Blue Cross Blue Shield of Michigan
Leading Michigan to a healthier future℠

Helping Group Health Plan Sponsors Navigate the Federal Health Care Reform Law

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The Patient Protection and Affordable Care Act (H.R. 3590) was signed into law by President Obama on March 23, 2010. The companion bill, the Health Care and Education Reconciliation Act (H.R. 4872), was signed into law on March 30, 2010. Together, these two bills constitute the new "Federal Health Care Reform Law."

This document outlines key provisions of the Patient Protection and Affordable Care Act. There is a high degree of uncertainty associated with the impact of reform legislation as key regulatory guidance is still pending. This overview is intended as an educational tool to begin to help Blue Cross Blue Shield of Michigan employer groups as they work to understand and meet health care reform requirements.

Notes:

Fully-insured vs. self-insured group health plans: Most items in this summary apply to both fully-insured and self-funded groups. Exceptions are noted where applicable.

Grandfathered plans: Group health plans in which an individual is enrolled on March 23, 2010 are called grandfathered plans. These plans have special effective dates for some health care reform requirements and are completely exempt from others, which are noted where applicable. Grandfathered plans are allowed to enroll new employees and their dependents and dependents of currently covered employees without jeopardizing their grandfathered status. Any plan not in existence prior to March 23, 2010 is considered a non-grandfathered plan.

Collectively-bargained plans: For group health plans maintained under one or more collective bargaining agreements ratified before March 23, 2010, the provisions of the Patient Protection and Affordable Care Act may be postponed until the termination date of the last collective bargaining agreement relating to the plan, with the exception of coverage requirements required for grandfathered plans as noted where applicable.

Key Provisions for Employers

Play or Pay

Description: Employers with an average of at least 50 employees during 121 days or more in the preceding calendar year are required to offer "minimum essential benefits" packages to full-time employees and their dependents. Part-time workers are converted to full-time equivalents by adding all hours worked by part-timers during the month and dividing by 120 to determine whether the employer has more than 50 full-time employees. Seasonal employees are excluded from the calculation.

Note: In determining penalties, employers can exclude the first 30 employees from their calculations.

Employers with more than 50 full-time employees that do not offer coverage or that offer coverage that does not qualify as "minimum essential benefits" coverage must pay an "assessment" of $2,000 times the number of full-time employees if at least one full-time employee receives government-subsidized coverage through an insurance exchange. If the employer offers "minimum essential benefits" coverage, but a full-time employee receives government-subsidized coverage through an insurance exchange anyway, the employer must pay an "assessable payment" equal to the lesser of $3,000 for each employee receiving a subsidy or $2,000 for each full-time employee.

There is no assessment if the employee's share of the cost of coverage is between 8.0 percent and 9.5 percent of income. All non-grandfathered plans will have to offer at least bronze level coverage (i.e., minimum coverage of 60 percent coinsurance with HSA out-of-pocket maximums), which will satisfy the "minimum essential benefits" requirement. Grandfathered plans are deemed to satisfy the "minimum essential benefits" requirement already.

Effective date: Jan. 1, 2014 for both grandfathered and non-grandfathered plans.

Action Items

- Evaluate and calculate "play or pay" assessments where applicable.
- Work with BCBSM to ensure appropriate benefit levels and manage changes as necessary.

Key Provisions for Employers

Excise Tax (Cadillac Plan Tax)

Description: A 40 percent excise tax is imposed on insurers (for insured coverage) and employers (for self-insured coverage) to the extent that the aggregate annual value of an employee's health coverage, including medical, prescription, HRA, health care FSA, and employer HSA contributions exceeds $10,200 for an individual or $27,500 for a family.

Threshold values are indexed to changes in the consumer price index. For retirees age 55 to 64, the threshold is raised by $1,650 for individuals and $3,450 for families. The threshold is also raised for certain high-risk professions, including law enforcement, fire protection, certain utility workers and others. The threshold is also adjusted to reflect higher health care costs attributable to age or gender in the workforce. Employers are responsible for calculating the value of excess coverage using COBRA rules and for making reports to insurers and the government.

