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CORRESPONDENCE MEMORANDUM

DATE: January 10, 2013

TO: Group Insurance Board

FROM: Arlene Larson, Manager of Federal Health Programs & Policy

SUBJECT: Recent changes under the Patient Protection and Affordable Care Act

This memo is for informational purposes only. No Board action is required.

This memo is provided to inform the Group Insurance Board (Board) of items that health plans and staff are implementing to conform to the requirements of Patient Protection and Affordable Care Act (PPACA) for 2013 and 2014. In addition, we describe some elements of the law that do not apply to our program at this time, but are being presented for the Board's information. Staff will continue to monitor the law, bring updates to the Board, and develop materials accordingly. The items that will be discussed are:

1. Fee and tax impact
2. Play or Pay, the employer responsibility mandate
3. 90 day rule regarding waiting periods for coverage
4. Exchanges
5. Essential benefits
6. Wellness
7. Auto enrollment of newly hired full-time employees

Board	Mtg Date	Item #
GIB	2.5.13	7H

Reviewed and approved by Lisa Ellinger, Administrator, Division of Insurance Services.

Lisa Ellinger
Signature

1/15/13
Date

Discussion:

1. Fees and Taxes. Several of these will apply to our program. Most will be paid by the health plans. Some will be paid by the Department of Employee Trust Funds (ETF), as noted.

   a. A "Reinsurance Fee" is being implemented to be used to lessen the impact of high cost cases in the individual market. Nationwide, it is expected to raise $26 billion over three years. In our program, this fee applies to health benefits for Administrative Services Only (ASO) and fully insured employees, non-Medicare retirees and their non-Medicare dependents. Federal law lists the fee as $5.25 per member per month (PMPM) ($63 per member per year (PMPY)) in 2014. We estimate our overall cost in 2014 to be $13.23 million.

   b. A "Health Insurer Tax" also known as a "Health Insurer Provider Fee" is expected to raise $8 billion nationwide in 2014. The anticipated cost is approximately 2.5% of the premium to be paid by our fully insured health plans. Not-for-profit insurers may pay less than for-profit insurers under the law. Seven of ETF's participating health plans are not-for-profit. They are analyzing federal guidance to estimate how this fee will impact them. The fee does not apply to the ASO Standard Plans or to the Navitus pharmacy benefit plan.

      Our estimated cost to the state in 2014 using 2013 estimated state share of health insurance premium is $19.96 million.

   c. A "Patient Centered Outcome Research Institute (PCOR)" fee also known as the "Comparative Effectiveness Research Fee (CERF)" is initially due to be paid in July of 2013. Fully insured health plans will pay the fee for their subscribers, however, ETF will pay the fee for the ASO plans. The fee applies to ASO Pharmacy Benefit Manager (PBM) programs in certain circumstances. If the PBM is offered alongside an ASO health plan, the fee is due once per member. However, when an ASO PBM and a fully insured health plan are offered together, the fee is paid twice for each member. The fee applies only for US residents, both active and retired.

      The fee under current regulation is $1 PMPY in the first year and $2 PMPY in the second year. We estimate a 2013 cost of: fully insured members with the ASO PBM to be $2 * 235,000 = $470,000 and ASO health and PBM members $1 * 13,000 = 13,000 for an estimated total of $483,000.

2. The “Employer shared responsibility” mandate or "play or pay" tax is a regulation that has several components ETF is tracking. The primary impact on the state is that it must be determined if the employee’s contribution for health insurance exceeds 9.5% of his/her income. If so, penalties are assessed to the employer. We do not believe that ETF has any administrative role to play with this fee. At current employee contribution rates, it is unlikely to affect the state.

    a. If an employer with 50 or more full-time employees offers unaffordable or low value coverage and at least one affected full-time employee qualifies for a premium tax credit in the exchange, the employer will be assessed a monthly penalty of $250 per month per full-time employee ($3,000 per year). Employee exchange premium assistance will be available to individuals whose income falls between 100%-400% of the federal poverty line ($23,050 to $92,200 for a family of four at this time). An employee’s contribution for employer sponsored health insurance cannot exceed 9.5% of household income for a taxable year or the penalty will apply for that employee. This threshold applies to the cost of single coverage under the lowest cost plan offered by the employer if it is at or above a prescribed minimum value. The mechanism to determine 9.5% of family income has not been developed at this time, so employers are being instructed to use employee’s income for 2014.

    b. If the employer fails to offer health insurance to at least 95% of its full-time employees, and more than 30 full-time employees (full-time is defined as working 30 or more hours per week) are certified to receive a federal premium tax credit or cost sharing reductions, the employer will be assessed a penalty. The penalty will be $166.67 per month per affected full-time employee ($2,000 per year).

