

**Affordable Care Act
Update
September 14, 2011**

What we're going to cover

1. Federal Legislation

- ACA update and recent guidance

2. New York State Legislation

- Implementing Health Care Reform in NYS
- Legislation from the 2011 session

3. Connecticut Legislation

- Implementing Health Care Reform in CT
- Legislation from the 2011 session

ACA: An Uncertain Future?

- Jan. 1, 2011: House of Representatives majority changes to Republican
- House vote to repeal PPACA (HR.2) passed on January 19, 245-189
- Bill sent to Senate but failed due to a technical motion on the Senate floor
- The result was amendments with bipartisan support to repeal certain onerous sections of the statute

ACA Provisions Repealed Or Eliminated

- 1099 Reporting requirements repealed
- Employee Free Choice Voucher Program eliminated
- \$2.2 billion of the funding for Co-Op Plans was eliminated

Constitutionality Challenge

- 24 constitutional challenges to the law so far
- 26 state attorneys general or governors have filed opposition to the law on several constitutional concerns including;
 - Deprivation of individual rights
 - The law violates the Commerce Clause
 - The law creates illegal taxing and spending policies
- Six cases decided to date in District Courts
 - 4 decisions supporting the law
 - 2 decisions either striking down certain portions of the bill or the entire bill as unconstitutional

Constitutionality Challenge

- 3 Decisions from Circuit courts on appeal from District Courts
 1. June 29th, 6th Circuit Court of Appeals upheld the constitutionality of the individual mandate
 2. August 12th, 11th Circuit Court ruled that the individual mandate was unconstitutional
 3. September 8th, 4th Circuit Court dismissed 2 appeals on procedural grounds. Constitutionality not addressed
- Now likely headed for the Supreme Court

Immediate Insurance/Benefit Change Timeline for Employers

2011	<ul style="list-style-type: none">•FSAs/HRAs/HSAs — OTC drugs not allowed without Rx•HSA distribution tax increases•SIMPLE cafeteria plan rules•Medical Loss Ratio requirements begin for carriers•Small business wellness grants should be made available
2012	<ul style="list-style-type: none">•New Summary of Benefits and Coverage•New quality reporting requirements (to HHS and beneficiaries) for all employer plans and all individual and group carriers•Delayed W2 Reporting begins•CLASS Act options for the new national long-term care program should be announced by HHS.•Employers whose carrier did not meet MLR standards may receive a rebate. Carriers responsible for ensuring that any rebate is shared with employees based on employer-contribution standards.•New Medicare Taxes on unearned income and higher income employees and self-employed
2013	<ul style="list-style-type: none">•FSA contributions capped at \$2,500•New federal premium tax on fully insured and self-insured group health plans to fund comparative effectiveness research program begins. It imposes an annual fee on private insurance plans equal to two dollars for each individual covered.•Employer requirement for notification to employees of Insurance Exchange

Changes to PPACA Requirements for Employers: Guidance Pending

- Non-discrimination rules for fully insured non-grandfathered plans
 - Originally set for 1/1/2011
 - Enforcement delayed per guidance of December 2010
 - IRS solicited comments due by March 2011
 - Final regulations expected late 2011
- Automatic enrollment of new employees into health plans (employers of > 200 employees)
- CLASS Act

New Guidance Recently issued for Employers

1. W-2 Reporting
2. Summary of Benefits and Coverage (SBC)
3. Annual limit waiver extensions
4. Claims and Appeals
5. Preventive Care Benefits

1. W-2 Reporting delayed until 2012

- New Guidance Issued on March 29 for Tax Year 2012
- For affected employers the guidance includes information on how to report, what coverage to include and how to determine the cost of the coverage
- Relief for smaller employers (those filing fewer than 250 W-2 forms) by making this requirement optional for them at least for 2012 and possibly longer (or until more guidance is issued)

2. Summary of Benefits and Coverage (SBC)

- A four page document “providing clear and consistent information to consumers about their health insurance coverage.” Also includes a two page Glossary of Terms
- Template document provided
- For insured plans, document should be provided by insurer to plan (employer)
- Employer has responsibility to distribute to members
- For Self Funded plans, the employer has the responsibility to develop and distribute the SBC

Summary of Benefits and Coverage

- Distribution
 - Must be paper unless the employer can meet the ERISA requirements for electronic distribution
 - 30 days prior to enrollment and must be included in all enrollment materials (open enrollment materials included)
 - If multiple plans are offered, member only receives a copy for the plan they're in unless they ask for others
 - Initial SBC required on or before March 23, 2012 although the Departments have asked for comments on the feasibility of meeting that date.

