



Fully Insured

Navigating the next phase of health care reform

Health care reform timeline

A year-by-year look at what to expect

2010	<ul style="list-style-type: none"> • Early Retiree Reinsurance Program began • Began closing the Medicare Part D “donut hole”
Beginning of plan year that starts on or after September 23, 2010	<ul style="list-style-type: none"> • Dependent coverage for adult children up to age 26 (or higher if state law mandates it) • No lifetime dollar limits on benefits • Restricted annual dollar limits on essential health benefits • No pre-existing condition exclusions for children • 100% coverage for preventive services in network* • No prior authorization for emergency services or higher cost-sharing for out-of-network emergency services* • No referrals required for OB/GYN services • Any available primary care physician (PCP) accepting new patients may be selected • Pediatrician may be selected as a PCP for children • Revised appeals process and changes to adverse benefit determinations (enforcement of some regulations delayed until detailed guidance is issued)* • No discrimination in favor of highly compensated employees (enforcement delayed until detailed guidance is issued)*
2011	<ul style="list-style-type: none"> • Prescription required for health account reimbursement for over-the-counter medications • 20% tax for nonqualified HSA withdrawals • Medical loss ratio standards go into effect (85% for large group) • CLASS long-term care program developed (enrollment date to be determined)
2012	<ul style="list-style-type: none"> • Uniform coverage summaries/60-day notice for material modifications • Value of employer-sponsored coverage on W-2s for 2012 tax year – meaning W-2s issued in January 2013 (originally required earlier, but the IRS delayed the requirement until the 2012 tax year for large employers and the 2013 tax year for employers who issue fewer than 250 W-2s) • First year medical loss ratio rebates may be issued
2013	<ul style="list-style-type: none"> • Employee notification of exchanges, premium subsidies and free choice vouchers • Medical flexible spending account contributions limited to \$2,500 per year • Annual per-member fee for Patient-Centered Outcomes Research Institute (for fiscal year 2013, which technically begins October 1, 2012)
2014	<ul style="list-style-type: none"> • Penalties for employers who don't provide minimum coverage to full-time employees (50+ employees) • Employer requirement to auto-enroll employees into health benefits (200+ employees) • Free choice voucher required to be provided to qualifying employees • 90-day limit on waiting periods for coverage • Small group redefined as 1-100 (states may defer until 2016) • No annual dollar limits on essential health benefits • Individual mandate • Guaranteed issue • 30% incentive cap for wellness programs • Coverage of routine patient costs for clinical trials of life-threatening diseases*
2014	<ul style="list-style-type: none"> • 40% excise tax on high-cost “Cadillac” plans

*Not required for grandfathered group health plans

Benefit changes. Coverage requirements. Automatic enrollment. Free choice vouchers. When it comes to health care reform, there's a lot to know – and a lot to do. The more you understand the law and its provisions, the better you can prepare for change and make strategic decisions that fit your organization and your employees.

On the other hand, too much information can be overwhelming. That's why this guide focuses only on the key provisions that will affect you and the key decisions you need to make. If you want more details, chat with your broker or account representative or visit our website at bcbsga.com/healthcarereform.

Moving reform forward for the benefit of you and your employees

To minimize disruption for you and your employees, we aim to implement health care reform as quickly and effectively as possible. While unresolved legal and legislative challenges have created uncertainty about the future of health care reform, these challenges will not affect our current implementation efforts. We will continue to implement reform in good faith for the benefit of our customers and members.

Exempted plans

The federal health care reform law will impact many types of plans, but there are exceptions. In general, these plans are exempted from all or some provisions of health care reform:

- Retiree-only plans with no active employees
- HIPAA-excepted benefits (benefits that are not an integral part of a health plan, such as stand-alone dental and vision, life and disability plans)
- Short-term health insurance plans
- Medigap and Medicare Supplement plans
- Long-term care insurance
- Employee assistance plans

Looking back at 2010

Employers weigh the pros and cons of grandfathering

For many employers, the big decision in 2010 was whether to grandfather their benefit plans. Under the health care reform law, plans that existed on or before March 23, 2010, and haven't made certain changes since then may be considered grandfathered plans. Grandfathered plans may be exempt from some of the requirements of the health care reform law.

