FEDERAL HEALTHCARE REFORM

June 10, 2010

This summary is provided for informational purposes only and is not intended as legal advice. Please consult your legal advisor for additional information.

OVERVIEW

- Patient Protection and Affordable Care Act
  - Enacted March 23, 2010
  - Extends coverage to 94% of non-elderly Americans
  - Requires individuals to obtain coverage
  - Requires employers with 50+ employees to offer coverage
- Significant new requirements for benefit levels, rating, marketing, consumer protection, and new taxes
- Provisions begin to go into effect in 2010 and are phased in through 2018

NEAR-TERM REFORMS

2010 | 2011 | 2012 | 2013+

- High-risk pool (July 2010 through January 2014)
- Rate reviews by Department of Health and Human Services (HHS), in conjunction with states, starting in 2010
- HHS Internet Portal, beginning in July 2010
  - Run by HHS, state-level information for individuals and small businesses
  - **Phase 1** - information about commercial and public insurance
  - **Phase 2** - pricing and benefit information

NEAR-TERM REFORMS

2010 | 2011 | 2012 | 2013+

- Early retiree reinsurance, effective July 2010 through January 2014
  - Federal “reinsurance” payments to employers based on claims for retirees in group plans aged 55-64
  - Covers 80% of claims between $15,000 and $90,000
  - $5 billion allocated
  - Employer “maintenance of effort” required
    - Allowed to use reinsurance payments to offset future increases or reduce employee cost sharing, but not for general funds

NEAR-TERM REFORMS

2010 | 2011 | 2012 | 2013+

- Medical Loss Ratio (MLR) reporting requirements, effective for plan years after September 23, 2010
  - ≥ 80% for individual and small group
  - ≥ 85% for large group
  - Beginning 2014, must be ≥ 85% for nonprofit Blues (BCBSRI)
- Coverage and cost-sharing transparency and disclosure, effective for plan years after September 23, 2010.
  - Information submitted to HHS, the Rhode Island Office of Health Commissioner
  - Posted on the internet

NEAR-TERM REFORMS

2010 | 2011 | 2012 | 2013+

- Grandfathering
  - Plans in effect on enactment date (March 23, 2010) may be grandfathered
  - BCBSRI's position on grandfathering
- Nondiscrimination
  - Fully-insured plans can not discriminate in favor of highly compensated employees regarding eligibility and benefits

NEAR-TERM BENEFIT CHANGES

2010 | 2011 | 2012 | 2013+

- Dependents covered to age 26
- Limits removed
  - Lifetime limits
  - Annual limits on essential benefits
- Preventative and emergency services coverage

SHORT -TERM REFORMS

2010 | **2011** | 2012 | 2013+

- MLR rebates, effective 2011
  - Consumer rebates required if thresholds are not met
- Consumer spending account changes

  Health savings account (HSA), Medical savings account (MSA), Flexible savings account (FSA), and Health reimbursement account (HRA)
  - Prescriptions required for the disbursement to be tax-free, including over-the-counter drugs
  - Penalty for non-qualified disbursements from HSAs & MSAs increases to 20%
  - Contributions to FSAs limited to $2,500

SHORT -TERM REFORMS

2010 | 2011 | **2012** | 2013+

- Uniform Coverage Documents (March 23, 2012)
- Notice of mid-year changes (March 23, 2012)
- Quality reporting
  - Regulations to be issued by March 23, 2012
  - Insurers and group health plans must provide information about programs which improve health outcomes to HHS and public
- Employer responsible for W-2 reporting (2011)
  - Disclose aggregate cost of benefits, calculated as for COBRA coverage

LONG -TERM REFORMS

2010 | 2011 | 2012 | **2013+**

- Additional benefit requirements, effective 2014
  - Minimum essential benefit package includes:
    - Ambulatory services
    - Emergency services
    - Hospitalization
    - Maternity
    - Newborn care
    - Mental health
    - Substance abuse
    - Prescriptions
    - Rehabilitative and habilitative services and devices
    - Lab services
    - Preventative and wellness services
    - Chronic disease management
    - Pediatric services (including oral and vision care)
  - Out-of-pocket and deductible limits
  - Actuarial value requirements
  - Clinical trials coverage
- Waiting periods cannot exceed 90 days, effective 2014

