New York State Public Employee Conference



Affordable Care Act

Where We've Been and Where We're Heading

December 10, 2013

Segal Consulting

Today's Presenters

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- Lawrence Singer
- Howard Goldsmith

Our presenters are long-time supporters of PEC and are here today to lead a panel discussion on The Affordable Care Act.

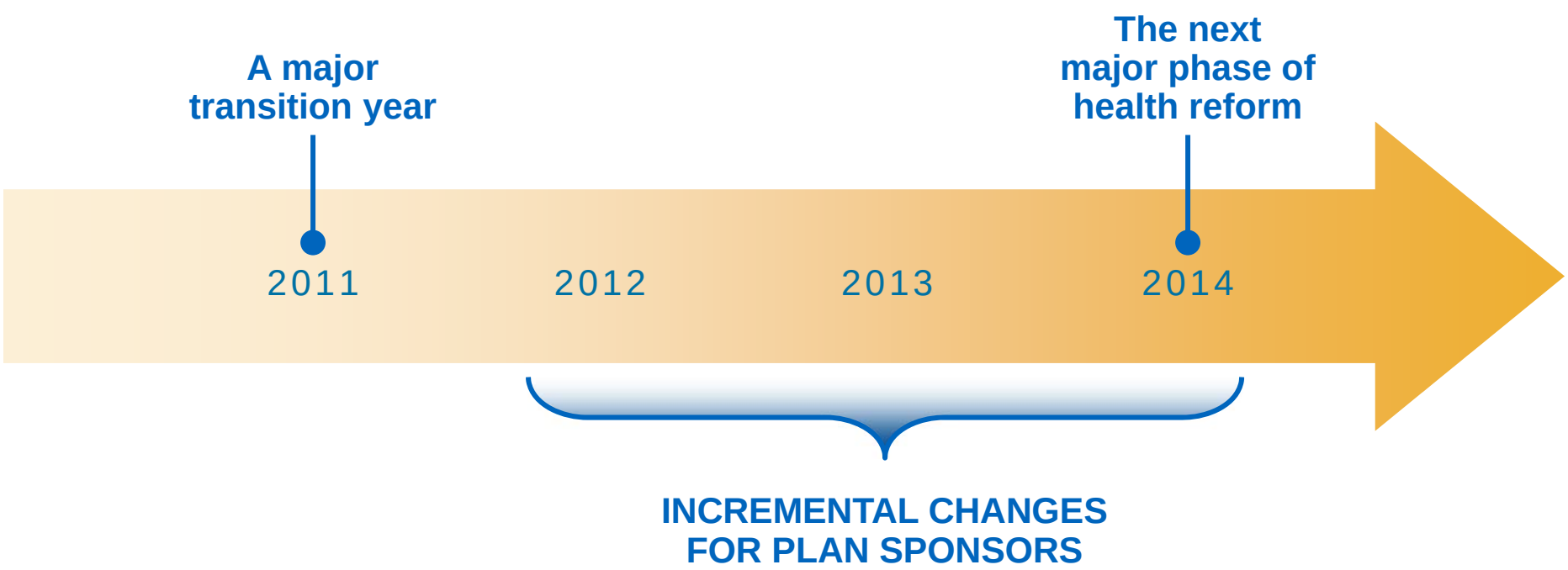
Agenda

- ACA Basics
- ACA Complexities
- ACA Unknowns
- Questions

We have a broad audience with differing levels of understanding and interest in ACA. This presentation will provide context for your questions.

The Basics: Affordable Care Act (ACA)
Where We've Been and Where We're Heading

- **Public Law 111–148** March 23, 2010 (906 pages)
  - Aka, Affordable Care Act
- **Public Law 111–152** March 30, 2010 (55 pages)
  - Aka, Health Care and Education Reconciliation Act of 2010



What does the Affordable Care Act accomplish?

It changes who gets healthcare benefits

- Dependent eligibility rules to age 26
- Pre-existing condition limits

It changes what benefits are provided

- Essential benefits with no annual or lifetime maxima
- Paid-in-full preventive services
- No prior authorization for emergency services

It changes how health plans are administered

- Claims and appeals
- Summary of Benefits and Coverage
- Medical loss ratio limits
- Reporting the value of employer-sponsored coverage on W-2s

What does the Affordable Care Act accomplish?

It has certain new taxes and fees

- Comparative Effectiveness Research Fee
- Reinsurance Fee
- Insurance Tax
- Pharmaceutical Industry Tax
- Medical Device Manufacturer Tax
- Indoor Tanning Services Tax
- 20% tax for non-qualified HSA withdrawals
- High Cost Health Plan Excise Tax

It makes various Medicare changes

- Closes the coverage gap under Part D
- Reduces the subsidy in Medicare Advantage Plans
- Slows the increase in provider payments by making various changes to the delivery system- Accountable Care Organizations

What does the Affordable Care Act accomplish?