Effective date: Jan. 1, 2018 for both grandfathered and non-grandfathered plans.

Action Items

- Evaluate whether group health plan would be subject to excise tax.

Government Subsidies for Small Employers

Description: The government will provide a tax credit to small employers that pay at least 50 percent of their employees' health insurance premiums. The full value of the tax credit is 35 percent of the small employers' cost for businesses with up to 10 employees and average annual wages of less than $25,000. The tax credit also applies on a reduced sliding scale to small employers with up to 25 employees and average annual wages of $50,000.

Effective date: Starting in 2010 for both grandfathered and non-grandfathered plans.

Action Items

- Apply for tax credit if applicable.

Key Provisions for Employers

Plan Design Requirements

Lifetime Dollar Limits on Plan Benefits

Description: Group plans may not place lifetime limits on essential health benefits.

Effective date: Beginning with first plan year on or after Sept. 23, 2010 for both grandfathered and non-grandfathered plans.

Annual Dollar Limits on Plan Benefits

Description: Group plans may place only "restrictive" annual limits on essential health benefits as defined by the Health and Human Services (HHS) Secretary for plan years expiring before Jan. 1, 2014, but all annual limits on essential health benefits will be phased out by 2014.

Effective date: Requirement for government-approved limits for group health plans is effective beginning with first plan year on or after Sept. 23, 2010, and full prohibition is effective with first plan year beginning in 2014 for both grandfathered and non-grandfathered plans.

No Pre-existing condition exclusions for those under age 19

Description: Group plans may not impose a pre-existing condition exclusion with respect to children under age 19, with pre-existing condition exclusions eliminated for all participants by 2014.

Effective date: First plan year beginning on or after Sept. 23, 2010 for both grandfathered and non-grandfathered plans.

Adult child coverage

Description: All group health plans must extend eligibility to married or unmarried children of the covered employee until the child turns 26 as long as the child is not eligible for coverage under another employer-sponsored group benefit plan. The lack of other available coverage for the child as a requirement is eliminated in 2014.

Action Items

- Amend plan documentation.

BCBSM Note:

BCBSM already announced it will cover dependents for insured business up to age 26 in advance of the requirement to do so.

Coverage does not need to extend to children of adult children. Health care benefits for adult children are excludable from taxable income through the end of the calendar year in which the child turns 26.

Effective date: For grandfathered plans, effective for first plan year beginning on or after Sept. 23, 2010 if the adult child is not eligible for other employer-sponsored coverage. Coverage must be extended to all children up to age 26 effective with the first plan year beginning in 2014 for grandfathered plans.

For non-grandfathered plans, effective the first plan year beginning on or after Sept. 23, 2010.

Key Provisions for Employers

W-2 Reporting

Description: The value of the employee's health coverage must be disclosed on their W-2 forms.

Effective date: Effective starting with 2011 tax year for both grandfathered and non-grandfathered plans.

Health Insurance Portability and Accountability Act (HIPAA) Wellness Programs

Description: Employers may offer financial incentives to employees for participating in wellness programs of up to 30 percent of the cost of coverage. Wellness programs must satisfy the HIPAA nondiscrimination requirements, and the government can increase the limit to 50 percent if deemed appropriate.

Effective date: 2014 for both grandfathered and non-grandfathered plans.

Action Items

- Develop tax reporting mechanism.
- Amend plan documentation.
- Look for additional guidance from the government.

BCBSM Note:

BCBSM and BCN products such as Healthy Blue Outcomes℠ and Healthy *Blue* Living℠ are incentive-based.

Key Provisions for Retiree Plans

Excise Tax

Description: The Excise Tax applicable to high-value health coverage applies to retiree plans.

Effective date: Starting in 2018 for both grandfathered and non-grandfathered plans.

Reinsurance for Employer-Provided Retiree Health Coverage

Description: Health and Human Services (HHS) will create a temporary reinsurance program to reimburse employers for part of their retiree health care costs for retirees over age 55 who are not eligible for Medicare or active employer-provided health benefits. The program will reimburse employers 80 percent of the cost per enrollee in excess of $15,000 and below $90,000.

