Swerdlin & Company
Actuaries and Employee Benefit Consultants

# The Swerdlin Quarterly

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# Health Care Reform: Is The Sky Falling?

During the 2009 and 2010 Congressional debates over health care reform, cost containment took a back seat to coverage expansion. Actuaries at the US *Centers for Medicare and Medicaid Services* performed an analysis of the new law in April, 2010 and focused on the overall effect of health reform on national health spending.

The study showed that health expenditures, as a share of the gross domestic product (GDP), would increase from 17.8% in 2010 to 21.0% in 2019. However, without reform, health expenditures were projected to be 20.8% of 2019 GDP. The 0.2% of GDP difference was $45 billion out of the total 2019 national health expenditures of $4.7 trillion. Depending on the perspective of the commentator, this $45 billion was a fair price to pay for reducing the ranks of the nation's uninsured by 34 million people, or proof that Congress could not be counted on to control ever-increasing health care costs.

This 2010 analysis was the first of many from different government and private-sector organizations. The most recent study to catch the public eye,

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# Dorn's Corner

Since this newsletter focuses on health care reform, I devote this article to health. WHO defines health as "a state of complete physical, mental, and social wellbeing, and not merely the absence of disease or infirmity." Note that WHO is not the name of the first baseman per the famous Abbott and Costello sketch, but rather the World Health Organization.

Unfortunately, Western medicine operates on the assumption that health is the absence of disease. No offense to you MDs out there. I believe that integrative medicine, a combination of alternative and Western medicine, is the best approach to well-being. Integrative doctors have an M.D. along with knowledge of an alternative medical approach. Many of the alternative approaches originate from other countries such as India, China, and Japan. Use of alternative medicine is becoming more popular in Western countries, as many see the downside of Western medicine alone. Please note that I am not suggesting that Western medicine is bad or should be avoided, but rather adding alternative ideas along with Western science results in better health care, in my opinion. We as individuals must take responsibility for our own health and well-being.

Along with my practice of meditation, I was introduced to an ancient Indian health approach called Ayurveda. The word means "science of life." Some key

*(continued on the back cover)*

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## *Service Spotlight:* Health Care Reform *(cont. from page 1)*

*Cost of the Future Newly Insured under the Affordable Care Act (ACA)*, was published by the Society of Actuaries (SoA) in draft form in January, 2013 and as a final report in March, 2013. The Society of Actuaries is an educational, research, and professional organization.

Immediately, the press responded with headlines like, "Independent study sees 32% average rise in premium costs" (*Reuters*) and "Health overhaul to raise claims' cost 32%" (*USA Today–AP*). The Administration's response was a bit more measured: "Some people, purchasing new insurance policies for themselves this fall, could see premiums rise because of requirements in the health-care law" (HHS Secretary Kathleen Sebelius).

As the nation, and particularly its employers, ramp up for the 2014 effective date of many of the ACA's provisions, worries about increased health care costs and insurance premiums are foremost in many minds, and a sound bite like "32% cost increase" catches one's attention.

Let's look at the SoA's 32% cost increase. First, it focused on the newly insured, not on those currently covered. Second, it focused on people currently uninsured, and who are not expected to be covered in the group market (i.e., by employer plans). Third, it focused on health care costs, not premiums.

In Georgia, for example, the study estimates there are currently 350,000 people with some sort of non-group coverage and 1.88 million without insurance (including Medicare and Medicaid).

After three years under the ACA, the study estimates those numbers to have grown to 935,000 insured (140,000 purchasing individual health insurance policies and 795,000 finding coverage through the new health insurance exchange), and decreased to 1.1 million uninsured. Of course, the demographic movements are not as simple as these two categories alone. Among some of the larger movements are the 155,000 employees estimated to leave employer coverage and join the exchange; 20,000 are estimated to join the uninsured.

The SoA study uses state-wide demographic data carved along 250 dimensions of age, sex, family status, socio-economic status, employment status, and the like. The study assumes that the newly-insured will use health care services at the same rate as similarly-situated people with health care coverage, without adjustment for any pent-up demand by the newly insured for health care services. The SoA notes that research on pent-up demand shows mixed results and users of the study can make short-term adjustments based on their estimates of the effect of pent-up demand.

