Discussion on National Health Reform

Grand Rapids Chamber of Commerce 2010 Federal Health Care Reform: Critical Business Issues you Need to Know

November 19, 2010

BCBSM Reform Preparations

Established dedicated teams focused on understanding and evaluating impacts of reform

Working with regulators and policy makers on emerging regulations and guidance

Greater deal of work implementing immediate reform changes, including

- **Benefits changes/protections (post 9/23)**
- **New federal web portal for health insurance**
- **Appeals processes**

Communicating about reform with a variety key constituencies

Identifying key issues and initiatives required to address reform challenges and opportunities across our company and its stakeholders

BCBSM's Office of National Health Reform

Context leading to the creation of the Office of National Health Reform

- National health care reform will have impacts that are widespread and substantially impact the organization
- These impacts are near term and will necessitate action across our organization and the market, requiring a cross-functional mechanism to coordinate the response to healthcare reform

Objectives of the Office of National Health Reform

1. **Ensure that BCBSM fulfills all mandated actions under health reform legislation**
   - Near-term products and patient protection
   - Longer-term fulfillment with industry assessments, reporting requirements and other requirements
2. **Enable the capture of short-term value associated with provisions of health reform**
   - e.g., early retiree reinsurance, small business tax credits
3. **Support the building of capabilities and approach to succeed in a post-reform world**
   - Adapting to major changes in the coverage landscape, including a major shift to Medicaid and individual
   - Changing distribution environment in the form of exchanges
   - Innovations in reimbursement and health care delivery
   - Insurance reforms, such as the ability to sell plans across state lines

Market Implications of Reform

Health care reform impacts will occur over three distinct phases

Regulatory "turbulence"

Before 2014

- Interpretation and regulatory rule writing
- Competitive positioning

Market "turbulence"

2014-2017

- New entrants and strategies
- Reactions and rule re-writing

"New Normal"

Post 2017

- Winners and Losers
- Marketshare and pricing stabilize

Major reform provisions will have lasting impact on the marketplace

Market-Shaping Reform Provisions

- Medicaid expansion
- Subsidies for individuals
- Insurance reforms
- Penalties for not having or offering coverage
- Medicare fee-for-service payment changes
- Health insurance exchanges
- Funding (fees and taxes)

Major reform provisions will have lasting impact on the marketplace

Potential Market Impacts

- Pressure on employer-group coverage
- Increased individual market
- Coverage and payer shifts: private and group to government and consumer
- Downward pressure on payments to hospital and physicians
- Price competition and benefit standardization
- Administrative complexity and compliance risks
- Insurance price pressure and affordability problems

Notable Near-term Changes

Nearer-term Issues and Decisions

Retiree Reinsurance

- Have you decided if / how you will apply for retiree reinsurance?

180-day product changes

- Will you try to hold on to grandfathered status?
- How will you address increased costs from new coverage mandates?

SB tax credit

- Do you qualify for the small business tax credit?

Admin requirements

- Are you prepared for the administrative requirements (payroll changes and tax, W-2 and IRS reporting)?

Key Provisions: Retiree Reinsurance

General Provision

- HHS to pay 80% of accumulated claims between $15,000 and $90,000 for retirees aged 55-64 (spouses and dependents of early retiree also eligible)
- $5 billion appropriation for this program (not enough for program to last through 2013)

Getting it done (in time to receive the funds)

- Ensure timely (and accurate) filing of application
- Ensure timely submissions of claims

Key near-term benefit changes

Several changes are required to ensure plans are compliant with PPACA regulations for new plan years beginning on or after September 23, 2010:

1. Lifetime limits	Prohibits lifetime dollar limits on essential benefits
2. Annual limits	Restricts annual dollar limits on essential health benefits to HHS-defined amount until 2014; prohibited in 2014
3. Children's pre – ex	Prohibits pre-existing condition waiting periods and exclusions for members under age 19
4. Dependent age	Requires allowing dependents to remain on coverage until age 26 if dependent coverage is offered under the plan
5. Preventive care	Requires specified preventive care services and immunizations set by USPSTF and others with no cost share
6. Rescissions	Prohibited unless fraud or intentional misrepresentation

Near-term patient protections

Several changes are required to ensure plans are compliant with PPACA regulations for new plan years beginning on or after September 23, 2010:

1. Internal Appeals	Requires plans to meet standards as stipulated by HHS
2. External Appeals	Requires plans to meet standards set by the National Association of Insurance Commissioners
3. Emergency services	No preauthorization for services and equivalent cost-sharing in and out of network
4. PCP/ Pediatrician Choice	Requires choice of any participating PCP accepting new patients; choice of pediatrician. BCBSM/ BCN already compliant
5. OB/GYN Access	Requires direct access to OB/GYNs for female enrollees. BCBSM/BCN already compliant

Provisions affecting all health plans
For Plan Years Starting after September 23, 2010*

	New Plans		Grandfathered	
	Indiv	Group	Indiv	Group
Lifetime Limits: Prohibits lifetime dollar limits on essential benefits	✓	✓	✓	✓
Annual Limits: Restricts annual dollar limits on essential health benefits to HHS-defined amount until 2014; prohibited in 2014	✓	✓		✓
Children's Pre-Ex: Prohibits pre-existing condition waiting periods for children under age 19	✓	✓		✓
Dependent Age: Requires allowing dependents to remain on coverage until age 26	✓	✓	✓	✓
Preventive Care: Requires specified preventive care services and immunizations with no cost share	✓	✓		
Rescissions: Prohibited unless fraud or intentional misrepresentation	✓	✓	✓	✓

Notes

*Collective bargaining agreement (CBA) plans must comply at the same time as non-CBA plans, regardless of when the CBA expires. All grandfathered CBA plans, fully-insured and self-insured, must implement the reforms without a delayed effective date.

