Blue Cross Blue Shield of Michigan

Leading Michigan to a healthier future℠

Helping employers understand health care reform — 2013 and beyond

Information in this document is current as of August 2013.

Visit **bcbsm.com/healthreform** for up-to-date information.

Helping employers understand health care reform

Updated July 2013

The Patient Protection and Affordable Care Act (PPACA, H.R. 3590) was signed into law by President Obama on March 23, 2010. The companion bill, the Health Care and Education Reconciliation Act (H.R. 4872), was signed on March 30, 2010. Together, these two bills constitute the federal health reform law (collectively known as the Affordable Care Act).

This document outlines key provisions of health reform. There is uncertainty associated with all of the impacts of the reform legislation, as key regulatory guidance is still pending. This overview is intended as an educational tool to help Blue Cross Blue Shield of Michigan customers as they work to understand and meet health reform requirements now and in the future.

2013

- Issuers and plan sponsors begin paying Comparative Effectiveness Fee
- W-2 reporting for tax year 2012 mandatory
- Deduction for expenses allocable to employer, Part D retiree drugsubsidy eliminated
- Medicare payroll tax increases for high-wage employees and new tax on unearned income
- Salary-reduction contributions to health flexible spending arrangements capped
- Employee Health Insurance Marketplace notification required

2014

- Health Insurance Marketplaces open
- Individual health coverage mandate in effect
- Premium tax credits for individuals available
- Individual market premium and cost-sharing subsidies for low- and middle-income individuals available
- Annual dollar limits on essential benefits must be removed
- Optional Medicaid eligibility expansion (under 65)
- Guaranteed issue and renewability required of carriers
- Pre-existing condition exclusions and waiting periods prohibited
- Federal Insurance Premium Tax, Reinsurance Fee, Marketplace Fee and Risk Adjustment Fee in effect
- Limitations on general waiting periods for employees in effect
- Coverage for qualified individuals participating in certain clinical trials allowed
- Restrictions placed on out-of-pocket maximums and deductibles
- Essential benefits and actuarial value metal levels required in small group and individual
- Wellness discounts expanded
- Additional protections for employees required

2015 and beyond

- Employer mandate in effect
- Certain employers required to automatically enroll applicable employees in employer coverage
- IRS reporting of health insurance coverage required for applicable employers
- Quality reporting required
- High Cost Health Plan Excise Tax in effect for high-cost group health plans

More health care reform information is available at **bcbsm.com/healthreform** and **healthcare.gov**

2013 Employer responsibilities for health care reform requirements

This section provides more information on employer responsibilities related to 2013 health care reform requirements.

Comparative Effectiveness Fee

Description: The Comparative Effectiveness Fee imposes a fee for plan or policy years ending after Sept. 30, 2012. This fee will help fund health outcomes and comparative clinical effectiveness research conducted or financed by the Patient-Centered Outcomes Research Institute. The fee is also known as the "PCORI fee."

Initially, the Comparative Effectiveness Fee will impose a $1 fee per covered life for plan years ending on or after Oct. 1, 2012, and before Oct. 1, 2013. This fee will increase to $2 per covered life for plan years ending on or after Oct. 1, 2013.

The fee is calculated by multiplying the average number of covered lives in a plan or policy year by the applicable dollar amount (which depends on when a plan or policy year ends). There are different calculations for covered lives for fully insured versus self-insured business. Issuers and plan sponsors will be required to fill out and submit a specific tax return form, *Form 720*, to pay and report this fee. The IRS has updated *Form 720* to provide more details on the payment and reporting process for this annual fee.

Effective date: The first payments are due to the IRS by July 31, 2013, or July 31, 2014, depending on plan or policy year-end dates. This also applies to retiree-only and grandfathered plans. This fee will end with plan or policy years ending in the federal fiscal year 2019.

Employee Health Insurance Marketplace notification

Description: Employers must notify new employees in writing at the time of hire (or current employees no later than October 1, 2013) with information regarding:

- The existence of a Health Insurance Marketplace
- A description of the services provided by the Marketplace and how to contact the Marketplace
- The potential availability of premium tax credits and cost-sharing reductions in the individual Marketplace if the employer does not offer coverage with at least 60 percent actuarial value
- The loss of the employer contribution to coverage (and the employer-sponsored coverage tax exclusion) if the employee purchases a Qualified Health Plan through the Marketplace

Effective date: Beginning on and after October 1, 2013.