Cost concerns versus benefit implications

In 2010, we saw muted market interest in retaining grandfathered status. Why? Many employers cited the complexities of remaining grandfathered, as well as a perception that it would offer limited benefit to them. This reflects the difficulty of health care reform for many employers: balancing today's cost concerns with tomorrow's potential benefit implications:

Employers' reasons to not grandfather	Employers' reasons to stay grandfathered
<p>Now (2010-2013):</p> <ul style="list-style-type: none">• More flexibility to manage immediate cost concerns through benefit buy-downs and changes to employer contribution levels• Fewer administrative responsibilities such as notices and mandatory language on plan documents• Access to all of the additional benefits the health care reform law requires, such as 100% coverage for in-network preventive care services* <p>Later (2014 and beyond):</p> <ul style="list-style-type: none">• To be determined	<p>Now (2010-2013):</p> <ul style="list-style-type: none">• Not required to include some benefits, such as 100% coverage for in-network preventive care services*• Able to maintain plan designs that aren't allowed for nongrandfathered plans <p>Later (2014 and beyond):</p> <ul style="list-style-type: none">• Not limited to four benefit tiers, all of which must include essential health benefits• Not required to implement community rating requirements and restricted age-based rating factors (small groups only)

Can you grandfather? Should you?

For the 2011 plan year, we supported the efforts of customers who wished to remain grandfathered. For the upcoming plan year we will continue to administer grandfathered plans upon the request of our customers who qualify. To help you decide whether you're eligible to grandfather – and if grandfathering is the right decision for you – we've developed a simple, interactive online tool that offers customized feedback based on your input. Try out the tool at bcbsga.com/healthcarereform or talk to your account representative.

*While not all health care reform changes are required in grandfathered plans, in some cases our company has decided to adopt health care reform provisions in both grandfathered and nongrandfathered plans. According to the U.S. Department of Health and Human Services (HHS), adoption of these additional provisions has no impact on the grandfathering status of those plans. For specific benefit plan impacts of health care reform, please refer to plan materials provided to you.

Looking back at 2010

How we implemented the first round of provisions

Here's an overview of how we implemented some key provisions for group health plans in 2010. These provisions went into effect for plan years beginning on or after September 23, 2010:

Dependent coverage to age 26

For many plans, we implemented this provision early to avoid a coverage gap for spring 2010 graduates. Group plan members were given the opportunity to enroll dependents younger than 26 at their first open enrollment after September 23, 2010. We decided to cover dependents to age 26 for most vision and dental plans as well, even though the health care reform law doesn't apply to these HIPAA-exceptions benefits.

No lifetime dollar limits/restricted annual dollar limits on essential health benefits

We removed lifetime dollar limits from plans where required and gave individuals who may have previously reached their lifetime maximum an opportunity to re-enroll at the group's regular open enrollment. We implemented the annual limits provision, removing annual benefit and plan dollar limits. In general, we are not administering restricted annual limits on essential health benefits (also known as transitional annual limits).

No member cost share for in-network preventive care*

We expanded our standard preventive care list and updated nongrandfathered plans to cover these services with no member cost share. We also chose to include this coverage in some grandfathered plans.

Patient protections*

We decided to include these provisions in all plans, even though they aren't required for grandfathered plans.

Revised appeals process and adverse benefit determinations*

We created a standard appeal process that complies with health care reform for fully insured and self-insured groups. We're in the process of updating adverse benefit determinations (including explanation of benefit forms) to comply with this provision's notice requirements. Enforcement of some regulations has been delayed until detailed guidance is issued.

