plan offered to the State's other non-Medicaid employees if their agency does not operate a health program or activity that receives HHS funds.

- Practical issue: if both sets of employees participate in a single State employee health plan, 1557 applies to that plan.

- Would apply to group health plans that directly take premium assistance for employees from Medicaid programs.
So, What if 1557 Applies?

- Entity must provide **assurances** that it will comply with 1557 when it applies for federal financial assistance.

- Entity must take **remedial action** if found to have discriminated on basis of the protected characteristics.

- Entity with over 15 employees must **designate at least one employee** to ensure that the entity complies with 1557 and must adopt grievance procedures.

- Entity must **provide notices** to individuals relating to the entity's compliance with 1557 and individuals' rights.
So, What if 1557 Applies? (cont’d)

- Entity must take reasonable steps to provide meaningful access to each individual with limited English proficiency that it serves or encounters in its health programs and activities.
- Language assistance services must be free of charge, accurate and timely, and protect the individual's privacy.
- Includes provision of a qualified interpreter.
- Entity must ensure effective communication with people with disabilities (including in connection with health programs and activities provided through electronic and information technology – unless undue financial or administrative burdens exist).
Entity must provide individuals with equal access to its health programs or activities **without sex discrimination**.

Entity must treat individuals **consistent with their gender identity**.

Except that a covered entity may not deny or limit health services that are ordinarily or exclusively available to individuals of one sex, to a transgender individual based on the fact that the individual’s sex assigned at birth, gender identity, or gender otherwise recorded is different from the one to which such health services are ordinarily or exclusively available (e.g., a hysterectomy must be available to a transgendered man, even if he identifies as a male).
So, What if 1557 Applies? (cont’d)

- Entity may not, on the basis of the protected characteristics:
  - Deny, cancel, limit, or refuse to issue or renew health coverage;
  - Deny or limit coverage of a claim;
  - Impose additional cost sharing or other limitations or restrictions; or
  - Have or implement marketing practices or benefit designs that discriminate.
So, What if 1557 Applies? (cont’d)

Entity may not deny or limit coverage, deny or limit coverage of a claim, or impose additional cost sharing or other limitations or restrictions on coverage, for any health services that are ordinarily or exclusively available to individuals of one sex, to a transgender individual based on the fact that an individual’s sex assigned at birth, gender identity, or gender otherwise recorded is different from the one to which such health services are ordinarily or exclusively available.

For example, a transgender woman cannot be denied a prostate exam, even if the plan's records lists her gender as female.
So, What if 1557 Applies? (cont’d)

- Entity may not have or implement a categorical coverage exclusion or limitation for all health services related to gender transition.

- Entity may not deny or limit coverage, deny or limit coverage of a claim, or impose additional cost sharing or other limitations or restrictions on coverage, for specific health services related to gender transition if such denial, limitation, or restriction results in discrimination against a transgender individual.

- HHS states that it does not affirmatively require covered entities to cover any particular treatment, as long as the basis for exclusion is evidence-based and nondiscriminatory.
Currently there is a nationwide injunction in effect on the Regulations' prohibition against discrimination on the basis of gender identity and on the basis of termination of pregnancy.

On December 31, 2016, the U.S. District Court for the Northern District of Texas determined that the Regulations' interpretation of "sex" as inclusive of gender identity contravened the clear meaning of Title IX, in whose terms the regulatory prohibition was defined.

HHS announced its intent not to enforce the regulatory prohibition against discrimination on the basis of gender identity while the injunction remains in effect.
HHS has not appealed the decision, so the prohibition against discrimination on the basis of gender identity cannot currently be enforced by HHS.

This does not mean that an employer would be without risk in failing to comply with the gender identity protections of the Regulations.

The EEOC interprets "sex" under Title VII to include gender identity. The EEOC enforces Title VII's prohibition on discrimination on the basis of sex with respect to fringe benefits including health coverage.