For more information, go to the **Department of Labor's Employee Benefits Security Administration website**.

2014 Employer responsibilities for health care reform requirements

This section provides more information on employer responsibilities related to 2014 health care reform requirements.

Cost-sharing limits

Description: Nongrandfathered group health plans are prohibited from the following:

- Maximum out-of-pocket limits: Imposing annual cost-sharing limits that exceed the applicable threshold to health savings account-qualified high deductible health plans. For example, in 2014 the maximum out-of-pocket cost for a health savings account-compatible high deductible health plan will be $6,350 for self-only coverage and $12,700 for coverage other than self-only.
- Deductible limits: Imposing a deductible greater than $2,000 for self-only coverage or $4,000 for coverage other than self-only.

Effective date: The maximum out-of-pocket limits apply to all nongrandfathered individual, small group, large group, and self-funded coverage for plan years beginning on or after Jan. 1, 2014.

The deductible limits apply to small group health plans beginning on or after Jan. 1, 2014.

Participation in certain clinical trials covered

Description: Nongrandfathered individual market and group coverage (including self-insured) must allow qualified individuals to participate in approved clinical trials for the treatment of cancer and life-threatening conditions. Group health plans and insurers are required to continue to provide coverage of routine costs for items or services associated with participation in the clinical trial and are prohibited from discriminating against clinical trial participants.

Effective date: Beginning with plan years that start on or after Jan. 1, 2014.

90-day waiting periods

Description: A group health plan or group health insurance issuer cannot apply a waiting period based solely on the passage of time that exceeds 90 days for employees eligible to participate in the group health plan.

The restriction on waiting periods does not imply that employers have to offer coverage to all types of employees. Employers can apply other eligibility criteria. For example:

- Employers will still be allowed to offer coverage to full-time employees but not to part-time employees. If an employee went from part-time to full-time, the 90-day period would begin when the employee becomes eligible for coverage.
- For example, a part-time employee hired on Jan. 1 may be determined to be ineligible for coverage. Once that employee becomes eligible for health benefits, the waiting period for this employee's benefits cannot extend beyond 90 days.

If an employer makes health plan eligibility conditional on the employee working a certain number of hours per period, and it cannot be reasonably determined that the employee is expected to work those hours, the employer may use a measurement period. The measurement period begins at the employee's start date and cannot last more than 13 months, plus the time remaining until the first of the next month. This measurement period is used to determine if the individual is eligible for health coverage.

Effective date: Beginning with plan years starting on or after Jan. 1, 2014. This applies to grandfathered, nongrandfathered, and self-funded plans.

Federal Insurance Premium Tax

Description: Beginning in calendar year 2014, health insurance issuers must pay an annual tax to the IRS based on the issuer's share of the national market of net premiums written in the preceding calendar year. An issuer is liable for the tax if it provides health insurance for any United States health risk during the calendar year in which the tax is paid. Issuers will be required to submit data to the IRS about their net premiums written. This information will be used to determine the total net premiums written nationally, and to allocate the assessment to each issuer.

This tax generally applies to fully insured business, including the individual market, small group market, large group market, fully insured Medicaid managed care contracts and fully insured Medicare Advantage business. It does not apply to self-insured coverage or to individual Medigap plans. Ancillary health insurance, such as dental, vision and pharmacy benefits, is included in the net premiums written calculation.

For each issuer, the fully insured net premium revenue that counts toward the tax calculation is determined based on the following graduated scale:

- $0 to $25 million: 0 percent
- $25 million to $50 million: 50 percent
- More than $50 million: 100 percent

Next, only 50 percent of premium revenue (after taking into consideration the graduated scale amounts above) counts for federally tax-exempt non profits (as defined by IRC Sec. 501(a)). This is a 50 percent reduction in the premium revenue (not a 50 percent discount on an issuer's tax liability) that is used to calculate the total national market size, and those applicable issuers' tax obligation.

