



# Bringing Health Care Reform Into Focus

## A HEALTH CARE REFORM REFERENCE GUIDE

Blue Cross and Blue Shield of North Carolina (BCBSNC) HEALTH POLICY OFFICE - CURRENT AS OF JUNE 2013

# Table of Contents

## Basics About Health Care Reform

High Level Summary of the Affordable Care Act (ACA)	2
Current Thinking on Business Impacts	3
Timeline of ACA Provisions	4-6
Communication & Education about the Law (Including links to various important resources)	7
How to Read What Follows	8
What Does "Grandfathering" (GF) Mean? This one is important to understand	9



## Blue Cross and Blue Shield of North Carolina (BCBSNC) Proprietary and Confidential, Current as of June 2013

Specific Provision or Issue Examined	Impacts Individual Market	Impacts Small Group Market	Impacts Large Group Market	Page
ACA Benefit Requirements in 2014	Individual	Small Group		10
Essential Health Benefits	Individual	Small Group	May apply	11
Fund Products (changes to HSA, FSA)	Individual	Small Group	May apply in 2017	12
Exchanges General Impact on Markets & Groups	Individual	Small Group	May apply in 2017	13
Individual Mandate	Not segment-specific but impacts overall health care system			17
Employer Shared Responsibility Excise Tax ("Play or Pay")			More than 50 FTEs	18
Subsidies	Individual	In some cases, employee may qualify		19
Small Business Tax Credits		Fewer than 25 FTEs		20
ACA Taxes and Fees	Individual	Small Group		21
Medical Loss Ratio (MLR)	Individual	Small Group	ASO exempt	23
Impact of Reform on Premiums	Individual	Small Group		24
Rate Review	Individual	Small Group	ASO exempt	25
Uniform Coverage Summaries	Individual	Small Group		26
Accountable Care Organizations (ACO)	Not segment-specific but impacts overall health care system			27
Preventive Care	Individual	Small Group		28
ACA Changes to Date	Individual	Small Group		29
Impact of ACA on Brokers	Individual	Small Group		30
Employer Shared Responsibility		Small Group		31

**Remember:** BCBSNC is unable to provide legal or tax advice regarding provisions of the ACA that impact groups. Groups should consult their own attorneys and/or tax advisors to ensure they understand their responsibilities and are compliant with the new requirements.

On July 2, 2013, the Treasury Department announced that mandatory reporting requirements will be delayed for large employers (50+ employees) who provide coverage to employees and insurers offering enrollment in coverage. As a result, the IRS is delaying enforcement/imposition of penalties on large employers who do not offer coverage to their employees in 2014.



## High Level Summary of the Affordable Care Act

Congress passed the Affordable Care Act (ACA) in March 2010. The law intends to address certain fundamental issues with our current health care system, outlining a plan to:

1. increase access to health insurance
2. implement insurance industry reforms
3. improve health care quality, and
4. curb rapidly rising health care costs.

Some provisions of ACA's early consumer protections have had a staggered implementation throughout 2010, 2011, 2012 and 2013 and implementation will continue through 2018 (for details, see the high-level America's Health Insurance Plans (AHIP) timeline on page 5) – but the major, more transformational aspects of health care reform will not take effect until 2014. These include:

- + The individual mandate to purchase health insurance (coupled with federal subsidies for individuals or families under 400% of the Federal Poverty Level – FPL)
- + Expansion of the Medicaid program
- + Employer Shared Responsibility Excise Tax ("Play or Pay" penalties) for employers with 50+ employees
- + New rules which will change the way insurers operate, including:
  - Requiring insurers to accept any applicant, regardless of health status (i.e. "guarantee issue")
  - Prohibiting insurers from considering health status in determining what premium to charge (i.e. eliminating "medical underwriting")
  - "Community Rating" requirements, including:
    - o Limiting the premium impact of a person's age to no more than a 3 to 1 ratio for adults
    - o Limiting the premium impact of a person's tobacco use to no more than a 1.5 to 1 ratio
    - o Prohibiting premiums from varying based on gender
- + Changes to the way Americans shop for and buy insurance through the creation of "Exchanges," which allow small employer groups and individuals to compare and purchase health coverage plans from a variety of health insurers
- + Many provisions requiring that certain standard benefits are included at a minimum level of coverage

Other significant elements that will be phased in over the months and years ahead include new taxes on insurers, elimination of the Medicare Part D 'Doughnut Hole' and significant reductions in Medicare Advantage fees to insurers.

## Market Impacts

- + New products needed
- + Medicare Advantage cuts
- + Shifts in market segments
- + New opportunities from subsidy market

## Sales Impacts

- + New competitors
- + Better prepare producers
- + Higher premiums likely
- + Employers will consider whether to “play or pay”

## New Processes/Functions

- + New methods of risk management
- + Increased reporting requirements
- + Increased transparency
- + New, yet-to-be-determined capabilities
- + Data exchange with government entities

# Current Thinking on Business Impacts

The ACA does many things that BCBSNC supports, however, we believe it does not do enough to address the rapid rate of increase in the cost of health care.

As explained later in this document, BCBSNC believes the law's combination of insurance reforms, additional benefit requirements and new health care taxes will increase premiums – particularly in the Individual and Small Group markets. These increases will be greater when coupled with ACA's penalties for those who don't buy insurance, which are less than the expected cost of premiums. For all of these reasons, preserving – and strengthening – the individual mandate is critical to the success of the ACA.

## Implementation of the Law and Business Impacts

The Secretary of the US Department of Health and Human Services (HHS) is charged with overseeing the implementation of most provisions of the ACA. While the law offers potential to improve health care access, quality, and population health, it will also create challenges for the state of North Carolina, businesses large and small, health care professionals, and insurers.

The law creates complex and far-reaching new requirements for health plans that will fundamentally change insurer business models beginning in 2014, including many new requirements related to Exchange participation, risk mitigation, insurance reforms, benefit requirements, and more.

Other impacts will be gauged with final regulations from HHS and any additional action by the State of North Carolina, which will be needed to clarify the operational requirements in the post-2014 environment. Providing adequate lead-time to plan for and implement the many new requirements will be essential to ensuring the smoothest possible transition, with open enrollment starting on October 1, 2013. BCBSNC's Health Policy Office is working closely with the Blue Cross and Blue Shield Association (BCBSA), America's Health Insurance Plans (AHIP) and internal business areas to ensure the business impacts of each provision are understood and planned for (or implemented) properly; this process will be ongoing and intensive over the next several years.







# ACA timeline

# Timeline of ACA Provisions

High-level AHIP timeline summarizing requirements of the Affordable Care Act and selected impacts:

## Summary

### January 1

- + State grants to establish or expand ombudsman programs are awarded
- + New federal rate review process is established
- + National risk-pool is created 90 days from enactment
- + Temporary retiree reinsurance program is established

### October 1

- + Prohibits lifetime benefit limits
- + Allows restricted annual limits for essential benefits (as determined by HHS)
- + Rescissions are prohibited (except for fraud or intentional misrepresentation)
- + Cost-sharing obligations for preventive services are prohibited
- + Dependent coverage up to age 26 is mandated
- + Internal and external appeal processes must be established
- + Discrimination based on salary is prohibited
- + Internet portal to facilitate consumer and small employer shopping is created
- + Coverage for emergency services at in-network cost-sharing level with no prior authorization is mandated
- + Pre-existing condition exclusions for dependent children (under age 19 years of age) are prohibited
- + New health plan disclosure and transparency requirements are created

## Grandfathered Plans

### October 1

- + Prohibits lifetime benefit limits
- + Rescissions are prohibited (except for fraud or intentional misrepresentation)
- + Dependent coverage up to age 26 is mandated
- + Pre-existing condition exclusions for dependents are prohibited
- + Allows restricted annual limits for essential benefits (as determined by HHS)

### January 1

- + Uniform coverage documents and standard definitions are developed by HHS (in consultation with NAIC)
- + 85% MLR for large group (with refund) is mandated
- + 80% MLR for individual and small group (with refund) is mandated
- + August – some preventive services must be covered with no cost sharing

- + Employers issuing 250 or more W-2s must report the value of benefits on each employee's W-2 form for tax year 2012

- + A variety of women's preventive services must be covered with no cost share

## Impact

### January 1

- + Health plans develop and file new rates
- + States approve (or disapprove) new rate filings
- + HHS Secretary and states create new rate review process
- + HHS Secretary establishes new national risk-pool
- + HHS Secretary establishes temporary retiree reinsurance program

### October 1

- + Health plans create and file new policy forms
- + Health plans develop and file new rate filings
- + States approve (or disapprove) new policy forms
- + States approve (or disapprove) new rate filings
- + HHS Secretary and states approve (or disapprove) premium rate increase requests
- + HHS Secretary establishes new Internet portal

2010

2011

2012

	Summary	Impact
2013	<b>January 1</b> <ul style="list-style-type: none"> <li>+ Health insurance fee to fund Comparative Effectiveness begins October 1st – Open enrollment for Health insurance Exchanges begins</li> </ul> <b>October 1</b> <ul style="list-style-type: none"> <li>+ Health insurance Exchanges are established</li> </ul>	<b>January 1</b> <ul style="list-style-type: none"> <li>+ Health plans develop and file new rates</li> <li>+ States approve (or disapprove) new rate filings</li> <li>+ HHS Secretary and states approve (or disapprove) premium rate increase request</li> </ul>
	<b>January 1</b> <ul style="list-style-type: none"> <li>+ Health insurers collectively assessed \$8 billion in the form of an annual fee to increase over time</li> <li>+ Guaranteed issue is required</li> <li>+ Rating restrictions that, among other things, limit use of age as a rating factor are imposed</li> <li>+ Individual and employer responsibility requirements are established</li> <li>+ Individual affordability tax credits are created and small business tax credits are expanded</li> <li>+ Essential benefit plan is created</li> <li>+ Pre-existing condition exclusions are prohibited</li> <li>+ Lifetime and annual dollar limits are prohibited for essential benefits</li> <li>+ Coverage for approved clinical trials is mandated</li> <li>+ Multi-state qualified health plans are created and offered through the Exchange</li> </ul> <b>Grandfathered Plans</b> <b>January 1</b> <ul style="list-style-type: none"> <li>+ Pre-existing condition exclusions are prohibited</li> <li>+ Annual benefit limits are prohibited</li> </ul>	<b>January 1</b> <ul style="list-style-type: none"> <li>+ Health plans create and file new policy forms</li> <li>+ Health plans develop and file new rates</li> <li>+ States approve or approve new policy forms</li> <li>+ States approve or approve new rate filings</li> <li>+ HHS Secretary and states approve (or disapprove) premium rate increase requests</li> <li>+ States (and/or HHS Secretary) establish Exchanges</li> </ul>
2015	<b>January 1</b> <ul style="list-style-type: none"> <li>+ Health insurer tax assessment increased to 11.3 billion</li> </ul>	
2016	<b>January 1</b> <ul style="list-style-type: none"> <li>+ Health insurer tax assessment remains at 11.3 billion</li> </ul>	
2017	<b>January 1</b> <ul style="list-style-type: none"> <li>+ Health insurer tax assessment increased to 13.9 billion</li> </ul>	
2018	<b>January 1</b> <ul style="list-style-type: none"> <li>+ High-cost insurance excise tax is established</li> <li>+ Health insurer tax assessment increased to 14.3 billion</li> </ul>	



## Communication and Education about the Law

BCBSNC was among the nation's first insurers to explain the meaning of health care reform broadly, launching an educational, stakeholder-specific website ([www.nchealthreform.com](http://www.nchealthreform.com)) just four months after ACA passage.

