Healthcare Roundtable
Wednesday, April 8, 2015
8:00 A.M. – 9:30 A.M.

Thank you to our sponsors:
Commerce and Industry Association of NJ
Healthcare Roundtable

Christine A. Stearns
Counsel, Government Affairs
April 8, 2015
At Five Year Anniversary Of The Law, Public Views Remain Divided, But Have Narrowed

As you may know, a health reform bill was signed into law in 2010. Given what you know about the health reform law, do you have a generally favorable or generally unfavorable opinion of it?

SOURCE: Kaiser Family Foundation Health Tracking Polls
The Public’s Reasons Behind Views Of The Law

Among the 43% who have an unfavorable view: Could you tell me in your own words what is the main reason you have an unfavorable opinion?

As you may know, a health reform bill was signed into law in 2010. Given what you know about the health reform law, do you have a generally favorable or generally unfavorable opinion of it?

Among the 41% who have a favorable view: Could you tell me in your own words what is the main reason you have a favorable opinion?

Financial and cost considerations: 26%
Against individual mandate: 18%
Government-related issues: 10%

Very unfavorable: 28%
Very favorable: 22%
Somewhat favorable: 19%
Somewhat unfavorable: 15%
Don’t know/Refused: 16%

Expanding access: 61%
Will make healthcare more affordable: 10%
Country/people will be better off generally: 7%

Note: Only top three responses shown for each follow-up question.
Source: Kaiser Family Foundation Health Tracking Poll (conducted March 6-12, 2015)
Views Vary On What Comes Next For ACA

What would you like to see Congress do when it comes to the health care law?

- Expand what the law does: 23%
- Move forward with implementing the law as it is: 23%
- Scale back what the law does: 10%
- Repeal the entire law: 30%

By Political Party ID

- Democrats
  - Expand what the law does: 32%
  - Move forward with implementing the law as it is: 40%
  - Scale back what the law does: 7%
  - Repeal the entire law: 11%

- Independents
  - Expand what the law does: 22%
  - Move forward with implementing the law as it is: 20%
  - Scale back what the law does: 13%
  - Repeal the entire law: 30%

- Republicans
  - Expand what the law does: 10%
  - Move forward with implementing the law as it is: 6%
  - Scale back what the law does: 13%
  - Repeal the entire law: 61%

NOTE: None of these/something else (Vol.) and Don’t know/Refused responses not shown.
SOURCE: Kaiser Family Foundation Health Tracking Poll (conducted March 6-12, 2015)
The Individual Mandate

Requires most U.S. citizens and legal residents to purchase health coverage or incur a tax penalty of $95 (or 1% of adjusted gross income), whichever is greater for 2014.
Penalty Calculation

- The flat dollar amount is phased in over three years ($95 for 2014; $325 for 2015; and $695 for 2016 and then indexed for inflation).

- The applicable percentage is 1% for 2014; 2% for 2015; and 2.5% for 2016 but cannot exceed the premium for the “bronze” level plan offered thru the exchange.
Effects of the Individual Mandate

- Gives all taxpayers, including employees, an incentive to obtain coverage:
  - Information sought from employers
  - Pressure on employers to provide coverage
  - Employees seeking a premium tax credit which may trigger IRS assessments against employers
Small Employer Tax Credit

- Beginning in 2014, the credit refunds up to 50% of health insurance expenses for eligible employers purchasing thru exchange and is available for any two consecutive years (credit was 35% for 2010 – 2013).

- The credit is fully available to companies with 10 or fewer full-time employees and average wages below $25,000. The credit phases out as the number of employees increases to 25 and wages grow to $50,000. Tax-exempt organization of maximum credit of 35%.
Knowledge Of Individual Mandate Tax Penalty

As you may know, the law requires nearly all Americans to have health insurance or else pay a fine when they file their taxes. As far as you know, did the requirement to report your health insurance status on your tax return take effect last year, that is for filing 2013 taxes, this year, that is for filing 2014 taxes, or does it take effect next year for 2015 taxes?

As far as you know, when someone gets financial help from the government to pay their health insurance premium, is it possible they would end up owing money to the government if their income or family size changes during the year, or not?

SOURCE: Kaiser Family Foundation Health Tracking Poll (conducted March 6-12, 2015)
Federal Marketplace: The Basics

Each plan’s actuarial value (AV) must fall within the metallic tier (Bronze – 60%, Silver- 70%, Gold – 80% and Platinum – 90%). AV=% of total average costs for covered benefits that a plan will cover.