No discrimination in favor of highly compensated employees*

In December 2010, the government issued a notice delaying enforcement of this provision until more guidance is available. It is the employer's or group's responsibility to ensure compliance with this provision.

Early Retiree Reinsurance Program

Five billion dollars has been set aside to help employers continue to provide coverage to certain retirees. This is a temporary program, beginning in June 2010 and ending in 2014 or when the funds are exhausted - whichever comes first. We have helped customers apply for these funds by supplying required reporting and information.

*Not required for grandfathered group health plans

Looking forward

Making gradual shifts from 2011 to 2013

From 2011 to 2013, reform shifts to a new phase: less emphasis on benefit changes and more emphasis on industry regulation and funding reform-related programs. Some key provisions you should be aware of:

Spending account changes

Starting January 1, 2011 (regardless of plan year dates), prescriptions are required for spending account reimbursement of over-the-counter drugs other than insulin. Also on January 1, the penalty for nonqualified health savings account distributions went up to 20%. Starting in 2013, flexible spending account contributions will be limited to \$2,500 per year. The limit will be adjusted for the cost of living every year.

Uniform coverage summary/notice of material modification

Starting in 2012, plan summaries must have consistent contents and formatting. For fully insured plans, the plan issuer must provide a compliant paper or electronic summary at certain times in the enrollment process. Also, the plan issuer must provide 60-day notice for material modifications to plan benefits.

W-2 reporting

Employers must start reporting the value of employer-sponsored coverage on W-2 forms for the 2011 tax year – meaning W-2s issued in January 2012. This will be a new, separate entry on the W-2 form. The requirement applies to anyone who is still receiving benefits from their employer, including COBRA participants and retirees (even though retiree-only plans are exempted from the health care reform law). This is a reporting obligation only and does not change the current tax-free nature of the benefit.

Medical loss ratios

Health insurance issuers will report medical loss ratios (the percentage of premiums spent on medical care, as opposed to administrative expenses) to HHS on a calendar-year schedule. This reporting starts with calendar year 2011. Issuers that don't meet the minimum medical loss ratio (85% for large group) during the calendar year will need to pay rebates by August 1 of the following year. The first rebate payments, if any, must be made by August 1, 2012. For group plans, the regulations state these rebates should go to enrollees, defined as anyone covered by the plan.

Comparative effectiveness research plan fees

For plan/policy years ending after September 30, 2012, and before October 1, 2019, the plan issuer or sponsor will pay a fee to partially support the Patient-Centered Outcomes Research Institute. In the first year, the annual fee will be \$1 multiplied by the average number of covered lives. In the second year, it will increase to \$2 multiplied by the average number of covered lives.

Notification requirements

Starting in 2013, employers will need to start telling employees about health insurance exchanges, premium subsidies and free choice vouchers.

What do you need to do?

- If you offer spending accounts, update your employee benefit materials to reflect the new rules.
- Make sure your payroll department or vendor is prepared for W-2 reporting.

Looking forward

Moving to a new health insurance market in 2014

The most significant health care reform requirements start in 2014. These are some of the key requirements that will affect employers:

Employer responsibility to provide coverage

Employers with 50 or more full-time employees must offer minimum coverage to active employees (see sidebar). Employers will be subject to penalties if they don't provide minimum coverage to full-time employees or if they provide coverage that is not "affordable." These penalties will range from \$2,000 to \$3,000 per employee.

Automatic enrollment

Employers with more than 200 employees must automatically enroll new and existing full-time employees in health insurance plans. Employees may opt out.

Health insurance exchanges

States will begin to operate health insurance exchanges, which are envisioned to be marketplaces for individuals and some employer groups to obtain private health insurance.

Employers will also be able to purchase coverage outside of the exchanges.

Federal rules for exchanges are expected to be released in 2011. In addition, state legislatures and regulators are expected to set up exchanges before 2014. Leading up to this time, we've encouraged policymakers to design exchange policies that maximize product choice inside the exchange and minimize disruptions to the existing marketplace.