The BCBSNC Health Policy Office regularly authors a series of white papers on ACA-related topics which are particularly relevant to the business, or the public at-large. Each "Spotlight" article contains an issue summary, BCBSNC's position on the matter, expected impacts on the state of North Carolina specifically and more. All current editions can be found in the Spotlight Archive at [www.nchealthreform.com](http://www.nchealthreform.com).

- + ACA Employer Impacts
- + ACA Impact on Insurance
- + ACA Insurance Reforms
- + ACA Taxes on Insurers
- + Accountable Care Organizations V1
- + Accountable Care Organizations V2
- + Actuarial Value
- + Basic Health Plan
- + Comparative Effectiveness Research
- + Co-Ops
- + Dental
- + Early Retiree Reinsurance Program
- + Electronic Health Records
- + Essential Benefits
- + Exchanges
- + Fraud
- + "Grandfathering"
- + Health Disparities
- + Health Insurance Subsidies
- + HHS Web Portal
- + High Risk Pools
- + Impact of ACA on Providers
- + The Individual Mandate
- + Medicaid Expansion
- + Medical Loss Ratios (MLR)
- + Medicare Advantage
- + Medicare Part D
- + Medicare Supplement
- + Mental Health Parity/Disabilities
- + "Mini-Meds"/Annual Limit Waivers
- + New Game, New Players
- + New Taxes on Insurers/Impact
- + North Carolina and Rate Review
- + Pharmaceuticals
- + Prevention
- + Provider Quality
- + Provider Reimbursement
- + Provider Supply
- + Reforms Implemented in 2010
- + Reforms Implemented in 2011
- + Reforms Implemented in 2012
- + Reforms in 2013
- + Risk Assessment
- + Small Business Tax Credit
- + Student Plans
- + Supreme Court, After the Decision
- + Uniform Summaries
- + Wellness





## How to Read What Follows

*Generally, the content which follows is broken out by subject area and is presented in the following table format.*

### Context

The big picture

### Specifics

Supporting details

### Our View

Our positions, perspectives or actions taken to date.

### Glossary of terms used in the Reference Guide:

**EHB** – Essential Health Benefits

**FSA** – Flexible Spending Account

**HSA** – Health Savings Account

**MLR** – Medical Loss Ratio

**QHP** – Qualified Health Plan



# Grandfathering

*The ACA allows some plans in effect prior to March 23, 2010 to be “grandfathered” and exempt from certain ACA requirements.*

## Context

Grandfathered plans are exempt from certain requirements of ACA.

## Specifics

- + Grandfathered plans are exempt from the following ACA provisions:
  - Preventive Services covered at 100%
  - Patient Protections (Emergency Services, Access to OB/GYN, Peds, Primary Care)
  - Internal/External Appeals
  - Community Rating
  - Clinical Trials mandate
  - Essential benefits
  - Risk Corridor/Transitional Reinsurance/Risk Adjustment Programs
  - Meeting minimum 60% actuarial value in order to satisfy the individual mandate
- + Certain changes to a grandfathered plan (like increases in cost sharing requirements or out-of-pocket maximums) would result in the plan losing grandfathered status.
- + Carriers can decide whether or not to allow grandfathering.

## Our View

- + We will enable many individuals and large groups (51 or more members) to take advantage of grandfathering. However, due to the complexity of maintaining grandfathered plans, BCBSNC will not offer grandfathering to small groups (those with 1 to 50 members).
- + Also due to the administrative requirements defined by the strict regulations and complexity resulting from maintaining grandfathering, BCBSNC made the business decision that any change in plan benefits will result in loss of grandfathered status. (Only applies to underwritten plans; ASO plans make their own determination as to whether their plan is grandfathered and use the federal definition.)
- + Beginning in Q2 2013, BCBSNC Individual Members have access to the “Blue Map” – an online tool to assist BCBSNC members in understanding how to navigate health care reform. The tool helps members make informed decisions about changing their plans given ACA coverage requirements, grandfather status and subsidy availability by answering two simple questions. The tool is available by going to [www.bcbsnc.com](http://www.bcbsnc.com) and logging in at Member Services.
- + For additional information on this topic, please go to [www.nchealthreform.com](http://www.nchealthreform.com). Click “In the Spotlight.”



# ACA Benefit Requirements in 2014

*The ACA includes many provisions relating to benefits. Some provisions require certain standard benefits be included at a minimum level of coverage; others govern which (and how) medical services must be covered.*

*As with any insurance policy, more generous benefits cost more to provide and therefore lead to increased premiums.*



## Context

Benefit requirements that have gone into effect so far have had a limited impact on BCBSNC premiums, but benefit requirements in 2014 are much more comprehensive, and will come at a greater cost.

## Specifics

- + Minimum “essential health benefits” will be required for all plans offered to individuals and small groups. There are several options to define the essential health benefits package. In NC, EHBs will be determined by using a benchmark plan – and all other plans must include the EHBs available in that benchmark plan. The NC benchmark plan is the BCBSNC Blue Options PPO product.
- + Small Group health plan deductibles are subject to a maximum of \$2,000 for single employees and \$4,000 for families. Small group is defined as 1 to 100 members except that states may set the level at one to 50 members in 2014 and 2015, as is the case in North Carolina.

## Our View

- + Today some of our small group customers choose plans that have an actuarial value below 60%.
- + Some plans will need to be supplemented in order to meet all the categories required in ACA (e.g. habilitative care, pediatric oral care and pediatric vision care).
- + Specifically, in the individual market maternity will be required in all plans.
- + Annual dollar limits will no longer be allowed.
- + There may be an option for plans to exceed the deductible limits if that plan cannot reasonably reach a given actuarial value (level of coverage) without doing so.







# Essential Health Benefits

*The ACA requires that all health insurance coverage include certain treatments and procedures deemed “essential.” While the law only explicitly requires Essential Health Benefits for Individual and Small Group Underwritten business, many feel this will be extended to Large Underwritten Groups too.*

## Context

Beginning in January of 2014, all individual and underwritten small group plans will have to cover essential benefits at minimum.

## Specifics

ACA lists the following as services that make up Essential Health Benefits:

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

Beginning in 2015, if a large group (fully-insured or self-funded) offers any category of EHB, the out-of-pocket maximum applies.

States have discretion to pick from a definitive list of options to create a state-specific benchmark plan. The federal fallback benchmark plan, should a state neglect to make a selection, is the largest small group plan in the state by enrollment.

## Our View

- + Everyone agrees that comprehensive coverage is optimal, but it won't come cheap.
- + It will be imperative to balance the need for comprehensive, evidence-based coverage with the need to ensure access to affordable coverage.
- + Since NC opted not to choose a benchmark, the federal fallback is a BCBSNC small group product – Blue Options PPO.
- + One provision of health care reform requires that all of a member's cost-sharing responsibility (including co-pays, coinsurance, and deductibles) be counted toward an out-of-pocket maximum of \$6,350/\$12,700 (for 2014).





## Fund Products (changes to HSA, FSA)

*Fund Products (FSA/HSA/HRA) traditionally permit individuals to use pre-tax dollars for a broad range of eligible medical expenses (copayments, coinsurance, deductibles).*

*It is a common misperception that these types of products will go away when the ACA is fully implemented. They will still be available.*



### Context

The ACA makes changes to fund products which impact what can be reimbursed pre-tax, the amount you can put away pre-tax and the penalty for using monies for nonqualified medical expenses.

### Specifics

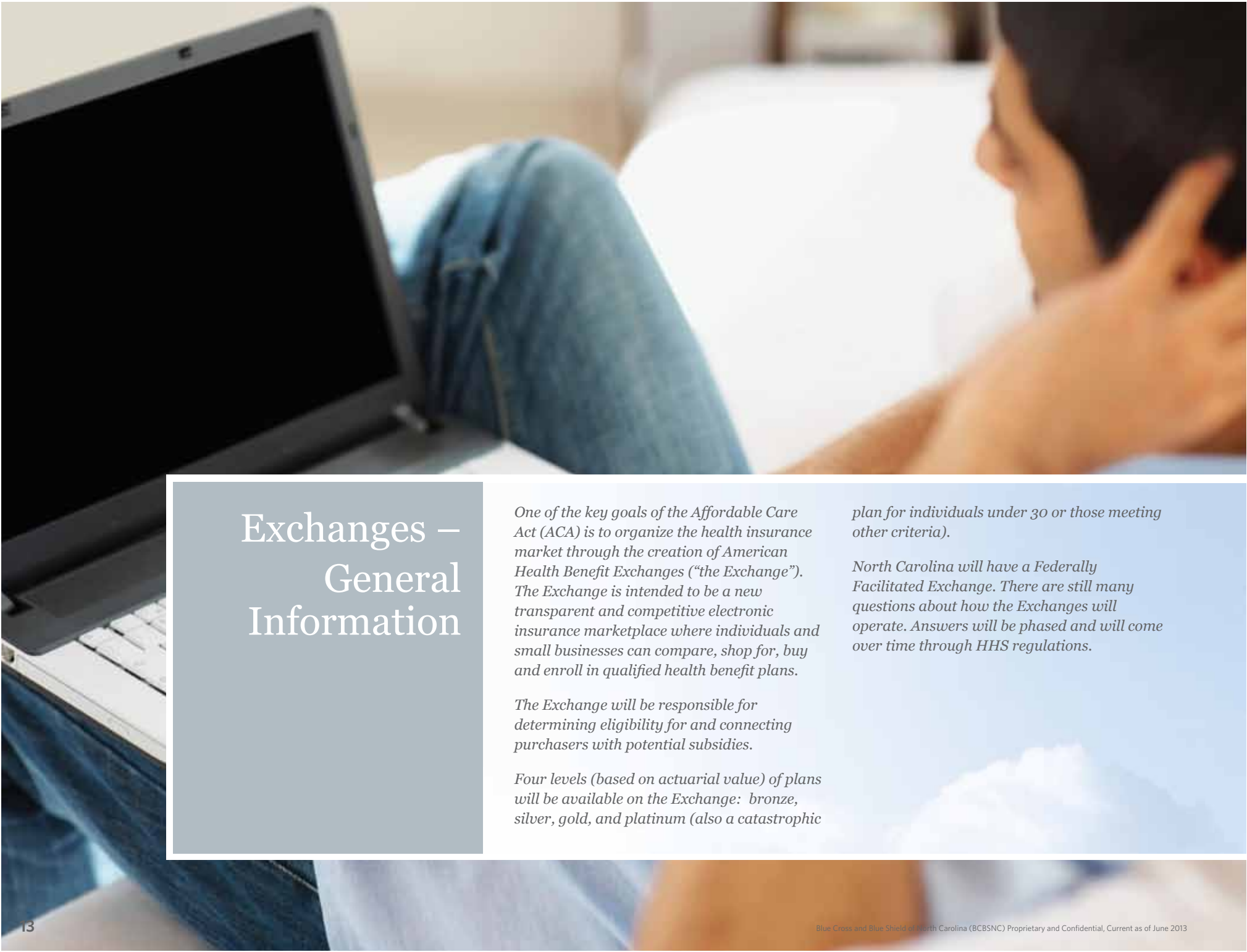
- + Effective January 1, 2011, the cost of an over-the-counter medicine or drug cannot be reimbursed from an FSA/HRA or HSA unless a prescription is obtained. The change does not affect insulin, even if purchased without a prescription, or other health care expenses such as medical devices, eye glasses, contact lenses, co-pays and deductibles.
- + Effective January 1, 2011, the penalty for using HSA funds for nonqualified medical expenses increased from 10% to 20%.
- + Beginning 2013, health FSA contributions are capped at \$2,500 a year, to be indexed annually for inflation.