- **It provides certain subsidies to health plans**
  - Small group tax credit
  - Small employer grants for wellness programs
  - Early retirement reimbursement program for non-Medicare coverage
  - Temporary high-risk pool for individuals with pre-existing conditions
- **It gives access to coverage to people who otherwise might not have had coverage—through State Exchanges.**
- **It contains many provisions that employers sponsoring benefit plans must address, beyond the issues noted above.**

Stakeholders

Employer

Plan sponsor for hospital and physician

Plan sponsor for Rx, dental, vision, life, disability, other

Members

Covered lives

Some Definitions

Grandfathered Plan: a group health plan in existence as of March 23, 2010, when the Affordable Care Act was signed into law

Non–Grandfathered Plan: a group health plan that has lost its grandfathered status due to changes in design

Essential Benefits: 10 categories of benefits that must be covered in individual plans

Excepted Benefits: are exempt from having to comply with many of the requirement of both HIPAA as well as most of the new plan requirements under ACA

Employer Mandate: requirement that **employers** provide coverage that is affordable and is of minimum value

Individual Mandate: requirement that most **individuals** have health insurance or pay a penalty

How a Plan Could Lose Grandfather Status

Any one of the following will cause a Plan option to lose its grandfathered status:

- An increase in a percentage cost-sharing requirement (i.e., coinsurance), regardless of the amount
- An increase in the deductible or out-of-pocket maximum by an amount that exceeds medical inflation plus 15%
- An increase in copayments if the increase exceeds the greater of $5 (adjusted for medical inflation) or medical inflation plus 15 percentage points
- A decrease in the employer's contribution rate by more than five percentage points (measured for each tier of coverage)
- Elimination of all or substantially all benefits to diagnose or treat a particular condition, or
- Adding a new overall annual dollar limit or decreasing the overall annual dollar limit in effect on March 23, 2010

Coverage Mandates for Non-Grandfathered Plans in effect now

Coverage Mandates that Apply to Non-Grandfathered Plans for Plan Years on or after September 23, 2010:

- Revised internal and external claims and appeals procedures
- No cost sharing for preventive care/immunizations
- Patient protections: choice of primary care physician (including pediatrician), and direct access to OB/GYN services
- Emergency services: without prior authorization, and in- and out-of-network

Additional non-grandfathered rules, beginning with plan year on/after January 1, 2014

- Plan must have out-of-pocket maximum that does not exceed $6,350 individual/$12,700 family (amounts indexed in future years). Deductibles, coinsurance, copayments and similar charges must count toward this maximum. FAQ published February 20, 2013 provides transition rule for first year for plans that use multiple service providers—plan's "major medical coverage" must comply, and if plan has a maximum for other coverage (e.g., Rx), that limit must comply. Provision likely to apply only to in-network cost sharing.
- Coverage relating to routine costs associated with approved clinical trials
- Provider nondiscrimination
- Reporting relating to transparency in coverage—effective no sooner than when comparable standards apply to Qualified Health Plans in the Exchanges (i.e., not before 2015)
- Protection of employees, an employer issue that will have limited application to supplemental benefit plans.

Additional non-grandfathered rules, beginning with plan year on/after January 1, 2014

- **Dental caries chemoprevention—preschool children:** The USPSTF recommends that primary care clinicians prescribe oral fluoride supplementation at currently recommended doses to preschool children older than 6 months of age whose primary water source is deficient in fluoride. This needs to be covered only when prescribed. This is generally covered under a prescription benefit and may not be a covered benefit under the dental plan.

