

federal healthcare reform overview

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major components of reform

Coverage expansion

- \$150 billion annually for Medicaid expansion and premium subsidies
- 32 million uninsured expected to gain coverage

Insurance reforms

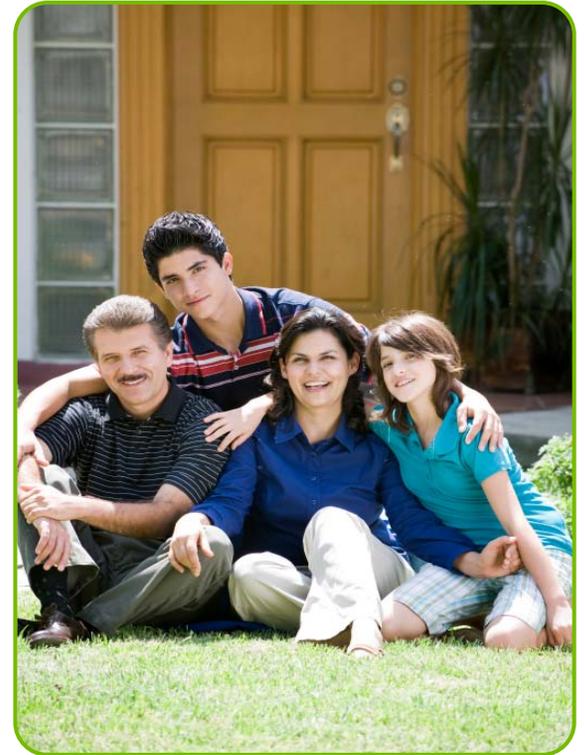
- Major overhaul of individual and small group markets
- Far less impact on large groups, but still some significant changes

Healthcare delivery system reforms

- Medicare payment advisory board
- Pilot programs to test new approaches to providing higher value care
- Comparative effectiveness research

coverage expansion: who benefits

- Expands Medicaid in 2014 to cover those with incomes up to 133% of the federal poverty level (\$29,000 for a family of four)
- Premium subsidies made available starting in 2014 for those with incomes up to 400% of the federal poverty level (\$88,000 for a family of four)
- Beginning in 2010, gradually closes the Medicare Part D “donut hole”