Employer reporting requirements

Employers will be required to report certain information to the IRS annually. This information includes:

- Whether minimum coverage is offered to full-time employees
- Any waiting periods for health coverage
- The monthly premium for the lowest cost option in each enrollment category under the plan
- The employer's share of the total allowed cost of benefits provided under the plan
- Number of full-time employees during each month
- Name, address and taxpayer identification number (or Social Security number) of each full-time employee, and the months each employee was covered under the employer's plan
- Other information that HHS may require (which will likely be refined in later regulations)

Requirements for minimum coverage

To be considered minimum coverage, a plan must:

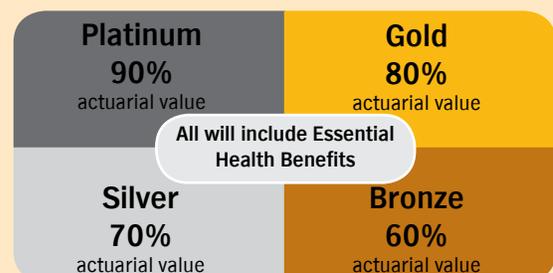
- Provide 60% actuarial value minimum – basically, this means the plan covers at least 60% of covered health care costs.
- Not cost more than 9.5% of the employee's household income.

Note: Benefit package requirements are not defined; current guidance does not indicate that large group and self-insured plans will need to include the essential health benefits package.

Requirements for exchange plans

To be offered in an exchange, a plan must:

- Include the essential health benefits package.
- Provide 60% actuarial value minimum.
- Comply with one of the four benefit tiers with specified actuarial values (shown on the right).



Plus catastrophic plan offerings for individuals who are younger than 30 or qualify because of financial hardship

FAQs

Answering common questions about health care reform

Can we increase our deductible a little bit each year and stay grandfathered?

A small increase every year could cause a loss of grandfathered status. That's because grandfathered status is determined by comparing benefits and contributions to the baseline plan in place on March 23, 2010, not the plan in place during the previous plan year. For more details about changes that would cause a loss of grandfathered status, visit our website at bcbsga.com/healthcarereform. You can also discuss your unique situation with your account representative.

If we make a benefit change that causes us to lose grandfathered status, when do we need to move to a nongrandfathered plan?

Plans must comply with applicable health care reform requirements at their first renewal on or after September 23, 2010. So, if you make a benefit change that causes a loss of grandfathered status:

- Between September 23, 2010, and your next renewal, then you would need to move to a nongrandfathered plan at your next renewal.
- Anytime after your first renewal after September 23, 2010, then you would need to move to a nongrandfathered plan immediately.

This assumes changes to plan benefits only. If a change triggers a new contract (for example, moving from an HMO legal entity to a PPO legal entity), the plan must move to nongrandfathered benefits immediately.

What preventive care services were added for nongrandfathered plans?

Most of the services required by HHS were already included in our preventive care guidelines; however, we did make some modifications:

- We added certain services, including several additional screening tests and certain services associated with previously covered screenings and vaccines.
- We added counseling related to aspirin use, tobacco cessation, obesity and alcohol.
- Some services currently covered as medical/maternity will now be considered preventive and covered with no cost share applied.

What services are considered essential health benefits?

HHS has not yet defined the specific services; however, we do know that essential health benefits include at least these general categories:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services
- Chronic disease management
- Pediatric services, including oral and vision care

Does the health care reform law require health plans to cover members' costs for clinical trials?

Starting in 2014, nongrandfathered plans must include coverage of routine patient costs for clinical trials of life-threatening diseases.

How does a fully insured plan determine whether it is complying with nondiscrimination tests?

We recommend that the group work with its legal and benefits counselors as we cannot provide legal or tax advice. The health care reform law states that the rules for determining compliance for fully insured plans are similar to the rules that apply for self-insured plans. These rules are outlined in Internal Revenue Code Section 105. In December 2010, the government issued a notice delaying enforcement of this provision until more guidance is issued.