Rating is now to the member level so a rate is paid for each individual and each member of their family.

e.g. At Widget LLC Adam pays $300/m, Betsy pays $225/m, and Chris pays $350/m.
Marketplace: The Basics

- Other rating changes:
  - No gender rating.
  - Tobacco use is not a permitted rating factor in NJ, but is permitted in other states.

- Plans available “on the exchange” are also available “off the exchange”.

- Employers with 1-49 employees: Considered a “small employer”. This is a “new” definition. New Jersey formerly defined small employer as having 2-49 employees.
The Employer Mandate

“Large employers” must offer their workers “affordable” and “minimum essential” health care coverage that has “minimum value” or pay a penalty.

What is minimum essential coverage? No definition yet but we know the broad categories that

What is affordable coverage? An employee’s contribution may not exceed 9.5 percent of the employee’s income.

What is “minimum value”? Generally, the plan’s share of total allowed cost of benefits is not less than 60%.
Who is a large employer?

- The mandate applies to employers with 50 or more full-time employees during the previous calendar year.

- The law considers an employee who works at least 30 hours a week a full-time employee, as well as two employees who each work 15-hours per week to count as one full-time employee.

- The mandate does not apply to employers that exceed 50 employees for 120 days or less, and whose extra employees are considered seasonal workers.
What is the penalty?

- The company could be subject to an annual penalty of $2,000 for each full-time employee that 1) doesn’t offer health coverage and 2) at least one employees receives government subsidized insurance through the marketplace, minus the first 30 employees.

- Employers whose coverage is deemed unaffordable or low value could be subjected to a penalty of $3,000 for full-time employees that receives government subsidized insurance through the government insurance exchange.
The Phase-in: Employers with 50-99 Employees

- Required to provide a minimum level of affordable coverage

- **2015:** Must provide information on the number of employees

- **2016:** Penalties are assessed
The Phase-in: Employers with 100+ Employees

- Required to provide a minimum level of affordable coverage
  
  - **2015**: Must cover 70% of employees
  
  - **2016 (and beyond)**: Must cover 95% of employees. Penalties are assessed.
How is the ACA paid for? New taxes …

- Health Insurance Tax: Taxes health insurance (not self-funded coverage) and is paid by the carrier.

- Generates $8B in 2014 and more then $100B over the next 10 years.

- Transitional Reinsurance Fee: A fee of $63 for each covered person which will be collected for three years. The purpose is to offset cost of coverage for people with preexisting conditions.

- Cadillac Tax in 2018.
Key ACA Dates: 2014

- Marketplace coverage began
- Individual mandate for health coverage
- Medicaid expansion
- New taxes and fees:
  - Reinsurance fee: $63 per covered life
  - Health insurer fee: 2-3% to collect $8 billion
  - Medicare withholding for high wage earners: individual over $200,000/joint over $250,000
  - FICA increases from 1.45% to 2.35%
Key ACA Dates: 2014

- Maximum 90-day waiting period
- Maximum-out-of-pocket $6,350/$12,700 (all non-grandfathered plans) for 2014. Increases to $6,600 in 2015
- No annual dollar limits on essential benefits
- Pre-existing condition exclusions are prohibited (all plans)
- Dependent to age 26 (applies to all plans now)
- Provider discrimination: All non-grandfathered plans cannot discriminate on covered services based on the provider
Key ACA Dates: 2015-2018

2015
- Employer "play or pay" mandate (delayed from 2014)
- Employer information reporting to the IRS on employee coverage

2016
- All SHOP exchanges must open to employers with up to 100 FTEs

2017
- States may open exchanges to businesses with more than 100 employees

2018
- Cadillac Tax – 40% excise tax on high-cost health plans
Where Are We Headed?

- Exchanges: Watch the trend toward private exchanges

- Workplace wellness

- Self-funding of health benefits (100+)

- Changing benefit design (co-pays, reference based pricing)

- Consumerism: High-deductible health plans
Thank You!

Christine A. Stearns
Counsel, Government Affairs
cstearns@gibbonslaw.com
(609) 858-2443
The ACA’s Impact in N.J.