coverage expansion: who pays

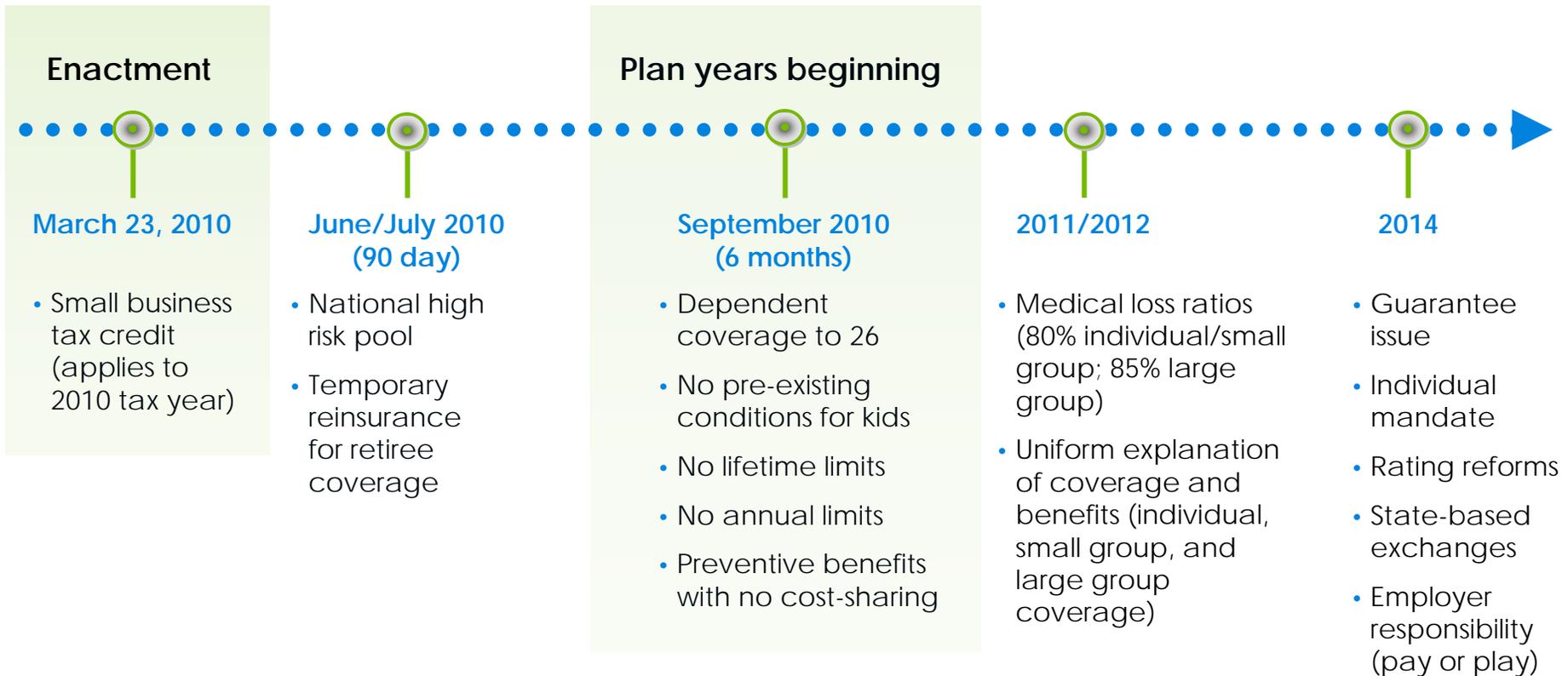
Higher taxes

- 10% tax on indoor tanning services (2010)
- Fee on pharmaceutical companies that starts at \$2.5 billion (2011)
- Excise tax of 2.3% on the sale of medical devices (2012)
- For individuals/couples earning over \$200K/\$250K, a 0.9% increase in Medicare payroll tax and a new 3.8% tax on unearned income (2013)
- Fee on insurers that starts at \$8 billion (2014)
- 40% tax on health benefit plans that cost more than \$10,200 single/\$27,500 family (2018)

and...

- Cuts in payments to Medicare Advantage insurers
- Reductions in future Medicare payment increases to hospitals

insurance reforms



small business tax credit

Eligible groups: Small employers (up to 25 employees) with less than \$40,000 in average wages who contribute at least 50% to total premium cost.

- **2010-2013:** Credit amount is up to 35% of employer costs (25% if tax exempt) with sliding scale for firm size and wages
- **2014 and beyond:** Credit amount is up to 50% of employer costs (35% if tax exempt) with sliding scale for firm size and wages. Coverage must be obtained through exchange and credit is limited to first 2 years of coverage.

90-day reforms

Reforms taking effect 90 days after enactment:

National high risk pool

- \$5 billion in funding to subsidize coverage for individuals with pre-existing conditions through high risk pools until 2014
- High risk pools must conform to federal standards to qualify for funding
- Important details to be determined in forthcoming regulations

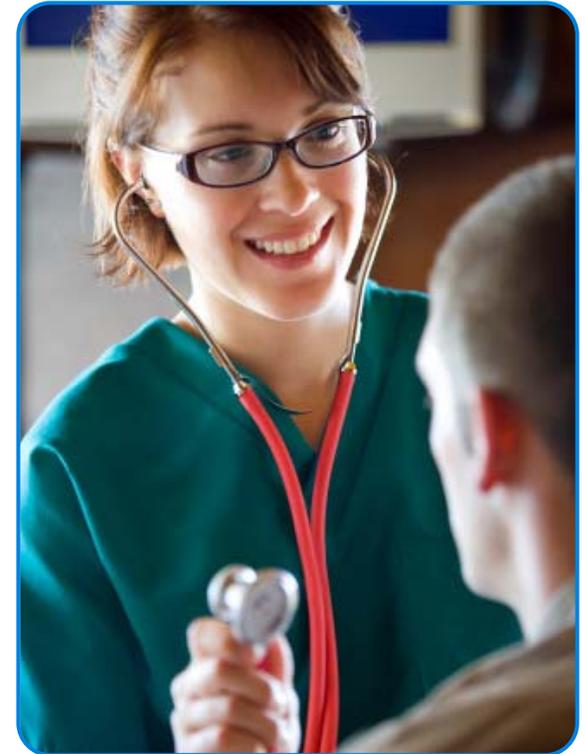
Temporary reinsurance for early retiree coverage