### Our View

- + BCBSNC believes that fund products – including HSA products – are a key part of the product portfolio and we support efforts to maintain them.
- + BCBSNC offers HRA and FSA administrative services to our underwritten and ASO groups. We have changed our product portfolio such that most group products may now be paired with a HRA.

MARKET IMPACTED





## Exchanges – General Information

*One of the key goals of the Affordable Care Act (ACA) is to organize the health insurance market through the creation of American Health Benefit Exchanges (“the Exchange”). The Exchange is intended to be a new transparent and competitive electronic insurance marketplace where individuals and small businesses can compare, shop for, buy and enroll in qualified health benefit plans.*

*The Exchange will be responsible for determining eligibility for and connecting purchasers with potential subsidies.*

*Four levels (based on actuarial value) of plans will be available on the Exchange: bronze, silver, gold, and platinum (also a catastrophic*

*plan for individuals under 30 or those meeting other criteria).*

*North Carolina will have a Federally Facilitated Exchange. There are still many questions about how the Exchanges will operate. Answers will be phased and will come over time through HHS regulations.*

# Exchanges – General Information



Context	Specifics	Our View
<p>States are given authority to create their own Exchange, allow the federal government to create one in their state, or engage in a Partnership Exchange, a hybrid of the other two.</p>	<p>+ <b>NC Market Definition</b></p> <p>In 2014, ACA requires Exchanges to open to Individuals and Small Groups up to 100 members. States have the discretion to limit small group to 50 but only until 2016. States can also merge the small group and individual markets.</p>	<p>+ Preserve market outside Exchange in order to maintain market stability in light of other changes being implemented.</p> <p>+ Keep Small Group at up to 50 until 2016 aligns with current state law and limits upheaval.</p> <p>+ Do not merge markets (separate individual and small group programs/products/pooling) in order to limit disruption for all stakeholders (consumers, employers, brokers, and insurers).</p>
	<p>+ <b>Products</b></p> <p>ACA provides very specific requirements for Exchange plans. States can consider whether they want to include more standardization and if they feel the number of plans on the Exchange should be limited for each carrier participating.</p>	<p>+ Insurers should not be limited in the number of plans they can offer within the confines of ACA requirements for each plan tier.</p> <p>+ Product flexibility should be maintained; no standardized plans. This enables wide choice in order to meet varying market needs and encourages carriers to be innovative which serves the consumer and employer.</p>
	<p>+ <b>Distribution</b></p> <p>ACA does not prohibit the involvement of brokers, and in fact, HHS and National Association of Insurance Commissioners (NAIC) have made statements supporting a continued role for brokers.</p> <p>Navigators are new entities under ACA established under grants to states to help consumers weigh options and facilitate enrollment. Navigators will work under the authority of the Exchange.</p>	<p>+ Consumers should have the right to use a producer when they buy through the Exchange.</p> <p>+ The Exchange should not be involved in producer compensation but should leave this to insurance carriers.</p> <p>+ Navigators will be trained (certified).</p>
	<p>+ <b>Board Composition</b></p>	<p>+ Multiple insurers should be represented on the board along with other stakeholders, and BCBSNC, as the largest insurer in the state, should have a seat.</p>
	<p>+ <b>Funding</b></p> <p>Grant funding was designated to help states plan, establish and operate Exchanges. Exchanges must be self-sustaining by 1/1/15.</p>	<p>+ NC will have a Federally Facilitated Exchange (FFE) and insurers who sell on the Exchange will be subject to a 3.5% user fee.</p>
	<p>+ <b>Status of North Carolina legislation</b></p>	<p>+ In December 2012, Senate Bill 4 established that North Carolina will have a federally facilitated Exchange.</p>





## Exchanges – Impact on Markets and Groups

*Most people think about the individual market when discussing Exchanges – but the ACA also calls for states to establish Small Business Health Options Programs – or a “SHOP Exchange” – to create a new online marketplace for small groups. The law allows states to keep the two separate, or to merge them into a single Exchange.*

*Many decisions about the SHOP Exchanges have yet to be made – but that doesn’t mean you can’t start thinking how critical issues might impact your business...*



# Exchanges – General Information



Context	Specifics	Our View
<b>NC Market Definition</b>	<ul style="list-style-type: none"> <li>+ In 2014, ACA requires Exchanges to open to Individuals and Small Groups up to 100 members. States have the discretion to limit small group to 50 but only until 2016. States can also merge the small group and individual markets.</li> <li>+ These decisions will have big implications on the small group market and therefore BCBSNC will work to influence the state decisions.</li> </ul>	<ul style="list-style-type: none"> <li>+ It is important to preserve traditional markets in order to maintain market stability in light of all other changes being implemented. Keeping small group market at up to 50 members aligns with current state law.</li> <li>+ BCBSNC recommends against merging small group and individual markets; keeping them separate will prevent disruption for all stakeholders (consumer, insurer, employer, brokers).</li> </ul>
<b>Small Group Tax Credit</b>	<ul style="list-style-type: none"> <li>+ Starting in 2014, the small group tax credit is only available for groups that purchase employer coverage through the Exchange and is only available for two consecutive years.</li> </ul>	<ul style="list-style-type: none"> <li>+ Groups eligible for the subsidy will be motivated to purchase on Exchange to take advantage of this savings opportunity.</li> <li>+ The two-year limit brings into question how many employers will stay on the SHOP Exchange over the long term.</li> </ul>
<b>"Employer Choice" vs. "Employee Choice"</b>	<ul style="list-style-type: none"> <li>+ An 'Employer Choice' model would seem more familiar to employees, who are used to having their insurance options presented to them upon being hired. Generally speaking, if the Exchange is 'Employer Choice', you would pick a single health plan (with a single insurer) to meet your employees' needs and they'd go to the Exchange to enroll.</li> <li>+ An 'Employee Choice' model would be fundamentally different. The employer would determine a set amount that would be contributed; each employee would then take that contribution and shop for the plan of their choice, at the benefit level determined by the employer. This could result in administrative complexity, since 10 employees could have 10 plans from 10 different insurers.</li> </ul>	<ul style="list-style-type: none"> <li>+ ACA states that the Exchange will offer employee choice.</li> <li>+ One of the regulations issued during the summer of 2012 clarified that states can offer employer choice in addition to the required employee choice model.</li> <li>+ Exchanges have the potential to undermine employer-sponsored coverage by encouraging employers to drop their plan and move to a fixed contribution.</li> <li>+ FFE states will only have employer choice in year 1 as employee choice has been delayed.</li> </ul>
<b>"Employer Dumping"</b>	<ul style="list-style-type: none"> <li>+ A national debate continues about whether employers will stop offering coverage to their employees – effectively "dumping them" onto the subsidized individual Exchange market – once the ACA's main provisions are enacted in 2014.</li> <li>+ Why would employers consider dumping? Employers may consider "dumping" employer-based coverage in order to give their employees access to the Premium subsidies addressed in the following section. These premium subsidies are only available to individuals with household incomes between 138-400% of the federal poverty level and who do not have access to affordable employer coverage that meets the 60% actuarial value requirement. (See definition of affordable employer coverage in the Subsidy section that follows on page 19.)</li> <li>+ It is likely that employers will reconsider contribution strategies for employees and dependents in the context of subsidy qualification.</li> </ul>	<p>Employers have many factors to consider before deciding to drop coverage. Among these are:</p> <ul style="list-style-type: none"> <li>+ Overall value of compensation package - health benefits are regularly rated the #1 most important employee benefit</li> <li>+ Tax impact on employees (Employees will not be able to get a tax deduction for their portion of premium that they pay under an individual plan.)</li> <li>+ Tax impact on employer (Employers will lose certain employment tax benefits they currently receive for paying health benefits if they simply funnel money into payroll.)</li> </ul>

MARKET IMPACTED





# Individual Mandate

*Beginning in 2014, most individuals will be required to have health coverage.*

## Context

The mandate will only work if people comply with it. And penalties for not complying with the mandate are generally less expensive than the cost of insurance.

## Specifics

- + In 2014: Penalty for not complying with the mandate will be \$95 annually or 1% of an individual's income, whichever is greater and rising to
- + \$695 or 2.5% of an individual's income, whichever is greater, in 2016 and thereafter

## Our View

- + The primary purpose of the mandate is to enable the law's insurance reforms to work. Even though we think the mandate's penalty is weaker than it should be, it's still the glue that holds the rest together.
- + If the young and healthy population chooses not to purchase insurance, insurers could be left with a disproportionately sick population since they are required to accept everyone regardless of their health status (Guarantee Issue) and forbidden from using health history as a gauge for determining premiums (Community Rating), there would be little incentive for people to carry coverage.
- + This could make insurance premiums extremely expensive.
- + For additional information on this topic, please go to [www.nchealthreform.com](http://www.nchealthreform.com). Click "In the Spotlight."