Although HHS may not enforce the gender identity protections of the regulations, individuals may still file actions in court. 45 C.F.R. § 92.302(d) ("An individual or entity may bring a civil action to challenge a violation of Section 1557 or this part in a United States District Court in which the recipient...is found or transacts business.").
Other ACA Issues
Out-of-Pocket Maximums

- "Non-grandfathered" plans (even if the plans are not HDHPs) maximum out-of-pocket limits:
  - Self-Only Coverage: $7,150 for 2017 and $7,350 for 2018
  - Family Coverage: $14,300 for 2017 and $14,700 for 2018

- HDHP max out-of-pocket limits:
  - Self-Only Coverage: $6,550 for 2017 and $6,650 for 2018
  - Family Coverage: $13,100 for 2017 and $13,300 for 2018

- Do not have to include OON, non-covered items and services, premiums, balance billing, selecting a brand name drug when a medically appropriate generic is available. In addition, reference based pricing programs may also be acceptable to encourage plans to negotiate cost-effective treatments.

- PPACA transitional relief for PBMs expired as of first plan year after 1/1/15

- Can split the applicable limits between medical and prescription drug (as long as both do not exceed the annual limit).
Other HDHP Limits

- **Annual Deductible**
  - Self-Only Coverage: $1,300 for 2017 and $1,350 for 2018
  - Family Coverage: $2,600 for 2017 and $2,700 for 2018

- **Maximum Annual HSA Contribution**
  - Self-Only Coverage: $3,400 for 2017 and $3,450 for 2018
  - Family Coverage: $6,750 for 2017 and $6,900 for 2018
  - Catch-Up Contribution of $1,000 for individuals who are age 55 or older
Section 18A of the FLSA, as added by section 1511 of the Affordable Care Act, generally required an employer to which the FLSA applies, and that has more than 200 full-time employees, to automatically enroll new full-time employees in one of the employer’s health benefits plans.

On November 2, 2015, the Bipartisan Budget Act of 2015 repealed the automatic enrollment requirement.

Nondiscrimination rules under Code Section 105(h) already apply to self-insured group health plans.

Extension of similar rules relating to eligibility and benefits to fully-insured non-grandfathered group health plans.

No regulations issue yet; therefore, no enforcement yet.
Employer Payment Plans

- IRS Notice 2013-54, issued on September 13, 2013, provides that "employer payment plans" constitute group health plans within the meaning of the ACA and are, therefore, subject to the ACA coverage mandates, including the prohibition on annual dollar limits on essential health benefits and the requirement to cover preventive benefits without cost sharing.

- Notice 2013-54 defines "employer payment plans" as group health plans under which an employer reimburses an employee for some or all of the premium expenses incurred for an individual health insurance policy, such as a reimbursement arrangement, or arrangements under which the employer uses its funds to directly pay the premium for an individual health insurance policy covering the employee.

- Cafeteria plans may not be used to allow an employee to pay for individual health insurance coverage via salary reduction on a pre-tax basis.
Employer Payment Plans (cont’d)

- Notice 2015-17 provided transition relief for certain small employers for up to June 30, 2015.
- These arrangements do not comply with the ACA rules even if the reimbursements are provided on an after-tax basis.
- Increases in compensation that are not tied to the purchase of health coverage are not employer payment plans.
- Retiree-only HRAs are still valid and can reimburse retirees for individual health insurance premiums (but it constitutes MEC).
Beginning in 2017, small employers (e.g., 50 FTEs or less) may establish a small employer HRA.

HRA rules generally apply, except that:

- QSEHRAs are not group health plans subject to coverage mandates.
- Employer cannot sponsor a group health plan.
- QSEHRA must be provided on same terms to all eligible employees of the employer.
- The permitted benefit cannot exceed $4,950 for employee only HRAs or $10,000 for employee plus HRAs.
QSEHRAS (cont’d)

- HRA rules generally apply, except that:
  - Qualified medical expenses include premiums for health insurance.
  - Employee must have minimum essential coverage (MEC) for the HRA benefits to be excluded from gross income.
  - Employee may not be subsidy eligible if they purchase coverage on the public exchange.
  - Employer must provide a written notice to employees.
ACA Fees and Cadillac Tax

- **Transitional Reinsurance Fee**
  - 2016 benefit year was the last year for the fee.