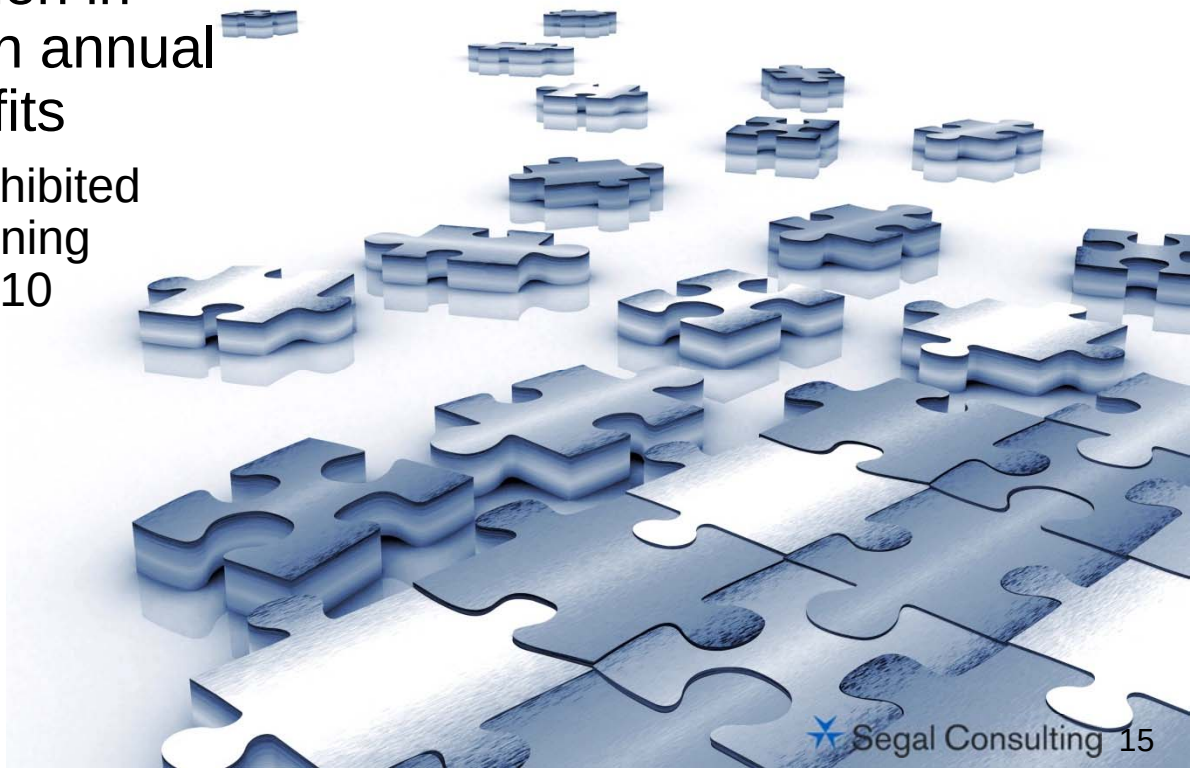
- **Internal and External Appeals:** Plans must provide for internal and external review of coverage determinations and provide notices to enrollees of the available processes. In addition, plan sponsors had until July 1, 2012 to contract with at least three independent review organizations (IRO).

Overview of Compliance Status
All Plan options (Whether Grandfathered or Not)

- Coverage of children to age 26
  - Eligibility Rules
  - Required Enrollment
- Early Retiree Reinsurance Program (ERRP), if participating
  - Maintenance of contribution testing
  - Questionnaire
- Prohibition of rescission of coverage unless due to fraud or intentional misrepresentation of material fact
- Prohibition of Pre-Existing Condition Exclusion (for children >19)
- Implement Prescription Requirement for Over-the-Counter Medication
- Required notices
  - Plan changes
  - Special Enrollment
- Update Plan Documents/SPD
- Prohibition on Lifetime Dollar Limits for Essential Benefits
  - Elimination of lifetime limits on essential benefits or conversion to annual limits
- Restricted Annual Dollar Limits on Essential Benefits
  - Removing annual limits on essential benefits; or
  - Applied for Waiver

Essential Health Benefits

- Essential benefits must be offered by Exchange plans
- Each state will determine the essential benefits package by selecting among certain benchmark plans
- Self-insured group health plans do not have to offer essential benefits, but if they do, then in 2014 they cannot have an annual maximum on those benefits
  - Lifetime maximums were prohibited effective for plan years beginning on or after September 23, 2010



Essential Health Benefit Categories in Statute

1. Ambulatory patient services
2. Hospitalization
3. Emergency services
4. Maternity and newborn care
5. Mental health and substance use disorder services, including behavioral health treatment
6. Prescription drugs
7. Rehabilitative and habilitative services and devices
8. Laboratory services
9. Preventive and wellness services and chronic disease management
10. Pediatric services, including oral and vision care

Group health plans do not need to offer all the above essential services, but if they do, coverage may not be subject to annual or lifetime limitations.

Excepted Benefits

- ACA imposes significant requirements on group health plans (GHPs) (both insured and self-insured).
- Generally applies to GHPs as defined under the Health Insurance Portability and Accountability Act of 1996 (better known as HIPAA).
- **"Excepted Benefits" are exempt from having to comply with many of the requirements of both HIPAA as well as most of the new plan requirements under ACA.**
- Can supplemental benefits be considered "excepted benefits"?

The Affordable Care Act may not have considered the impact on supplemental funds which now have issues associated with complying with the law.