MARKET IMPACTED: **NOT SEGMENT-SPECIFIC BUT IMPACTS OVERALL HEALTH CARE SYSTEM**

# Employer Shared Responsibility Excise Tax (Play or Pay Penalty)

For employers with  
50+ employees

*Effective 2014, employers with 50 or more employees will be required to offer a health care plan meeting specified standards or they may be subject to the employer “shared responsibility” excise tax, known as the “Play or Pay” penalty.*

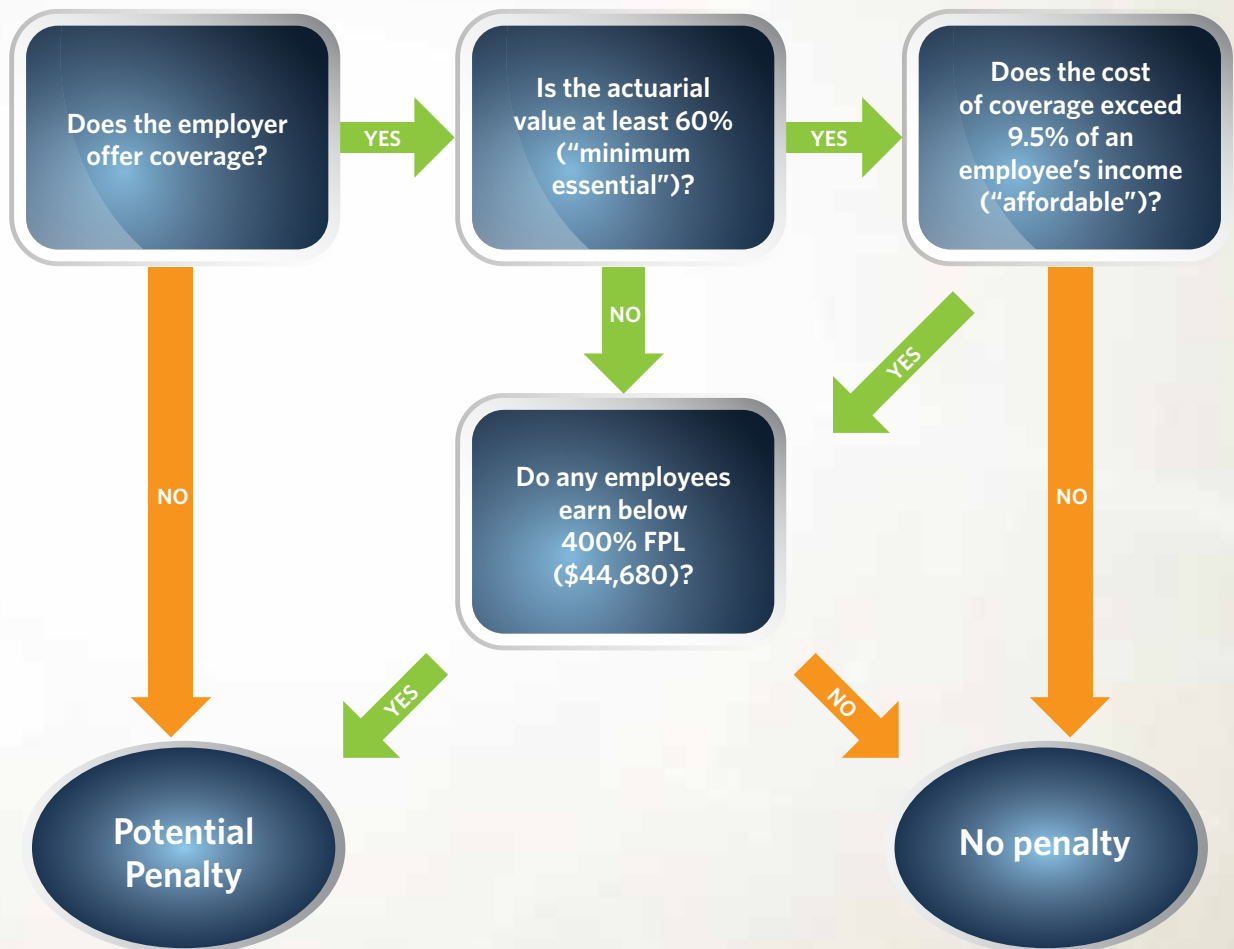
*The fee will be determined by a complex formula. A decision matrix explaining it at a high level follows.*

*A common misperception in the market is that the penalty will cost groups only \$2,000 per employee – but that doesn’t take into consideration a number of relevant factors like the potential loss of corporate tax deductions, payroll taxes, penalty growth and more. BCBSNC believes that all things considered, the actual per employee penalty is likely to exceed \$4,000.*

*Details on the Shared Responsibility Requirement were recently released by the IRS and can be found here: <http://www.gpo.gov/fdsys/pkg/FR-2013-01-02/pdf/2012-31269.pdf>*

*Groups should consult their own attorneys, HR professionals and/or tax advisors to ensure they understand their responsibilities and are compliant with the new requirements.*

## Decision Matrix for Groups of 51+





## Subsidies

*Federal subsidies will be available to millions of low- and middle-income Americans to purchase insurance starting in 2014.*

*Based on 2013 Federal Poverty Level, an individual whose income is up to \$45,960/year or a family of four with an income of up to \$94,200/year would be eligible for some level of subsidy.*

*Federal subsidies provided to individuals will likely mask premium increases, but subsidies don't affect the premium that must be charged; they merely shift part of the burden of payment from the purchasers to the government – and hence to tax payers.*

## Context

The ACA offers premium subsidies to eligible individuals who fall between 100% and 400% of the federal poverty level and purchase insurance on the Exchange in the individual market.

Cost-sharing subsidies may also be available to people below 250% FPL who purchase a 'silver plan' in the Exchange.

## Specifics

- + Most low- and middle-income individuals who aren't offered other 'acceptable' coverage (Medicaid, Medicare etc.) will be eligible.
- + If offered employer coverage, employees may only qualify for a federal tax credit if: household income is <400% FPL; AND the employer coverage offered has an Actuarial Value <60% OR employee (self-only) premium cost is >9.5% of household income; AND the employee does not enroll in employer coverage.
- + Subsidy payments will be determined using the prior year's income, as noted on the prior year's tax return (meaning 2012 tax return will determine 2014 subsidies).
- + In 2013, 400% FPL is about \$45,960 for an individual or \$94,200 for a family of four.
- + Subsidies will be based on a sliding scale, based on income; those between 100% and 150% FPL will have the vast majority of their premium paid for by the federal government. The subsidy amount decreases as income increases.
- + Cost-sharing subsidies will be available to individuals who fall between 100% and 250% FPL and purchase a silver plan through the Exchange.
- + Special cost-sharing reductions for American Indians and Alaskan Natives exist that eliminate cost-sharing at any plan level for all AI/ANs with incomes under 300% FPL. (American Indians and Alaskan Natives who make more than 300% FPL are eligible for no cost-sharing through Indian Health Services, Tribal Organizations, Urban Tribal Organizations, and Contract Health Services.)

## Our View

- + According to the 2010 census, about two-thirds of North Carolinians are below 400% FPL, meaning they would be eligible either for subsidies or other public programs (Medicaid).
- + With an estimated price tag of \$465 billion (through 2020), subsidies are the single most expensive component of the ACA.
- + Subsidies will make insurance appear cheaper to consumers (because they may pay less out of pocket) but they do NOT lower premiums – they merely shift who is paying the bill.
- + Both the advanced premium tax credit and cost-sharing reduction will be paid directly to the insurer from the federal government.
- + Individuals are responsible for reporting changes in income and the Exchange makes all eligibility determinations.
- + For additional information on this topic, please go to **[www.nchealthreform.com](http://www.nchealthreform.com)**. Click "In the Spotlight."

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## Small Business Tax Credits

*The ACA provides assistance for certain small businesses who offer coverage currently or who want to begin to offer coverage.*

*Tax credits may provide some relief in the short-term, but they are temporary.*

### Context

For businesses with fewer than 25 full time employees with average annual wages below \$50,000 who pay for 50% of the health coverage premiums for their employees.

### Specifics

- + Maximum credit starting in 2010 is 35% of employer paid health insurance coverage
- + Beginning in 2014, the maximum credit increases to 50%, only insurance purchased through the Exchange is eligible and only for two years

Eligibility Requirements include:

- + Providing health care coverage. A qualifying employer must cover at least 50 percent of the cost of health care coverage
- + Firm size. A qualifying employer must have less than the equivalent of 25 full-time workers
- + Average annual wage. A qualifying employer must pay average annual wages below \$50,000
- + Both taxable (for profit) and tax-exempt firms qualify

### Our View

- + We were an early and active supporter of the tax credits. We built a website to help North Carolina small businesses find out if they were eligible and promoted it widely.
- + We were even recognized by the White House for our efforts to promote the tax credits to small businesses.
- + Still have questions? Lots of answers from the IRS can be found by visiting **IRS.gov** and entering 'Small Business Tax Credits' in the search field.



## ACA Taxes & Fees

*The ACA contains taxes and fees that will raise the cost of insurance.*

*There are a few kinds, and they will become effective over time. Taxes for Comparative Effectiveness Research will begin in 2013, followed by taxes on insurers in 2014 and the 'Cadillac Taxes' in 2018.*