LONG -TERM REFORMS

2010 | 2011 | 2012 | **2013+**

- Rating reforms (2014)
  - Age bands for 3:1
  - Tobacco rating 1.5:1
  - Eliminate health status
  - Group size changes
- Wellness programs
  - Incentives capped at 30% of cost of coverage, HHS can further increase to 50%
  - Program must be designed to promote health/prevent disease and not discriminate based on health status (allow reasonable alternative)

LONG -TERM REFORMS

2010 | 2011 | 2012 | **2013+**

- New Insurers
  - Co-ops
  - Interstate compacts
  - Multi-state plans sold through exchanges
- Tax Implications for insurers
  - BCBSRI special tax status requires MLR of ≥ 85%
  - Comparative effectiveness tax $1 per covered life in 2013 to $2 per covered life in 2014 (applies to self-funded plans)
  - Premium tax beginning 2014 – raising $8 Billion up to $14 Billion in taxes in 2018

LONG -TERM REFORMS

2010 | 2011 | 2012 | **2013+**

- Individual Mandate (2014)
  - Most US residents required to obtain minimum essential coverage
  - Coverage requirements satisfied by group plans regardless of level of coverage, governmental programs, individual market plans
  - Penalty greater of flat dollar (grows to $695 in 2016) or percent of income (grows to 2.5% in 2016)
  - Insurer/Employer reporting requirements
- Subsidies (2014)
  - For coverage purchased through the Exchange
  - Based on income, so that cost of coverage ranges from 2% of income for those at 133% of Federal Poverty Level to 9.5% for those at 400% of FPL
  - Ineligible if covered by employer, unless employer coverage is below 60% actuarial value *or* if premiums exceed 9.5% of income

LONG -TERM REFORMS

2010 | 2011 | 2012 | **2013+**

- Employer Responsibility - “Play or Pay” requirements (2014)
  - **Play:** provide minimum essential coverage, no minimum contribution is mandated but penalty could be triggered if employee receives a subsidy because the cost is too high
  - **Pay:** If an employee receives a federal subsidy, then the penalty is:
    - Employers not offering coverage = $2,000 x total number of FTEs (minus first 30 FTEs)
    - Employers offering coverage, the penalty is lesser of:
      - $2,000 x total FTEs (minus first 30 FTEs) *or*
      - $3,000 x number of employees receiving the subsidy

LONG -TERM REFORMS

2010 | 2011 | 2012 | **2013+**

- Employer Responsibility:
  - Auto-enrollment applies if > 200 employees
    - Effective after Dept. of Labor issues regulations
  - Reporting to Treasury (2014)
    - Employer (and insurers) provide information to Treasury for tracking compliance with coverage requirements
  - "Free Choice" Voucher (2014)
    - If employee's contribution is between 8% and 9.8% of household income and income is < 400 percent FPL
    - Used in Exchange

LONG -TERM REFORMS

2010 | 2011 | 2012 | **2013+**

- Retiree Drug Subsidy (2013+)
  - Employers no longer receive the subsidy payments tax-free
- High Cost Plan “Cadillac” Excise Tax (2018+)
  - Tax of 40% on the aggregate value of benefits exceeding $10,200/$27,500

LONG -TERM REFORMS

2010 | 2011 | 2012 | **2013+**

- Health Insurance Exchanges, effective 2014
  - State-based
  - Can be single or separate exchanges (one for small group and one individual)
  - In 2017, states can expand to large group
  - Federal subsidies available only through the Exchange
  - Strict qualifications on products and insurers inside Exchange, four actuarial tiers
  - Insurers can offer products outside Exchange

QUESTIONS?