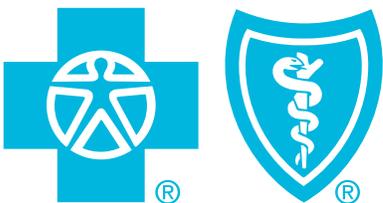




Blue Cross Blue Shield of Michigan
Leading Michigan to a healthier futureSM

Navigating the national health care reform law

Updated February, 2011



Navigating the national health care reform law

The Patient Protection and Affordable Care Act (PPACA) 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.”

The Congressional Budget Office estimates that the bill package would cost \$938 billion over 10 years. It would provide insurance to 32 million Americans who would otherwise be uninsured, leaving roughly 25 million without coverage.

However, the CBO also estimates that the reform package would reduce federal deficits by \$143 billion during the first decade and more in the second.

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National health care reform at a glance

Jan. 1, 2010	March 23, 2010 (Bill enactment date)	June/July 2010	Sept. 23, 2010	2011
<ul style="list-style-type: none"> • Small business tax credits • Part D “donut hole” rebate 	<ul style="list-style-type: none"> • Federal funds to states for rate review of insured products • Consumer information grants to states • Health plans considered “grandfathered” if in effect on this date 	<ul style="list-style-type: none"> • Early retiree reinsurance for employer-provided retiree benefits • HHS internet portal for individuals and small group • High risk pool funding begins 	<ul style="list-style-type: none"> • Dependent coverage to 26 • Restrictions on rescissions • No pre-existing condition exclusion period for people under age 19 • Preventive services with no cost-sharing • No lifetime limits or restrictive annual limits • Patient protections • Emergency services 	<ul style="list-style-type: none"> • Part D discounts in the “donut hole” • Medical loss ratio reporting • Medicare Advantage <ul style="list-style-type: none"> – 2010 payments frozen for 2011 – Limits on out-of-pocket costs • HHS begins CLASS Act • Rate review



2010 requirements and impacts

Small business tax credits

Starting in 2010, 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 employers' cost if they have 10 or less employees and average annual wages are less than \$25,000. The tax credit also applies on a reduced sliding scale to employers with up to 25 employees and average annual wages of \$50,000.

Medicare Part D “donut hole” rebate

Seniors enrolled in Medicare Part D received a \$250 rebate when they hit the “donut hole” during the 2010 calendar year. The donut hole is the gap in prescription drug coverage that occurs when spending on covered Part D drugs, including copays and deductibles, exceeded \$2,830 (now \$2,840 for 2011). There is no application process and private companies are not involved with sending rebate checks.

Rate review

Before implementing new rates, all individual and small group health insurance provided directly by a health insurer will be subject to a rate review for all “unreasonable” proposed premium increases. Insurers must submit the proposed premium increase, along with an explanation of the need for the increase in excess of a certain threshold, to

2012	2013	2014	2016	2018
<ul style="list-style-type: none"> • Presidential election • HHS defines CLASS Act benefits • Medical loss ratio rebates 	<ul style="list-style-type: none"> • Medicare payroll tax increased for high-wage employees and new tax on unearned income • Cap on salary-reduction contributions to health FSAs 	<ul style="list-style-type: none"> • Employer “free-rider” penalty • Individual health coverage mandate • Insurance 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 		<ul style="list-style-type: none"> • Excise tax on high-cost group health plans (Cadillac plan tax)

2010 requirements and impacts

state insurance commissioners, who review the rate in coordination with HHS. Insurers with excessive or multiple increases may not be allowed to participate in the insurance exchanges that begin in 2014.

Federal grants of at least \$1 million per year from 2010 to 2014 have been made available to states to improve or create rate review processes. The Michigan Office of Financial and Insurance Regulation plans to use its \$1 million grant to expand its in-depth review and analysis capabilities of health insurance rate filings from health maintenance organizations and commercial carriers. OFIR has said it intends to use its new tools to ensure that rate review processes are fair and transparent. Appropriate uses for the funds include enhancing staffing or technology capacity, increasing the scope of current rate review processes and enhancing consumer protection standards (i.e. posting rate increases to public websites.)