Like HR benefits professionals, the study uses monthly costs (per-member-per-month) as its metric. For the people it's focusing on, those with individual insurance (or as the study puts it, "other non-group coverage"), the current 350,000 people have a monthly cost of $310, while the monthly cost is $383 for the expected post-ACA 935,000, a 23% increase in the average cost.

The study notes that health care costs are not the same as health care insurance premiums, which include administrative expenses, taxes, insurer profit, and adjustments reflecting the insurer's competitive position in its marketplace, among other items.

The study and its state-by-state detail tables hold a pirate's treasure of information for those who want to dig in. If that would be you, point your web browser to http://www.soa.org/NewlyInsured. ■

# Important Effective Dates for ACA

This Legislative Brief provides effective dates for key Affordable Care Act reforms that affect employers and individuals. In the chart below, we provide the significant deadlines for calendar years 2013 and beyond. For details on the provisions of ACA or deadlines effective prior to 2013, **please refer to the detailed chart on our website at www.swerdlin.net.**

| 2013 | |
|---|---|
| **EFFECTIVE DATE** | **ACA PROVISION** |
| Taxable years beginning after Dec. 31, 2012 | Additional Medicare Tax for High-wage Workers |
| Plan years beginning after Dec. 31, 2012 | Health Flexible Savings Account (FSA) Contribution Limits |
| Beginning in 2013 | Administrative Simplification |
| March 1, 2013 (delayed) | Employee Notice of Exchanges |
| July 31, 2013 | Patient-centered Outcomes Research Institute (PCORI) Fee Payments |
| Dec. 31, 2013 | HIPAA Certification |
| **2014** | |
| **EFFECTIVE DATE** | **ACA PROVISION** |
| Calendar years beginning after Dec. 31, 2013 | Health Insurance Provider Fee |
| Jan. 1, 2014 (transition relief may apply) | Employer Coverage Requirements |
| Jan. 1, 2014 | Individual Coverage Mandates |
| | Individual Health Insurance Subsidies |
| | Health Insurance Exchanges |
| | Reinsurance Payments |
| Plan years beginning on or after Jan. 1, 2014 | Employer Wellness Programs |
| | Annual Limits Prohibited |
| | Guaranteed Issue and Renewability |
| | Pre-existing Condition Prohibition |
| | Nondiscrimination Based on Health Status |
| | Nondiscrimination in Health Care |
| | Insurance Premium Restrictions |
| | Excessive Waiting Periods Prohibited |
| | Coverage for Clinical Trial Participants |
| | Comprehensive Benefits Coverage |
| | Limits on Cost-sharing |
| Coverage provided on or after Jan. 1, 2014 | Reporting of Health Insurance Coverage |
| Taxable years beginning in 2014 | Small Business Health Care Tax Credit |
| After 2014 (delayed) | Automatic Enrollment |
| **2018** | |
| **EFFECTIVE DATE** | **ACA PROVISION** |
| Jan. 1, 2018 | High Cost Plan Excise Tax |

# F.A.Q.

## Health Care Reform: Employers' Commonly Asked Questions

***I've heard a lot about the health care reform law over the past few years. When do the reforms go into effect?***

The health care reform law, the Affordable Care Act (ACA), was signed into law by President Obama in March, 2010. The changes made by ACA take effect over a period of years. Some of the law's changes are already in effect, such as the prohibition on pre-existing condition exclusions for individuals under age 19. Other changes will become effective in the future. For example, the requirement that large employers provide a certain level of health coverage to full-time employees and their dependents, or pay a penalty, goes into effect in 2014.

***Does health care reform allow people to keep their current health coverage?***

Yes. Nothing in the law requires individuals to terminate their current coverage. However, due to the law's health care reforms, the coverage provided under a health plan may undergo changes. In addition, beginning in 2014, ACA requires most individuals to obtain acceptable health coverage or pay a penalty. The penalty will start at $95 per person for 2014 and increase each year.

