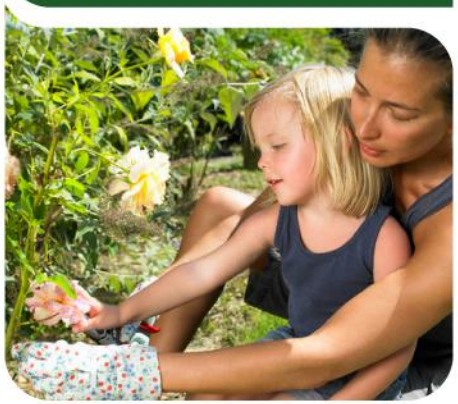
Affordable Care Act – Implementation

Small Business Employers

August 2012



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Disclaimer

This document is designed to provide a general overview of portions of the health reform law - Affordable Care Act. It does not attempt to cover all of the law's provisions and should not be used as legal advice for implementation activities. We encourage you to seek any professional advice, including legal counsel, regarding how the new requirements will affect specific plans.

Table of Contents

Introduction

Introduction

The following summary provides an overview of these provisions and our anticipated implementation plans. While our implementation plans may change - in some cases we are still waiting for final guidance from the federal government- we feel it is important to share the information we have today so you can begin discussing these changes with your clients.

- Please note that additional communications will be sent once Humana implementation plans are finalized or final guidance is received by the federal government. As more information is available on the impact of health care reform to you and your clients, we will provide materials for your review.

Women’s Preventive Health

Women's Preventive Health - Summary

On August 1, 2011 the Department of Health and Human Services released new guidelines regarding coverage of preventive health services for women. The guidelines were adopted from recommendations that had been made by the Institute of Medicine. They supplement the interim final rules for coverage of preventive services that were released in 2010, which require health plans to cover services such as mammograms and screenings for cervical cancer, without cost-sharing.

Two of the benefits under the new guidelines, breast-feeding support and FDA–approved contraceptive methods and counseling (prescriptions include generic or generic equivalent), were not required to be covered at 100% during the first phase of healthcare reform. Insurance carriers are now required to cover these benefits at 100% for non-grandfathered insurance plans with plan years beginning on or after August 1, 2012.

Women's Preventive Health – Key Points

- New and/or renewing groups that have a non-grandfathered plan(s) will have preventive coverage expanded to include breast-feeding support and contraceptive methods/counseling. Hereafter, we will refer to these added benefits as "*Women's Preventive*" benefits.
- The additional Women's Preventive benefit changes will not impact a group's grandfather status.
- Religious employers, who meet eligibility requirements, such as churches, synagogues, mosques, may opt-out entirely from the contraceptive coverage.
- Nonprofit religious employers, such as universities, hospitals, and social service organizations who, based on religious beliefs do not currently provide contraceptive coverage in their plans, are eligible for a one-year safe harbor from enforcement of these new guidelines.

Women's Preventive Health - Implementation

What Humana will do: Humana has implemented and is fully compliant with the new coverage guidelines. As mentioned before, grandfathered plans are not required to add this incremental *Women's Preventive* benefit; however, they could choose to do so.

Important Note: When Humana applies the Women's Preventive benefits to a plan, or if a group chooses to add the benefit, it could result in an increase to that group's premium. Groups/brokers will need to work with their Humana Sales Executives to determine the actual impact to the group. It's important to note that increases in premiums could be offset by decreased costs from better health outcomes due to increased use of preventive services.

Women's Preventive Health - Implementation

A few of the implementation efforts include:

- A new *Preventive Care 2012* rider is being included in all quoting information, renewal information and applicable plan information. If the plan is non-grandfathered, this rider will automatically be included.
- The rider will be added to groups upon renewal.
- Benefits for generic or generic equivalent prescriptions and supplies for these newly covered services will be paid at 100%. If a brand name supply and/or medication is prescribed, the member could be responsible for the difference between the generic and brand name cost.
- The Preventive Services Guide was updated to include the women's preventive benefits.