Summary of Benefits and Coverage

Additional requirement

- **Notification of Material Modifications**
 - Differs somewhat from ERISA Summary of Material Modifications (SMM)
 - Notification only required if it causes a change in the SBC
 - Required to be sent 60 days prior to the change
 - Question of timing for rate change is still pending

3. Annual Limit Waivers

- Health plans with annual limits need waiver from phase-in limits
- After September 22, 2011, no applications or requests for extensions to waivers will be accepted.
- After September 22, 2011 no new applications for annual limit waivers accepted
- Waivers will only be allowed to be in effect through 2013, since new health reform requirements and protections will become effective on January 1, 2014
- Waiver extension forms available on line for those who had previously been granted waivers. Deadline for submitting waiver extension forms is September 22, 2011

Annual Limit Waivers

Recent guidance

1. August 19th 2011: HHS exempted HRA plans from annual limit waiver requirements
2. Originally, the waiver process was designed to require plans to submit a new waiver application each year through 2013 .
 - New guidance eliminates the annual re-application requirement, replacing it with
 - annual informational filings to HHS
 - Requirement to provide more detailed notices about the plans' annual benefit limits to plan participants.
 - Recordkeeping responsibility for plan remains

4. Claims and Appeals Process

- Applies to non-grandfathered plans only
- Appeal process developed at the Federal Level
- States that met specific standards received a waiver from complying with the Federal Law
- New York and Connecticut both met the stricter standard and therefore, their state review policy takes precedence over Federal standards

5. Exemption from Preventive Care Requirements

- Applies to non-grandfathered plans only
- July 2011; new services were added to the list of No-Cost Sharing Preventive Services
- Included were all FDA approved contraception methods and contraception counseling
- Effective date is plan years beginning after August 2012
- Certain religious employers may be exempted from the requirement to provide contraceptive benefits

