OBAMACARE PRESENTATION
August 2013

General Information

The Patient Protection and Affordable Care Act (Pub. L. 111-148) [HR 3590] (March 23, 2010) (AKA The Affordable Care Act or Obamacare)

Individual Health Insurance vs. Employer-Based Health Insurance

Fully-insured vs. Self-funded plans

Small Employer vs. Large Employer (Fully-Insured)

Grandfathered vs. Non-Grandfathered

Important elements of Obamacare that are scheduled to begin in 2014:

- Individual Mandate

  Nearly every American must carry "minimum essential" health insurance coverage or pay a tax equal to the greater of a flat dollar amount or a percentage of income amount ($95 or 1% in 2014; $325 or 2% in 2015; and $695 or 2.5% in 2016 and thereafter). Coverage can be through an individual policy, an employer-sponsored plan, a government-sponsored plan (*e.g.*, Medicare, Medicaid, CHIP, TRICARE), or a grandfathered plan.

- Employer Mandate – DELAYED UNTIL 2015

  For the employer "play or pay" mandate:
  - Small employer = 2-50 (exempt)
  - Large employer = 51+ (applies)

  The employer mandate requires employers with more than 50 employees to provide affordable health insurance with "minimum value" to their employees and their children (but not spouses) or face penalties of $2,000 per full-time employee (less 30) (if the employer doesn't offer coverage) or $3,000 per full-time employee that obtains insurance through an Exchange and receives a subsidy (if the employer's coverage isn't "affordable"). In both cases, the penalty is only triggered if at least one full-time employee enrolls in a qualified health plan ("QHP") on the exchange and receives a premium tax credit or a cost-sharing subsidy.
  - Application – Employers that employed an average of at least 50 full-time employees (FTE is 30+ hours/week, but it also includes part-time and seasonal employees in the aggregate)
  - Penalty - Part-time equivalent employees are relevant for counting employees for eligibility purposes, but not penalty purposes. Only employees who work 30+hours/week are relevant for penalty

- Benefit Changes

For the essential health benefits requirement:

- Small employer = 2-50 (Essential health benefits applies (unless grandfathered)).
- Large employer = 51+ (Essential health benefits does not apply (but limit on cost sharing does apply)).

- Essential health benefits for non-grandfathered plans
  - Ambulatory patient services
  - Emergency services
  - Hospitalization
  - Maternity and newborn care
  - Mental health and substance abuse
  - Prescription drugs
  - Rehabilitative and habilitative services
  - Laboratory services
  - Preventive and wellness services
  - Pediatric services (*e.g.,* pediatric dental care and vision services)
- No preexisting condition exclusion for anyone (Note: This was tried in New Jersey in 1992. In 2013, the cheapest $2,500 deductible policy is $17,000 (single) and $34,000 (family)
- No annual or lifetime limits (applies to all insurance coverage (GF and non-GF and self-insured)
- Waiting periods must be 90 or less
- Cost sharing limitations (also applies to self-insured plans, but grandfathered (and possibly non-grandfathered large group health plans) are exempt)
  - Annual deductibles cannot exceed $2,000 for an individual and $4,000 for two-party or family coverage
  - Out-of-pocket maximums cannot exceed $6,350 for individuals and $12,700 for two-party or family coverage in 2014. [DELAYED ONE YEAR for certain plans]
  - Cost sharing does not include premiums, balance billed amounts for non-network providers, or amounts paid for non-covered items and services.
- Clinical trials must be covered

- SHOP Exchanges

For Small Business Health Options Program ("SHOP") eligibility:

- Small employer = ≤ 100 employees
- Large employer = 101+ (Not eligible for the SHOP exchange until 2017)

These "Exchanges" are marketplaces run by the state, the federal government, or both, where employees of employers with 100 or fewer employees can shop for and obtain qualified health insurance coverage. It is important to note that you will need to purchase your insurance through one of these exchanges if you qualify for a refundable premium tax credit or a cost sharing subsidy. Qualified employers and qualified employees are eligible for a SHOP Exchange. A qualified employer is defined as an employer that meets three requirements: (1) is a small employer; (2) elects to offer, at a minimum, all full-time employees coverage in a Qualified Health Plan ("QHP") through a SHOP; and (3) either has its primary office in the Exchange service area and offers all its employees coverage through that SHOP, or offers coverage to each eligible employee through the SHOP servicing the employee's primary worksite. To determine SHOP eligibility and application to the employer shared responsibility (play or pay)

requirement, it is necessary to count not only full-time employees (those averaging 30 hours of service per week) but also part-time employees (as full-time equivalents).