Consumer information grants to states

Health and Human Services has provided \$30 million in grants to states to set up health insurance consumer assistance or health insurance ombudsman programs. Michigan received \$900,000 to:

- Add staff to OFIR
- Expand consumer service offerings
- Train employees on national health care reform
- Expand data collection capabilities needed to fulfil the reform law
- Increase consumer awareness of OFIR services

States receiving grants must collect and report data on the types of problems and inquiries encountered by consumers. The data will be shared with state insurance regulators, the Secretary of Labor and the Secretary of Treasury to identify areas where enforcement action is necessary.

Grandfathered plan and enrollee status

Health plans in which an individual is enrolled on March 23, 2010 either as part of a group or as an individual member are called grandfathered plans. These plans have special effective dates for some health care reform requirements and are completely exempt from others. Grandfathered group plans are allowed to enroll new employees and their dependents, as well as dependents of currently covered employees without jeopardizing their grandfathered status. Similarly, people who are enrolled in a grandfathered health plan purchased in the individual market may add dependents to their policies. Any plan not in existence prior to March 23, 2010 is considered a non-grandfathered plan.

High risk pool

HHS contracted with Physicians Health Plan of Mid-Michigan to create a **temporary high-risk pool program** to help expand access to health coverage until other reforms begin in 2014. It is likely the pool will impact a small percentage of the population – uninsured individuals with pre-existing health conditions who haven't had insurance for the last six months.

Until 2014 when all carriers are required to accept anyone, regardless of health status, individuals can still be rejected by commercial carriers for pre-existing conditions that don't qualify them for the risk pool.

Early retiree reinsurance

The Early Retiree Reinsurance program was implemented in July 2010. Plans approved by HHS to participate are eligible for reimbursement payments from HHS of up to 80 percent of a group's employee claims between \$15,000 and



\$90,000 for early retirees between the age of 55 and 64. Details and directions about how employers can apply will be posted on the HHS website.

Internet portal for individuals and small groups

A new portal is up and running at **healthcare.gov** to help consumers navigate their options in the individual and small business private market and help them determine if they may be eligible for a variety of existing public programs, including high-risk pools, Medicaid, Medicare and the Children's Health Insurance Program (CHIP). States are required to link consumers to this new portal. This portal is not intended as a mechanism for consumers to buy insurance, but rather as a tool for them to get information until the exchanges become active in 2014.

Dependent coverage extended to age 26

All group health plans that offer coverage for their employees' children must extend eligibility to married or unmarried children of covered employees up to age 26. There are no additional criteria to qualify other than being a child of a policy holder under age 26. Health plans that were not in existence on or before Mar. 23, 2010, must comply beginning the first plan year beginning on or after Sept. 23, 2010. Plans that existed (grandfathered plans) on or before March 23, 2010, have to do this with the first plan year beginning after Sept. 23, 2010, but only for adult children up to age 26 who are not eligible for employer-sponsored coverage elsewhere. Starting in 2014, dependents up to age 26 must be allowed to be covered on their parents' policy even if they have access to employer-sponsored health coverage.

This provision had little impact on Blue Cross Blue Shield of Michigan, as the Blues already had a long-standing policy of allowing college graduates to remain on their parents' BCBSM health insurance coverage for the remainder of the calendar year after graduating; or if they turn 19 and choose not to attend college.

Restrictions on rescissions

Starting with plan years after Sept. 23, 2010, health insurers cannot rescind health coverage except in cases of fraud or material misrepresentation. Rescinding is an insurance practice of retroactively voiding or undoing the health insurance contract. Blue Cross Blue Shield of Michigan has never rescinded policies for any reason other than fraud or material misrepresentation.