***Am I required by law to offer health coverage to my employees?***

The health care reform law does not require companies to offer health coverage to their employees. However, beginning in 2014, large employers will be subject to ACA's "pay or play" rules. A large employer is one with 50 or more full-time employees, including full-time equivalents (FTEs).

Under the pay or play rules, large employers who do not offer health coverage to full-time employees and their dependents will be subject to a penalty if any of their full-time employees receive a tax credit or cost-sharing reduction for health coverage through an insurance exchange.

Also, large employers will be subject to a penalty under ACA's pay or play rules if they offer health coverage and any full-time employee still receives a tax credit or cost-sharing reduction for coverage through an insurance exchange. This can occur if the employer's coverage is unaffordable or does not provide minimum value.

These penalties will not apply to employers who had fewer than 50 full-time equivalent employees during the prior calendar year.

***What are the penalty amounts for large employers who do not offer coverage?***

Large employers who do not offer health coverage to full-time employees will be subject to an annual penalty of $2,000 per full-time employee, excluding the first 30 employees, if any of their full-time employees receive a tax credit or cost-sharing reduction for coverage through an insurance exchange.

***What are the penalty amounts for large employers who offer coverage and have employees receiving subsidized coverage through the Exchange?***

These employers are subject to a penalty of $3,000 for each full-time employee who receives a tax credit or cost-sharing reduction for coverage through the Exchange. The maximum penalty is the amount equal to $3,000 times the number of full-time employees, excluding the first 30 employees.

***What is the small business tax credit and how do I know if I am eligible?***

Beginning with the 2010 tax year, tax credits are available to qualifying small businesses that offer health insurance to their employees. In general, your business qualifies for the credit if you cover at least 50 percent of the cost of health care coverage for your workers, pay average annual wages below $50,000, and have fewer than the equivalent of 25 full-time workers. For example, a firm with fewer than 50 half-time workers would be eligible.

The size of the credit depends on your average wages and your number of employees. For tax years beginning in 2010 through 2013, the maximum credit is 35% of the employer's premium expenses that count toward the credit. The full credit is available to firms with average wages below $25,000 and less than 10 full-time equivalent workers. This phases out gradually for firms with average wages between $25,000 and $50,000 and for firms with the equivalent of between 10 and 25 full-time workers.

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# Health Care Reform: Employers' Commonly Asked Questions

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***What if our small business does not offer insurance today, but we choose to start offering insurance this year? Will we be eligible for these tax credits?***

Yes. The tax credit is designed to support those small businesses that currently provide or plan to provide such coverage. Beginning in 2014, the amount of the maximum tax credit will increase, and the credit will only be available for employers purchasing insurance coverage through the Exchange.

***What is a health insurance exchange?***

Beginning in 2014, each state will have a health benefits exchange. Each state can decide whether to operate its own Exchange or have the federal government run the Exchange for its residents. Individuals and small businesses will be able to purchase health insurance through these Exchanges. The intent of the health insurance exchanges is to provide increased purchasing power by pooling a number of insurance buyers together. Beginning in 2017, states may allow employers of any size to purchase coverage through the Exchange.

***Does the health care reform law affect dependent care and health flexible spending accounts?***

Dependent care flexible accounts are capped at $5,000 annually. Prior to 2013, health flexible spending accounts (health FSAs) had no cap, although many employers implemented their own caps, typically at the $5,000-$6,000 level or less. The health care reform law does not change the limits on dependent care flexible accounts which remain capped at $5,000. However, the law does establish an annual cap of $2,500 on employee pre-tax contributions to health FSAs. This change is effective for plan years beginning on or after Jan. 1, 2013.

***What is the Form W-2 reporting requirement and when do we need to comply?***

ACA requires employers to disclose the value of the health coverage provided to their employees on their annual Forms W-2. This reporting was optional for the 2011 tax year. It remains optional for small employers (those filing fewer than 250 Form W-2s) until further guidance is issued. Employers who file at least 250 Forms W-2 must comply with this reporting requirement for 2012 (for W-2 Forms that must be issued by the end of January, 2013) and future years.