Can an employer impose an eligibility waiting period before enrolling new employees?

Yes, to the extent that the federal health care reform law and state law permits. Starting in 2014, under the federal health care reform law eligibility waiting periods cannot exceed 90 days.

Does the employer mandate provision require employers to offer dependent coverage?

No, dependents do not have to be offered coverage based on the employer mandate.

How will the free choice vouchers work?

An employer would provide a free choice voucher in an amount equal to what the employer would have paid to provide coverage to the employee if all of the following apply:

- The employee's income is less than 400% of the federal poverty level
- The employee's share of the health insurance premium is more than 8% but is less than 9.8% of his or her household income
- The employee chooses to enroll in an exchange plan rather than the employer's plan

What is considered a "Cadillac plan"?

The health care reform law defines high-cost coverage (also known as a "Cadillac plan") as a plan that costs more than \$10,200 (multiplied by the health cost adjustment percentage) for single coverage or \$27,500 (multiplied by the health cost adjustment percentage) for family coverage. The health care reform law imposes a 40% excise tax on these plans starting in 2018. The insurer or employer will be responsible for the tax. The amounts will increase in future years based on factors that will be provided to the insurer or employer.

Find more questions and answers on our website

We're constantly adding new health care reform resources to our website, including answers to common questions. If you have a question about health care reform that isn't answered here, be sure to visit bcbsga.com/healthcarereform.

Summary

Pulling it all together

Provision	Required for grandfathered plans	Required for nongrandfathered plans
No lifetime benefit dollar limits	✓	✓
Dependent coverage for adult children up to age 26 (or higher if state law mandates it)	✓	✓
No annual dollar limits on certain types of benefits for group plans	✓	✓
100% coverage for preventive care in-network	*	✓
No prior authorization for emergency services or higher cost sharing for out-of-network emergency services	*	✓
No pre-existing limitations for children under the age of 19 for group plans	✓	✓
No discrimination in favor of highly compensated employees		✓
Revised appeals process and changes to adverse benefit determinations	*	✓
Reporting the value of employer-sponsored coverage on W-2s (2012 tax year)	✓	✓
Uniform explanation of coverage (2012)	✓	✓
Pre-enrollment document sent explaining benefits and exclusions (2012)	✓	✓
60-day notice for material modifications to plan benefits (2012)	✓	✓
90-day limit on waiting periods for coverage (2014)	✓	✓
Penalties for 50+ employers who don't provide minimum coverage to full-time employees (2014)	✓	✓
Automatic enrollment in health plan for employers with 200+ employees (2014)	✓	✓
Coverage of routine patient costs for clinical trials of life-threatening diseases (2014)		✓

*In some cases our company has decided to adopt these health care reform provisions in both grandfathered and nongrandfathered plans.

What do you need to do?

- Visit our health care reform website for details about maintaining grandfathered status.
- Update spending account materials to reflect new rules.
- Prepare for W-2 reporting for the 2012 tax year.

Need help making decisions in the complex post-health care reform environment?

We've developed tools to make health care reform information more understandable and customized.

Check out our comprehensive online resource for up-to-the-minute information and tools:

- Articles and fact sheets summarize the regulations and answer common questions.
- User-friendly layout makes it easy to find the information you need.

It's all at bcbsga.com/healthcarereform.

There's a lot to know when it comes to the health care reform law. And there's more to come as this law continues to take shape. For the latest developments, check in at bcbsga.com/healthcarereform.



This content is provided solely for informational purposes. It is not intended as and does not constitute legal advice. The information contained herein should not be relied upon or used as a substitute for consultation with legal, accounting, tax and/or other professional advisers.

Blue Cross and Blue Shield of Georgia, Inc. and Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. are independent licensees of the Blue Cross and Blue Shield Association. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.