SEGAL

333 West 34th Street New York, NY 10001-2402
T 212.251.5000 F 212.251.5490 www.segalco.com

MEMORANDUM

To: Lynette Metz

From: Lawrence Singer, Karen Johnson

Date: July 19, 2013

Re: Affordable Care Act (ACA) – Action Items for Supplemental Benefit Funds to Consider

Segal was asked to prepare a summary of ACA issues that NYSUT locals and benefit funds may face. This is a brief summary of complex issues. Further, some of these items have regulations still being developed and some involve coordinating with the school districts' (as employer) position, which still also may have to be developed. Any actions that a particular board of a particular fund may take on ACA issues should be made in consultation with that fund's legal counsel.

This memorandum presumes that the supplemental funds provide a mix of the following benefits generally, but not always, on a self-insured basis (except where indicated as insured): term life insurance, short and/or long term disability coverage, dental coverage, optical coverage, legal benefits, the Catastrophe Major Medical insurance plan endorsed by the NYSUT Member Benefits Fund (which will be covered in a separate notice to the funds that offer this coverage), reimbursement of basic medical plan copays or coinsurance or costs in excess of the basic plan's maximum allowable fees.

As you know, the ACA imposes significant requirements on health plans (both insured and self-insured) and generally applies to group health plans as defined under the Health Insurance Portability and Accountability Act of 1996 (better known as HIPAA).[1] However, the existing HIPAA regulations contain several exceptions that exclude certain types of arrangements (known as "excepted benefits") from having to comply with many of the requirements of both HIPAA as well as most of the new plan requirements under ACA. We believe that many supplemental fund trustees decided, in consultation with their legal counsel, that their term life insurance, short and/or long term disability, legal benefits and dental and optical benefits could be defined as "excepted benefits" and would be exempt from many of the requirements of the ACA. With that said, below is a summary of the types of excepted benefits for those funds that may still have open questions. In addition, we have noted under each requirement whether or not compliance is required for "excepted benefits."

[1] See PPACA Section 1551 and PHSA Section 2791.

Benefits Covered and Exempt from the ACA

There are many types of excepted benefits under current law. HIPAA and its implementing regulations categorize them as follows:

1. Benefits excepted in all circumstances:

    - Coverage only for accident (including accidental death and dismemberment);
    - Disability income coverage;
    - Liability insurance, including general liability insurance and automobile liability insurance;
    - Coverage issued as a supplement to liability insurance;
    - Workers' compensation or similar coverage;
    - Credit-only insurance (for example, mortgage insurance); and
    - Coverage for on-site medical clinics.

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 are otherwise not an integral part of a group health plan. Benefits are not an integral part of a group health plan (whether provided through the same plan or a separate plan) only if: participants have the right to elect not to receive the coverage, and a participant who elects the coverage pays an additional premium or contribution for that coverage. Self-insured dental or vision benefits are excepted benefits only if they are not an integral part of the group health plan. Accordingly, if a plan provides its dental (or vision) benefits pursuant to a separate election by a participant and the plan charges even a nominal employee contribution towards the coverage, the dental (or vision) benefits would constitute excepted benefits.

    - Long-term care benefits that: are subject to state long-term care insurance laws; consist of qualified long-term care services, as defined in IRC §7702B(c)(1); are provided under a qualified long-term care insurance contract, as defined in IRC §7702B(b); or are based on cognitive impairment or a loss of functional capacity that is expected to be chronic.

    - Health flexible spending arrangements (FSAs)

3. Non-coordinated benefits

    - Coverage for only a specified disease or illness (for example, cancer-only policies) if it meets these three conditions: the benefits are provided under a separate policy, certificate, or contract of insurance; there is no coordination between the provision of these benefits and an exclusion under any group health plan maintained by the same plan sponsor; and the benefits are paid with respect to an event without regard to whether benefits are provided under any group health plan 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 (for example, $100 per day) regardless

of the amount of expenses incurred. A policy that pays a percentage of expenses up to a set maximum, rather than a fixed dollar amount, is not excepted. The three conditions set out above must also be met for this type of benefit to be an excepted benefit.