Effective date: January 1, 2014. The payment will be based on the preceding calendar year's net premiums. The tax will be paid by the annual payment date, which the Internal Revenue Service has proposed to be September 30.

Reinsurance Fee

Description: The transitional Reinsurance Fee, also referred to as "reinsurance contributions," will be paid by health insurance issuers (for applicable fully insured coverage) and plan sponsors or third-party administrators (for applicable self-funded coverage). The fee, paid on an annual basis beginning in January 2015 (based on 2014 life counts), will be a per-capita assessment remitted to the Department of Health and Human Services or to state reinsurance entities, as applicable.

The Reinsurance Fee applies to the insured and self-funded group markets (including grandfathered and retiree-only coverage) and to the individual market. It does not apply to Medicare Advantage, Medigap or Medicaid, for example. It will be used to fund the transitional reinsurance program that will subsidize nongrandfathered individual market plans (on and off the Health Insurance Marketplace) for at least three years, beginning in 2014.

Effective date: A reinsurance contribution rate of $63 per covered life per year will apply with respect to lives covered during the 2014 calendar year. The first payment is likely due in January 2015. Payment is due within 30 days of the U.S. Department of Health and Human Services notice of the amount owed. Payments are due yearly.

Marketplace Fee

Description: The Marketplace Fee will be paid by health insurance issuers participating and offering health plans on the state or federal Health Insurance Marketplace. The fee, paid on a monthly basis beginning in January 2014, will be 3.5 percent of the monthly premium. The Marketplace Fee will be used to make the Health Insurance Marketplace self-sustaining by January 1, 2015. This fee generally applies to the fully insured individual and small group markets. It does not apply to fully insured middle and large group markets, self-insured coverage, administrative service contracts, Medicare or Medicaid.

Effective date: January 1, 2014 (expected).

Risk Adjustment Fee

Description: The Risk Adjustment Fee will be paid annually by health insurance issuers. The per-member per year assessment, paid to HHS, will be due in June or July of the year following the benefit year (e.g., June or July 2015 for the 2014 benefit year). The Risk Adjustment Fee will be used to pay for the administrative expense of running the federal risk adjustment program, which seeks to stabilize premiums in the individual and small group market.

This fee generally applies to nongrandfathered fully insured business in the individual market and small group market. It does not apply to self-insured coverage, the large group market, Medicare or Medicaid. In 2014 the fee will be $0.96 per member per year.

Effective date: The fee applies to risk adjustment covered plans beginning January 1, 2014.

Employee protections

Description: Employers are prohibited from discriminating against employees who:

- Receive a subsidy for purchasing insurance on the Health Insurance Marketplace
- Report any violation by their employer of any provision of the ACA

Discrimination is also prohibited against group health plans and health insurance issuers who engage in similar activities.

Effective date: Pending regulations, but anticipated to be effective Jan. 1, 2014.

Wellness discounts

Description: Employers may offer incentives to employees of up to 30 percent of the cost of coverage for participating in wellness programs where the reward (such as premium discounts, cost-sharing reductions or enhanced benefits) is based on satisfying a standard related to health status. Programs that are designed to reduce tobacco use may provide an additional 20 percent reward, for a combined total reward of up to 50 percent.

Employers can't discriminate as to eligibility or benefits based on health status factors. Under the rules, it is permissible for benefits to vary based on participation in compliant wellness programs. Wellness programs must satisfy the HIPAA nondiscrimination requirements.

Effective date: Starting Jan. 1, 2014, for both grandfathered and nongrandfathered plans.

Defining group size for 2014 rating purposes

Description: For product and rating purposes, a small employer is an employer that employed, on average, 1 to 50 full-time equivalent employees in the preceding calendar year. To calculate the number of full-time equivalent employees:

- Determine the number of full-time employees for each month of the calendar year using a 130-hour per month standard.
- Calculate the number of full-time equivalent employees for each month of the calendar year using a 120-hour per month standard. For this purpose, any employee that works more than 120 hours but less than 130 hours in a month is treated as having worked 120 hours in the month.
- Find the sum of the number of full-time and full-time equivalent employees for each month in the calendar year.
- Add up the 12 monthly calculations and divide by 12. Round down to the nearest whole number.