***What is a Summary of Benefits and Coverage?***

ACA requires employer-sponsored health plans and health insurance issuers to provide a Summary of Benefits and Coverage (SBC) to applicants and enrollees. Both non-grandfathered and grandfathered plans need to provide the SBC.

The SBC is a concise document providing simple and consistent information about health plan benefits and coverage. It must be provided free of charge. Its purpose is to help health plan consumers better understand their coverage and help them easily compare the different options when shopping for new coverage.

Federal agencies have provided a template to health plans and issuers. Health insurance issuers must provide the SBC to health plan sponsors at certain times, including at renewal and upon request, beginning Sept. 23, 2012. In addition, health plans must provide the SBC to participants and beneficiaries at specific times, including at enrollment, before the start of each plan year, and upon request. If the issuer of a fully-insured plan provides a timely and complete SBC to plan participants and beneficiaries, the employer is not required to provide the SBC to those individuals.

Plans and issuers must provide the SBC to participants and beneficiaries who enroll or re-enroll during an open enrollment period beginning with the first open enrollment period that begins on or after Sept. 23, 2012.

For participants who enroll in coverage other than through an open enrollment period (for example, newly eligible individuals and special enrollees), employers and issuers must provide the SBC beginning with the first plan year beginning on or after Sept. 23, 2012.

***How does the additional Medicare tax for high-wage earners work?***

Effective Jan. 1, 2013, ACA increased the Medicare hospital insurance tax rate by 0.9% on wages over $200,000 for an individual ($250,000 for married couples filing jointly). An employer must withhold the additional Medicare tax from wages it pays to an employee in excess of $200,000 in a calendar year, regardless of the individual's filing status or wages paid by another employer.

There is no employer portion corresponding to the amount payable by the employee. All wages that are currently subject to Medicare tax are also subject to the additional Medicare tax, including non-cash fringe benefits, tips, and other non-cash wages. ■

# ACA Definitions of "Large" or "Small"

The Affordable Care Act (ACA) imposes different requirements on employers based on if they qualify as a "large employer" or a "small employer." However, the health care reform law does not use a consistent definition for these terms. As a result, an employer may be considered a small employer for one rule but a large employer for another. The following definitions apply for the key provisions in the ACA:

| Defined as "Large Employer" | Defined as "Small Employer" |
|---|---|
| **Health Care Tax Credit** Effective for tax years beginning in 2010, the ACA provides a tax credit to certain small employers who provide health care coverage to their employees. | |
| Large employers with 25 or more full-time employees are ineligible for the health care tax credit. | Must have fewer than 25 full-time employees or a combination of full-time and part-time staff (for example, two half-time employees equal one employee for purposes of the credit); the average annual wages of employees must be less than $50,000, and the employer must pay at least half of the insurance premiums. |
| **Form W-2 Reporting** Beginning in the 2012 tax year, large employers are required to report the aggregate cost of employer-sponsored group health plan coverage on their employees' Forms W-2. | |
| Required to file 250 or more Forms W-2 in the prior calendar year. | Required to file fewer than 250 Forms W-2 for the prior calendar year. Small employers may be subject to this reporting in the future. The IRS has delayed the reporting requirement for small employers by making it optional until further guidance is issued. |
| **Employer Shared Responsibility Requirements** Beginning in 2014, large employers may be subject to penalties if they do not offer health coverage to their employees, or if their health coverage does not meet certain standards. | |
| Must employ at least 50 full-time employees, or a combination of full-time and part-time employees that equals at least 50 (for example, 40 full-time employees working 30 or more hours per week on average plus 20 half-time employees working 15 hours per week on average are equivalent to 50 full-time employees). | Small employers with fewer than 50 full-time employees (or full-time equivalent employees) will be exempt from the employer-shared responsibility provisions. |
| **Health Insurance Exchanges** Effective Jan. 1, 2014, each state must have a health insurance exchange (Exchange) to provide a competitive marketplace where individuals and small businesses will be able to purchase affordable private health insurance coverage. Beginning in 2014, small employers can offer coverage to their employees through the Exchange. Beginning in 2017, states may allow large employers to obtain coverage through the Exchange. | |
| Must employ an average of at least 101 employees during the preceding calendar year; and must employ at least one employee on the first day of the plan year. | Must employ an average of one to 100 employees during the preceding calendar year, and must employ at least one employee on the first day of the plan year. However, until 2016, States have the option to limit small employers' participation in the Exchanges to businesses with up to 50 employees. |
| **Special Rule for SHOP Exchanges** By 2014, each state Exchange must establish insurance options for small businesses through a Small Business Health Options Program (SHOP). | |
| Large employers with at least 101 employees are ineligible to participate in the SHOP. | To qualify as a "small employer" for purposes of Exchange participation (see above); must elect to offer, at a minimum, all full-time employees coverage in a qualified health plan through a SHOP; and must either have its primary office in the Exchange service area and offer all its employees coverage through that SHOP, or offer coverage to each eligible employee through the SHOP servicing the employee's primary worksite. |
| **Automatic Enrollment** Large employers who are subject to the FLSA will be required to automatically enroll new full-time employees (subject to any waiting period authorized by law) and to continue the enrollment of current employees in a health benefits plan offered through the employer. Before this requirement can take effect, the DOL must issue implementation regulations. The DOL has stated that the automatic enrollment guidance will not be ready by 2014 and employers are not required to comply with the rule until final regulations are issued and become applicable. | |
| Must have more than 200 full-time employees. | Small employers with 200 or fewer employees will be exempt from the automatic enrollment requirements. |