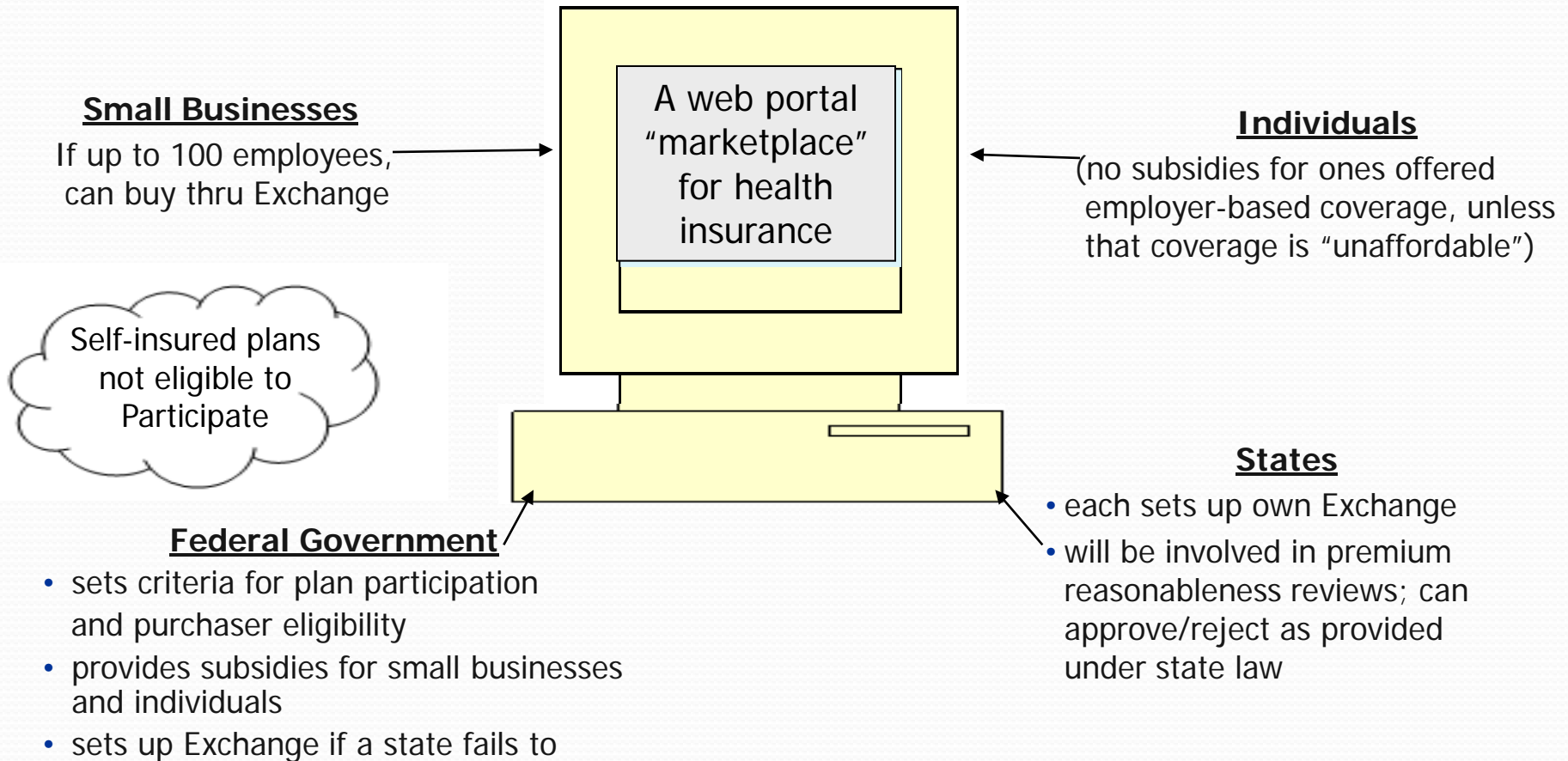
Exemption from Preventive Care Requirements

- Criteria for exemption is:
 - The entity must be a non-profit organization
 - The inculcation of religious values must be the purpose of the entity
 - They primarily employ persons who share the same religious tenets of the organization
 - They primarily serve persons who share the same religious tenets

The Major Changes: ACA in 2014

- Health Insurance Exchanges operational
- Individual Mandate to maintain minimum essential benefits
- Employer Responsibility requirement
- Individual market guaranteed issue requirement
- Initial waiting period limited to maximum of 90 days
- All non-grandfathered small group plans and all individual plans must meet minimum essential benefits

Exchanges



Health Insurance Exchanges

- Health insurance “department store” for individuals and small groups
- State-based health insurance exchanges
 - Law requires the creation of an American Health Benefit Exchange (AHBE) (for individuals) and Small Business Health Options Program (SHOP) Exchange for small employers up to 50 lives (100 at the option of the state until 2016)
 - States can combine their individual and small employer exchanges
 - States can choose to expand their exchanges to serve employer groups of 100+ in 2017
- Not Optional—If a state doesn’t create one, federal government will
- Transparent and more standardized benefit packages

Employer Responsibility Requirement

- Effective January 1, 2014
- Employer must count all full-time employees and part-time employees – on a full-time equivalent basis – in determining if they have 50 or more employees
 - Certain seasonal workers are not counted in determining if employer has 50 workers
 - Full-time = 30 or more hours per week, determined on a monthly basis
- Penalties differ based on “no coverage” or coverage that is “not affordable”
- Single employer goes by IRC Sec 414 rules for common control groups
- Employer penalties apply only when at least one employee purchases subsidized coverage through the Exchange

Will the Employer Pay A Penalty? *beginning in 2014*

Are you a large employer?
at least 50 full-time equivalent workers
• including full-time [30+hours per week] and part-time workers [prorated]
• excluding seasonal workers [up to 120 days per year]



Are any of your full-time employees in an exchange plan and receiving a premium credit ?



Do you have more than 30 full-time employees?



Do you provide health insurance?