If the number is less than or equal to 50, then the employer is considered a small employer. If the number is greater than 50, then the employer is likely to be a large employer, as long as the exemption for seasonal workers does not apply.

If an employer's workforce exceeds 50 full-time equivalent employees for 120 days or fewer during a calendar year, and the employees in excess of 50 that were employed during that period were seasonal employees, the employer would not be a large employer.

For more information regarding counting employees, go to the **Internal Revenue Service website**.

Effective date: Jan. 1, 2014.

Guaranteed issue

Description: Carriers must accept all individual and group applicants regardless of pre-existing condition and health status, and must use adjusted community rating.

Effective date: Starting Jan. 1, 2014, for individual and group plans.

Guaranteed renewal

Description: Carriers must renew individual and group policies except in some limited circumstances such as nonpayment of the applicable premium. This does not limit the amount that can be charged for coverage or require insurers to maintain policies that are non-compliant with other federal rules.

Effective date: Jan. 1, 2014.

Reporting of health insurance coverage

Description: Requires every applicable large employer to submit an information return to the Internal Revenue Service. The return must contain:

- Name, date and employer ID number
- The date the return is filed
- Certification as to whether the employer offered its full-time employees and their dependents the opportunity to enroll in a health benefits plan or grandfathered health benefits plan
- The number of full-time employees for each month during the calendar year
- Name, address and tax identification number of each full-time employee and the months during which the employee (and any dependents) were covered under any health plans offered by the employer
- Any other information determined by the IRS

If the applicable large employer offers coverage, the return must also include:

- The length of any waiting period
- Months when coverage was available
- Monthly premium for lowest cost option in each enrollment category
- Actuarial value or minimum value determination for the coverage option
- The option for which the employer pays the largest portion of the cost of the plan and the portion of the cost paid by the employer in each of the enrollment categories under such option

Employers required to file a return must provide an information return to each full-time employee whose name is required to be included on the employer's return. This statement must include:

- The name and address of the applicable large employer required to make the return and the phone number of the information contact for that employer
- All the information that the applicable large employer was required to report to the IRS with respect to the full-time employee

Additional reporting of health insurance coverage

Description: An additional information reporting requirement applies to health insurance issuers for fully insured coverage and employers that sponsor self-insured plans. These returns — provided to the IRS and to each individual for whom information is reported to the IRS — must include the following information:

- Name, address and tax identification number of the primary insured and name and TIN of other individuals covered under the policy
- Dates of coverage (for each individual to which the return applies) during the calendar year
- Any other information required by the IRS.

If the coverage is fully insured, the return must additionally include the following information:

- Whether the coverage is a qualified health plan offered through a Health Insurance Marketplace
- Amount of any advance premium tax credit and cost-sharing subsidies applied to the coverage (if applicable)

If the coverage is group coverage, it must include the following:

- Name, address and employee identification number of the employer maintaining the plan
- Portion of the premium paid by the employer
- If coverage is a qualified health plan in the small group market, any information the IRS requests be included to administer the small business tax credit

It is likely that the IRS will reconcile these two reporting requirements to reduce redundancy.

Effective date: Expected to be voluntary in 2014 and then mandatory in 2015 for applicable large employers.

Employer responsibilities for health care reform requirements for 2015 and beyond

This section provides more information on employer responsibilities related to health care reform requirements for 2015 and beyond.

Employer shared responsibility

Description: Employers with 50 or more full-time equivalent employees that do not provide their full-time employees coverage that meets affordability and minimum value standards may have to pay an excise tax.

If the employer offers coverage, the employer is only potentially liable for this excise tax:

- If the employee share of premium cost exceeds 9.5 percent of the employee's household income OR,
- If the coverage does not pay for 60 percent of the expected benefit costs (60-percent actuarial value), and the employee receives a premium tax credit or cost-sharing subsidy via a Health Insurance Marketplace.

The reporting to the IRS for applicable large employers (refer to page 10) is primarily intended to monitor compliance with this requirement.

Excise tax penalty amounts: While the definition of a large employer is determined on an annual basis, the penalty calculation is assessed on a monthly basis.