Supplemental Benefit Trusts

Provide a mix of benefits:

- Term Life Insurance
- Short and/or Long-term Disability Coverage
- Dental benefits
- Optical benefits
- Legal services benefits
- Catastrophe Major Medical coverage
- Reimbursement of basic medical plan copays or coinsurance or costs in excess of the basic plan's maximum allowable fees
- Fixed indemnity or disease-specific benefits (e.g., through AFLAC)

How does HIPAA Categorize “Excepted Benefits”?

1. Benefits excepted in all circumstances

- Coverage only for accident (including AD&D coverage)
- Disability income coverage
- Liability insurance (general and automotive) and coverage issued as a supplement to liability coverage
- Workers’ compensation and similar coverage
- Credit only insurance (e.g., mortgage insurance)
- Coverage for on-site clinics

HIPAA "Excepted Benefits"

2. Limited Excepted Benefits

- Limited Scope Dental or Vision benefits if they are:
  - Provided under a separate policy, certificate or contract of insurance (e.g., the dental or vision benefits are insured) or
  - Not otherwise an integral part of a GHP. Self-insured benefits are not an integral part of a GHP only if (i) participants have the right to elect not to receive the coverage; and (ii) for a participant who elects coverage, pays an additional premium or contribution for the coverage.
- Long-term care benefits
- Health flexible spending arrangements (FSAs)

HIPAA “Excepted Benefits”

3. Non-coordinated benefits

- Coverage for only a specified disease or illness (for example, cancer-only policies if:
  - (i) benefits are provided under a separate policy, certificate or contract;
  - (ii) there is no coordination between the provision of these benefits and an exclusion under any GHP of the same plan sponsor; and
  - (iii) benefits are paid with respect to an event without regard to whether benefits are provided under any GHP maintained by the same plan sponsor.
- Hospital indemnity or other fixed indemnity insurance that pays a fixed dollar amount per day (or other period) of hospitalization or illness (e.g., $100/day) regardless of amount of expense incurred. Can’t be based on fixed dollar amount.

HIPAA “Excepted Benefits”

4. Supplemental Benefits

- Medigap Medicare supplemental health insurance
- Similar supplemental coverage designed to fill gaps in primary coverage, such as coinsurance or deductibles. This does not include coverage that becomes secondary or supplemental only under a COB provision.
- Generally, Health Reimbursement Arrangements (HRAs) or reimbursement-type benefits would not be considered excepted under this provision.

Which Benefits are Excepted Benefits

YES

- Life Insurance (while not specifically listed, generally agreed that life insurance is excepted benefit) and AD&D benefits
- Legal services benefits are not “medical care”
- Insured dental and/or optical benefits
- Policies offered through AFLAC if:
  - For only a specified disease/illness
  - Hospital or other fixed indemnity insurance

NO

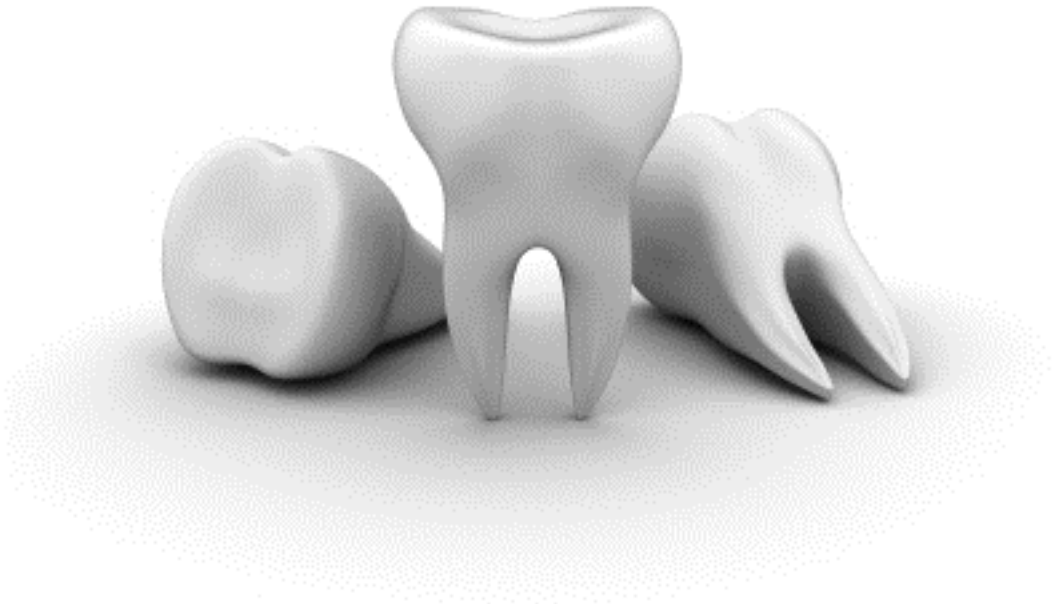
- Catastrophe Major Medical benefits
- Probably NOT
  - HRA-type accounts