No penalty

Pay Monthly Penalty, lesser of:

$1/12 \times \$2,000 \times$
(Number of full-time employees - 30)

or

$1/12 \times \$3,000 \times$
(Number of full-time employees who receive credits for exchange coverage)

Pay Monthly Penalty

$1/12 \times \$2,000 \times$
(Number of full-time employees - 30)

2014: Changes to the Way Employer Plan Premiums Are Calculated

- Changes for all fully insured group plans:
 - All guaranteed-issue with no preexisting condition limitations
 - Annual and lifetime limits will be fully prohibited, including for grandfathered plans
 - Size of a small-employer group will be redefined to one to 100 employees (although states may elect to keep the size of a small groups at 50 employees until 2016)

2014: Changes to the Way Employer Plan Premiums Are Calculated

- Market reforms for fully insured small groups up to 100 employees (and any larger fully insured groups if a state allows groups of 100+ in their exchange):
 - Strict modified community rating standards with premium variations only allowed for age (3:1), tobacco use (1.5:1), family composition and geographic regions
 - Experience rating would be prohibited
 - Wellness discounts will be allowed for group plans under specific circumstances.

Other Employer Plan Reforms in 2014

- Employee waiting periods of more than 90 days are prohibited for all plans, including grandfathered plans.
- Auto enrollment for groups of 200+ presumed to take effect
- Employer-sponsored wellness program rules for all employer group plans under HIPAA are codified
- Employers can increase the value of workplace wellness incentives up to 30% of premiums, with HHS discretion to increase the incentives to 50%
- Small businesses prohibited from buying coverage with deductibles in excess of \$2000 individual/\$4000 family

Other Employer Plan Reforms in 2014

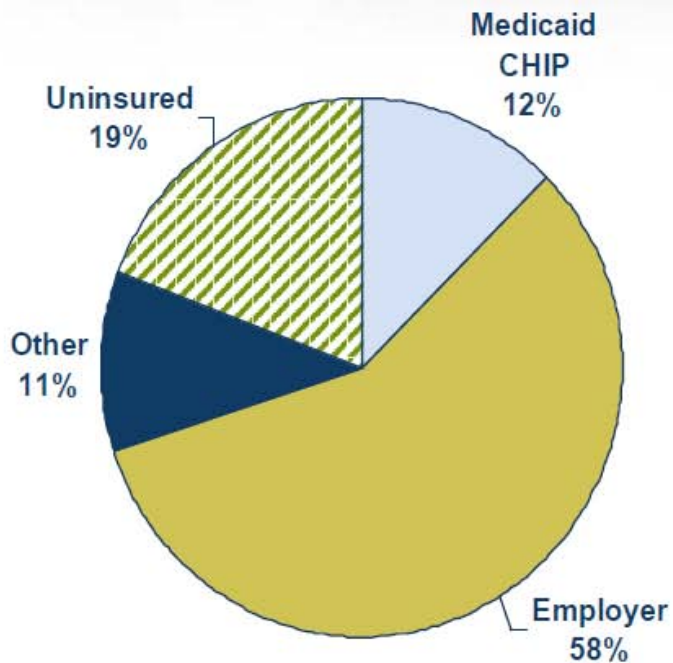
- The essential benefit standards for qualified coverage begin.
 - Standard will apply to all fully insured small group and individual products to be sold both inside and outside the exchanges.
 - The standards will also be used to determine if large employer coverage is sufficient enough relative to the employer responsibility requirements.
 - The essential benefit standards include specific mandated benefits, cost-sharing requirements, out-of-pocket limits and a minimum actuarial value of 60%