No pre-existing condition exclusion period for people under age 19

Group health plans and carriers cannot deny coverage for a child under 19 due to a pre-existing condition starting with the first plan year beginning on or after Sept. 23, 2010. This provision also prohibits exclusion periods for children under age 19 with a pre-existing condition.

However, until 2014 when the law requires all carriers to guarantee issue coverage to all individuals without health status rating, it is possible that commercial carriers may charge these individuals much higher premiums due to their pre-existing condition.

Blue Cross Blue Shield of Michigan currently is the only insurer in the state to guarantee issue coverage without health status rating. This will change in 2014 when the law requires all carriers to accept everyone, with no exclusions for pre-existing conditions and without rating based on health status.

2011 requirements and impacts

Preventive services with no cost-sharing

Beginning on the first plan years that start on or after Sept. 23, 2010, plans must provide coverage without cost-sharing for:

- Services recommended by the U.S. Preventive Services Task Force
- Immunizations recommended by the Advisory Committee on Immunization Practices of the CDC
- Preventive care and screenings for infants, children and adolescents supported by the Health Resources and Services Administration
- Preventive care and screenings for women supported by the Health Resources and Services Administration

No lifetime limits or restrictive annual limits

Beginning plan for years on or after Sept. 23, 2010, plans may not place lifetime limits on essential health benefits. Beginning with plan years starting after Jan. 1, 2014, there will be no annual limits on essential health benefits. HHS has yet to define “essential health benefits.”

Medical loss ratio reporting

Medical loss ratio (MLR) is the percentage of health insurance premiums spent by an insurance company on health care services. The reform law requires that large group plans spend 85 percent of premiums on clinical services and other activities for the quality of care for enrollees. Small group and individual market plans must devote 80 percent of premiums to these purposes. The first reporting will occur in April 2011, based on 2010 experience.

Patient protections

All new plans starting after Sept. 23, 2010 that require a designation of a primary care provider must allow the choice of any participating primary care provider who is available to accept them, including pediatricians. Such plans may not require authorization or referral for a female patient to receive obstetric or gynecological care from a participating provider, and they must treat their OB/GYN-related authorizations as the authorization of a primary care provider. Michigan law is consistent with the federal statute, and all carriers comply.

Expanded appeals process

Effective for new plans (non-grandfathered) for plan years beginning on or after Sept. 23, 2010, group health plans and health insurance issuers offering individual and group coverage must have internal and external appeals processes. These health insurers must provide notice to consumers of the available internal and external appeals procedures in a culturally and linguistically appropriate manner. The appeal provisions of the law do not apply to grandfathered policies.

Emergency services

If a plan provides coverage for emergency services, the plan must do so without prior authorization, regardless of whether the provider is a participating provider. Cost-sharing for services provided by nonparticipating providers cannot be greater than for participating providers.



Medicare Part D discounts in donut hole

Medicare Part D enrollees who reach the donut hole — which starts at \$2,840 for 2011 — will receive a 50 percent discount on the total cost of their brand-name drugs in the gap. Medicare will gradually phase in additional subsidies in the coverage gap for brand-name drugs (beginning in 2013) and generic drugs (beginning in 2011), which will reduce copay rates for Part D enrollees in the gap from 100 percent to 25 percent by 2020.

Medical loss ratio rebates

Health insurers that do not meet the MLR thresholds outlined previously must provide rebates to members equal to the dollar amount needed to meet the thresholds. The rebates will first be paid by Aug. 1, 2012, based on 2011 experience.

Medicare Advantage

The Centers for Medicare and Medicaid Services plan to reduce health insurer payments to Medicare Advantage that will affect benefits and premiums, a process that will be phased in between 2011 and 2017. Also, health insurers and providers will receive bonus payments for providing high quality care for enrollees in Medicare Advantage plans. Health insurers must spend at least 85 percent of premium dollars to pay for Medicare Advantage enrollees' medical costs starting in 2014.

CLASS Act

Effective Jan. 1, 2011, HHS will begin working on the framework for a new national insurance program for purchasing long-term care known as the Community Living Assistance Services and Supports program (CLASS Act).