MAYBE

- Self-insured dental benefits
- Self-insured optical

Self-Insured Dental and Optical Benefits

- Do not meet the strict definition of excepted benefits unless:
  - They are elected separately, and
  - The participant pays a premium/contribution for the coverage (even a nominal $1, for example)
- Implement an enrollment process and charge a nominal contribution/premium toward the coverage



Health Reimbursement Arrangements (HRAs)
Overview of the New HRA Guidance

- Effective with the plan year beginning on or after January 1, 2014, a stand-alone HRA (i.e., an HRA account that pays for benefits regardless of whether an individual is enrolled in a group health plan) that is not a retiree-only plan will violate the annual dollar limit prohibition and will therefore not be permitted.
- The stand-alone HRA has a *per se* dollar maximum on essential health benefits, which the government states violates the Affordable Care Act. Such a stand-alone HRA would also violate the preventive services requirement, because it would not pay for all required preventive services without cost sharing.

Health Reimbursement Arrangements (HRAs)
New Rules Governing HRAs (that are not Retiree-Only)

- The HRA must be offered only to plan participants who are actually enrolled in other group health plan coverage (not individual insurance coverage).
- The other group coverage must comply with the annual dollar limit prohibition and, if non-grandfathered, the preventive services requirements.
- The other group health plan does not have to have the same plan sponsor, the same plan document or the same Form 5500 filing as the HRA.
- If the other group health plan with which the HRA is paired does not meet the ACA minimum value standard, there will be limits on the types of expenses that the HRA may reimburse. In that circumstance, the HRA may only reimburse for copayments, coinsurance, deductibles, expenses that are not essential health benefits, and premiums for the purchase of the other group health plan.

Health Reimbursement Arrangements (HRAs)
New Rules Governing HRAs continued

- Opt-out provision
  - An active or former participant must be allowed, at least annually, to permanently opt out of HRA coverage and waive future reimbursements from the HRA.
  - Upon termination of employment, a participant must be able to permanently opt out of and waive future reimbursements from the HRA, or if this option is not made available in the plan documents, the remaining amounts in the participant's HRA must be forfeited.
- The reason for the opt-out is to give the participant the choice of spending down the HRA balance (in accordance with the terms of the plan) or applying for a premium assistance tax credit in a health insurance Marketplace. Retaining any balance in the HRA would mean the participant could not get the tax credit.
- If not waived, unused HRA amounts that are credited to a permissible HRA may be used to reimburse qualified medical expenses after the participant ceases to be covered by the other group health plan coverage (for example, when the participant retires).

Health Reimbursement Arrangements (HRAs)
Exception for Retiree-Only HRAs

- Retiree-only HRAs may continue to operate on a stand-alone basis as they do now. Because they do not have to be paired with other group coverage, these HRAs may reimburse for the purchase of an individual health insurance policy through the Marketplace or the individual market outside of the Marketplace.
- A retiree with any money in a retiree-only HRA would not be able to receive a premium assistance tax credit for coverage purchased through a Marketplace. If any funds remain in the account, even after the contributions cease, the retiree would not be eligible for the federal premium subsidies for that month. As a result, plan sponsors offering retiree-only HRAs may wish to give retirees the choice to permanently opt out of HRA coverage and waive future reimbursements so that the retiree could gain eligibility for a subsidy in a Marketplace plan.
- The guidance does not describe what arrangements qualify as a retiree-only HRA. Plans will need to work with legal counsel to determine whether an HRA offered to retirees qualifies as a retiree-only HRA.