# ACA Taxes & Fees



Context	Specifics	Our View
<p>Comparative Effectiveness Research (CER) Fee (also called Patient-Centered Outcomes Research Trust Fund Fee (PCORI))</p> <p>The law includes fees for the creation of a new Trust Fund for Comparative Effectiveness Research.</p>	<ul style="list-style-type: none"> <li>+ The general idea of CER is to study in-depth how effective certain medical procedures/drugs/surgeries are, so that health care providers can make decisions based on the best available evidence.</li> <li>+ The issuer of insured policies and the plan sponsor for a self-insured health plan are liable for payment of the fee</li> <li>+ Fee is assessed based on when the plan year ends. For groups this was effective October 2011.</li> <li>+ Beginning on or after October 2, 2012, the fee is \$1 per "average" covered life. The fee increases to \$2 per participant in 2013, then to an amount indexed to national health expenditures thereafter. The comparative effectiveness fee phases out by 2019.</li> </ul>	<ul style="list-style-type: none"> <li>+ At BCBSNC, all of our medical policies are based on the best available evidence.</li> <li>+ BCBSNC is responsible for paying this fee on behalf of its insured members.</li> <li>+ Third-party administrators are not permitted to pay or report the tax on behalf of self-funded plans.</li> <li>+ The tax is reportable on an IRS form 720 and due annually on or before July 31st.</li> <li>+ For additional information on this topic, please go to <b><a href="http://www.nchealthreform.com">www.nchealthreform.com</a></b>. Click "In the Spotlight."</li> </ul>
<p>Insurer Tax – Under the law, beginning in 2014 insurers will be assessed new federal taxes in the form of an annual fee.</p>	<ul style="list-style-type: none"> <li>+ In 2014, insurers will owe \$8 billion per year – the tax increases every year, hitting the \$14 billion mark just a few years later and will fluctuate thereafter.</li> <li>+ Each insurer's share of the tax will be based on its market share.</li> <li>+ In addition, other taxes will be levied on pharmaceutical and medical equipment manufacturers.</li> <li>+ These new taxes and fees will be "passed through" to consumers and make health care even more expensive for small businesses.</li> </ul>	<ul style="list-style-type: none"> <li>+ Most insurers will likely pass on their share of this cost to consumers in the form of higher prices. As a non-profit with a long-range profit margin between 3.5 and 4.5%, we'll have no choice.</li> <li>+ We expect this provision alone to increase premiums by a couple of points – that will amount to a few hundred dollars for a typical North Carolina family (husband, wife and 1.5 children).</li> <li>+ We continue to support the repeal of this tax as well as education efforts on what drives premium prices.</li> <li>+ For additional information on this topic, please go to <b><a href="http://www.nchealthreform.com">www.nchealthreform.com</a></b>. Click "In the Spotlight."</li> <li>+ The National Federation of Independent Business (NFIB) is very aggressive on this issue – check out their website at <b><a href="http://www.StopTheHit.com">www.StopTheHit.com</a></b>.</li> </ul>
<p>Cadillac Tax – High-cost or "Cadillac" plans will be subject to an excise tax starting January of 2018.</p>	<ul style="list-style-type: none"> <li>+ If a plan design is offered that costs more than \$10,200 for individual coverage or \$27,500 for coverage other than individual coverage, the plan administrator or health insurance issuer will be subject to a 40% tax on the cost of the coverage that exceeds these limits.</li> <li>+ These limits are subject to inflation and may also be adjusted if health insurance costs increase as measured by the increase in the cost of the standard plan option offered by the Federal Employees Health Benefits Plan.</li> </ul>	<ul style="list-style-type: none"> <li>+ At this time, this tax should not be a major concern for small groups; a lot can happen between now and 2018 (including another presidential election) that may change whether the tax is implemented and/or what it looks like.</li> <li>+ Groups will likely want to assess their plan offerings and bring them below the "Cadillac" threshold.</li> </ul>





# Medical Loss Ratio (MLR)

*The ACA requires that a certain minimum percentage of each premium dollar an insurer collects be spent on medical care. We've exceeded this requirement for many years.*

*If an insurer does not meet the MLR requirement, they must issue refunds to their members.*

## Context

The MLR must be publicly reported and meet 80% for individuals and 85% for small and large groups.

## Specifics

- + For plan years beginning after January 1, 2011, insurers falling below the required MLR will have to provide rebates to their members.
- + The rebate report must be included in the MLR report to HHS by June 1.
- + The final rule clarified that, for ERISA plans, insurers will pay the rebate to the policyholder (typically the employer).

## Our View

- + Even before it was required, BCBSNC has consistently met MLR thresholds.
- + We have already met the MLR standards now required by ACA; BCBSNC exceeded every ACA MLR requirement. Preliminary numbers for 2012 for individuals, the MLR was 87.4%; for small groups it was 85.3%; and for large groups it was 91.7%. (MLR is required to be calculated as a result of ACA which would also include Quality Improvement Expenses and Taxes.) Final numbers will be filed in June 2013.
- + For additional information on this topic, please go to **[www.nchealthreform.com](http://www.nchealthreform.com)**. Click "In the Spotlight."





# Impact of Reform on Premiums

*Historically health insurance premiums have tracked directly with spending on actual medical services. It is a proportional cause and effect relationship – as the amount spent on medical services rises, so too does the premium.*

*However, with the majority of the mandatory provisions of the ACA taking effect in January, 2014, we believe that premiums will increase, with individuals and small groups being most impacted. Key mandates that will impact premiums include guarantee issue, modified community rating, new taxes and fees for insurers, richer benefit plans, etc.*

## Context

While the Affordable Care Act is intended to provide access to care for many new people beginning in 2014, there is concern that the imposition of new taxes, expansive benefits and new rating restrictions will result in increasing the cost of coverage for many.

## Specifics

- + There are three main reasons why premiums will rise.
- + The first two are easy to explain – the third is far more complicated.

## Our View

- + Number one: The new law imposes a number of new taxes and fees on insurers.
- + Number two: The new law requires minimum benefit levels richer than many plans today. As with any insurance policy, more generous benefits cost more to provide and therefore lead to increased premiums.
- + Number three: Potential for adverse selection due to the combination of:
  - o More low-income and less healthy individuals entering the insurance pool.
  - o Changes to insurance rules that will require insurers to accept all applicants without taking health status or gender into consideration when determining premiums.
  - o Changes to rating rules that will cause younger and healthier people to be charged higher premiums so that premiums charged to older individuals can be lowered.
  - o A low penalty for the individual mandate compared to the cost of buying coverage, which will incentivize young and healthy individuals to avoid buying insurance until they're sick.



## Rate Review

*The ACA allows the Department of Health & Human Services (HHS) to work with states to establish an annual review of increases in premiums exceeding 10% and will require justification from insurers as to whether or not they are “unreasonable.”*

*North Carolina, which has a long history of effective state regulation, will retain rate review authority. BCBSNC must file any changes in product rates with the North Carolina Department of Insurance (NCDOI) at least annually.*

### Context

In North Carolina, the Commissioner of Insurance has the authority to review and approve all health insurance rates.

### Specifics

- + HHS will work with states to establish or strengthen their rate review process. HHS deemed North Carolina’s individual and small group rate review process as “effective”, which means state processes will largely continue to be used to review and approve rates.
- + NC has been awarded close to \$5 million to enhance the rate review process and improve transparency and consumer interfaces.

### Our View

- + We agree that premium increases should be justified and have long supported that process in NC.
- + We support the state regulation of rates since states can consider the local market and environment.
- + We strongly support a level playing field for the rate review process.
- + We believe that strong, actuarially-based regulation of premiums is critical, not only to avoid unreasonable rate increases, but to ensure that neither political considerations nor concern over public perception (apart from consumer fairness) lead to rates that are inadequate and jeopardize the financial solvency of an insurer.



# Uniform Coverage Summaries

*Health insurance is a highly complex product, and few would dispute that it can be perplexing for the average consumer to grasp. The ACA tries to simplify things by requiring two standard forms to be distributed to all insured individuals to help them better understand their benefits.*

*The administration often compares these standard forms to being akin to Nutrition Facts labels found on food; but unfortunately, the complexity of health insurance products makes simplification efforts challenging.*

## Context

The US Department of Health and Human Services (HHS) developed a "Summary of Benefits and Coverage" (SBC) and a Uniform Glossary of insurance terms to assist individuals with understanding their coverage.

## Specifics

The Summary of Benefits and Coverage is a highly personalized document depending on one's plan and is therefore, complicated and costly to create.

In general, the SBC must be provided when a plan or individual is comparing their coverage options; it also must be updated if their information changes, for example, at renewal.

For employers, an SBC for each benefit package offered must be provided to each participant or beneficiary at the time of enrollment, at renewal, and at other times must be provided upon request.

Each SBC must include a great deal of plan-specific information including but not limited to:

- + A description of the coverage, including cost sharing, for each category of benefits
- + Exceptions, reductions and limitations of coverage
- + Cost-sharing provisions of the coverage, including deductible, coinsurance and copayment obligations
- + Specifics surrounding renewability and continuation of coverage provisions
- + "Coverage Examples" that illustrate benefits provided under the plan for common benefits scenarios (including pregnancy and serious or chronic medical conditions)
- + Premiums (or in the case of a self-insured group health plan, cost of coverage)

## Our View

- + While the intent of providing uniform coverage summaries is good, the regulation providing details for how the provision must be implemented was far more complex than expected by industry observers and presented insurers with an enormous administrative burden with questionable value.
- + SBCs were implemented beginning in September of 2012.
- + The Glossary is available upon request by calling BCBSNC customer service.



# Accountable Care Organization (ACOs)

*The ACA has touted many potential benefits of ACOs, including improved quality, addressing physician shortage, and more efficient care.*

## Context

The ACA has touted many potential benefits of ACOs, including improved quality, addressing physician shortage, and more efficient care. (Legislation on this subject is pending as a "Proposed Rule.")

## Specifics

- + Beginning 2012, ACOs are established under the Medicare Shared Savings Program on a voluntary basis. ACOs will have to commit to participating in the program for at least three years.
- + Providers agree to be accountable for quality, cost, and overall care of Medicare beneficiaries, while benefitting from a share in the savings if they are successful.

## Our View

- + We support a move toward quality, patient-centered care. We see a need for flexibility so that insurers and providers may implement innovative payment schedules to promote quality-based care.
- + There are several areas where BCBSNC can help overcome challenges to the ACO model. ACO success will depend on having a solid data infrastructure to provide data on care assessment, coordination, management, and measurements of outcomes and costs.
- + In 2012, BCBSNC announced its first ACO in conjunction with Wilmington Health, a multi-specialty physician group practice located in Southeastern North Carolina. This physician-led ACO is one of the first payer-provider collaborations of its kind in the area. The arrangement complements our industry-leading initiatives underway to improve care while reining in costs. Similar to other initiatives, the organization will focus on improving efficiencies, preventative health and wellness, chronic disease management, coordination and outreach programs for at-risk patients and improving the overall health of patients in the Southeastern area of NC. Shortly after this announcement, BCBSNC opened another ACO with Key Physicians in Wake County, Cape Fear Valley in Fayetteville and Cornerstone Health Care serving customers in 11 counties, and continues to search out additional partnerships.
- + Established in December 2011, Carolina Advanced Health Center was created to focus on improved health outcomes for chronically-ill patients through a team-based model with on-site primary care, pharmacist, nutritionist, care manager and behavioral health providers. The first center of its kind, CAH operates with the key objectives: Payer - Demonstrating leadership in changing the healthcare system; Provider - More time to fully engage patients in their care with access to information and tools to provide quality care; and Patient - Improved health and well-being. Better, more confident self-management of chronic conditions. CAH is a different type of practice based on access and convenience, effective encounters, self-management support, one-stop shopping, technological support, and coordination of care.
- + BCBSA and Blues plans have extensive experience pioneering innovative payment approaches that move away from fee-for-service and toward quality and outcomes-based payment. For example, Plans collectively support the nation's largest network of Patient-Centered Medical Homes, covering more than three million members through 45 initiatives ranging from early pilots to established models.
- + For additional information on this topic, please go to [www.nchealthreform.com](http://www.nchealthreform.com). Click "In the Spotlight."

MARKET IMPACTED: NOT SEGMENT-SPECIFIC BUT IMPACTS OVERALL HEALTH CARE SYSTEM

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# Preventive Care

*In 2011 and 2012 two different phases  
of preventive care covered at  
100% were phased in.*

## Context

Prevention was one of the overarching goals of the ACA, which even created a National Prevention Council to direct preventive funding for public health initiatives.