4. Supplemental benefits

- Medigap Medicare supplemental health insurance;
- Coverage supplemental to TRICARE; and
- 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 coordination-of-benefits provision.

While not specifically listed, it is generally agreed that life insurance would be considered an excepted benefit. Legal services benefits are not "medical care" and can also be considered excepted benefits as well. Short and/or long-term disability benefits are always considered excepted benefits. The insurer of the catastrophe excess major medical insurance did not define the benefit as excepted and generally, the reimbursement benefits would not meet any of the above definitions of excepted benefits.

Insured dental and/or optical benefits would be considered excepted benefits by definition. For self-insured benefits, they would not meet the strict definition of excepted benefits unless (i) they are elected separately, and (ii) the participant pays a premium/contribution for the coverage (even a nominal one of $1, for example). Some groups have decided that in order to meet this technical requirement, that they will implement an enrollment process and charge a nominal contribution toward the coverage.

Reporting and Notices

With this as background, here is a brief review of issues to prepare you to discuss this with the supplemental benefit funds:

- **W-2 Reporting** - The ACA requires employers to report the aggregate cost of employer-sponsored health coverage on employees' W-2 forms starting with the 2012 W-2 form, which was prepared in January of 2013. School districts as members' employers, of course, issue fund members this form. We presume districts and supplemental fund trustees have addressed this issue in January of 2013. The cost of non-health benefits clearly do not have to be reported. The cost any "excepted benefits," including dental and vision benefits, do not have to be reported if they qualify as "excepted benefits" under HIPAA. Some supplemental funds provide catastrophe major medical insurance or reimburse uncovered expenses in the basic health plan. Some school districts might have requested that funds providing such benefits report they value to the districts. If this was the case, trustees of those funds should discuss the need to report the value of these benefits (and how to value them) with their legal counsel.

- **SBC** - The ACA requires that fund members get a Summary of Benefits and Coverage that describe coverage terms in particular formats. SBCs must be distributed at the following times:

- Annually, with open enrollment materials (if any); if no open enrollment materials, then 30 days before the start of the plan year
- Upon request (within 7 business days following receipt of request)
- To new enrollees, with written application materials (if any); if no such materials, then no later than first day individual is eligible for coverage
- To special enrollees (such as new spouse added mid-year) (within 90 days of enrollment)

Any funds that have not issued SBCs for year one will need to issue an SBC for benefits that are not considered excepted benefits (e.g., catastrophic excess major medical, any reimbursement benefits and/or non-excepted dental or optical benefits (only pediatric benefits are required to be described)). For funds preparing SBCs for year two, a new template was released April 23, 2013 and should be reviewed for required changes. It should be noted that the government's policy of not enforcing penalties has been extended through Year Two to plan sponsors making good faith effort to comply

If, in the future, the terms of the plan or coverage reflected in the SBC are modified in any material way, the Plan needs to notify participants at least 60 days prior to the date the modifications become effective.

- **Plan Notice requirements** – The funds should ensure that all required Notices have been issued (waiver, grandfathered plans (as applicable), etc.) were issued.

- **Plan Documentation** – Ensure that plan documentation (SPD) has been amended to reflect any changes made to comply with the ACA.

Benefit and Eligibility Changes

- **Increased Maxima for Essential Benefits** - Self-insured and large insured group health plans (covering over 50 employees) do not have to provide "essential health benefits" (EHB) but for the EHBs that a plan does provide, the ACA prohibits plans from imposing annual and lifetime dollar limits. Therefore, if a benefit is considered an EHB, lifetime dollar limits are no longer allowed, and a restricted annual dollar limit on essential benefits is allowed until plan years beginning on or after January 1, 2014. This restricted annual dollar limit increased each year from 2011-2014 until it becomes unlimited in 2014. This requirement took effect with the first plan year that began on or after September 23, 2010.[2] At that time, plan sponsors made good faith decisions about what benefits were an EHB and what limits needed to be eliminated. Now that the agencies have published more guidance on how to define EHB, plan sponsors should review any benefits on which dollar limits remain.