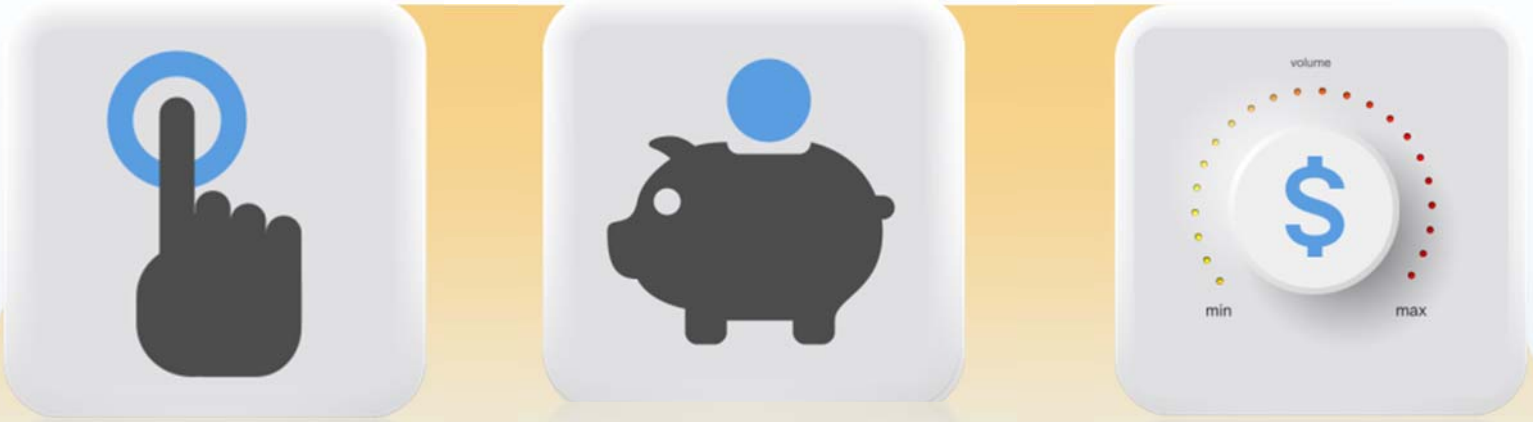
Health Reimbursement Arrangements (HRAs)
Action Steps

- The new rules for HRAs (other than retiree-only HRAs) take effect with the plan year beginning on or after January 1, 2014. For plans operating on a calendar-year basis, plan sponsors need to take the following steps immediately:
  - Revise plan documents, reimbursement policies and procedures, and HRA claims forms to reflect the new rules.
  - Establish procedures under which an participant provides documentation of other group health plan coverage, if the HRA reimburses expenses for individuals covered outside of the plan sponsor's group health plan. A process could include requiring:
    - a copy of the other group health plan's Summary of Benefits and Coverage (SBC), which must state whether the plan meets the minimum value standard.
    - a copy of the individual's enrollment card in that other group plan.
  - If the plan permits participant to spend down accrued balances after termination of employment, provide an opt-out procedure so that participant can decline HRA coverage and apply for premium assistance tax credits if they purchase Marketplace coverage.

Where are HRAs headed?

Employer Mandate

Accessible **Affordable** **Minimum Value**



Employer Shared Responsibility Penalty—2014
Overview (Delayed)

- Purpose is to encourage large employers to continue providing health coverage
- Applies to employers with 50 or more full-time employee equivalents
  - Full-time employee = 30 hours of service or more per week, on average
- Is assessed only when one full-time employee obtains subsidized coverage through Exchange
- Penalty calculated differently depending on whether employer offers health coverage or does not offer coverage
- Guidance provides a safe harbor for determining whether variable hour employees and seasonal employees are treated as full-time employees under the ACA

Large Employer
Determining Size (Delayed)

- Penalty applies to **employers** with 50 or more full-time employee equivalents (FTEs) on business days during the preceding calendar year, based on hours of service during that year
  - Must aggregate hours of part-time employees to create total number of full-time employees
- All employees of a controlled group or an affiliated service group are taken into account in determining whether the threshold is met
- But, each employer-member of the group is treated separately for purposes of computing and assessing any applicable penalty
- State or local governmental entities, Indian tribal entities or churches may apply a reasonable, good-faith interpretation of the controlled group rules to their operations
  - Governmental employers may wish to document how entities are aggregated for purposes of implementing the penalty until further guidance is available

The “4980H(a)” Penalty *(Delayed)*

- If a large employer **does not** offer coverage to at least **95%** of its full-time employees (and their dependent children under 26) and one full-time employee receives federally subsidized coverage in the Exchange
- Penalty is $2,000 (annualized) times the **total #** of full-time employees (minus first 30 workers)
- To avoid the 4980H(a) penalty, employer must offer coverage to at least **95%** of its full-time employees (and their dependent children under 26)
- Spousal coverage is not required