ACA in 2018

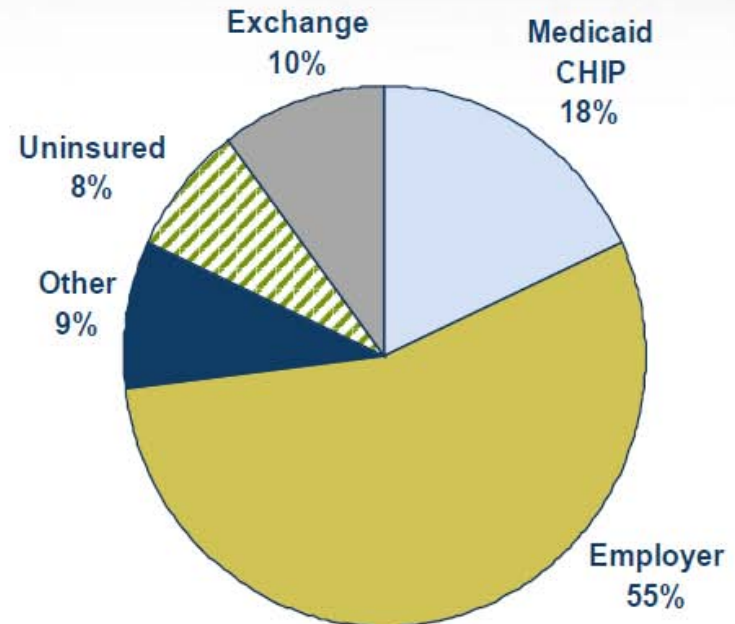
- Cadillac tax goes into effect for all group plans, including self-insured plans. The tax would be paid by the insurer in the case of a fully insured group or the TPA in a self-insured arrangement, but would be passed on directly to the employer.
- 40% excise tax on insurers of employer-sponsored health plans with aggregate values that exceed \$10,200 for singles and from \$27,500 for families takes effect in 2018
- Arbitrary numbers and lack of adequate indexing may be problematic

CBO 2019 Estimates of Insurance Coverage

Baseline: Without PPACA



With PPACA



Among nonelderly (under age 65). 'Exchanges' include 2% (5M) that CBO counted as 'Employer.' If excluding unauthorized immigrants, CBO's uninsured projection for PPACA would be 6%.

Small Business Health Care Tax Credit

- Designed to encourage small employers to offer health insurance coverage for the first time or maintain coverage they already have.
 - Employers have to pay at least 50% of the premium
- For tax years 2010 to 2013;
 - Maximum tax credit is 35 percent of premiums paid by eligible small business employers
 - Up to 25 percent of premiums paid by eligible tax-exempt employers not to exceed the amount of payroll tax they pay

Small Business Health Care Tax Credit

- The maximum credit is for employers with 10 or fewer full-time equivalent (FTE) employees – paying annual average wages of \$25,000 or less.
 - The credit is completely phased out for employers that have 25 FTEs or more or that pay average wages of \$50,000 per year or more.
 - The eligibility rules are based in part on the number of FTEs, not the number of employees; businesses that use part-time help may qualify even if they employ more than 25 individuals.

Small Business Health Care Tax Credit

- In 2014 and 2015, the maximum tax credit will go up to 50 percent of premiums paid by eligible small business employers and 35 percent of premiums paid by eligible, tax-exempt organizations
- Eligible small businesses can claim the credit as part of the general business credit starting with the 2010 income tax return they file in 2011.
- Small businesses are defined under IRS Common Control rules

State Legislation

2011 Session ACA Related and non-ACA related bills
Connecticut and NYS

NYS Legislation : ACA Related

- Pre-Existing Condition Insurance Plan (PCIP)
- Created by ACA for states who didn't have Guaranteed Issue markets
 - NYS version is the **NY Bridge Plan**
 - Administered by Emblem Health statewide
 - www.nybridgeplan.com
 - No income test but must have been uninsured for prior 6 months and have a pre-existing condition
 - Rates run from \$362 to \$421 per month

NYS Legislation: ACA Related

- \$1 million grant rec'd in 2010 for planning the Health Insurance Exchange
- \$27 million Innovator grant received in 2010
- Health Insurance Exchange bill status as of Sept. 14th 2011
 - Senate bill was introduced on June 10th S5652
 - Identical Assembly bill A8514, introduced on June 22nd, **passed** by the Assembly on June 23rd
 - Senate Republicans raised issues of Obamacare and didn't bring the bill to the floor for a vote
 - Unless there's a special session, bill will have to be voted on in 2012
 - Contract let by NYS for development of IT infrastructure

NYS Exchange Bill

- Creates a new Public Authority to operate the Exchange
- Exchange is governed by a 9 person Board of Directors,
- The Bill creates 5 Regional Advisory Committees in NYC, Metropolitan Suburban Region, Northern Region, Central Region and Western Region. The Board will decide which counties go into which regions.
- The Regional Advisory Committee will consist of 5 members