CIANJ Healthcare Roundtable • April 8, 2015
Sarah M. Adelman
New Jersey Association of Health Plans
Presentation Outline

- Enrollment & Trends in Coverage:
  - ACA Exchange Marketplace
  - Medicaid
  - Employer Coverage

- ACA Subsidies
  - New Jersey Premium Assistance Rates
  - New Jersey Population Impacted by King v. Burwell

- ACA’s Impact on Cost & Premium
- What Employers Have Seen: Healthcare Cost
- What Employers Should Expect: Healthcare Cost
NJAHAP Member Health Plans

- Aetna
- AMERIGROUP Community Care
- AmeriHealth of New Jersey
- Cigna
- Health Republic
- Horizon Blue Cross Blue Shield
- Oscar
- UnitedHealthcare
- WellCare
ACA Marketplace Enrollment
*as of 2/15

A total of 252,792 New Jerseyans chose marketplace plans by the initial February 2015 open enrollment deadline.

That’s about 40 percent of the 589,000 residents who were estimated to be eligible.

Year-1 Trends: greatest take up rates among females, and among those age 45+; silver plan was most popular.

<table>
<thead>
<tr>
<th>Date</th>
<th>Number of NJ Residents Enrolled</th>
</tr>
</thead>
<tbody>
<tr>
<td>June 30, 2014</td>
<td>137,856</td>
</tr>
<tr>
<td>September 30, 2014</td>
<td>145,581</td>
</tr>
<tr>
<td>January 9, 2015</td>
<td>202,732</td>
</tr>
<tr>
<td>January 16, 2015</td>
<td>211,788</td>
</tr>
<tr>
<td>January 23, 2015</td>
<td>213,573</td>
</tr>
<tr>
<td>January 30, 2015</td>
<td>216,425</td>
</tr>
<tr>
<td>February 6, 2015</td>
<td>222,640</td>
</tr>
<tr>
<td>February 15, 2015</td>
<td>252,792</td>
</tr>
</tbody>
</table>

Source: For 2014 data, the New Jersey Department of Banking and Insurance. For 2015 data, the U.S. Department of Health and Human Services

Graphic Source: NJ Spotlight
N.J. Medicaid Enrollment
*as of 12/14

Total Enrollment:
- New Jersey Population: 8,938,175
- Total Medicaid Enrollees: 1,680,938
- 1 in 5 New Jerseyans

2014 Expansion:
- Newly Eligible Adults (Medicaid Expansion): 315,593
- Previously Eligible Children & Parents (Woodwork): 84,401
- Adults Transitioned to Exchange: -3,537
- NJFamily Care/Medicaid Net Increase: 396,457

Source: NJ DMAHS, NJFamilyCare
Employer Market Enrollment

- Small Employer Market (2-50) seeing steady decline in enrollment in recent years
- No exit polls - explanation unclear:
  - Migration to self-funded, MEWA, exchange, other?
  - Dropping coverage?
  - Changes in full/part time status?

<table>
<thead>
<tr>
<th>Market</th>
<th>12/31/13</th>
<th>3/31/14</th>
<th>6/30/14</th>
<th>9/30/14</th>
<th>12/31/14</th>
<th>12/31/13 to 9/30/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>146,095</td>
<td>186,402</td>
<td>259,449</td>
<td>261,477</td>
<td>250,386</td>
<td>115,382</td>
</tr>
<tr>
<td>Small Group 2-50 employees</td>
<td>647,374</td>
<td>599,037</td>
<td>562,398</td>
<td>521,484</td>
<td>Not available</td>
<td>-125,890</td>
</tr>
<tr>
<td>TOTAL</td>
<td>793,469</td>
<td>785,439</td>
<td>821,847</td>
<td>782,961</td>
<td>Not available</td>
<td>-10,508</td>
</tr>
</tbody>
</table>

Source: Department of Banking and Insurance
Note: Insured Market data - does not include self-funded coverage
ACA Subsidies

- Of 252,792 New Jerseyans enrolled in Exchange plans, **83 percent** of enrollees were deemed eligible for premium subsidies
- Average monthly tax credit was **$309**
- Average monthly premium between **$481 to $172** after subsidies
- Those between 100 percent and 250 percent of the poverty level also qualify for cost-sharing subsidies to reduce their out-of-pocket expenses