- Coverage Options

  Health insurance sold through the Exchanges will be available at four levels: bronze, silver, gold, and platinum. These four "metal plans" will have actuarial values of 60%, 70%, 80% and 90% respectively, and they will cover at least the ten "essential health benefits" as defined by the federal government (including dental and vision care for kids up to age 19).

- Tax Credits and Cost-Sharing Subsidies

  In an effort to assist individuals and families who can't afford or who don't have minimum essential coverage, the ACA provides for refundable and advanceable premium tax credits for low-income individuals (provided coverage is purchased through an eligible government exchange). Generally, these "low-income individuals" are defined as taxpayers with income between 100-400% of the federal poverty line ("FPL"), and they are based on federal adjusted gross income ("AGI"). In other words, under the current FPL guidelines, an individual with income of $45,960, and a family of four with household income of $94,200 would qualify for a premium tax credit. In addition, individuals and families at or below 250% of the FPL may qualify for an additional "cost-sharing reduction subsidy" which will further help them pay for deductible and co-payment amounts.

- Modified community rating and modified composite premium rating for group insurance plans will replace health underwriting (grandfathered plans are exempt).

  All non-grandfathered small employer plans will have the same basic rates. There are a few minor exceptions to this community rating requirement, which will allow for limited group-specific underwriting. These limited exceptions are: (1) coverage category (*e.g.*, individual versus family coverage); (2) geographical differences; (3) age (limited to three times the lowest rate); and (4) tobacco use (limited to 1.5 to one) [DELAYED in Exchanges]. Expect the rates of healthy groups to jump significantly, while the rates for the unhealthy groups will come down as allowable rate bands get squished together.

- Guaranteed availability and guaranteed renewability. (Grandfathered plans are exempt)
  - Guaranteed availability rules are extended to the large group market under PPACA. Large employers can purchase insurance at any point during the year. Small employers can be limited to open enrollment period (11/15-12/15). Minimum participation and contribution requirements can't be enforced for guaranteed availability purposes, but they can be enforced for guaranteed renewability purposes.
  - Guaranteed renewability rules already applied to both small and large employers, but the guaranteed availability rules now create a conflict. Carriers can refuse to renew a policy for failure to meet participation, but they can't refuse to issue it for the same reasons. Since minimum participation and contribution requirements can still be applied to small employers on renewal, this inconsistency could cause small employers to seek a new carrier every year.

- Non-discrimination against individuals based on health status (individual market). (Grandfathered plans are exempt) No longer can individuals who purchase their insurance in the individual health market be charged different premiums based on healthiness. Wellness and adherence discounts are o.k.

- Non-discrimination against health care providers

  Health plans can't discriminate against any health care provider acting within the scope of the provider's license.

- Medicaid expansion Medicaid will be available to people with income up to 133% of the federal poverty level (currently $30,657 for a family of four).
  Currently, Medicaid requires states to cover certain limited categories of people (*e.g.*, impoverished families, pregnant women, children, the blind, the elderly, and the disabled). Initially, Obamacare was supposed to have extended Medicaid coverage to 17 million more Americans; however, because the Supreme Court reined in this mandate, states are now free to decide for themselves whether they want to expand their Medicaid programs to adults with incomes of 133% of the FPL ($14,856) or below. The federal government has promised to pay 100% of the cost of the "newly eligible" Medicaid enrollees through 2016, and 90% thereafter.

Grandfathered vs. non-grandfathered

Provisions that apply to grandfathered and non-grandfathered plans:

- Coverage of dependent children up to age 26 (2010)
- Medical Loss Ratio ("MLR") requirements (2011 plan years / payable in 2012)
- Summary of benefits and coverage ("SBC") must be provided (2012 plan years)
- No PEC for anyone (no longer just children) (2014)
- No waiting periods of more than 90 days (2014)
- No annual or lifetime limits on any essential health benefits that are currently covered (2014)
- [DELAYED] Play or Pay (employers of 51+) (2014)

Provisions that apply only to non-grandfathered plans

- First dollar coverage of preventive health services at PPO providers at 100% (2010). Applies to fully-insured and self-funded plans unless grandfathered.
  - Evidence-based items or services with an A or B rating recommended by the United States Preventive Services Task Force (USPSTF) (*e.g.*, mammograms, colonoscopies, blood pressure screenings, diabetes screenings, cholesterol screenings);
  - Immunizations for routine use in children, adolescents, or adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
  - Evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA) for infants, children, and adolescents; and
  - Other evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by HRSA for women.
- [DELAYED] - IRC §105(h) applies to non-grandfathered fully-insured plans. Already applies to self-funded plans. (2010 – postponed indefinitely for fully-insured plans only)
- Enhanced internal claims and appeals requirements and external review procedures for self-funded health plans and health insurers. (2010)
- Patient Protections (2010)
  - Choice of health care professionals
  - Coverage of non-PPO emergency services at PPO percentages
- [DELAYED] – Insurers required to report quality of care information to HHS (2012 – delayed indefinitely)
- Fair health insurance premiums and rating limitations: community rating with adjustments for age, tobacco, geography, family status (2014)
- Guaranteed availability (now also applicable in large group market) (2014)