- Employers that do not offer coverage and have at least one full-time employee that receives a premium tax credit on the Health Insurance Marketplace will be assessed an excise tax equal to $2,000 annually multiplied by the number of full-time employees (minus the first 30).
- If the employer offers coverage and a full-time employee receives a premium tax credit through a Health Insurance Marketplace (due to the employer's coverage not satisfying the affordability or minimum value standards), the employer must pay an amount equal to the lesser of $3,000 annually for each full-time employee receiving a subsidy or $2,000 annually for each full-time employee (minus 30 employees).

Effective date: Expected in 2015.

Automatic enrollment

Description: Requires certain employers to automatically enroll their new full-time employees in one of their employer-sponsored health plans as soon as they are eligible for coverage, and these employers should continue enrollment of current employees. Employers' automatic enrollment processes should include providing their employees with adequate notice and opportunity to decide not to enroll in the designated health plan.

This applies to employers with more than 200 full-time employees that also offer enrollment in one or more health benefits plans.

Effective date: There is no clear effective date at this time, but it will be no earlier than 2015. Employers will not be expected to meet these requirements until regulations are provided.

High Cost Health Plan Excise tax

Description: A 40-percent excise tax will be assessed on the value of employer-sponsored insurance that exceeds certain thresholds. This tax will generally be remitted by insurers for fully insured benefits and by the plan administrator, which is usually the employer, for self-funded business. A tax liability occurs if the aggregate value of applicable benefits (including employer and employee share of premiums) exceeds $10,200 for an individual or $27,500 for a family (threshold values will be indexed beginning in 2019).

The aggregate value includes medical and drug benefits, along with employer and employee contributions to health flexible spending arrangements, employer and certain employee contributions to health savings accounts and employer contributions to health reimbursement arrangements. This does not include certain "excepted" benefits, such as stand-alone dental and vision benefits, accident only, disability income coverage and workers compensation.

For retirees age 55 to 64 and for certain high-risk professions, thresholds will increase by $1,650 for individuals and $3,450 for families. Thresholds may be increased to reflect higher health care costs attributable to age or gender distribution within the workforce. In addition, the base threshold amounts in 2018 may be adjusted upwards if health care costs rise more than expected prior to 2018.

Employers are responsible for reporting the amount of excess coverage and the required tax payment to insurers and the government.

Effective date: Waiting for final regulatory guidance, which is expected in 2015.

Quality reporting

Description: Insurers and group health plans must report plan or coverage benefits and health care provider reimbursement structures that improve quality outcomes. They must also implement:

- Activities to prevent hospital readmissions
- Activities to improve patient safety and reduce medical errors
- Wellness and health promotion activities

Reports must be submitted to HHS/DOL annually and must be available to plan enrollees at open enrollment.

Effective date: Pending regulations.

Ongoing health care reform requirements – implemented in 2012 and early 2013

This section provides information about ongoing employer responsibilities related to health care reform requirements that became effective in 2012 and early 2013.

Women's preventive services

Description: Under the Affordable Care Act, many insurers are required to cover certain preventive services at no cost to individuals. By no later than August 2013, this will include:

- Annual well-woman visits
- Screening for gestational diabetes
- Human papillomavirus testing, also known as HPV testing
- Counseling for sexually transmitted infections
- Counseling and screening for human immune-deficiency virus, or HIV
- Contraceptive methods and counseling
- Breastfeeding support, supplies and counseling
- Screening and counseling for interpersonal and domestic violence

Blue Cross Blue Shield and Blue Care Network of Michigan already cover many of these services; however, some will now be covered with no cost sharing when provided by an in-network provider. Group health plans sponsored by certain religious* employers, and group health insurance coverage in connection with such plans, are exempt from the requirement to cover contraceptive services.

* A religious employer is one that is organized and operates as a nonprofit entity and is referred to in section 6033(a)(3)(A)(i) or (a)(3)(A)(iii) of the Internal Revenue Code of 1986 [45 CFR 147.131(a)].

Effective date: Plan years beginning on or after Aug. 1, 2012.