** For plan years before 2014, Grandfathered Group Plans only have to offer dependent coverage to age 26 if the adult child is not eligible for other employer group coverage.)

Implementation of items effective 6-months from enactment

What changes will we make?

- As of 1/1/2011*, BCBSM / BCN will be making the following changes:
  - Extension of coverage to dependents up to age 26
  - Removal of lifetime dollar limits
  - Removal of pre-existing condition exclusions for members up to age 19
  - Prohibit rescissions
  - Emergency services
  - Preventive without cost sharing
- Already compliant with Pediatric and OB/GYN protections
- Other provisions (appeals, annual limits) being evaluated

* For groups with plan years between 9/23 and 12/31, changes will be made at their new plan year

Small business tax credit

Some small group customers may be eligible for a tax credit under new reform law

The government will provide a tax credit to some small business employers that pay at least 50 percent of their employees' health insurance premiums.

The size of the credit depends on the average wages and number of employees. The tax credit is worth up to 35 percent of the employer's health care cost for businesses with up to 10 employees and average annual wages of up to $25,000.

EXAMPLE: If the employer contributes $100, the tax credit would be up to $35. The tax credit phases out as the number of employees increases from 10 to 25, and phases out as well as average wages increase from $25,000 to $50,000. Tax exempt small businesses are also eligible, but their tax credit is up to 25 percent of the employer's health care costs.

Small business employers can use this IRS work sheet to determine if they qualify for the tax credit.

The tax credits are available retroactive to Jan. 1, 2010, and apply to both grandfathered and non-grandfathered health plans. Under national health care reform, "grandfathered" plans are defined as those in existence on or before March 23, 2010. For more information, visit the IRS Small Business Health Care Tax Credit for Small Employers website.

Administrative impacts for employers (1 of 3)

Dependent Re-enrollment	• Host a 30-day open enrollment period for dependents under age 26 that were previously dropped from coverage • Employer to notify employee of this enrollment period
Tax on non-qualifying HSA	• Tax on non-qualifying HSA increased from 10 to 20%, effective 2011
W-2 forms	• Healthcare costs must be included on the employee's W-2 form beginning for 2011 tax year. Excludes cost of FSA, HSA or MSA • Can be calculated in two ways: - Use of COBRA rare (minus 2% administrative fee) as an illustrative rate - Actual premium paid (both employer and employee components)
Plan enrollment	• Employees must be automatically enrolled into health coverage as new-hires.

Administrative impacts for employers (2 of 3)

Communication & standardization	• Federal regulations will determine standardized processes and format for communicating benefits, plan changes and rights
1099 forms	• Beginning in 2012, 1099 form must be filed for most vendors paid more than $600
FSA	• In 2013, flexible spending contributions are limited to $2,500. In 2011, over-the-counter drugs must be prescribed to use FSA
CLASS enrollment	• In 2013, Employees must be auto-enrolled in new federal long-term care plan
Payroll taxes	• Employee share of Medicare hospital tax will increase 0.9% for individuals with income >=$250K (joint) or $200K (single), effective 2013. Employers will have to withhold additional payroll taxes from individual's income once it exceeds $200k
Comparative effectiveness fee	• Beginning with policy years ending during 2014 fiscal year, $2 fee per covered life that plan sponsors remit for self-insured plans (insurer remits for fully insured covered lives). $1 per covered life fee for policy years ending during FY2013

Administrative impacts for employers (3 of 3)

Exchange notification	• Notify employees of the existence of their state Healthcare Exchange (HCE) and the services offered by the exchange by March 1, 2013
Reporting to IRS	• Reporting required in 2014 to identify employees with coverage through their employers
Exchange eligibility	• Exchanges open to small employers in 2014. States may open to large employers beginning 2017
Free choice vouchers	• Beginning 2014, all employers offering healthcare coverage will be required to provide "free choice vouchers" to qualified employees to purchase insurance through the HCE • Employees qualify for free choice voucher if employee premium contributions are at least 8% but less than 9.8% of income and the employee's income is at or below 400% of the FPL

Longer-term Issues and Decisions

- How will you approach offering health coverage after 2014?
- Will your employees be better off receiving subsidies on a future exchange? Will you need to provide vouchers?
- How will you address cost of covering additional “essential benefits” and fees/assessments in 2014?
- How will you deal with the high cost health plans excise tax?

Key takeaways on Health Reform

1. **The health insurance marketplace will change radically over the next few years**

2. **The operating environment will be characterized by uncertainty, disruptive change and instability**

3. **Stakeholders in the industry will need to think about their businesses differently, adapt to the environment and be able to respond quickly**

4. **The onus is upon us to work together to meet the challenges and opportunities presented by reform**

Questions?