Source: HHS Office of the Assistant Secretary for Planning and Evaluation

King v. Burwell

- New Jersey elected to use the Federally-Facilitated Marketplace (FFM)
- More than 8 in 10 exchange enrollees in New Jersey qualify for subsidies
- The decision in King v. Burwell could impact the availability of subsidies in FFM states
Implementation & Affordability

Implementation of the Affordable Care Act (ACA) began in 2010 and various elements of the law are scheduled to roll-out through 2018. However, much of the ACA’s reforms occurred in 2014, including:

- individual mandate for coverage;
- launch of the www.healthcare.gov public exchange;
- availability of sliding-scale government subsidies to obtain individual health insurance;
- state expansion of Medicaid;
- new mandated coverage benefits (e.g., pediatric dental and vision coverage, and the elimination of any dollar limits);
- new rules for how insurers can price policies;
- requirements that the actuarial value of all policies conform with the ACA’s metallic tiers (*i.e.*, Bronze - Platinum);
- and a slew of new taxes and fees.

While insurers tried to make the 2014 transition as seamless as possible for businesses and individuals, this unprecedented level of change created some market disruption.
Coverage Changes Impacting Premium

- In 2014, several new factors impacted premium costs:
  - 10 “essential health benefits” for individual and small employer coverage (generally what you have + pediatric dental and pediatric vision)
  - Limits on out-of-pocket maximums
  - Minimum benefit levels for larger employers
  - No lifetime limits and restrictions on annual limits
  - Preventive services covered with no cost-sharing
Rating Changes Impacting Premium

- Requirement for single risk pool in small employer market
- Plans previously used age, gender, and geography as rating factors. Gender rating is no longer permitted under the ACA. Smoking status while permitted under the ACA, is not permitted under NJ law
- ACA requires 3:1 rate bands; the state requires 2:1 rate bands for small employer market. Overlay of two laws has resulted in individuals inside your group to be rated on a 3:1 basis while the group overall is rated at 2:1
- Individual market rating constricted from 3.5:1
Taxes and Affordability

- ACA premium tax for New Jersey is estimated to be about $5 billion over 10 years
- Comparative effectiveness fee: $1 per avg. number of covered lives going to $2
- Transitional reinsurance fee: $5.25 per month per member fee (2014-2016)
- 3.5% surcharge on exchange premiums
- Cadillac Tax (2018)
## PAYING FOR PPACA: THE FIRST 10 YEARS

<table>
<thead>
<tr>
<th>Source</th>
<th>Type</th>
<th>2011-2019 Amount ($B)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare Reimbursements</td>
<td>I.P.A.B. Changes, F, W, A. Changes</td>
<td>$285</td>
</tr>
<tr>
<td>Medicare Premiums</td>
<td>Increased for higher income individuals</td>
<td>$210</td>
</tr>
<tr>
<td>Medicare Advantage Subsidies</td>
<td>Reduction in Subsidy to MA Plans</td>
<td>$136</td>
</tr>
<tr>
<td><strong>CLASS ACT</strong></td>
<td>Mandatory long term insurance program</td>
<td>$76</td>
</tr>
<tr>
<td>Health Insurance Providers</td>
<td>Annual Fee to Sell Insurance in U.S.</td>
<td>$60</td>
</tr>
<tr>
<td>Medicare Part D Claims</td>
<td>Increased rebate requirements to Pharma</td>
<td>$43</td>
</tr>
<tr>
<td>Health Insurance Tax on Premiums</td>
<td>Tax on high value health insurance (2018)</td>
<td>$32</td>
</tr>
<tr>
<td>Drug Manufacturers</td>
<td>Annual Fee to Sell drugs in U.S.</td>
<td>$27</td>
</tr>
<tr>
<td>Medical Device Manufacturers</td>
<td>Impose 2.3% VAT on sales</td>
<td>$20</td>
</tr>
<tr>
<td>Taxpayers with medical expenses</td>
<td>Medical expense deduction to 10% (fr. 7.5%)</td>
<td>$15</td>
</tr>
<tr>
<td>Individuals, Businesses</td>
<td>Fines for Non-Compliance</td>
<td>$15</td>
</tr>
<tr>
<td>Employees</td>
<td>Limit contributions to FSA's to $2,500 annually, no OTC drugs</td>
<td>$13</td>
</tr>
<tr>
<td>Medicare Part D Premiums</td>
<td>Reduction in Subsidy</td>
<td>$10</td>
</tr>
</tbody>
</table>
Other Pressures on Premium