Payers are expected to contribute to the preventive strategy as well.

## Specifics

- + The ACA directed that all current preventive recommendations should now be covered at 100%.
- + Subsequent to that we have had numerous “recommendations” that have been added to the list including women’s preventive care, fall prevention and several others.
- + Recommendations continue to be released (though we hope most have been identified).

## Our View

- + BCBSNC has a long, well-documented history as an industry leader in promoting prevention.
- + We’ve been an industry leader in offering co-payment waivers for generic drugs, by providing free nutritionist visits, by rewarding North Carolinians for routine physical activity and more.
- + As the many benefit changes for ACA are implemented, it is important to consider cost and affordability.
- + For additional information on this topic, please go to **[www.nchealthreform.com](http://www.nchealthreform.com)**. Click “In the Spotlight.”



# ACA Modifications to the Law to Date

*While “repeal and replace” has not come to be, critics of ACA have been effective in chipping away at the law’s less popular provisions.*

## Context

Some ACA provisions have been modified or repealed since the law passed.

## Specifics

- + 1099 – The requirement for small groups to report the cost of certain services over \$600 has been repealed.
- + W-2 – ACA requires employers to report the aggregate cost of benefits on an employee’s W-2. Recently clarification was provided that this would only be required for employers issuing 250 or more W-2 forms. This transition relief will continue until the issuance of further guidance.
- + Employer Vouchers – The requirement for employers to provide vouchers to employees whose portion of the health care cost was between 8 and 9.5% of their income has been repealed.
- + Medicaid – The requirement that states expand their Medicaid program to cover people up to 138% FPL was made optional by the Supreme Court decision this past summer. As of this writing, Medicaid expansion in North Carolina appears unlikely.

## Our View

- + BCBSNC supported the elimination of these employer requirements, which were going to be an administrative burden.
- + We expect there are more changes like this coming in the future.





# Impact of ACA on Brokers

*During this time of tremendous change, BCBSNC remains committed to supporting brokers by providing tools and information to help them retain existing clients and win new ones.*

## Context

There is concern that, between Exchanges and tighter MLR restrictions, brokers will be impacted negatively.

## Specifics

- + Exchanges will connect people and employers directly to health insurance coverage and new MLR requirements restrict the amount that may be spent on administrative costs, which include commissions.
- + Navigator programs are established by the Exchange and tasked with public education, distribution of information about enrollment and tax credits, providing referrals, etc.

## Our View

- + We are committed to ensuring brokers continue to play their essential role in serving customers and businesses.
- + As navigators are introduced, it is important that they be appropriately trained and certified.
- + On the issue of MLR, we hold that it is important that the final methodology both protects consumers and preserves the role of brokers and agents. Currently, BCBSNC meets the MLR standards required by ACA, including our brokers' commissions.
- + For additional information on this topic, please go to **[www.nchealthreform.com](http://www.nchealthreform.com)**. Click "In the Spotlight."

A man with dark hair, wearing a light blue button-down shirt and a watch, is smiling and pointing his right index finger towards the right. He is in a meeting room with large windows in the background. Other people are partially visible in the foreground, out of focus.

## *Employer Shared Responsibility (“Play or Pay”) Provision of the Affordable Care Act For Employers*

*Updated as of June 2013*



## Notice

This document is for informational purposes to assist employers in understanding the requirements of the Affordable Care Act. It's offered as a convenience and is **not intended to provide legal or tax advice**. Groups should consult their attorneys and tax advisors with any specific questions regarding their situation. As regulations and other interpretive guidance are published, this information may change.

## Overview

The Affordable Care Act (ACA) and recently proposed rules by the Department of Treasury describe a requirement referred to as Employer Shared Responsibility (also known as "Play or Pay"). If a large employer (50 or more employees) either fails to offer coverage to substantially all of its full-time employees and their dependents or offers coverage that is unaffordable or does not provide minimum value as defined by the ACA, that employer may be subject to monetary penalties.

**This document contains information on the following topics:**

- + Which Employers Are Subject to Employer Shared Responsibility?
- + How to Determine if an Employer is Large
- + Optional Safe-Harbor for Determining Full-Time Employee Status
- + Does a Penalty Apply?
- + How Does the Employer Calculate the Penalty?
- + When Is Employer Shared Responsibility Effective?

## Which Employers Are Subject to Employer Shared Responsibility?

Employer Shared Responsibility applies to grandfathered/non-grandfathered, fully-insured and self-insured **large employers**.

**Large Employer** = An employer with an average of at least 50 full-time employees (including full-time equivalent employees) on business days during the preceding calendar year (includes private, public, churches, non-profit, controlled or affiliated groups).

- + **Average** is determined by taking the sum of the total employees for each month in the prior year and dividing by 12, rounded to the next lowest whole number.
- + If an employer is part of a **controlled group** and the total full-time employees (including full-time equivalent) of the controlled group equals at least 50, each member employer is considered a large employer regardless of the number of employees. Penalty rules apply separately to each member employer.
- + Just because an employer is a "small employer" for other ACA requirements does not necessarily mean that that employer is not a large employer for Employer Shared Responsibility purposes. For example, it's possible that an employer group is defined as a small employer (< 50) for the Small Business Health Options Programs, or SHOP, but a large employer (50+) for Shared Responsibility.

**NOTE:** If the group does not meet the definition of a large employer as described above – employer will not be subject to a penalty related to Employer Shared Responsibility.

## Frequently Asked Questions – Coverage, Group Size and Benefits/Rating

### Who must be offered coverage?

Employers are required to offer coverage to substantially all (at least 95%) full-time employees and their dependents ("dependent" is defined as an employee's child under age of 26). Full-time employee means an employee who is employed an average of at least 30 hours of service per week, based on 130 hours of service in a calendar month. Groups do not have to offer coverage to spouses.

### How are dependents defined under ACA?

Dependents are defined based on qualifying as a dependent on the employee's federal income tax return, up to age 26. For purposes of the Employer Shared Responsibility provisions, a spouse is not a dependent.

### Are employers required to offer coverage to employees who work less than 30 hours per week?

No. Employers are only required to offer coverage to full-time employees. The term full-time employee means, with respect to a calendar month, an employee who is employed an average of at least 30 hours of service per week. In determining the 30 hours of service per week, employers must base their calculations on 130 hours of service in a calendar month.

### Currently many employers have part-time employees who work 30 hours per week. Will they be required to offer these part-time employees coverage?

Yes. For purposes of Employer Shared Responsibility, full-time is defined as an average of 30 hours of service worked per week in a calendar month. How the employer defines part time is irrelevant with respect to Employer Shared Responsibility.

### Will the determination around Employer Shared Responsibility come into play with the rating and benefit offering for a group?

No, the methodology and calculation for Employer Shared Responsibility provision is separate from the determination of group size for rating/benefit purposes.

## How to Determine if an Employer is Large for Purposes of Employer Shared Responsibility

When calculating whether a group is a large employer for purposes of Employer Shared Responsibility, all full-time employees and full-time equivalent employees must be counted.

Employee Category	Counting Employees
Full-time (at least 30 hrs./week)	Counted as one employee, based on 30-hour or more work week
Full-time Equivalent Employee	Add the total hours worked in a month (not more than 120 hrs./employee) by all employees, other than full-time employees, and divide by 120.
Seasonal	Do not include those working up to, but no more than, 120 days in a year
Temporary Agency Employees	Generally these are counted as employees of the temporary agency (except for those workers who are independent contractors)
Franchise Employees	For franchise owners, if they own more than one entity, all employees across the entities must be counted

Source: Congressional Research Service Report for Congress, April 8, 2013, R41159/CRS Analysis of P.L. 111-148 and P.L. 111-152.

For greater detail on Employer Shared Responsibility and determining "large employer" status, visit <http://www.gpo.gov/fdsys/pkg/FR-2013-01-02/pdf/2012-31269.pdf>.

**Seasonal Worker Exception** – You are not a large employer if (a) you exceed 50 full-time employees for 120 days or fewer in a calendar year, and (b) the employees in excess of 50 who were employed during that period of no more than 120 days (4 calendar months) were seasonal employees.

- + Full-time equivalents only apply for purposes of determining large employer status (not for calculating the penalty)
- + Hours worked = hours worked + any paid leave (vacation, sick, holiday, STD, LTD, FMLA, leave of absence)

**NOTE:** If you are a large employer but none of your full-time employees will be eligible for a subsidy (all are highly compensated employees), or if you do not have more than 30 full-time employees – you will not pay a penalty related to Employer Shared Responsibility.

**NOTE:** See Appendix for a helpful decision tree.

## Examples of Counting Employees to Determine Shared Responsibility

### Example 1 - Employer with Full-Time Employees and Full-Time Equivalent Employees (FTE)

Employer A has 20 full-time employees each of whom works 35 hours of service per week and 40 employees each of whom averages 90 hours of service per month (no seasonal workers).

- + Each of the 20 full-time employees would count as one full-time employee for each month.
- + To determine the number of Full-time Equivalents for each month, the total hours of service of each of the employees who are not full-time (maximum of 120 hours of service per employee) are aggregated and divided by 120.

$40 \times 90 = 3,600 / 120 = 30$  Full-time Equivalents  
 20 Full-time Employees + 30 Full-time Equivalents =  
**50 Full-time Employees**

**Employer A would be an applicable large employer.**

### Example 2 - Seasonal Worker Exception

Employer B has 40 full-time employees for the entire calendar year (no seasonal). In addition, Employer B also has 80 seasonal full-time employees who work for Employer B from September through December. Employer B has no full-time equivalents during the calendar year.

While Employer B's workforce exceeded 50 full-time employees the seasonal exception when applied results in the number of full-time employees being less than 50 if the number of seasonal full-time employees is disregarded.

**Employer B is NOT an applicable large employer.**

Month	Full-Time Employees
January	40
February	40
March	40
April	40
May	40
June	40
July	40
August	40
September	<del>120</del> 40
October	<del>120</del> 40
November	<del>120</del> 40
December	<del>120</del> 40
<b>Yearly Total</b>	<del>120</del> 480
<b>Average Per Month (Yearly Total/12)</b>	40

## Determining Full-Time Employee Status

This is an overview of the optional look-back measurement methodology an employer may use to determine full-time employee status. Groups should consult with their legal and/or tax advisors if they have specific questions about determining full-time employee status.

### Look-Back Measurement Period

The IRS outlines a Standard Measurement/Stability Period for determining which employees are considered full-time for purposes of administering the Employer Shared Responsibility penalty provision. This option includes a measurement/look-back period which enables an employer to measure how many hours an employee averaged per week in a defined period of not less than three, but not greater than 12 consecutive months. If an employee is determined to have worked full-time during the measurement period, the employer has the option to engage an administrative period during which the employee may be enrolled in a health plan. Finally, following the administrative period (if applied), the employee is treated as a full-time employee during a stability period.