- Guaranteed renewability (2014)
- Nondiscrimination against an individual based on health status (individual market) (2014)
- Nondiscrimination against health care providers acting within the scope of their license (2014)
- Comprehensive health insurance coverage (essential health benefits package) (2014)
  - Ambulatory patient services
  - Emergency services
  - Hospitalization
  - Maternity and newborn care
  - Mental health and substance use disorder services, including behavioral health treatment
  - Prescription drugs
  - Rehabilitative and habilitative services and devices
  - Laboratory services
  - Preventive and wellness services and chronic disease management
  - Pediatric services, including oral and vision care.
- Coverage for clinical trials (2014)
- Transparency in coverage requires QHP insurers to disclose certain information (2014)

Important elements of Obamacare that have been postponed, repealed, ignored, or discarded:

- Class Act (the long-term care insurance plan) – discarded because it wasn't financially viable.
- IRC §105(h) – prevents employment-based health plans from discriminating in favor of highly compensated employees – indefinitely postponed (as to fully-insured plans, but still applies to self-funded plans)
- W-2 reporting – delayed indefinitely for employers with less than 250 W-2s
- "Play or pay" mandate for employers with 51+ employees – delayed one year
- Out-of-Pocket maximums – delayed one year for certain plans
- Tobacco use surcharge for non-grandfathered small employers – delayed because of system limitations
- SHOP Exchange plan options – delayed because of system limitations – only one option available until at least 2015
- Employers required to provide insurance vouchers to certain employees - repealed
- Subsidy eligibility verification – delayed (replaced with honor system)
- Automatic enrollment – certain employers with 200 full-time employees are required to automatically enroll new full-time employees in one of the employer's health benefit plans (subject to waiting period). No clear effective date, but expected to be delayed until at least 2015

Taxes and Fees under Obamacare:

- Patient-Centered Outcomes Research Institute ("PCORI") Fee – Used to provide evidence-based research so people can make informed health care decisions. In 2013, the fee is $1 per covered life. In 2014, the fee increases to $2 per covered life. After 2019, this fee will be phased out.
- Transitional Reinsurance Program and Fee – This program is basically insurance for insurers. It operates from 2014 through 2016. The fee is $63 per individual covered life in 2014. It is

payable by all insurers and self-funded plans, but it only benefits insurers in the individual market.

- Annual Fee on Health Insurers – This permanent program is designed to generate income to fund certain components of the ACA. In 2014, health insurers must pay a fee that will generate a combined $8 billion. (Self-insured plans exempt, but grandfathered plans are not.)
- Risk Adjustment Program and Fee – This permanent program applies to non-grandfathered individual and small employer plans (inside and outside the Exchange marketplace). The purpose of this program is to stabilize premiums in the individual and small employer markets. It will shift profit from insurers with less risk and better claims experience to insurers with more risk and worse claims experience.
- Risk Corridors – Caps profits and losses for qualified health plans ("QHPs") sold on Exchange marketplaces. This program runs from 2014 through 2016.
- Exchange Marketplace User Fees – To fund Exchanges, participating insurers will pay a monthly user fee of 3.5% of premium.
- Cadillac Excise Tax – This provision of Obamacare imposes a 40% excise tax on high cost employer-sponsored coverage. The thresholds for these high-cost plans are $10,200 for single coverage and $27,500 for family coverage. The implementation date of this tax is 2018.

OBAMACARE TIMELINE

2010

- Tax credits are available for qualified small employers to purchase health insurance coverage. The employer must have no more than 25 full-time employees and have average annual wages of less than $50,000.
- Federal review of health insurance premium rates begins.
- All group health plans must comply with the IRS §105(h) rules that prohibit discrimination in favor of highly compensated individuals.
- Lifetime limits on the dollar value of benefits for any insured are prohibited (but annual limits for "non-essential" benefits allowed until 2014).
- Insurance companies and self-funded plans are prohibited from imposing preexisting condition exclusions for children 19 and under.
- Insurance companies are required to provide coverage for married and unmarried dependents up to age 26.
- Health insurance policy rescissions are prohibited (except for cases of fraud or intentional misrepresentation).
- New internal and external review procedure standards are established for claim determinations.
- Coverage of immunizations and certain preventive services is mandated with no cost sharing.
- Coverage of emergency services at in-network benefit level is mandated regardless of provider status.
- A tax on pharmaceutical manufacturers and importers of branded prescription drugs is imposed.