- New Jersey’s health insurers paid billions of dollars in claims last year. About half of total payments went to hospitals.
- High-cost specialty drugs now represent a quarter of pharmaceutical payments, but represent only one percent of prescriptions written. While specialty drugs offer tremendous promise and are ground breaking, a course of treatment for Sovaldi, an effective Hepatitis C treatment, costs $84,000 for 12 weeks of daily pills leaving payers grappling with how to keep coverage affordable.
- Meanwhile, involuntary and surprise Out-of-Network costs total more than a billion dollars, with the threat of increasing.
- At the end of the day, premiums are a reflection of the underlying cost of health care and these high-ticket items continue to drive premiums higher.
- Addressing these cost-trends is critical to ensuring a sustainable health care system and achieving affordability for businesses and consumers.
2016: Employer Market

Looking forward to 2016, employers should anticipate another transition year as New Jersey’s small group market - currently groups with between 2 and 50 employees - is required to expand and bring in mid-sized employers with up to 100 employees.

Employers may begin looking to higher-deductible plans and new coverage arrangements.

Mid-Size Employers may consider self-funding.

The public Small Business Health Options Program (SHOP) on www.healthcare.gov launched on November 15, 2014.

A number of private exchanges are also available and may attract employers wishing to move to defined contribution plans.
Thank You

Contact Info
Sarah M. Adelman
sadelman@njahp.org
609-581-8237
Update on the Affordable Care Act: 
**King v. Burwell** and Beyond

CIANJ, Holy Name Medical Center, Teaneck, New Jersey, 
April 8, 2015
Presenter

Neil H. Ekblom, Esq.
Shareholder

LECLAIR RYAN
885 Third Avenue
Sixteenth Floor
New York, New York 10022
(212) 430-8031
Neil.Ekblom@Leclairryan.com
www.healthlawblog.com
The Issue in King v. Burwell

- Does Section 36B of the United States Code, passed along with the ACA, authorize the IRS to provide tax credits for insurance purchased on a “federal marketplace”
  - ACA §1311
    - [42 U.S.C. §18031(b)(1)]
      - “Each state shall, not later than January 1, 2014, establish [a Marketplace].”
  - ACA §1321
    - [42 U.S.C. §1804(1)(c)]
      - “If a state does not establish a Marketplace, HHS “shall establish and operate such [Marketplace] within the State.”
  - 26 U.S.C. §36B(b)(2)(A) and (c)(2)(A)
    - “The premium subsidy amount” is based on the cost of a “qualified health plan…enrolled through [a Marketplace] established by the State under §1311

NOTE: “Marketplace” and “Exchange” are synonymous.

What’s at stake

• 34 states have federally run exchanges
  – Approximately 7.5 million would lose subsidies within a month of the June decision (2016 coverage with subsidies estimated at 13,402,890. New Jersey has 388,209).
  – Subsidy recipients make up 87% of those who have signed up for coverage using federal marketplaces.

Information and graphic can be found at http://kff.org/interactive/king-v-burwell/
Immediate Consequences from Striking Subsidies

1. Average out-of-pocket premium costs increase 256% per enrollee.
2. 83% of those formerly subsidy-eligible uninsured are exempt from the individual mandate.
3. Premium revenues not enough to cover costs, requiring large premium increases in January 2016, or beyond. All ACA products affected.
4. Individual insurance markets become less stable; healthy enrollees drop insurance due to increasing cost, and pay tax of $95.00 or 1% of income.
5. Insurers exit markets, unable to re-enter for five years.
6. IRS rule invalidation means inability to tally and enforce ACA large employer requirement that full-time employees be offered minimum essential, minimum value and affordable insurance. Subsidies that trigger two types of penalties do not exist.

LARGE EMPLOYER PENALTY RULES FOR 2015 (100 FT) and 2016 (50-99 FT)

LARGE EMPLOYER = “50 FT EMPLOYEES”
AN EMPLOYER WHO EMPLOYEES AN AVERAGE OF 50 FT EMPLOYEES ON BUSINESS DAYS DURING THE PROCEEDING CALENDAR YEAR, USING BOTH FULL-TIME EMPLOYEES AND FTEs (PART-TIME EMPLOYEES).