Summary of benefits and coverage

Description: Insurers and group health plans are required to provide a *Summary of Benefits and Coverage* (SBC), coverage examples and a glossary of health insurance terms. These documents must be provided at no charge to applicants, enrollees, policyholders, certificate holders, insured group health plans (sponsors) and prospective members. Among other requirements, plan summaries must be no longer than four double-sided pages, use standardized medical or insurance terms, and feature information about how to renew and maintain coverage.

Effective date: Sept. 23, 2012, and after for grandfathered and nongrandfathered plans. For participants and beneficiaries enrolled in group health coverage through an open enrollment period, the first day of the open enrollment period that begins after Sept. 23, 2012. For disclosures to participants and beneficiaries enrolled in group health plan coverage other than through an open enrollment period, the first day of the first plan year that begins after Sept. 23, 2012. For disclosures to plans and to individuals and dependents in the individual market, Sept. 23, 2012.

W-2 reporting

Description: Beginning in tax year 2012, employers that issue 250 or more W-2 forms must report the cost of health coverage for each employee on their W-2 forms (beginning with the W-2 forms issued in January 2013). This reporting is for informational purposes only. The cost of coverage is not included in the employee's taxable income. Reporting remains optional for employers that issue fewer than 250 W-2 forms until further guidance is issued. This information will be entered in the W-2 form's Box 12, Code DD.

Effective date: 2012 tax year for employers that issue 250 or more W-2 forms.

Flexible spending arrangements capped

Description: Contributions to health flexible spending arrangements for medical expenses will be capped at $2,500 per year (indexed to inflation and rounded to the next lowest multiple of $50 after 2013). These contributions will continue to be excluded from taxable income. The cap does not increase based on the number of dependents or family members. However, if both spouses have access to a health flexible spending arrangement through their respective employers, then both spouses can contribute up to $2,500 each for their own health flexible spending arrangement.

Non-elective employer contributions to a health flexible spending arrangement do not count toward this cap.

Effective date: First cafeteria plan year beginning on or after Jan. 1, 2013.

Medicare payroll tax increase for high income earners

Description: The hospital insurance tax on wages will increase by 0.9 percent (from 1.45 percent to 2.35 percent) on earnings over $200,000 for individuals and $250,000 for married couples filing jointly. Employers are not required to increase their contribution to the Medicare payroll tax. If an employer does not deduct and withhold this tax as required, the employer may be liable for penalties or additions to this tax.

Effective date: Starting Jan 1, 2013.

Health care reform requirements for employer awareness

This section provides information about health care reform that may not require employer action.

Medical loss ratio rebates

Description: Health insurers will be required to annually report the ratio of premium dollars spent on clinical services and quality improvement versus administrative expenses. If a health insurer does not meet the medical loss ratio thresholds (85 percent for large groups of 51 or more employees and 80 percent for individual and small group plans of 50 or fewer employees), it must provide rebates to the groups or members within the segments that did not meet the thresholds. These rebates are equal to the dollar amount needed to meet the threshold.

Effective date: Beginning in 2012, any required rebates will be paid by Aug. 1, based on the prior year's experience.

Unearned income tax

Description: The tax applies to those with modified adjusted gross income over $250,000 for married couples filing jointly, $125,000 for married filing separately, and $200,000 for individuals. For individual taxpayers with MAGI in excess of the thresholds stated above, the tax is 3.8 percent of the lesser of net investment income or the excess of MAGI over the threshold amount. In certain circumstances, the tax could also apply to an estate or trust.

Effective date: Starting Jan. 1, 2013.

Premium tax credits

Description: Under the ACA, income-adjusted premium tax credits may be available for purchase of individual market policies on a Health Insurance Marketplace. In order to qualify, the applicant must be a U.S. citizen or legal immigrant and cannot be eligible for "minimum essential coverage" other than individual market coverage and must meet certain other criteria as defined by the IRS and the federal department of Health and Human Services. A state will have the option of expanding its eligibility criteria for its Medicaid program. If a state chooses to fully expand Medicaid, then income eligibility for premium tax credits would generally range from 139 to 400 percent of the Federal Poverty Level.*

If an individual is offered coverage from the employer, the individual market subsidies can only be accessed if:

- The employer-based coverage either does not have an actuarial value of at least 60 percent (the minimum value standard) or the employee's contributions for self-only coverage exceed 9.5 percent of household income, and
- The employee declines to accept the employer-based coverage and the employee qualifies for the individual market tax credit.