  As a reminder, there are 10 broad categories of essential health benefits that are listed in the ACA itself. There will not be a more detailed federal list of EHB, but, rather, separate EHB lists in each state. Each state will define EHB by selecting a "base-benchmark plan" from a list of acceptable benchmark options that HHS initially released in December 2011. This approach will apply for at least 2014 and 2015. Guidance from HHS instructs plan sponsors

[2] Plans with an approved annual limits waiver from the Department of Health and Human Services (HHS) can continue to impose annual dollar limits as allowed under the waiver. However, even these limits must be eliminated with the plan year that begins on or after January 1, 2014.

to select any available benchmark plan as a reference point for determining what is/is not an EHB. If that benefit is covered in the benchmark plan, it is an EHB. (Any dollar limits on that benefit, even if contained in the reference benchmark plan, would have to be eliminated.)

Any benefits that are considered "excepted benefits" do not have to comply with this restriction.

The insurer for the catastrophic excess major medical benefits has reviewed the benefit for compliance with this requirement.

The ACA itself explicitly lists "pediatric services, including oral and vision care" in the list of EHB. As such, any of the funds who still maintain a maximum on pediatric dental and optical benefits as well as orthodontia will need to review these benefits and determine steps to take to address the maximums. The final rule on EHB published by HHS on February 25, 2013, defines "pediatric" as under age 19, but allows states to set a higher age limit. Based on existing guidance, it appears that age-based benefit differences are allowed if they apply to employees, spouses and children alike – and not just to dependent children. The final rule states that "non-medically necessary" orthodontia is not an EHB. The final rule does not define the terms "non-medically necessary orthodontia" or "medically necessary orthodontia."

Following are some suggestions to address the issue of maxima on pediatric dental and optical benefits:

- A dollar maximum combined with a frequency limit (e.g., plan will pay $100 for one pair of glasses every year) is effectively an annual dollar limit. Therefore, a fund will need to eliminate either the dollar maximum or the frequency limit. However, a frequency limit combined with a UCR limit would generally not be considered a de facto annual dollar limit, as long as the UCR is reasonable (e.g., plan will pay for one pair of glasses per year at the UCR charge).

- If a plan has annual or lifetime dollar limits on specific benefits and would like to keep them (e.g., pediatric dental or optical), it would make sense to select an appropriate benchmark plan. Plan sponsors can pick any available benchmark option. A fund could also pick one of the three national medical plans offered through the Federal Employees Health Benefits Program (FEHBP) that are on the HHS list of acceptable benchmarks.

- Because the final rule provides that non-medically necessary orthodontia is not an EHB, a plan sponsor could remove dollar limits on medically necessary orthodontia, but keep dollar limits on non-medically necessary orthodontia, without going through the process of selecting a benchmark. If the fund desires to keep the dollar limit or orthodontia, they might consider selecting one of the FEHBP medical plans as its benchmark, specifically, the Government Employees Health Association, Inc. Benefit Plan Standard Option (GEHA) plan. All of the FEHBP benchmarks provide a limited dental benefit for adults and children. The GEHA plan does not appear to cover orthodontia at all, while the Blue Cross and Blue Shield Service Benefit Plan (BCBS) plans only cover orthodontia associated with surgery to correct accidental injuries. Thus, subject to review by legal

counsel, a fund selecting the GEHA plan as its benchmark could continue to have dollar limits on orthodontia.

- For purposes of defining EHB, plan sponsors may only select one benchmark plan. Since the funds do not have other dollar limits (e.g., on medical services) that they might like to retain, they will not have to be concerned with other services that are covered by the FEHBP medical plans that could not be subject to an annual or lifetime dollar limit. However, this should be review with fund counsel.

- **Coverage of Dependent Children to Age 26 –** The supplemental funds had to extend eligibility to all children to age 26 whether or not they are grandfathered. If such children are eligible for other employer-sponsored coverage, the fund may exclude such children from coverage until the plan year beginning on or after January 1, 2014 (non-grandfathered plans currently have to offer coverage to these dependents). However, the age 26 provision does not apply to excepted benefits. While funds may have decided that dental and optical benefits were excepted benefits, it may have been administratively difficult to apply a different eligibility requirement for excepted benefits and non-excepted benefits (or for fund benefits and basic medical benefits). This may have led such groups to comply with the age 26 rules on a voluntary basis.