Effective date: Effective 90 days after the March 23 enactment. HHS will set up an online portal for businesses to apply for reinsurance by July, 2010.

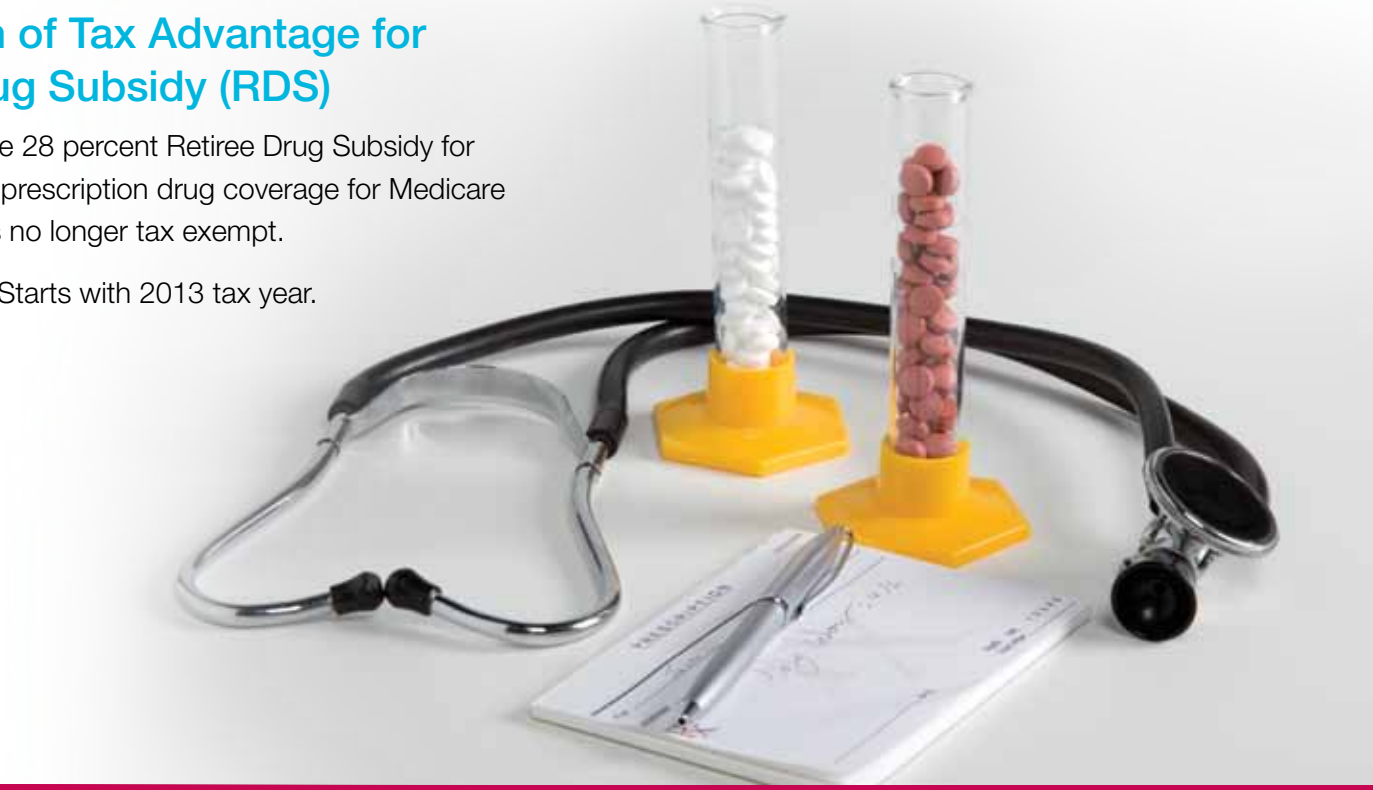
Elimination of Tax Advantage for Retiree Drug Subsidy (RDS)

Description: The 28 percent Retiree Drug Subsidy for employer-based prescription drug coverage for Medicare eligible retirees is no longer tax exempt.