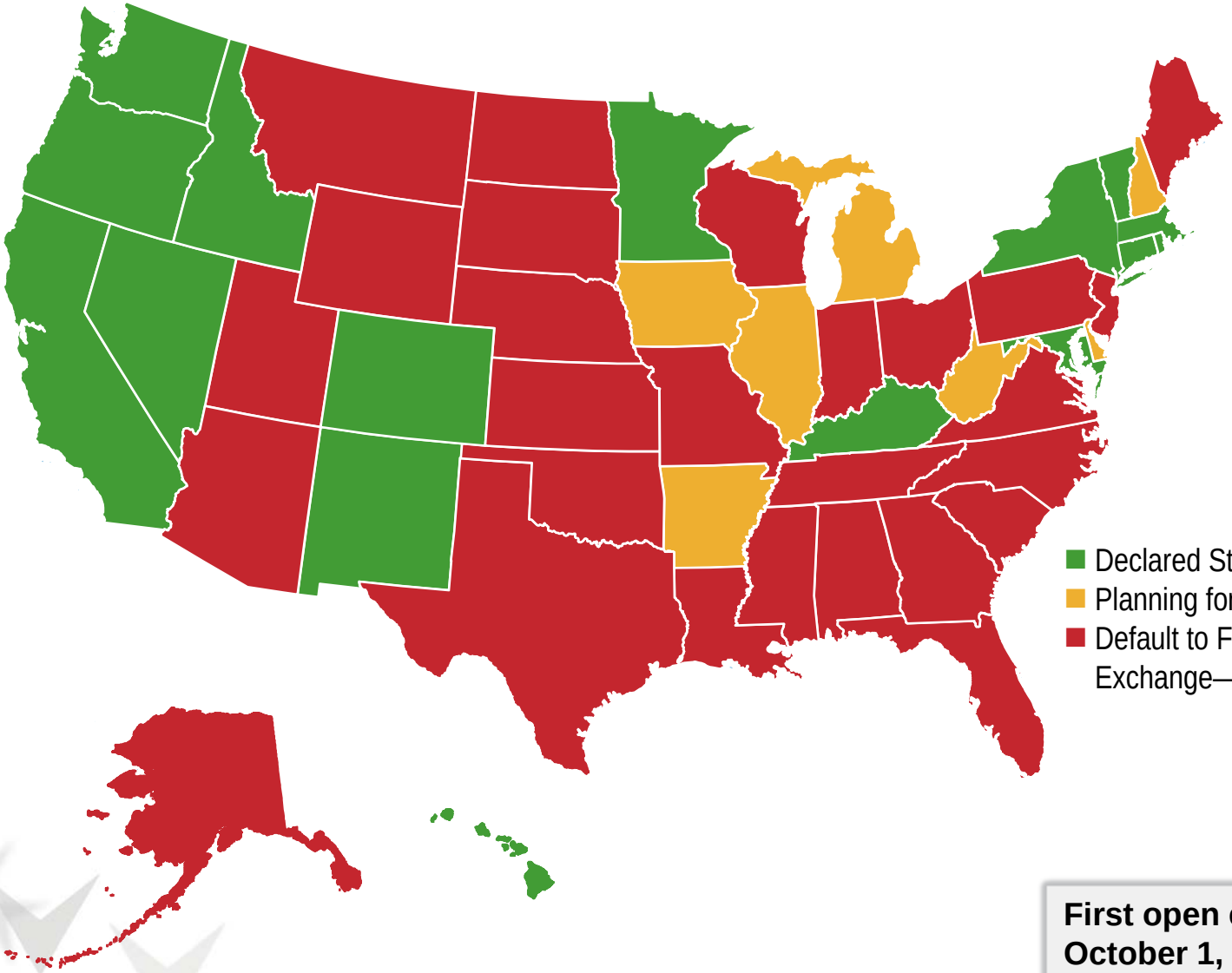
The "4980H(b)" Penalty *(Delayed)*

- If a large employer **does** offer coverage to 95% of its full-time employees (and their dependent children under 26), but one full-time employee still receives federally subsidized coverage in the Exchange
- Penalty is $3,000 (annualized) times the **# of full-time employees getting a tax credit** in an Exchange (subject to a penalty maximum)
- Full-time employees who are eligible for coverage will not qualify for the subsidy unless the coverage does not provide minimum value (i.e., does not meet the 60% test) or is unaffordable

Individual Mandate

- Individuals must have *minimum essential coverage* (including employer-sponsored coverage) or pay a monthly penalty
- Individual penalty accounted for as an additional amount of federal tax owed
- Phases in—$95 or 1% of income in 2014 (whichever is higher) to $695 or 2.5% of income (whichever is higher) in 2016
- No penalty if:
  - Cost of coverage exceeds 8% of household income
  - Short coverage lapses (3 months or less)
  - Other exemptions apply
- Supreme Court upheld the constitutionality of the individual mandate on June 28, 2012

Status of Health Insurance Exchanges



- Declared State-based Exchange—17
- Planning for Partnership Exchange—7
- Default to Federally Facilitated Exchange—27