NYS Exchange Bill

- This bill creates a single exchange for both individual and group markets
- The Exchange will have limited regulatory authority with most decisions requiring legislative approval
- Carriers will be allowed in the Exchange only if they offer at least one plan at both the Silver and Gold levels
- The Exchange will be financially self sufficient by 1/1/2015 so basically after one year in operation it has to be fully financed by its operations

NYS Exchange Bill

Still to be decided:

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- How to finance its operations
- Whether to require essential health benefits as defined by ACA to be included in all programs inside and outside the Exchange
- Whether state mandated benefits above and beyond the defined essential benefits should no longer be included in programs sold within or outside the Exchange
- Whether having different requirements within and outside the Exchange will cause adverse selection
- Whether to merge the individual and group markets for rating purposes

NYS Exchange Bill

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- Whether to increase the size of the small group market from 1 to 50 to 1 to 100 on 1/1/2014 rather than wait until 1/1/2016
- Whether to allow large groups in 2017
- Whether to make the definition of small employer outside the Exchange consistent with the definition inside the Exchange
- Whether to adopt the active purchaser, selective contractor or clearinghouse model
- The criteria for eligibility to serve as a navigator

NYS Legislation

Pending Bills:

- 188 bills introduced by the end of the session that touch health insurance
- 63 bills introduced in Senate, 125 introduced in Assembly

Bills passed in the 2011 session:

- Coverage for autism services. \$45,000 max per individual for applied behavioral analysis
- Oral Chemotherapy to be covered under medical, not Rx
- No mandatory mail order if retail pharmacies can match cost

NYS Legislation

Bills passed in the 2011 session:

- Fertility Drug Coverage: Requires insurance coverage for prescription fertility drugs purchased at non-mail order pharmacies to be the same as at mail order pharmacies
- Marriage Equality Act: Nothing specific to do. Employers should consider impact of domestic partner rider. Is it still needed?

Connecticut: ACA Related

- Pre-Existing Condition Plan
- Like NYS, created and seed funding from ACA
- Operated jointly by CT Dept of Social Services and the Health Reinsurance Association
- www.PCIP.gov
- Similar eligibility requirements to NYS Plan;
 - Guaranteed issue
 - Must have a pre-existing condition
 - Premiums run from \$242 to \$893 depending on age

Connecticut :ACA Related

Connecticut Health Insurance Exchange

- Public Act 11-53
 - Final Bill passed setting up an 11 person board to make the majority of decisions relative to the Exchange operations
 - First meeting scheduled for August 29th but was postponed until September 15th
 - Ct also received an Early Innovator Grant
 - Most decisions similar to NYS not resolved but left up to the Exchange Board

Connecticut Legislation

- 35 bills introduced into House and Senate directly related to health insurance; 9 passed so far
- Public Act 11-225
 - Requires health insurance coverage for external radiation therapy and brachytherapy for the treatment of prostate cancer and;
 - Specific prescription drugs to treat male issues related to radical prostatectomy

Connecticut Legislation

- Public Act 11-58
 - Allows various employers to join the State Health Plan
 - Creates a partnership plan for these employers
 - Details still being worked out
 - Non-state public employers effective on 1/1/2012
 - Non-profit employers effective on 1/1/2013
 - Small employers effective on 1/1/2014

Connecticut Legislation

- Public Act 11-172
 - Requires group and individual health insurance to cover routine patient costs associated with clinical trials for the treatment of disabling, progressive or life threatening medical conditions
- Public Act 11-170
 - Relates to procedures related to rate increase hearings
- Public Act 11-67
 - Requires insurance coverage for breast MRI when indicated by mammogram

Connecticut Legislation

- Public Act 11-204
 - Expands health insurance coverage of ostomy supplies from \$1,000 annually to \$5,000 annually
- Public Act 11-88
 - Requires coverage for testing related to bone marrow transplants with limits on cost sharing

Connecticut Legislation

- Public Act 11-169
 - Prohibits individual and group health insurance policies that provide Rx coverage from requiring insureds to use an alternative pain medication prior to using a brand name Rx. The prohibition applies to alternative brand name medication as well as over the counter drugs