Effective date: Starts with 2013 tax year.

Action Items

- Evaluate whether group health plan would be subject to excise tax.
- Apply for reinsurance if applicable.
- Account for RDS deduction elimination and consider other retiree pharmacy program cost mitigation strategies.



Key Provisions for Individuals/Employees

Individual Mandate

Description: U.S. citizens and legal residents are required to have "minimum essential benefits" consisting of at least bronze-level coverage (see "Insurance exchanges") or, if applicable, catastrophic coverage.

The tax penalty for noncompliance is $695 per year, up to a maximum of $2,085 per family. Lower penalties apply during the phase-in period from 2014 through 2016.

Exceptions will be made for financial hardship, religious objections, Native Americans, those without coverage for less than three continuous months, whenever the lowest cost plan option costs more than 8 percent of income, or whenever the individual's income is below the tax filing threshold, which is $9,350 for individuals, $18,700 for couples under age 65 without children, and $26,000 for couples under age 65 with two or more children in 2010.

Effective date: Effective starting in 2014.

Health Insurance Exchanges

Description: Individuals (U.S. citizens and legal immigrants) and small employers with an average of 100 or fewer employees in the previous calendar year may purchase insurance from state-run exchanges beginning in 2014. If the state agrees, large employers with an average of at least 101 employees in the previous calendar year may also purchase from the exchange beginning in 2017. All carriers doing business in Michigan will participate by offering products on the exchange.

Five tiers of coverage are offered through the exchange:

- Bronze — provides minimum essential benefits, covers at least 60 percent of actuarial value of covered benefits, with out-of-pocket limit equal to current limits on HSAs ($5,950 for individuals and $11,900 for families, in 2010)
- Silver — provides minimum essential benefits, covers at least 70 percent of actuarial value of covered benefits, with HSA out-of-pocket limits
- Gold — provides minimum essential benefits, covers at least 80 percent of actuarial value of covered benefits, with HSA out-of-pocket limits
- Platinum — provides minimum essential benefits, covers at least 90 percent of actuarial value of covered benefits, with HSA out-of-pocket limits
- Catastrophic — similar to high-deductible health plan, except available only to individuals up to age 30 in the individual market (not through an exchange)

Reduced out-of-pocket limits apply to individuals with incomes up to 400 percent of the federal poverty level.

Effective date: Effective starting in 2014.

Key Provisions for Individuals/Employees

Insurance Market Reforms

Guaranteed Issue

Description: Carriers must accept all applicants regardless of pre-existing condition and health status and must use adjusted community rating.

Effective date: Starting in 2014.

Guaranteed Renewal

Description: Carriers must guarantee renewal for individuals.

Effective date: Starting in 2014.

No Rescissions

Description: Plans cannot rescind coverage of an enrollee except in cases of fraud.

Effective date: First plan year beginning on or after Sept. 23, 2010 for individuals, grandfathered plans and non-grandfathered plans.

Preventive Care Coverage

Description: Employer plans must provide coverage without cost-sharing for preventive services rated A or B by the U.S. Preventive Services Task Force. This includes recommended immunizations, preventive care for infants, children and adolescents and preventive care and screenings for women.

Effective date: First plan year beginning on or after Sept. 23, 2010 for non-grandfathered individuals and group plans. Not applicable to grandfathered plans.

Health Insurance Exchanges

Description: See “Health Insurance Exchanges” on previous page.

BCBSM Note:

For more than 70 years, Blue Cross Blue Shield of Michigan has always provided guaranteed issue coverage and renewal and has never rescinded coverage except in cases of fraud or intentional material misrepresentation.

Key Provisions for Individuals/Employees

Premium and Cost-Sharing Subsidies

Government Subsidies for Individuals

Description: A government subsidy is available to U.S. citizens and legal immigrants with incomes of up to 400 percent of the federal poverty level to purchase coverage through an insurance exchange. This is not available if coverage is available from an employer plan, unless the plan has an actuarial value of less than 60 percent of covered benefits or the employee's contributions exceed 9.5 percent of household income.

Effective date: Starting in 2014.