Summary of Benefits & Coverage

Summary of Benefits & Coverage - Summary

The Summary of Benefits & Coverage (SBC) document is intended to provide consumers with consistent and comparable information regarding health plan benefits and coverage across health insurance carriers. To help you understand the key elements of this new document, the SBC:

- Will include key features of the plan or coverage such as the covered benefits, cost-sharing provisions, and coverage limitations and exceptions. In addition, it will include a new, standardized health plan comparison tool for consumers called "coverage examples," much like the Nutrition Facts label required for packaged foods.
- Is effective for new and renewing groups on or after September 23, 2012.
- Applies to insured and self-funded ERISA and non-ERISA group health plans (including grandfathered plans):

  - Fully insured plans and HMO's: the insurer and the employer are responsible for providing the summary;
  - Self-insured plans: the employer is responsible to provide the summary. An employer offering a self-insured plan may make arrangements with the carrier providing administrative services to produce the document.

Summary of Benefits & Coverage – Key Points

- Must be provided to employers and employees:
  - If making a carrier change at renewal: within 7 business days of receipt of completed applications and prior to the applicable coverage effective date;
  - If not making a carrier change at renewal: within 7 business days of receipt of completed paperwork for an employer to initiate a plan change. Additionally, the summary must be available 30 days before the group's renewal date, should they automatically renew on the same plan.
  - If the employer is making an off-renewal plan change, or if a carrier initiates a change, and these changes impact the Summary of Benefits & Coverage, the summary must be provided 60 days in advance.
  - Upon request: within 7 business days of notification.
- Language translation can be requested for individuals in certain regions as defined by the U.S. Census, where 10% of a county's population is only literate in a non-English language.

Summary of Benefits & Coverage – Uniform Summary

Health insurance companies and group health plans will be required to make available a uniform glossary of health-coverage and medical terms commonly used in those documents, such as “deductible” and “co-pay”. The Uniform Glossary is meant to help consumers understand some of the most common language used in health insurance documents.

- To help ensure the document is easily accessible for consumers, the Departments of Health and Human Services and Labor will also post the glossary on www.HealthCare.gov, www.cciio.cms.gov, and www.dol.gov/ebsa/healthreform.

Summary of Benefits & Coverage - Implementation

What Humana will do: Humana will implement the new Summary of Benefits and Coverage (SBC) document by September 23, 2012. Humana is currently finalizing our SBC policies and procedures and will communicate this information in the next several weeks.