Susan Petrirena is shown at Swerdlin's booth at the Trade Show at the NCEO Conference.

Joanne Swerdlin is pictured with Jack Stack of The Great Game of Business at the NCEO Conference in Seattle.

# What's Happenin'

Anniversaries we celebrate this quarter: **Dorn** and **Joanne Swerdlin**, 33 years; **Jaynie Cormier**, 27 years; **Donna Martin**, 20 years; **Dee Robbins**, 17 years; **Connie Woodmansee**, 12 years; **Barbara Sneed** and **Mike Raker**, 9 years; **Rigbe Hailessellassie**, 6 years; **Beverly Bailey**, **Craig Lindenlauf** and **Graeme Hefner**, 5 years; **Christy Kennison**, 3 years; and **Atiya Riley-Hart** and **Ed Ilano** 2 years.

Welcome to **Michael Oulette** who joined our Penret Team in our Holliston, MA office. Michael has years of experience as a pension consultant.

We welcome **Adrienne Judd** to the Actuarial Team. Adrienne graduated from Kennesaw State University on May 15 with a Bachelor of Science in Mathematics and will be working as an Assistant Actuarial Analyst.

On April 4, , ASPPA held its monthly breakfast meeting on EPCRS. Attending from Swerdlin were **Adrian Farnon**, **Connie Woodmansee**, **Craig Lindenlauf**, **David Brown**, **Gary Anderson**, **Kathy Latour**, **Lee Swerdlin** and **Susan Petrirena**.

Congratulations to **Mike Raker** who was recently elected Vice President of the Atlanta Actuarial Club.

Congratulations to **Adrian Farnon**. She was recently elected Vice President of the Southern Region of WEB, Worldwide Employee Benefits Network.

**Melissa Spencer**, **Joanne Swerdlin**, **Julie Isom**, and **Susan Petrirena** attended the National Center for Employee Ownership Annual Conference (NCEO), held April 23 – 26 in Seattle, Washington. Melissa and Susan participated in presentations at the conference.

**Lee Swerdlin**, who serves on the Advisory Board of TD Ameritrade, attended the recent board and TPA client meeting in Park City, Utah.

On May 2nd, WEB Atlanta held their 4th Annual Member Social at Turner Field when the Braves took on the Nationals. Attending were **Adrian Farnon** and **Kristin Hamilton**.

Swerdlin hosted a Cinco de Mayo Charity Lunch on May 2nd, raising $260 for our Swerdlin Charity Fund.