The program is designed to expand options for people who become functionally disabled and require long-term services and supports. It is voluntary for employees to contribute pre-tax payroll dollars to the CLASS fund.

The HHS Secretary is expected to define the CLASS benefit by October 2012. Enrollment and contributions will begin after the benefit is defined. CLASS enrollees must make payroll contributions managed by the government for at least 5 years before they can receive benefits. Employers may auto-enroll workers and enable them to opt out.

Consumer protections and market reforms

Starting in 2014, health insurers must guarantee issue. In other words, they must provide coverage to all applicants regardless of pre-existing condition and health status. It is not clear, however, whether guarantee issue will apply to an open enrollment period or year-round. All insurers must also use adjusted community rating and offer guarantee renewal for individuals.

Medicare payroll tax increased for high-wage employees and new tax on unearned income

Starting in 2013, individuals earning more than \$200,000 and couples earning more than \$250,000 will pay a 2.35-percent Medicare payroll tax on incomes above those thresholds instead of the current rate of 1.45 percent. Individuals and couples at these earnings levels will also pay an additional 3.8-percent tax on unearned income, such as interest and dividends from investments or income from rental property in certain circumstances.

Longer-term requirements and impacts

Individual health coverage mandate

Starting Jan. 1, 2014, U.S. citizens and legal residents are required to have “minimum essential coverage” This includes coverage offered in the individual market or by an employer and public health programs such as Medicaid and Medicare.

The tax penalty for noncompliance is phased in from 2014 to 2016. In 2014, the tax penalty will be the greater of \$95 or 1 percent of income. In 2015, the penalty will be the greater of \$325 or 2 percent of income, and in 2016 the tax penalty will be the greater of \$695 or 2.5 percent of income.

The tax penalty will not exceed \$2,085 per family or 2.5 percent of income. After 2016, the dollar penalties will be increased by annual cost-of-living adjustments.

Exceptions will be made for financial hardship, religious objections, Native Americans and those without coverage for less than three continuous months. Exceptions will also be made when the lowest cost plan option costs more than 8 percent of income, or when 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.

Employer “free-rider” penalty

Starting with plan years beginning after Jan. 1, 2014, employers with an average of at least 50 employees during 121 days or more in the preceding calendar year must offer minimum essential coverage packages to full-time employees and their dependents or pay a penalty if any of those employees seek subsidized coverage through the insurance exchange. Part-time workers are converted to full-time equivalents by adding all hours worked by part time

workers 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. 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 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 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. However, employees may use a voucher equal to the value of their employer’s contribution toward their coverage to offset the cost of buying insurance on the exchange.

Exchanges operational

Starting Jan. 1, 2014, individuals (U.S. citizens and legal immigrants) and small employers may purchase insurance from state-based exchanges. States can define small groups as having an average of 50 or fewer or 100 or fewer employees in the previous calendar year. Starting in 2016, small businesses are automatically defined as up to 100. If the state agrees, large employers with an average of 101 employees or more in the previous calendar year may also purchase from the exchange beginning in 2017.

Premium and cost-sharing subsidies for low- and middle-income individuals

Many details about the exchange will have to be clarified by either the federal rule making process or the states.

All carriers doing business in Michigan may participate by offering products on the exchange, which will offer four tiers of coverage:

- **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 health savings accounts (\$5,950 for individuals and \$11,900 for families in 2011). The out-of-pocket threshold applies to high-deductible health plans that are combined with an HSA.
- **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

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

*Actuarial value means that the health insurance coverage selected is estimated to cover a certain percentage of a member's costs. Therefore, a plan with a 60 percent actuarial value is estimated cover 60 percent of a member's total health care costs, leaving the member responsible for the remaining 40 percent.

Starting in 2014, a government subsidy is available to U.S. citizens and legal residents 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 covers less than 60 percent of an employee's medical costs (60 percent actuarial value or lower) or the employee's contributions exceed 9.5 percent of household income.