First open enrollment period:
October 1, 2013 – March 31, 2014

Data Source: Kaiser Family statehealthfacts.org

State Health Insurance Exchanges

- **2014:** State Health Insurance Exchanges will allow individuals and small employers to choose from a menu of insurance products
  - Exchange plans must offer “essential health benefits”
  - Rating restricted to geography, family size, age rated 3:1; tobacco use 1.5:1
  - Federal subsidies will be available to help people buy coverage
- **2017:** States may allow large employers to buy through Exchanges

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Core Functions of the Exchange

- **Consumer Assistance:** Toll-free information line; Internet comparison tool; Navigator program
- **Plan Management:** Certify and rate qualified health plans; conduct monitoring and oversight of plans
- **Eligibility:**
  - Verify eligibility, including for premium assistance tax credits and cost-sharing subsidies; connect applicants to Medicaid and CHIP if eligible
  - Use HHS-managed data services hub to connect to federal data sources (IRS, Social Security, Homeland Security)
- **Enrollment:** Facilitate enrollment in qualified health plans
- **Financial Management:** Process premiums; ensure stabilization of premiums through reinsurance and risk adjustment

Poverty Guidelines

2013 POVERTY GUIDELINES FOR THE 48 CONTIGUOUS STATES AND THE DISTRICT OF COLUMBIA

Persons in Family	100% FPL	133% FPL	400% FPL
1	$11,490	$15,282	$45,960
2	$15,510	$20,628	$62,040
3	$19,530	$25,975	$78,120
4	$23,550	$31,322	$94,200
5	$27,570	$36,668	$110,280
6	$31,590	$42,015	$126,360
7	$35,610	$47,361	$142,440
8	$39,630	$52,708	$158,520

Premium Assistance Tax Credit Calculation

The premium assistance tax credit is calculated based on:

- The premium cost of the second-lowest-cost silver plan offered through a state health benefit exchange, and
- The household income level of the applicant

Household Income Level (% above FPL)	Maximum Premium as Percentage of Household Income
Up to 133%	2.0%
133% – 150%	3% – 4%
150% – 200%	4% – 6.3%
200% – 250%	6.3% – 8.05%
250% – 300%	8.05% – 9.5%
300% – 400%	9.5%

New Fees and Taxes

Comparative Effectiveness Research Fees

- All plans (insured and self-insured) must pay a fee to fund comparative effectiveness research
  - Plan sponsor pays if coverage is self-insured; issuer pays if coverage is insured
  - Excepted benefits do not have to pay fees
- First effective for plan year beginning on/after November 1, 2011
  - First year: $1.00 per average number of covered lives
  - Second year: $2.00 per covered life (indexed starting in third year)
  - Sunsets in 2019
- Paid by July 31 of the calendar year after last day of plan year (first payment due July 31, 2014
- Potential for double counting—work with Legal Counsel to determine if supplemental fund needs to pay fees

Payments to Temporary (2014 – 2016) Reinsurance Programs

- Goal of reinsurance programs is to stabilize the individual insurance market in 2014 – 2016
- Self-insured plans will have to pay fees to help finance these reinsurance programs
- Health insurance issuers will also have to pay fees
- Fees will be based on a per capita (i.e., per person) contribution rate set by federal government
  - Final rate for 2014 is $5.25 per person per month (i.e., $63 per person per year)
  - Per person (not per employee)
- Fees apply to “major medical coverage”
- Potential for double counting—work with Legal Counsel to determine if supplemental fund needs to pay fees

Federal Premium Tax

- New federal taxes will apply to all insured health premiums beginning January 2014 in addition to current state insurance premium taxes.
- While the actual amount and applicability have not been fully defined, we are estimating that insured premiums will increase by 2.25% because of this new tax.
- Applies to GHPs (including medical, dental and vision) that are fully insured or minimum premium plans.
- Guidance is needed on whether the tax will also apply to non-ERISA government plans, VEBAs and MEWAs.
- Until guidance is provided, trustees of supplemental benefit funds (which are VEBA's and typically considered governmental plans) with an insured medical, dental or vision benefit should prepare to see a margin for this tax in the renewal rates for periods after January 1, 2014.
- Discuss with their legal counsel how to address removal of this margin if they feel it should not apply.

Excise Tax—2018

40% Excise Tax on Health Plans that Cost Above a Certain Threshold

- Threshold $10,200/$27,500 indexed to the CPI-U
- Adjustments due to age/gender; increased thresholds for high-risk professions and retirees
- Thresholds increased in 2018 if CBO projections incorrect
- Appears to exclude most dental and vision; includes health FSAs and HRAs
- Not issue for supplemental plan but may need to address a practical method of measuring the coverage provided by the employers to combine it with coverage provided by the supplemental benefit funds.

Discussion

Thank you

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