On May 9 - 10, **Connie Woodmansee**, **Dorn** and **Joanne Swerdlin**, **Julie Isom**, and **Susan Petrirena** attended the 36th annual ESOP Conference in Washington, DC. Connie co-presented the "ESOP Communication Goes On and On..."

**Craig Lindenlauf**, **Donna Martin**, **Ed Ilano**, and **Lee Swerdlin** attended the Benefits Conference of the South, held in Buckhead on May 9 – 10.

Swerdlin hosted a Workshop for their clients on Health Care Reform on May 16. **Cynthia Navan**, **David Benoit**, **Glenda Devechio**, and **Jeffrey Groves** spoke at the event.

**Patti Williams** attended the TD Ameritrade Operations Panel Meeting on May 23 in Denver.

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## Dorn's Corner

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points about Ayurveda are listed below.

- Ayurveda is used to integrate and balance the body, mind, and spirit. This is believed to help prevent illness and promote wellness.
- Ayurvedic medicine uses a variety of products and techniques to cleanse and restore balance.
- An Ayurveda practitioner should be consulted. I personally prefer an MD with experience and knowledge of the Ayurveda methods.

Your health care provider should be informed of any complementary or alternative practices you use in order to ensure coordinated and safe care.

Ayurveda includes 3 life forces (doshas) which control the activities of the body. Each person has a unique combination of the 3 doshas, although one dosha is usually prominent. Doshas are constantly being formed and reformed by food, activity, and bodily processes. An imbalance in these doshas can cause health problems.

The doshas are known by their original Sanskrit names: vata, pitta, and kapha.

To find out your dosha body type, google "Dosha quiz." The quizzes usually contain about a dozen questions and take a few minutes to complete. I have found this information helpful in the daily care of my body.

Hope you have a healthy summer! ■

## The following chart describes these doshas in more detail.

Understanding what you need to do to achieve total health is as simple as understanding Vata, Pitta and Kapha — the three fundamental principles of nature which govern all the activities of your mind and body; **Vata** is quick, cold and dry by nature. It governs motion, breathing, circulation, elimination and the flow of nerve impulses to and from the brain. **Pitta** is hot and precise by nature. It governs digestion and metabolism and the processing of food, air and water throughout the body. **Kapha** is solid and steady by nature. It governs structure and fluid balance and forms muscle, fat, bone and sinew.

We all have a certain amount of Vata, Pita and Kapha in our constitution and while all three of them are active, one or two usually dominate.

| Vata | Pitta | Kapha |
|---|---|---|
| When in balance<br>Vibrant, lively, enthusiastic, clear and alert mind, flexible, exhilarated, imaginative, sensitive, talkative, quick to respond | When in balance<br>Warm, loving, contented, enjoys challenges, strong digestion, lustrous complexion, good concentration, articulate and precise speech, courageous, bold, sharp wit, intellectual | When in balance<br>Affectionate, compassionate, forgiving, emotionally steady, relaxed, slow, methodical, good memory, good stamina, stability, natural resistance to sickness |
| When out of balance<br>Restless, unsettled, light interrupted sleep, tendency to over-exert, fatigued, constipated, anxious, worried, underweight | When out of balance<br>Demanding, perfectionist, tendency towards frustration, anger, tendency towards skin rashes, irritable and impatient, prematurely grey hair or early hair loss | When out of balance<br>Complacent, dull, oily skin, allergies, slow digestion, lethargic, possessive, overly-attached, tendency to oversleep, overweight |
| What aggravates **Vata**<br>Irregular routine, staying up late, irregular meals, cold, dry weather, excessive mental work, too much bitter, astringent or pungent food, travelling, injury | What aggravates **Pitta**<br>Excessive heat or exposure to the sun, alcohol, smoking, time pressure, deadlines, excessive activity, too much spicy, sour or salty food, skipping meals | What aggravates **Kapha**<br>Excessive rest and oversleeping, overeating, insufficient exercise, too little variety in life, heavy, unctuous foods, too much sweet, sour or salty food, cold, wet weather |

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