Fees and Taxes

- **Comparative Effectiveness Research Fee** - The ACA requires that all health plans that provide "accident and health coverage" pay a fee as a funding source of a Patient-Centered Outcomes Research Institute. This is required of both insured and self-insured plans. The Institute will conduct research evaluating and comparing health outcomes and assessing the clinical effectiveness of medical treatments. Health insurers will pay the fee on behalf of their insured population and "plan sponsors" will pay the fee when a plan is self-insured. Final regulations discuss who the plan sponsor is in the case of a VEBA, like the supplemental benefit funds. Regulations address which coverages are affected; the fee will not be assessed in connection with benefits that are "excepted benefits." Although Retiree-only plans do not have to comply with many of the ACA requirements, retirees and their families account as covered lives for this purpose when a supplemental benefit fund covers active employees and retirees. This fee is payable for seven years from 2012 through 2018. For a calendar year plan, the first payment is due by July 31, 2013. The first year the fee applies, it is $1 times the average number of total lives and in subsequent years it is $2. There are rules in the law and the regulations that address the potential for double counting lives when the same people are covered through two different plans. Supplemental fund trustees will need to work with their legal counsel to see if the employers' basic health plans paying the fees associated with the supplemental funds' members is sufficient reason for the supplemental funds to not have to pay the fees. Because the employers' basic health plans and the supplemental funds' boards of trustees are likely to be considered different sponsors, counsel may conclude fees need to be paid twice.

- **Transitional Reinsurance Program Fee** – The ACA requires that insurers and plan sponsors of self-insured plans pay a fee to help stabilize premiums in the individual marketplace from 2014 to 2016. This fee will be centrally collected and paid out to the states based on need. The ACA defines an aggregate amount of $10 billion for 2014, $6 billion for

2015 and $4 billion for 2016. The Department of Health and Human Services has proposed a per capita fee of $5.25 per month times the total number of lives for the first year. As with the Comparative Effectiveness Research Fee, retirees are generally included, although Medicare primary individuals are not. HHS will collect these fees from "major medical coverage" which is defined in proposed regulations. Supplemental funds boards of trustees will need to work with their legal counsel to see if the funds offer benefits that would not require payment of this fee. Benefits that qualify as "excepted benefits" do not count, but, again, all non-excepted benefits must be addressed. As with the Comparative Effectiveness Research Fee, there are special rules in the regulations (which remain proposed on this issue at this point in time) that address double counting. Like with the Comparative Effectiveness Research Fee, supplemental fund trustees will need to work with their legal counsel to see if employers' basic health insurance plans paying the fees associated with supplemental funds' members is sufficient reason for the supplemental funds to not have to pay the 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.

  This applies to all group health plans (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. However, until that 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. They should discuss with their legal counsel how to address removal of this margin if they feel it should not apply.

- **Tax on High Cost Coverage ("Cadillac Plan Tax") –** Beginning in 2018, there will be a 40% tax on then value of applicable plan sponsored coverage that is in excess of an annual minimum threshold of $10,200 per individual and $27,500 per individual and dependents. Such a tax will almost certainly not be an issue for any of the supplemental funds that cover active members as the benefits provided do not include hospital/medical coverage, although it may be something that needs to be addressed with school districts to develop a practical method of measuring the coverage provided by the employers to combine it with the coverage provided by the supplemental benefit funds.

Grandfathered Plans

- **Additional Provisions for Non-Grandfathered Plans:** There are additional requirements under the Affordable Care Act that a plan must comply with if it loses its status as a grandfathered plan. Again, these provisions will not apply to "excepted benefits." While most apply to the medical or prescription drug portions of a plan, one element would apply to a supplemental benefit fund that provides dental coverage and another to all plans who lost their grandfathering status. We do not know (or suspect you know) which supplemental benefit funds are grandfathered and, if so, what circumstances might result in the loss of grandfather status. Accordingly, we note the following :

- 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).

  In addition, there are 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 Feb. 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.