- **PCORI Fee**
  - Fee’s purpose is to advance comparative clinical effectiveness research.
  - The fee is assessed on issuers of health insurance policies and sponsors of self-insured health plans.
  - Payment for the 2016 plan year is due by July 31, 2017 on IRS Form 720
  - Amount is $2.26 per covered life on the plan for a 2017 calendar-year plan.
  - Plan year that ends before October 1, 2019 will be last year for the fee (2018 plan year for calendar-year plan)

- “Cadillac Tax” is delayed until 2020
  - AHCA would delay it until 2026
Selected AHCA Provisions Affecting Employers and Group Health Plans
AHCA Provisions Affecting Employers and Group Health Plans

- Repeal of ACA **individual mandate** as of 2016 by lowering tax to $0
- Repeal of ACA **employer mandate** as of 2016 by lowering tax to $0
- Does not repeal health plan and **employer reporting** under Code Sections 6055 and 6056
  - However, bill calls for reporting an offer of coverage on Form W-2 by employers
  - Secretary of Treasury can stop enforcing 6055 and 6056 reporting that is not needed for taxable purposes
AHCA Provisions Affecting Employers and Group Health Plans (cont’d)

- **Essential health benefit requirements** and other benefit “mandated benefits” unchanged (for now)
- States may seek waivers of the ESB requirements beginning in 2020 – waivers automatically approved unless HHS objects within 60 days
- If States obtain ESB waivers, employers may be able to re-impose annual and lifetime dollar maximums on benefits

- **Repeals cost sharing reduction subsidies** (2020)
  - Cost-sharing subsidies not replaced in any way
  - Individual coverage reduced – health care costs passed onto employer plans
AHCA Provisions Affecting Employers and Group Health Plans (cont’d)

- Imposes a **30% penalty** on individuals who do not maintain continuous coverage in the prior 12 months
  - Penalty would last for 12 months
  - Gap of no more than 63 days (old HIPAA standard) is allowed
  - Generally effective in 2019 (effective for 2018 special enrollments)
  - Would likely result in employer certifications of coverage (like old HIPAA certificates of creditable coverage)

- In lieu of the 30% penalty, **state can underwrite late enrollees** based on health status beginning in 2019
  - Conditioned on state operating a risk mitigation program or participating in a Federal Invisible Risk Sharing Program
  - Undermines the prohibition of pre-existing condition exclusions
AHCA Provisions Affecting Employers and Group Health Plans (cont’d)

- Encourages use of health savings accounts
  - Increases annual contribution limit to equal the maximum out-of-pocket allowed under a high deductible health plan ($6,550/S and $13,100/F in 2017)
  - Allows catch-up contributions to a spouse’s HSA
  - Allows OTC drugs to be reimbursed under HSA
  - Reduces penalty for non-qualified expenses back to 10% (ACA had increased it to 20%)
  - Allows reimbursement of certain expenses incurred before opening HSA
- Removes annual limit on flexible spending accounts (ACA had imposed limit of $2,500 (indexed for COLA))
AHCA Provisions Affecting Employers and Group Health Plans (cont’d)

- Repeals and Delays ACA Taxes
  - Repeals Medicare health insurance payroll tax increase (imposed on those making $250,000 or more) beginning in 2023
  - Eliminates employer withholding obligation
  - Repeals annual fee paid by branded prescription drug manufacturers beginning in 2017
  - Delays “Cadillac” tax through 2026
  - Repeals tax on health insurers (2017), medical devices (2017), pharmaceuticals
  - Restores the ability of employers to deduct the Medicare Part D Retiree Drug Subsidy
THANK YOU
A Public Employer’s Prospective:
The City of Rock Hill, SC
City of Rock Hill