2011

- Minimum loss ratio requirements for insurers are established and premium rebates must be paid to policyholders if minimum loss ratios are not met.
- Employers are required to disclose the cost of employer-sponsored health benefits on employee W-2s.
- Flexible Spending Account ("FSA") reimbursements for over-the-counter medicines is disallowed unless prescribed by a doctor, and new "simple cafeteria plans" are established for small employers (generally 100 or fewer employees) that these employers can adopt in exchange for satisfying minimum participation and contribution requirements.
- The tax on distributions from health savings accounts ("HSAs") that are not used for qualified medical expenses is increased from 10% to 20%.
- A new public long-term care program is established. Employers are required to enroll employees unless they actively opt out. Benefits start five years after people begin paying a fee for coverage.
- Group health plans and insurers are required to periodically provide a summary of benefits and a coverage explanation to all applicants and insureds. Employers and health plans that fail to do so will face fines of up to $1,000 per failure.
- A funding schedule is implemented for community health centers to provide care for many low income and uninsured people.

2012

- Group health plans and insurers are required to annually submit benefit information to the Secretary of the Department of Health and Human Services.
- A new federal premium tax on fully-insured and self-insured group health plans is implemented to fund research programs.

2013

- FSA contributions for medical expenses are limited to $2,500 per year (indexed for inflation).
- A 2.3% excise tax on medical devices is imposed.
- The Medicare Hospital Insurance tax on self-employed individuals and individuals making $200,000 per year ($250,000 for couples) is increased from 1.45% to 2.35%. A new 3.8% Medicare contribution on certain unearned income (*e.g.*, dividends, interest) from individuals meeting those income thresholds is levied.
- Employers are required to notify their employees of the existence of the state-based insurance "exchange."

2014

- Annual taxes on private health insurers based on net premiums are imposed.
- Insurance companies are required to offer coverage in all markets on a guarantee issue and a guarantee renewable basis.
- The prohibition on insurance companies and self-funded plans from imposing preexisting condition exclusions is extended to adults (age 19 and older).
- Strict rating requirements and restrictions are imposed on individual health insurance policies and fully-insured group policies with 100 lives or less. "Modified community rating standards" are mandated with premium variations only allowed for age (3 to 1), tobacco use (1.5 to 1), family composition, and geographic regions. Wellness discounts are allowed under specific circumstances.
- The 2010 prohibition on annual dollar limits is extended to "non-essential" benefits.
- State "exchanges" are to become operational to facilitate the sale of qualified benefit plans to individuals and small employer groups.
- Standards for qualified coverage, including mandated benefits, cost-sharing requirements, out-of-pocket limits and a minimum actuarial value of 60% are established.
- Premium assistance tax credits for non-Medicaid eligible individuals with incomes up to 400% of federal poverty line ("FPL") to buy coverage through the exchange are implemented.
- Medicaid eligibility level is increased to 133% of FPL. States are required to offer premium assistance to certain Medicaid beneficiaries who are offered employer-sponsored coverage.
- [DELAYED UNTIL 2015] The employer mandate is effective for employers with 51 or more employees. An employer doesn't have to offer coverage, but if the employer offers coverage and has at least one full-time employee receiving a premium tax credit, the employer must pay a fee of $2,000 per full-time employee or $3,000 per employee receiving the tax credit (whichever is less). If the employer does not offer qualified coverage and one or more employees receives a premium assistance tax credit, the employer must pay a fine of $2,000 per year per full-time employee (with the first 30 employees exempt). Part-time employees are counted based on the aggregate number of hours of service.
- Employers are prohibited from imposing a waiting period of more than 90 days before an employee can enroll in a health insurance plan.
- The individual mandate is effective. All American citizens and legal residents (with a few exceptions) must purchase qualified health insurance coverage The penalty for non-compliance is the greater of a flat dollar amount per person or a percentage of the individual's income, whichever is higher. The percentage penalty in 2014 would be 1%, increasing to 2% in 2015 and 2.5% in 2016. The flat dollar penalty would be $325 in 2015 increasing to $695 in 2016. The employer must provide coverage documentation to the IRS and to the covered individual.
- Employers of 200 or more employees must auto-enroll new employees into a health insurance plan unless they otherwise opt out. (Note: The effective date of this provision is unclear and may depend on issuance of regulations.)

2018

- Implements a 40% excise tax on insurers of employer-sponsored "Cadillac" health plans that offer generous levels of coverage.