A **standard measurement period** is defined as a time period of at least three but not more than 12 consecutive months that an employer selects and uses in determining whether an ongoing employee is a full-time employee. If the employer determines that an employee was employed on average at least 30 hours of service per week during the standard measurement period, the employer must treat the employee as a full-time employee during a subsequent **stability period**, regardless of the employee's number of hours of service during the stability period (so long as employee remains an employee).

The **optional administrative period** is a period between the measurement and stability period during which employees are notified and enrolled. This administrative period may last up to 90 days, but may not reduce or lengthen the measurement/stability periods.

The **stability period** is a time period selected by an employer that follows a standard measurement period that is the greater of six consecutive months or the length of the standard measurement period.

### Permissible Employee Categories

Employers may use measurement periods and stability periods that differ in either length or in their starting and ending dates for the following categories of employees:

- + Collectively bargained employees and non-collectively bargained employees
- + Each group of collectively bargained employees covered by a separate collective bargaining agreement
- + Salaried employees and hourly employees
- + Employees whose primary places of employment are in different states

### Change in Employment Status (Moving from seasonal/part-time to full-time or full-time to part-time/seasonal)

If a current employee has a change in employment status before the end of a measurement period, the change will not affect the classification of the employee as a full-time employee (or not a full-time employee) for the associated stability period.

### Transition Relief Related to Measurement Periods

For employers who choose to use the look-back measurement method and want to have a 12-month measurement period and a 12-month stability period, the IRS will allow an employer to adopt a transitional measurement period that is shorter than the 12 month stability period (for 2013 only), but cannot be less than 6 months. However, the measurement period must begin no later than July 1, 2013 and end no earlier than 90 days before the first day of the 2014 plan year.





## *Frequently Asked Questions - Measurement Periods*

### **How does the measurement period work?**

The measurement periods and process that a large employer must use are defined in the proposed regulations the IRS issued on January 2, 2013. The regulations and methodologies proposed are quite complex. This addendum covers the measurement periods and transition relief in greater detail but employers are advised to consult with their legal counsel and tax advisors to ensure compliance, given that every employer will have various circumstances impacting the time frame for measurement periods, applicability of transition relief, and other factors.

### **Is the calculation for FT equivalents based on 120 hours or 130 hours?**

The standard for calculating FT Equivalents is 120 hours. The 130-hour standard is used as a monthly equivalent of 30 hours per week as it relates to the 30 hour-per-week standard for full time employees hours worked  $(52 \times 30) \div 12 = 130$ .

The proposed IRS rule calculates the employer's FT Equivalents for a given month by (1) adding up the aggregate number of hours of service (but not more than 120 hours of service for any one employee) for all employees who were not employed on average at least 30 hours of service per week, and (2) dividing the total hours of service in step (1) by 120. The result is the number of FT Equivalents for that month.

### **What timeframe should a group look at when calculating FT Employees? Is it a one-time snapshot or a look-back period? If it's a look-back period, then what is that look-back period?**

Employers may select the time frame they wish to use for the measurement, stability and administration periods. For further detail, see the previous page, "Determining Full-Time Employee Status."

### **Does a group have to consider "travel" hours in its calculation of work hours during the snapshot period?**

Until further guidance is issued, employers must use a reasonable method for crediting hours of service – and so must include allowances for travel and other time related their service.

A method of crediting hours would not be reasonable if it took into account only some of an employees' hours of service with the effect of re-categorizing employees as non-full-time when their position traditionally involves more than 30 hours of service per week.

For example, it would not be a reasonable method of crediting hours to fail to take into account travel time for a travelling salesperson, or in the case of an instructor, such as an adjunct faculty member, to take into account only classroom or other instruction time and not the hours to perform other essential duties, such as class preparation time.

## Does a Penalty Apply?

Group has determined that:

- + It is a large employer; and
- + it has some full-time employees who may be eligible for a subsidy through the Exchange/Marketplace

In order to determine if a penalty will apply and to calculate what the penalty might be, the following two questions must be answered:

### Did the employer offer substantially all full-time employees (and their dependents) minimum essential coverage?

- + **Substantially all full-time employees (and their dependents)** is defined as offering coverage to 95% of full-time employees and their dependents.
  - o Spouses are not included as dependents.
- + **Minimum Essential Coverage** means coverage under any of the following: (1) Certain government programs; (2) Coverage under an employer-sponsored plan; (3) Plans in the individual market within the state; (4) Grandfathered health plan coverage; or (5) Other coverage recognized by HHS.
  - o Does not include coverage under excepted benefits (limited coverage like dental, vision, coverage only for a specified disease or illness, hospital indemnity).
  - o Does not require offering of Essential Health Benefits (EHB) – if EHBs are offered, annual and dollar limits apply.

*NOTE: If no, the employer will pay a penalty (see next section for calculating the penalty). If yes, go to the next question.*

### Did the employer offer substantially all full-time employees (and their dependents) minimum value coverage that is affordable?

- + **Minimum Value** means that the plan's actuarial value (share of the total allowed costs that the plan is expected to cover) is at least 60%.
  - o Current year employer contributions to a Health Savings Account (HSA) or an integrated Health Reimbursement Arrangement (HRA) are considered in determining minimum value.

o **Proposed Rules** (78 Fed. Reg. 25909) provide the following information:

- **Wellness Programs:** Employers must treat wellness program incentives for tobacco as earned when calculating minimum value (i.e., include the total amount the plan would pay if all employees earned the incentive when calculating minimum value); all other wellness program incentives are treated as unearned (i.e., do not take into account any amounts paid for wellness program incentives when calculating minimum value).
- **HSA:** Employer contributions for the current year are taken into account in calculating the plan's minimum value percentage for that plan year.\*
- **HRA:** Newly available funds for the current plan year in an integrated HRA are taken into account for that plan year's minimum value percentage if the amounts may be used only to reduce cost-sharing for covered medical expenses.\*

\*The amount taken into account is the amount of expected spending for health care costs in a benefit year.

- + **Affordable Coverage** is defined as affordable if the employee's required contribution to the self-only premium for the lowest cost option providing minimum value is no more than 9.5% of the employee's "household income."
  - o Safe Harbors regarding use of "household income" include use of W-2 wages, monthly rate of pay, or monthly federal poverty line.
    - **Form W-2 Safe Harbor** – if the employee's required contributions for the lowest cost self-only coverage do not exceed 9.5% of his or her annual W-2 wages.
    - **Rate of Pay Safe Harbor** – if the employee's required monthly contributions for the lowest cost self-only coverage do not exceed 9.5% of an amount equal to 130 hours multiplied by the employee's hourly rate of pay (or monthly salary) as of the first day of the coverage period (generally first day of plan year).
    - **Federal Poverty Line Safe Harbor** – if the employee's required contributions for a calendar month for the lowest cost self-only coverage do not exceed 9.5% of the monthly amount determined as the federal poverty line for a single individual for the applicable calendar year.

*NOTE: If the required contribution(s), do not exceed the 9.5% level, there is no penalty. If the required contribution(s) do exceed the 9.5% level, the group will pay a penalty. (See next section for calculations.)*



## *Frequently Asked Questions - Minimum Value and Wellness*

### **Does minimum value impact Grandfathered groups?**

Yes. Under the Employer Shared Responsibility provision, fully-insured, self-funded and grandfathered plans must all provide minimum value coverage.

### **How will the Exchange know that the 50+ employer (applicable large employer) has offered coverage that meets minimum value if an employee goes on Exchange to buy? Will an employer get notification of an employee who qualifies for a subsidy?**

There are a number of reporting requirements for the employer related to offering coverage and to enrollment in coverage offered. The logistics for and guidance on how the Exchange will confirm whether the employer's coverage met minimum value and whether any employees of the employer were eligible for a subsidy has not yet been determined. The IRS will provide employers with notice of any penalty assessments; no guidance at this time as to the method or timing of such notice.

### **Can the employer offer a reward or incentive to individuals for participation in a wellness program?**

Under the Final Rules, a group health plan or group health insurer is permitted to offer a reward or incentive to individuals who meet standards related to a health factor as long as the specified wellness program requirements are met. In addition, those rewards and incentives may be as much as 30% of the cost of coverage – up from the 20% limit under HIPAA. For more information, visit BCBSNC's employer portal on the Web.

### **If an employer's plan meets the minimum value and affordability requirements and is offered to employees and dependents, but excludes spouses, can the spouse qualify for subsidy dollars on the Exchange?**

Yes. Employers are not required to offer coverage to spouses under the Shared Responsibility provision. If they are excluded, spouses may shop on the Exchange and will be eligible for a subsidy. In the event dependents and/or spouses are offered employer coverage but decline, they may shop on the Exchange but will not be eligible for the subsidy if the group health plan met the minimum value and affordability requirements.

## How Does the Employer Calculate the Penalty?

Group has determined that:

- + It is a **large employer**; and
- + it has some full-time employees who may be eligible for a **subsidy** through the Exchange/Marketplace; **and**
- + it did not offer substantially all full-time employees (and dependents) minimum essential coverage; **or**
- + it did not offer substantially all full-time employees (and dependents) minimum essential coverage that met minimum value and affordable coverage standards.

The amount of the penalty differs as to whether the group failed to offer minimum essential coverage to substantially all full-time employees (and dependents) or whether they failed to offer minimum value coverage that was affordable.

Offers Coverage to all (at least 95%) of full-time employees and their dependents	Coverage provided was minimum essential	Coverage is minimum value	Coverage provided was affordable	At least one full-time employee* enrolls in exchange coverage and is eligible for premium tax credits	Calculated Annual Penalty
No	Yes	NA	NA	Yes	\$2000 multiplied by total number of full-time employees (excluding the first 30)
Yes	Yes	No to either or both		Yes	The lesser of (a) \$3000 multiplied by each full-time employee who enrolls in exchange coverage with a premium tax credit; or (b) \$2000 multiplied by total number of full-time employees (excluding the first 30)

*\*May include temporary agency employees and franchise employees who work full time, on average, up to 12 months.*

- + Determination of full-time employee status for calculating the penalty is required on a monthly basis.
- + See the previous section titled "Optional Safe-Harbor for Determining Full-Time Employee Status."



## When is Employer Shared Responsibility Effective?

Group has determined that:

- + It is a large employer; and
- + it has some full-time employees who may be eligible for a subsidy through the Exchange/Marketplace; and
- + it did not offer substantially all full-time employees (and dependents) minimum essential coverage; or
- + it did not offer substantially all full-time employees (and dependents) minimum essential coverage that was minimum value and affordable coverage.

### When does the rule become effective (i.e., when will the penalty begin or when will the group need to revise benefits and eligibility in order to avoid the penalty)?