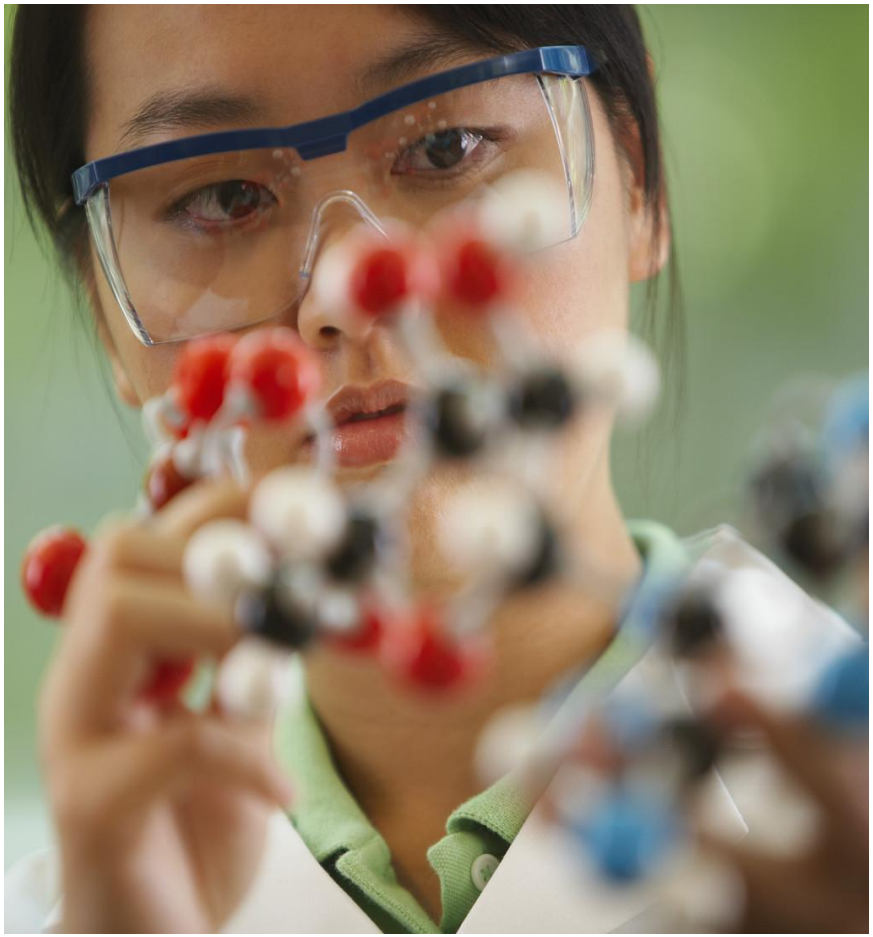
- To view the final template for the summary of benefits and coverage, visit: http://cciio.cms.gov/resources/other/index.html#sbcug
- In order to comply with regulations, benefit decisions will need to be communicated earlier so the SBC can be provided for the plan selected. More information will be forthcoming.

Taxes & Fees

Comparative Effective Fee - Summary

The Affordable Care Act includes several new taxes and fees including:

- **Comparative Effective Fee**: An annual assessment to fund a Patient-Centered Outcomes Research Trust Fund. This trust fund will be used for research into the effectiveness, advantages and risks of medical treatments, services and drugs. The fee applies to plan years that end on or after October 1, 2012 and before October 1, 2019. The initial fee is $1.00 per covered life, increasing to $2.00 the second year and then indexed medical inflation until 2019. This fee applies to medical coverage only, and not to "excepted benefits" such as dental, vision, AD&D, disability income, specified disease, hospital indemnity or Medicare supplement.



Federal Insurer Annual Fee - Summary

- **Federal Insurer Annual Fee** (Premium Tax): Designed to help fund the Affordable Care Act, this fee places an additional premium tax on insurers; $8 billion in 2014 rising to $14.3 billion by 2018. After that, the fee will increase in an amount proportional to overall premium growth. This fee is only applicable to fully-insured business and applies to medical, dental and vision plans. The assessment is based on all premiums collected in 2014 and includes plans that begin in 2013 and extend into 2014.

Federal Reinsurance Assessment - Summary

- **Federal Reinsurance Assessment**: An assessment to help offset large claims in the individual market associated with guarantee issue. For 2014 – 2016 insurers will be assessed $25 billion. Approximately $20 billion will be used to set up a reinsurance pool with a goal of mitigating adverse selection in the early years of the individual market insurance exchanges. In addition to the assessment of $20 billion - insurers will be assessed another $5 billion that will be added to the general fund of the U.S. Treasury. The assessment is based on all premiums collected in 2014, this includes plans that begin in 2013 and extend into 2014.

Taxes & Fees - Implementation

What Humana will do: It's important to note that detailed guidance regarding these fees has not been released. As such, implementation plans outlined below may need to be modified. Beginning with February 2013 renewal letters, the following message will indicate that the premium includes new taxes and fees.