*Federal poverty level: Medicaid eligibility is generally extended to 133 percent of the FPL calculated with a 5 percent income disregard. Thus, Medicaid eligibility is effectively up to 138 percent of the FPL.

Effective date: Jan. 1, 2014.

Health Insurance Marketplaces

Description: Small-group employers and individuals who are U.S. citizens or legal immigrants may purchase insurance from Health Insurance Marketplaces. A small group is expected to be defined in Michigan as 1-50 employees, although the state could elect to increase this threshold to 100 employees. In 2016, the threshold must increase to 100 employees. Beginning in 2017, states may opt to allow large-group employers to purchase coverage on the Marketplace.

Insurers can only offer qualified health plans on the Marketplaces. Coverage choices will be classified into four "metal" levels representing the actuarial value of covered essential health benefits. Coverage in each tier must include essential benefits and have out-of-pocket maximums no greater than the maximums that apply to health savings account-compatible high-deductible health plans in 2014. For example, these levels in 2014 will be $6,350 for self-only coverage and $12,700 for coverage other than self-only. Metal tiers and values are as follows:

- Bronze — 60 percent
- Silver — 70 percent
- Gold — 80 percent
- Platinum — 90 percent

Premium tax credits are generally available for coverage purchased on the Individual Health Insurance Marketplace if household income is between 100 and 400 percent of the federal poverty level. For those qualifying for premium tax credits, cost-sharing subsidies are available if household income does not exceed 250 percent FPL.

Effective date: Jan. 1, 2014.

Individual mandate

Description: U.S. citizens and legal residents are required to have "minimum essential coverage" or else face a penalty. Minimum essential coverage includes Individual Health Insurance Marketplace coverage, employer-sponsored group health plans, Medicare, Medicaid, government-sponsored coverage, CHIP, and high-risk pools. There are various exceptions to the individual mandate, including a cost-of-coverage test. For employees eligible for coverage from their employer, if the employee's share of self-only premiums exceeds 8 percent of household income, then the employee may be exempt from the individual mandate. An individual who is not eligible for coverage from an employer may take an affordability exemption from the individual mandate if the cost of the lowest cost bronze plan available to the taxpayer's family exceeds 8 percent of household income. In 2016, the penalty for noncompliance will be the greater of $695 per person per year (capped at $2,085 per family) or 2.5 percent of the taxpayer's household income in excess of the applicable tax filing threshold (percentage-based penalty is uncapped). Lower penalties apply during the phase-in period from 2014 through 2016. Beyond 2016, the $695 penalty is indexed for inflation.

Effective date: Jan. 1, 2014.

Medicaid expansion

Description: A state will have the option of expanding its eligibility criteria for its Medicaid program. Eligibility can be expanded to all individuals under age 65 with incomes up to 138 percent of the federal poverty level.

Effective date: On or after Jan. 1, 2014.

Key provisions for retiree plans

Early Retiree Reinsurance Program

Description: The federal Early Retiree Reinsurance Program was a temporary program designed to stabilize the health care market by providing financial assistance to health plan sponsors that make coverage available to millions of early retirees and their families. The program was created to help employers maintain quality health coverage for retirees age 55 and older who are not eligible for Medicare.

In February 2012, the ERRP announced it had received requests for reimbursement that surpassed the $5 billion originally allocated to fund the program. Reimbursement requests received after the funding was exhausted have been placed on hold in the order received. These requests will be held in case more funds become available when any overpayments previously given to plan sponsors are returned.

Effective date: HHS is no longer accepting applications. To assess If any overpayments were made, the Centers for Medicare and Medicaid Services will begin an audit process. Sponsors who are not using the funds according to the Affordable Care Act's requirements will be expected to return their funds to the agency.

Modification of tax advantage for retiree drug subsidy

Description: Health care reform changes the tax status of the retiree drug subsidy (RDS) for employer-sponsored prescription drug coverage for Medicare-eligible retirees. Beginning in 2013, expenses allocable to the RDS will no longer be tax deductible, but the RDS itself will retain exemption from income taxation.