In order to determine the effective date of Shared Responsibility, an employer must know the following information:

- (1) Is the plan a calendar year plan or a fiscal year plan?
- (2) Who did the plan cover as of 12/27/2012?
- (3) What was the greatest number of employees covered any day between October 31, 2012 and December 27, 2013?

Plan Year	Employees Covered/Enrolled	Effective Date of Shared Responsibility
January 1, 2014 – December 31, 2014	N/A	January 1, 2014
Fiscal Year Plan (General Rule)	Did NOT OFFER COVERAGE to SUBSTANTIALLY ALL employees (full and part-time over 30 hours) as of 12/27/12	January 1, 2014 (off-cycle changes required)
Fiscal Year Plans (Transition Relief)	SUBSTANTIALLY ALL employees covered (full and part-time over 30 hours per week) as of 12/27/12	Renewal date on or after 1/1/2014*
Fiscal Year Plans (Transition Relief)	Offered at least one-third** of employees (full and part-time) at the most recent open enrollment period (2012 open enrollment period)	Renewal date on or after 1/1/2014*
Fiscal Year Plans (Transition Relief)	Covered at least one-quarter** of employees (full and part-time)	Renewal date on or after 1/1/2014*

\*Failure to make appropriate changes upon 2014 renewal date will result in monetary penalties back to 1/1/2014.

\*\*For purposes of determining whether the plan covers at least one-third (or one-quarter) of the employer's employees, an employer may look at any day between October 31, 2012 and December 27, 2012.

### Resources:

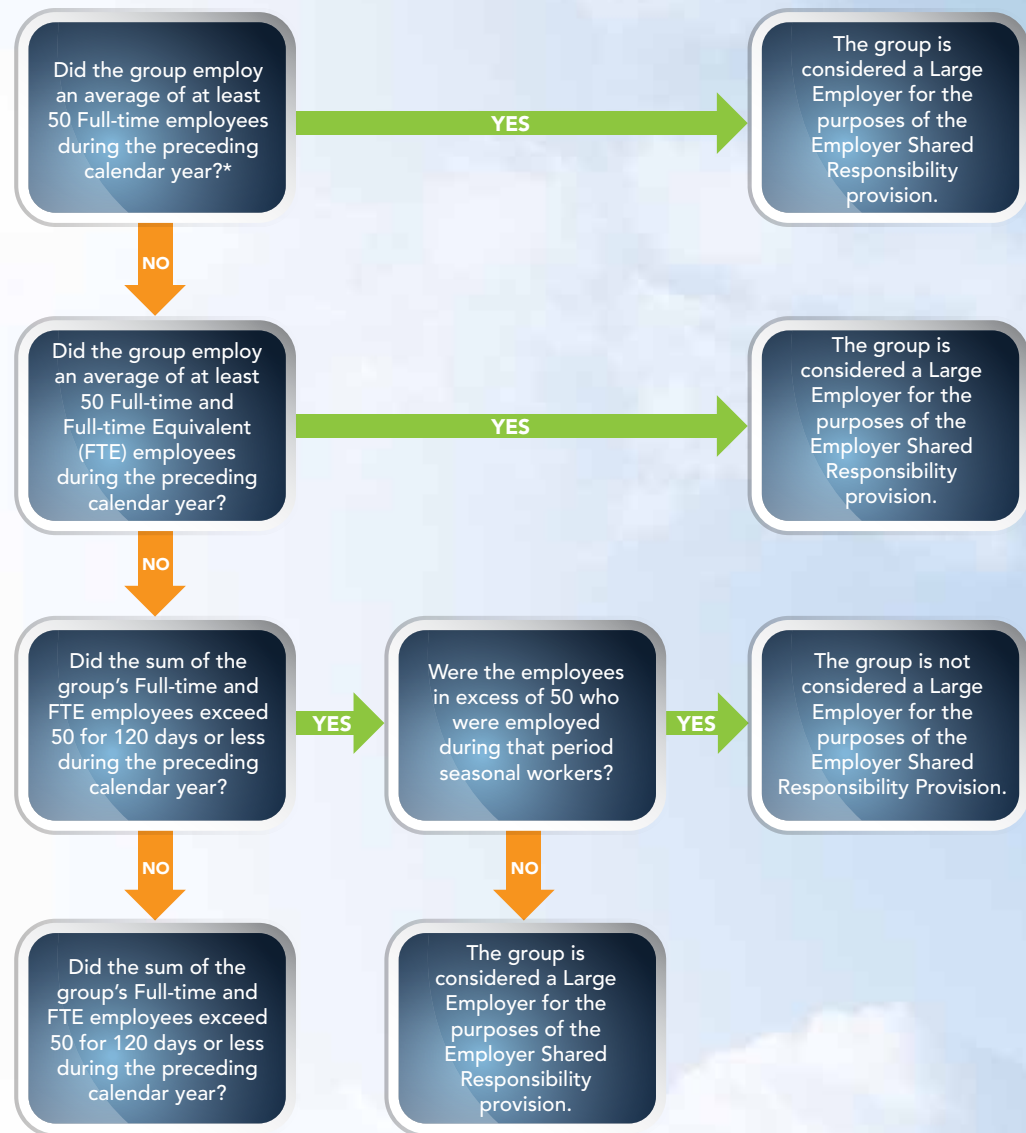
1. Federal Register, Vol. 78, No. 1, January 2, 2013. Shared Responsibility for Employers Regarding Health Coverage.
2. Congressional Research Service Report for Congress: Potential Employer Penalties Under the Patient Protection and Affordable Care Act (ACA). Janemarie Mulvey, April 8, 2013.

**NOTE:** See Appendix for a helpful decision tree.



Appendix /Additional Resources.

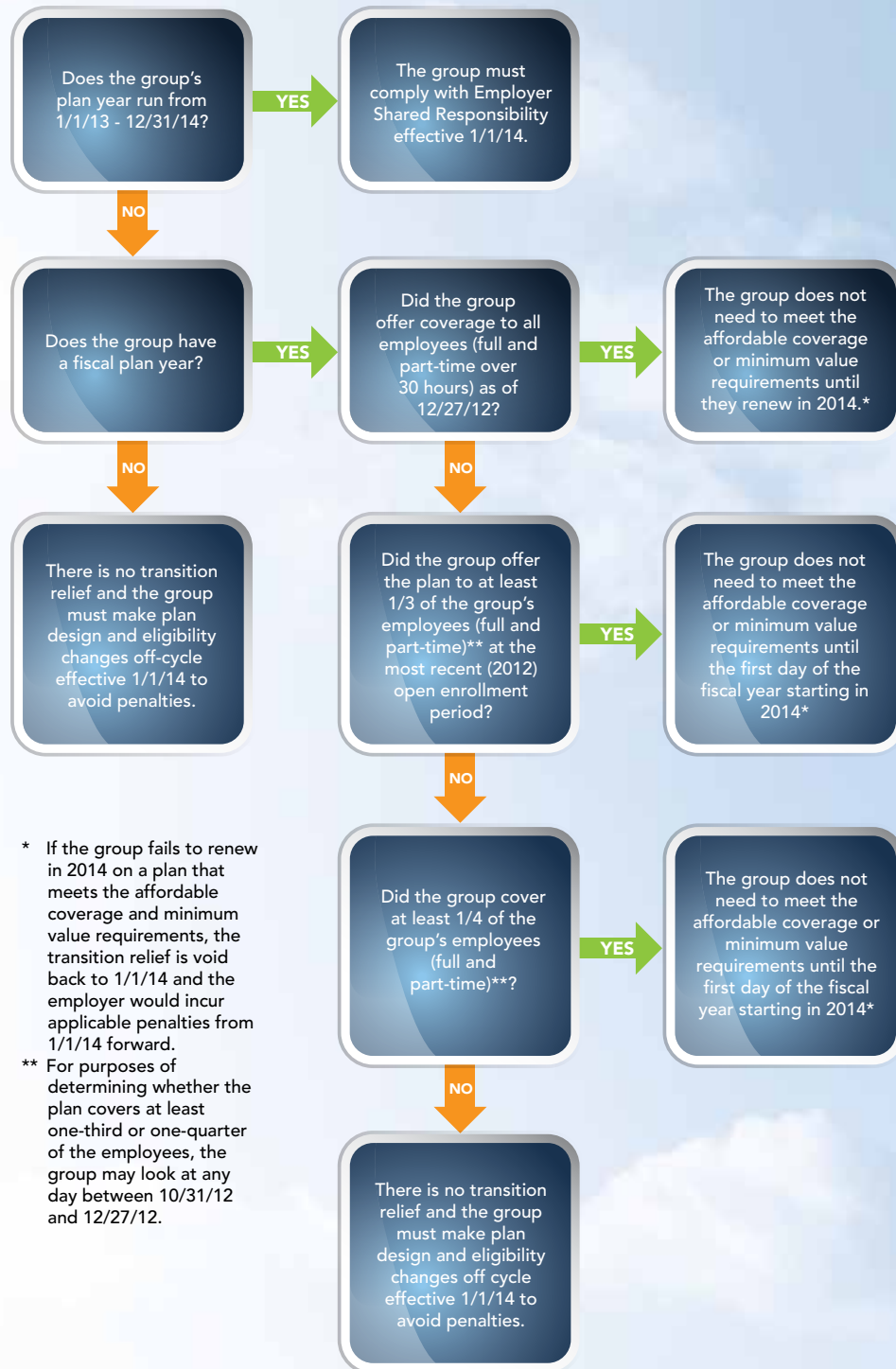
## How does a group determine whether they are a large employer?





## Appendix /Additional Resources.

# When is Employer Shared Responsibility effective?



\* If the group fails to renew in 2014 on a plan that meets the affordable coverage and minimum value requirements, the transition relief is void back to 1/1/14 and the employer would incur applicable penalties from 1/1/14 forward.

\*\* For purposes of determining whether the plan covers at least one-third or one-quarter of the employees, the group may look at any day between 10/31/12 and 12/27/12.

## More information

Many excellent resources about health care reform are available online:

- + **NCHealthReform.com** - The 'Blue View' of health care reform explained simply
- + **Healthcare.gov** - The federal government's official health care reform website
- + The White House - Information, blog about plans of the federal government
- + Kaiser Family Foundation - Objective and universally respected health care reform resources
- + Robert Wood Johnson Foundation - Another well-respected, objective source for all-things health policy
- + The Commonwealth Fund - Private foundation working toward a high performance health system
- + Patient Protection and Affordable Care Act (PPACA) - BCBSA on Health Care Reform
- + National Association of Insurance Commissioners (NAIC) Special Health Care Reform Section



# Bringing Health Care Reform Into Focus

**A HEALTH CARE REFORM REFERENCE GUIDE**

BCBSNC HEALTH POLICY OFFICE ~ CURRENT AS OF JUNE 2013