- \$5 billion in funding for reinsurance program for employers providing coverage to retirees age 55-64 who are not eligible for Medicare
- Pays 80% of eligible claims between \$15k and \$90k
- Program lasts until 2014 or the funding runs out
- Important details to be determined in forthcoming regulations

6-month reforms

Reforms applicable to individual and small and large group plans including self-funded, taking effect for “plan years” beginning 6 months after enactment (on or after September 23, 2010):

- Plans that provide dependent coverage must allow coverage of children until age 26
- No pre-existing condition exclusions for children
- No annual or lifetime limits on “essential benefits” (Secretary of Health and Human Services may allow restricted annual limits before January 1, 2014)
 - “Essential benefits” to be determined by regulations
- Preventive benefits with no cost-sharing
 - Mandate applies to services recommended by specified government health agencies
 - Health plans existing prior to March 23, 2010 are grandfathered and exempt from mandate



For existing policies, it is unclear which, if any, of the coverage changes must be instituted on the effective date of these provisions (six months following the law's enactment) as opposed to upon renewal following the effective date. We expect forthcoming regulations to clarify this issue.

2011 and 2012 reforms

Effective in 2011

- Insurers must pay refunds if they fail to achieve minimum medical loss ratios of 80% for small group and individual coverage, and 85% for large group coverage

Effective in 2012

- Uniform explanation of coverage and benefits, as detailed in forthcoming regulations, must be provided to enrollees for both individual, small group, and large group coverage



2014 insurance reforms

Major reforms taking effect in 2014

- Guarantee issue
 - No one can be denied coverage based on health status
- Individual mandate
 - Individuals must maintain coverage or pay penalties starting in 2014 at the lesser of \$95 or 1% of income and phasing up in 2016 and beyond to \$695 or 2.5% of income
 - Specified exceptions are made for affordability and other reasons
- Rating reforms
 - Rates may not be based on health status and can differ by a maximum of 3:1 based on age
- State-based insurance exchanges
 - Exchanges are open initially only to individuals and small groups, and may be opened by state to large groups starting in 2017 if the Secretary of Health and Human Services agrees



2014 insurance reforms

Major reforms taking effect in 2014

- Employer responsibility
 - Requirement to offer coverage or pay penalties
 - Reporting requirements, auto-enrollment
- Expansion of small groups
 - Small groups defined as 1-100
 - Prior to 2016, state has option to limit size to 50
- Wellness discounts
 - Employer may offer discount of up to 30% for participation in wellness programs
 - Secretary of Health and Human Services may increase to 50%



employer responsibility in 2014

Requirements for employers to avoid penalties (“play”)

Employers >50 FTEs must offer minimum coverage:

- Part-time are included on FTE basis in calculating >50 FTE
- FTE is 30+ hours/week
- No minimum premium contribution by employer is required
- Must provide “essential coverage” with 60% actuarial value minimum

When employers are subject to penalties (“pay”)

Employer has >50 FTEs and:

- Not offering coverage and at least one FTE receives subsidized coverage from exchange, then employer pays \$2,000 x total number of FTEs (minus first 30 FTEs)
- Offering coverage but actuarial value < 60% or employee cost is > 9.5% of household income and at least one FTE receives tax credit, then employer pays lesser of \$2000 x total FTEs or \$3000 x number of employees receiving tax credit

other employer responsibility provisions

Free choice voucher	Employers must offer voucher to qualified employees enabling them to apply employer premium contribution towards purchase of exchange provided coverage (employee qualifies if cost of employer coverage is 8-9.5% of household income)
Auto-enrollment	Employers >200 employees must auto-enroll FTEs into health plan, with opt-out right for employees (effective date of this provision is not specified)
Treasury reporting	Employers required to submit detailed annual reports regarding coverage to Treasury Department
W-2 reporting	Must disclose cost of coverage (effective 2011)

healthcare delivery system reforms

Key provisions:

- Independent Medicare payment advisory board
 - Recommends Medicare cost saving steps for expedited congressional action
- Pilot programs to test new approaches to paying for care that reward quality over volume
- Dedicated funding for research in comparative effectiveness of different drugs and treatments
 - Funded with annual assessment on Medicare trust fund and \$2-per-enrollee fee per year on all health plans, including self-funded



looking ahead



- No immediate changes to coverage or application processes are required
- Determining the exact impact of many provisions will not be possible until federal regulations are issued
- Blue Shield is currently examining the law and determining the specific actions we will take to implement it
- We will continue to keep you informed on all important developments