- City founded in 1852 and incorporated in 1892
- City encompasses approximately 37.58 square miles
- Current Population: 71,548 (estimated)
- 20 miles south of Uptown Charlotte, North Carolina
City of Rock Hill

- City owned and operated electric, water, and wastewater system serving over 100,000
- Public Safety – Fire and Police
- Public Works – Sanitation, Stormwater and Construction
- Large Parks, Recreation and Tourism Department
- Annual budget approximately $230 million
Sports Tourism

- BMX
- Velodrome
- Criterium Course
- Mountain Bike Trails
- Soccer Complex
- Softball/Baseball Complexes
- Tennis Center
- Indoor Sports Facility (Coming Soon)
Health Insurance Information

- Employees:
  - Full-time: 858
  - Part-time and seasonal: 93

- Insurance Subscribers: 790

- Covered Lives: 1,725
Health Insurance Information

- Self-insured

- Individual and Aggregate Stop Loss Policy

- Third Party Administrator to process claims and provide network access

- Offer insurance to employees, retirees under 65 and dependents.

- Health Insurance Committee
Issues from ACA Implementation

- Mandated coverage for essential health benefits
- Dependent coverage until age 26 increased risk pool
- “Grandfather Status”
- Change in calculation of out of pocket maximum
- “Interim Final” Guidelines
- Information Availability
Issues from ACA Implementation

- **Fees**
  - Transitional Reinsurance
  - Patient Centered Outcomes Research

- **Reporting Requirements**
  - Software
  - Contractors
  - Staff-time

- **Coverage Parameters**
  - “Measurement Period” for 30 hour average
  - Wages and Marketplace access
Health Insurance Options 2010

• Pre “ACA”

• Offered two health plans

Premium PPO
- $20 Copay
- $150 Deductible
- $1,500 Out of Pocket Maximum

Standard PPO
- $30 Copay
- $250 Deductible
- $2,500 Out of Pocket Maximum
Currently offer Three Plans

• **Premium PPO  2%**
  - $400 Deductible (Hard)
  - Copays $20 PCP/$30 Specialist
  - $2,500 Out of Pocket Max

• **Standard PPO  87%**
  - $600 Deductible (Hard)
  - Copays $30 PCP/$40 Specialist
  - $3,500 Out of Pocket Max

• **High Deductible Health Plan  11%**
  - $1,300 Deductible
  - $3,500 Out of Pocket Max
Action Items

• Held “Grandfather Status” as long as possible
• Increased individual Stop Loss
• Additional City contribution for employee insurance
• Employee contribution increases
• New coverage class – Employee + Children
• Dependent audit
Action Items

- Increased Out-of-Pocket Maximums
- Increased deductibles
- Generic drug mandate
- Pharmacy Pre-authorization, Step Therapy, Specialty Pharmacy, Quantity Management
- Educate insureds to become better health care consumers
Action Items

- Opened Employee Health Center On-site
- “Hard” Deductibles for PPO plans
- Implemented Tobacco Surcharge
- Increased Copays
- Increased Out of Pocket Maximums
- Wellness Program Shift from Participatory to Outcomes based.
Wellness Investment

- Two year shift to outcomes based program
- Allows employees to save on insurance premiums
- Medically based goals to achieve results
- Addresses chronic condition management and health risk markers using claims data and HRA
- Continued Evolution
Wellness Investment

- Program now managed by our on-site clinic staff
- Increased enrollment from 80 to 442 participants
- Incentive eligibility is managed by on-site clinic staff
- Focusing on five co-morbidities present in 13% of population
- Providing patient centered medical home
Continued Challenges

• Continued increasing costs
  – Care, Pharmacy and Pre-Medicare Retirees

• Other budget pressures (i.e. Pensions)

• Changing Legislation
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