50 – 99 FT Rules Commence 2016 with certification
100 FT commences 2015

EMPLOYER DOES NOT OFFER MINIMAL ESSENTIAL COVERAGE

MINIMUM ESSENTIAL

AT LEAST ONE FULL-TIME (≥ 30 HRS PER WEEK) EMPLOYEE RECEIVES A PREMIUM TAX CREDIT OR COST SHARING SUBSIDY IN AN EXCHANGE

MINIMUM VALUE AND AFFORDABLE

NO MINIMUM VALUE (LESS THAN 60% OF COVERED EXPENSES) OR EMPLOYEE PAYS MORE THAN 9.5% OF HOUSEHOLD INCOME (EMPLOYEE W-2 WAGES)

BUT

EMPLOYEE CHOOSES TO BUY COVERAGE IN AN EXCHANGE AND GETS A PREMIUM TAX CREDIT

AND

PROVIDES MINIMUM VALUE (MORE THAN 60% OF COVERED EXPENSES) AND EMPLOYEE DOES NOT HAVE TO PAY MORE THAN 9.5% OF HOUSEHOLD INCOME (EMPLOYEE W-2 WAGES)

PROVIDES MINIMUM VALUE (MORE THAN 60% OF COVERED EXPENSES) AND EMPLOYEE DOES NOT HAVE TO PAY MORE THAN 9.5% OF HOUSEHOLD INCOME (EMPLOYEE W-2 WAGES)

NO PENALTY: AFFORDABLE COVERAGE IS PROVIDED

ANNUAL PENALTY IS $2,000 X NUMBER OF FULL-TIME EMPLOYEES (30 HR WEEK) MINUS 30. PENALTY INCREASES YEARLY BY GROWTH OF INSURANCE PREMIUMS

ANNUAL PENALTY IS $3,000 X EACH FULL-TIME EMPLOYEE RECEIVING A TAX CREDIT (UP TO A MAX OF $2,000 X NUMBER OF FULL-TIME EMPLOYEES MINUS 30). PENALTY INCREASES EACH YEAR BY GROWTH OF INSURANCE PREMIUMS

70% 2015
95% 2016

EMPLOYER OFFERS MINIMUM ESSENTIAL COVERAGE

EMPLOYER OFFERS MINIMUM ESSENTIAL COVERAGE

EMPLOYER OFFERS MINIMUM ESSENTIAL COVERAGE

EMPLOYER OFFERS MINIMUM ESSENTIAL COVERAGE

EMPLOYER OFFERS MINIMUM ESSENTIAL COVERAGE

EMPLOYER OFFERS MINIMUM ESSENTIAL COVERAGE

EMPLOYER OFFERS MINIMUM ESSENTIAL COVERAGE

EMPLOYER OFFERS MINIMUM ESSENTIAL COVERAGE
Short Term and Long Term Solutions

1. Congress acts to preserve subsidies or extend subsidies in affected states for defined period, allowing states time to set up marketplaces.


3. GOP proposal to offer limited lower-cost insurance plans in states that don’t offer exchanges (removing insurances market reforms such as community rating and allowing high-risk pools).

4. Supreme Court decision delays deadline to voiding credits.
Chief Justice John Roberts
Justice Ruth Bader Ginsburg
Justice Stephen Breyer
Justice Sonia Sotomayor
Justice Elena Kagan
Justice Anthony Kennedy

Justice Antonin Scalia
Justice Samuel Alito
Justice Clarence Thomas

Audio and picture taken from http://blogs.wsj.com/washwire/2015/03/06/supreme-court-audio-six-highlights-from-king-v-burwell-arguments/?KEYWORDS=King+v+Burwell&mod=wsj_valettop_email
Update for Employers

• ACA reporting and disclosure requirement for employers
  – IRC §6055 and §6056
• Form 1094-C and IRC §4980H
• Group payment plan and reimbursement
Update for New Jersey’s Health Insurance Companies

• New Jersey’s Health Data Encryption Law
  • Response to Horizon Blue Cross data breach. (Could this law have prevented the Anthem data breach?)
  • “Insurance carrier(s) shall not...maintain...personal information, unless...secured by encryption.”
Thank you

Neil H. Eklom, Esq.

neil.ekblom@leclairryan.com | 212.430.8031
885 Third Avenue, Sixteenth Floor
New York, New York 10022

www.leclairryan.com