Employer Free-Choice Vouchers

Description: Employers with more than 50 full-time employees that offer the "minimum essential benefits" package to employees must give eligible employees the option of receiving a voucher from the employer to purchase coverage from an insurance exchange, which is tax-free up to the purchase price of coverage purchased. The voucher offsets any "play or pay" penalty.

The employee is eligible for a voucher if his or her share of the employer plan is between 8 and 9.8 percent of household income, and the employee's household income does not exceed 400 percent of the federal poverty level, and the employee does not participate in the employer plan.

The dollar amount of the voucher equals the employer's largest contribution for any employee-only coverage (or family coverage if elected by the employee) under the employer plan and is adjusted for age and category of enrollment. No voucher is required if the employee makes no contribution to the plan.

Effective date: Starting in 2014 for both grandfathered and non-grandfathered plans and individuals.

Medicaid Expansion

Description: Eligibility is expanded to all individuals under age 65 with incomes up to 133 percent of the federal poverty level. States are also required to offer premium assistance for cost-effective employer coverage of Medicaid-eligible working adults.

Effective date: Jan. 1, 2014.

Medicare Payroll Tax Increase

Description: Employees pay 2.35 percent, instead of the current rate of 1.45 percent, on earnings greater than $200,000 for individuals and $250,000 for married couples filing jointly. Automatic increase in withholding only applies to income above $200,000; married couples will reconcile additional payroll tax payments on income tax filings. The increase does not apply to the "employer share" of the Medicare payroll tax. Taxpayers with an income of at least $200,000 for individuals or $250,000 for married couples filing jointly will pay a 3.8 percent tax on certain investment income.

Effective date: Staring in 2013 for both grandfathered and non-grandfathered plans.

Account Plan Limitations

Description: The penalty on non-qualified Health Savings Account distribution is raised from 10 percent to 20 percent. Starting in 2013, Flexible Spending Account contributions are limited to $2,500 per year, indexed for inflation. Reimbursement for over-the-counter medications from Health Reimbursement Accounts, Health Savings Accounts or Flexible Spending Accounts are prohibited unless prescribed or for insulin.

Effective date: Jan. 1, 2011 for both grandfathered and non-grandfathered plans.

Reform Timeline
2010-2011

- Small business tax credits
- Part D "donut hole" decreased
- Sec. 833 changes
- Insurer exec comp limits

Jan. 1, 2010
(Retroactive Date)

- Rate review for insured products
- Consumer information grants to states
- Grandfathered plan and enrollee status if in effect on enactment

Mar. 23, 2010
(Enactment Date)

90 Days Out

- National high risk pool begins
- Early retiree reinsurance for employer-provided retiree benefits

July 1

- HHS internet portal for individuals and small group

June-July 2010

180 Days Out

- HHS regulations on state Exchange waivers
- HIT standards

Plan Yrs. 6 Mos. Out

- Dependent coverage to 26
- Restrictions on rescissions
- No pre-ex exclusion period < age 19
- Preventive services with no cost-sharing
- No lifetime limits; restricted annual limits
- MLR reporting
- Patient protections

September 2010

- MLR rebates
- Increases HSA/ MSA early withdrawal penalties
- Medicare Advantage
  - 2010 payments frozen for 2011
  - Authority to deny Plan bids (MA/PDP)
  - Limits on OOP costs
- Part D: protected classes

Jan. 1, 2011

Reform Timeline
2012-2018

2012

- Presidential Election

2013

- Deduction for employer Part D retiree drug subsidy eliminated
- Medicare payroll tax increased for high-wage employees and new tax on unearned income
- Cap on salary-reduction contributions to health FSAs

2014

- Employer mandates: play or pay, automatic enrollment, free-choice vouchers
- Individual health coverage mandate
- Health Benefit Exchanges operational
- Premium and cost-sharing subsidies for low- and middle-income individuals
- Required Medicaid eligibility expansion (under 65)
- Additional consumer protections and market reforms

2016

- Cross-border sales of health insurance

2018

- Excise tax on high-cost group health plans (Cadillac Plan Tax)