2011 data

Federal Poverty Level	100%	200%	300%	400%
Family Members				
1	\$10,830	\$21,660	\$32,490	\$43,320
2	\$14,570	\$29,140	\$43,710	\$58,280
3	\$18,310	\$36,620	\$54,930	\$73,240
4	\$22,050	\$44,100	\$66,150	\$88,200
5	\$25,790	\$51,580	\$77,370	\$103,160
6	\$29,530	\$59,060	\$88,590	\$118,120
7	\$33,270	\$66,540	\$99,810	\$133,080
8	\$37,010	\$74,020	\$111,030	\$148,040

For families with more than 8 members, add \$3,740 for each additional person.

Financing national health care reform

Medicaid eligibility expansion under 65

Starting Jan. 1, 2014, Medicaid eligibility is expanded to nearly 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. Individuals who are eligible for Medicaid are ineligible for subsidized coverage through the health exchange.

Children's Health Insurance Program (CHIP)

Children who are eligible for this program are not eligible for subsidized coverage through the health exchange unless they are unable to enter CHIP due to an enrollment cap. CHIP is authorized in federal law through Sept. 20, 2015.

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

Beginning Jan. 1, 2018, a 40-percent excise tax will be imposed on insurers (for insured coverage) and employers (for self-insured coverage) when the 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 cost-of-living adjustments. 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.

Financing national health care reform

The health care reform package costs approximately \$938 billion over 10 years*:

- \$434 billion for expansion of Medicaid and Children's Health Insurance Program enrollment
- \$466 billion for subsidies to fund qualified insurance products for individuals and families up to 400 percent of the federal poverty level
- \$40 billion for small employer tax credits

*This estimate does not include the CBO's estimate of \$115 billion in discretionary spending.

Key proposed sources of funding for the health care reform package:

- \$328 billion in reduced Medicare scheduled payments and Medicare Advantage cuts*
- \$210.2 billion Medicare payroll tax increases
- \$70 billion from premiums for long-term care program
- \$65 billion penalties paid by individuals and employers who do not buy insurance
- \$60 billion market share taxes on insurance companies
- \$36 billion in cuts to Medicare and Medicaid Disproportionate Share payments
- \$32 billion from taxes on "Cadillac" health plans
- \$27 billion taxes on brand-name pharmaceutical companies

- \$20 billion taxes on medical devices starting in 2013.

*These Medicare figures interact with great complexity and the figure could be higher

New taxes

- **Insurer market share tax:** Starting in 2014, health insurers are assessed a tax based on their share of certain premium revenue. Some nonprofit insurers that primarily serve Medicaid, Medicare and CHIP enrollees are exempt. Nonprofit HMOs have a partial exemption. The total value of this tax is approximately \$60 billion over 10 years.
- **Insurer excise tax (Cadillac tax):** Starting Jan. 1, 2018, a 40 percent excise tax is imposed on insurers (for insured coverage) and employers (for self-insured coverage) to the extent that the total 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 cost-of-living adjustment. 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.
- **Medical device tax:** Starting in 2013, all medical devices sold by a manufacturer, importer or producer are subject to a 2.3 percent tax of the value of the sold item. Some items are excluded from this tax, including eyeglasses, contact lenses and hearing aids. The total value of this tax is approximately \$20 billion over 10 years.
- **Pharmaceutical drug tax:** Starting in 2011, manufacturers of brand-name pharmaceutical drugs are assessed a tax based on the total amount of their drug sales compared to overall national drug sales. The total value of this tax is approximately \$27 billion over 10 years.
- **Medicare payroll tax Increase:** Currently, employers withhold 1.45 percent from a worker's salary as a Medicare tax. Starting in 2013, if the employee's salary exceeds \$200,000, or \$250,000 for married couples filing jointly, any amount above this threshold will be subject to a 2.35 percent withholding tax. This population will also pay a 3.8 percent tax on certain investment income under certain circumstances. These increases do not apply to the employer's portion of the Medicare payroll tax.

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