3. The 90 day eligibility rule regarding waiting periods for coverage may affect the Wisconsin Public Employers (WPEs) group health insurance program. This is a part of the “Play or Pay” regulation. Those WPEs who participate in our program are currently allowed to have employees wait for employer contribution toward coverage for up to six months from date of hire. This policy allows employees to enroll in the plan prior to the initiation of the employer contribution and complies with the law. However, when read with the penalties that can be assessed monthly if the employee’s contribution is more than 9.5% of income, penalties would be assessed if the employer contribution did not begin within 90 days of eligibility for coverage. Thus, ETF will modify the Guidelines contract for WPE groups so that employer contribution must begin no more than 90 days following eligibility.

4. Health insurance exchanges are to be effective for the individual and small group markets as of January 1, 2014. Plans offered through the exchanges must include ten federally required essential health benefits. There is some flexibility for the transition of coverage for services such as habilitative, which are not covered in the benchmark plan. Further federal guidance is expected in March of 2013. The federally required essential health benefits include:

   - 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

   A benchmark benefit was developed on a state by state basis, using criteria that included the largest plan by enrollment in the largest product in the state's small group market. The plan that has been selected for Wisconsin is the UnitedHealthCare Choice Plus Point of Service plan. Individuals will be able to select a plan like this at varying actuarial values of coverage for essential and other benefits. The varying coverage levels are: platinum at 90%/10%, gold at 80%/20%, silver at 70%/30% and bronze at 60%/40%. Deductibles, copays, coinsurance and other cost sharing features can be used to achieve these cost sharing thresholds.

   ETF will monitor the development of exchanges to determine their impact on the State's retiree population under Medicare age. These individuals are able to exit and rejoin our program per state statute. It is possible that retirees who are more frequent users of care could enroll in our program and those that use less services could move to the exchanges. If this creates a concern about the long term stability of the program, we may want to consider recommending changes to the program.

   Employers must notify employees of the health insurance exchanges this fall, as they are expected to be available in January 2014. ETF will work with employers to facilitate this communication.

5. Essential benefits apply to ETF's program in that no annual or lifetime dollar limits are allowed on those benefits. There is no requirement that large group or employer sponsored self-insured plans offer all categories of essential health benefits. Those required to offer them are non-grandfathered plans in the individual and small group markets. Our program contains dollar limits on what the health plan will pay for TMJ treatment, hearing aids and dental implants. We will monitor the regulation to determine if any of these services fall under the essential benefits listed above. The law does not prohibit the application of day limits.

   Note that when the state and WPE programs lost grandfathering status, we were required to offer 100% coverage for specific preventive services and follow other requirements, but we were not required to offer essential health benefits.

6. Wellness programs and incentive limits are changed under the law for 2014. There are two components. The state currently does not require these so we would not be affected by the regulation unless applicable program changes were made.

   First, for wellness programs that require a standard achievement in order to obtain a reward, provisions of nondiscriminatory health contingencies have been established that would not apply in our program if it remains in its current form. The contingencies apply to programs that provide a reward for decreases in tobacco use, cholesterol level or weight as well as those who fail to meet a biometric target but take certain additional required actions. They require that certain individuals must be given the opportunity to qualify for the same reward through other means.

   Second, for plans who offer a premium discount for a health contingent wellness program, the maximum limits on rewards have been increased. Note, premium discounts are currently not available in our program. If we institute premium differentials, they are limited to no more than 30% of the cost of health coverage and up to 50% for tobacco cessation. The regulations allow flexibility in determining the types of wellness programs that can be offered.

7. It is expected in 2014 that regulations will be provided to large employers to determine how the requirement to auto enroll newly hired full-time employees into the health insurance program will operate. Once in effect, employees must be provided the ability to opt out.

Staff will be available at the meeting to answer questions.