Plans should account for the change in the tax status of the retiree drug subsidy and consider other retiree pharmacy program cost mitigation strategies.

Effective date: Starts with the 2013 tax year.

Notes and definitions

Fully insured vs. self-insured group health plans: Most items in this summary apply to both fully insured and self-funded groups. Exceptions are noted where applicable.

Grandfathered plans: BCBSM will verify grandfather status with grandfathered groups at least annually.

A group health plan is a grandfathered plan with respect to individuals enrolled on March 23, 2010. Any plan not in existence on that date is considered a nongrandfathered plan.

Grandfathered plans have special effective dates for some reform requirements and are completely exempt from others, which are noted where applicable.

Grandfathered plans are allowed to enroll dependents of current enrollees and add new employees (newly hired and newly enrolled) and their dependents without jeopardizing grandfathered status. The newly added individuals receive the same coverage as the grandfathered individuals. Certain significant changes to the health plan, or failing to comply with administrative requirements relating to record-keeping and notice, can cause the health plan to lose its grandfathered status.

Retiree-only plans: Health care reform's insurance market reforms, which include but are not limited to requirements or prohibitions relating to lifetime and annual dollar limits, rescissions, preventive services, extension of dependent coverage, appeals processes, emergency treatment and preexisting conditions, generally do not apply to retiree-only plans, whether those plans are sponsored by non-federal governmental entities or private sector employers. Other health care reform provisions, however, may be applicable to such plans.

Collectively-bargained agreement plans: Health insurance coverage maintained under a collective bargaining agreement which was ratified before March 23, 2010 is a grandfathered health plan at least until the date on which the last agreement relating to the coverage that was in effect on March 23, 2010 terminates. Therefore, before the last of the applicable collective bargaining agreement terminates, any health insurance coverage provided under the collective bargaining agreements remains a grandfathered health plan, even if there is a change to the plan which would normally cause a health plan to lose grandfather status. This "special grandfather rule" is only for collectively bargained insured plans, not self-funded plans, and only if the collective bargaining agreement under which the insured plan is maintained was ratified before March 23, 2010. All plans, regardless of whether or not plan coverage is subject to collective bargaining agreements, must comply with applicable ACA requirements. The effective date for implementation of applicable reforms is not delayed for collectively bargained coverage.

Health reimbursement arrangement: An account funded by solely by an employer to reimburse employees for qualified medical expenses.

- Employers qualify for preferential tax treatment of funds placed in an HRA and can deduct the cost of an HRA as a business expense.
- Contributions are not taxable to the employee.
- Unused funds may be rolled over at the end of the year, at the employer's discretion.
- HRAs remain with the originating employer and do not follow an employee to new employment; however, COBRA may apply to the HRA.
- Depending on the design of the HRA, and at the employer's discretion, former employees, including retirees, may continue to be eligible for reimbursement from their share of unused reimbursement amounts.

Health savings account: A tax-exempt account offered in conjunction with a qualified high-deductible medical plan and used to pay for qualified medical or drug services not covered by the health care plan, including deductibles, coinsurance and copayments. Funds can be carried over from one year to the next.

Flexible spending arrangement: A tax-advantaged program offered by an employer allowing employees to pay for eligible out-of-pocket health care expenses with pre-tax dollars, thereby reducing the cost of care by the amount of tax that would have been due on the contributed sums. Contributions may be made by the employer, employee or both. Contributions not spent on eligible medical expenses are forfeited at the end of the plan year (or slightly later if a grace period applies) and become the property of the employer.

Notes and definitions

The information in this document is based on our review of the national health care reform legislation and is not intended to impart legal advice. Interpretations of the applicable statutes and regulations vary. The federal government continues to issue guidance on how the provisions of national health reform should be interpreted and applied. While some of the information deals with federal law, it does not constitute legal or compliance advice. Applicability and interpretation of the law depends on the specific facts and circumstances of each individual situation. Groups with questions about application of the law to their particular situation, should consult an attorney for advice. As required by IRS Circular 230, unless expressly stated otherwise, if this message contains any tax information concerning one or more Federal tax issues, it is not a formal legal opinion and cannot be used by any person to avoid Federal tax penalties.

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