- Fully Insured Medical Plans: *The federal Affordable Care Act includes several new taxes and fees that go into effect in 2014. The medical premiums reflected in this renewal notice include a prorated share of the impact of approximately 3.3% additional taxes and fees. The additional taxes and fees include (a) Comparative Effectiveness Fee, (b) Federal Insurer Annual Fee, and (c) Federal Reinsurance Assessment. Humana will pay the fee directly and add these fees to premiums.*

- Fully Insured Dental and Vision Plans: *The federal Affordable Care Act includes several new taxes and fees that go into effect beginning in 2014. The dental and/or vision premiums reflected in this renewal notice include a prorated portion of the Federal Insurer annual fee.*

Both the Federal Insurer Annual Fee and the Federal Reinsurance Assessment are based on all premiums collected in 2014 and includes plans that begin in 2013 and extend into 2014. Humana will phase-in these fees by proportionally adding it to premiums for most plans beginning February 2013.

Essential Benefits

Essential Benefits - Summary

Essential Health Benefits, which are defined through the Department of Health & Human Services, provide coverage for certain services. At a minimum, the coverage must include the items and/or services covered within the following categories:

- Ambulatory patient services
- Emergency services
- Maternity and newborn care
- Pediatric services, including oral and vision care
- Rehabilitative/habilitative services & devices
- Hospitalization
- Prescription drugs
- Laboratory services
- Limits cost-sharing for such coverage
- Mental health and substance use disorder services, including behavioral health treatment
- Preventive and wellness services and chronic disease management

Currently, not all regulations regarding Essential Health Benefits have been released by the Department of Health & Human Services. Humana is continuing its implementation efforts and will be fully compliant with the regulations. As more information is released, more information regarding Essential Health Benefits will be forthcoming.

Actuarial Value - Summary

All Small Business and Individual non-grandfathered plans must meet certain product requirements starting in 2014. The levels of coverage in the Affordable Care Act are not defined using specific deductibles, copays, and coinsurance. Rather, they are specified using the concept of an "actuarial value" (AV) and product limits. The higher the actuarial value, the less patient cost-sharing the plan will have on average.

If plans meet minimum actuarial value requirements, then the employer will not have to modify the cost sharing elements of their plan (i.e. copayments, deductible, coinsurance, maximum out of pocket, pharmacy, etc.); however, if a group health plan does not meet actuarial value requirements, the cost sharing elements of a group health plan would need to be changed.

Essential Benefits – Actuarial Value

A plan that is actuarial equivalent is defined as:

- Meets at least a 60% Actuarial value based on the Federal Actuarial Calculator (uses a standard, nationwide population to compare average Insurer spending under different benefit designs);
- Includes coverage for all Essential Health Benefits;
- Complies with plan specific limitations as indicated in the Affordable Care Act (maximum deductibles, maximum out of pockets, etc.);
- Small business employers, single/family deductibles cannot be greater than $2,000/$4,000, respectively.

Actuarial Value - Implementation

What Humana will do: Actuarial Value is effective beginning in 2014; however, Humana is already developing a plan to meet all guidelines indicated above and will work with brokers to develop strategies to move groups to appropriate actuarial value plans.

As regulations are released, more information about Actuarial Value plans and Essential Benefits will be forthcoming.

Explanation of Benefits

Explanation of Benefits – Summary & Implementation

The Explanation of Benefits will provide more information regarding how a consumer can gain a greater understanding of how a claim was processed. The following changes will be illustrated on an explanation of benefits starting in 2012:

- Service code(s) will now include a description, indicating what service was performed. These codes are listed on a claim form and determined by the provider of service (for example, a doctor).
- Individuals can request an explanation of the diagnosis/treatment codes that are illustrated on a claim form, which is determined by the provider of service. Individuals can call Humana's Customer Care Centers for assistance.
- Appeal Rights mandated by ACA are listed, which include rights to: 1) external review, 2) consumer assistance and 3) court review.
- Language translation can be requested for individuals in certain regions as defined by the U.S. Census, where 10% of a county's population is only literate in a non-English language.

What will Humana do: Humana implemented the Affordable Care Act requirement(s) in the first half of 2012.