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Navigating the next phase of health care reform

Your guide to making strategic decisions

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Health care reform timeline

A year-by-year look at what to expect

Benefit changes. Coverage requirements. Tax credits. Exchanges. When it comes to health care reform, there's a lot to know – and a lot to do. Here are some key provisions that will affect you through 2018:

2010	• Early Retiree Reinsurance Program began • Small employer tax credit began • Begin closing the Medicare Part D "donut hole"
Beginning of plan year that starts on or after September 23, **2010**	• Dependent coverage for adult children up to age 26 (or higher if state law mandates it) • No lifetime dollar limits on benefits • Restricted annual dollar limits on essential health benefits • No pre-existing condition exclusions for children • 100% coverage for preventive services in network* • No prior authorization for emergency services or higher cost-sharing for out-of-network emergency services* • No referrals required for OB/GYN services • Any available primary care physician (PCP) accepting new patients may be selected • Pediatrician may be selected as a PCP for children • Revised appeals process and changes to adverse benefit determinations (enforcement of some regulations delayed until detailed guidance is issued)* • No discrimination in favor of highly compensated employees (enforcement delayed until detailed guidance is issued)*
2011	• Prescription required for health account reimbursement for over-the-counter medications • 20% tax for nonqualified HSA withdrawals • Medical loss ratio standards go into effect (80% for small group) • CLASS long-term care program developed (enrollment date to be determined) • Grants for qualifying small employer wellness programs • Federal rate review
2012	• Uniform coverage summaries/60-day notice for material modifications • First year medical loss ratio rebates may be issued

*Not required for grandfathered group health plans

2013	• Value of employer-sponsored coverage on W-2s for 2013 tax year – meaning W-2s issued in January 2014 (originally required earlier, but the IRS made reporting optional for 2011 and 2012 tax years for employers who issue fewer than 250 W-2s) • Employee notification of exchanges and premium subsidies • Medical flexible spending account contributions limited to $2,500 per year • Annual per-member fee for Patient-Centered Outcomes Research Institute (for fiscal year 2013, which technically begins October 1, 2012)
2014	• Penalties for employers who don't provide minimum coverage to full-time employees (50+ employees) • Employer requirement to auto-enroll employees into health benefits (200+ employees) • 90-day limit on waiting periods for coverage • Small group redefined as 1-100 (states may defer until 2016) • No annual dollar limits on essential health benefits • Individual mandate • Guaranteed issue • 30% incentive cap for wellness programs • Coverage of routine patient costs for clinical trials of life-threatening diseases*
2018	• 40% excise tax on high-cost "Cadillac" plans

*Not required for grandfathered group health plans

Moving reform forward for the benefit of you and your employees

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

Looking back at 2010

How we implemented the first round of provisions

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

Dependent coverage to age 26

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

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

We removed lifetime dollar limits from plans where required and gave individuals who may have previously reached their lifetime maximum an opportunity to re-enroll at the group's regular open enrollment. We implemented the annual limits provision, removing annual benefit and plan dollar limits.

No member cost share for in-network preventive care*

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

Patient protections*

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

Revised appeals process and adverse benefit determinations*

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

No discrimination in favor of highly compensated employees*

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

Early Retiree Reinsurance Program

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

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

What do you need to do?

If you employ fewer than 25 employees and their average annual compensation is less than $50,000, you may qualify for the small employer tax credit. You'll need to submit Form 8941, Credit for Small Employer Health Insurance Premiums, which is posted on the IRS website. You can get more details and calculate your potential credit at anthem.com/healthcarereform.

Looking forward

Making gradual shifts from 2011 to 2013

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

Spending account changes

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

Uniform coverage summary/notice of material modification

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

W-2 reporting

This requirement was originally scheduled to start earlier, but the IRS delayed it until the 2013 tax year (meaning W-2s issued in January 2014) for employers who issue fewer than 250 W-2s. Until that time, reporting is optional. The value of employer-sponsored coverage will be a new, separate entry on the W-2 form. The requirement applies to anyone who is still receiving benefits from the employer, including COBRA participants and retirees (even though retiree-only plans are exempted from the health care reform law). This is a reporting obligation only and does not change the current tax-free nature of the benefit.

Medical loss ratios

Health insurance issuers will report medical loss ratio (the percentage of premiums spent on medical care, as opposed to administrative expenses) to HHS on a calendar-year schedule. This reporting starts with calendar year 2011. Issuers that don't meet the minimum medical loss ratio (80% for small group) during the calendar year will need to pay rebates by August 1 of the following year. The first rebate payments, if any, must be made by August 1, 2012. For group plans, the regulations state these rebates should go to enrollees, defined as anyone covered by the plan.

Comparative effectiveness research plan fees

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

Notification requirements

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

What do you need to do?

- If you offer spending accounts, update your employee benefit materials to reflect the new rules.
- Make sure your payroll department or vendor is prepared for W-2 reporting.
- If you have fewer than 100 employees who work 25+ hours per week, look into federal grant funding for workplace wellness programs started after March 23, 2010. Grant funding becomes available in 2011.

Looking forward

Moving to a new health insurance market in 2014

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

Employer responsibility to provide coverage

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

Automatic enrollment

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

Health insurance exchanges

States will begin to operate health insurance exchanges, which are envisioned to be marketplaces for individuals and some employer groups to obtain private health insurance. Small employer tax credits will be available only in the exchanges. Employers will also be able to purchase coverage outside of the exchanges.

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

Small group rating changes

The small group market must use the modified community rating. Rates are based on these factors only:

- Age (rates for highest age band no more than 3 times rates for lowest age band)
- Tobacco use (rates for tobacco users no more than 1.5 times rates for nontobacco users)
- Geography
- Family tier

Employer reporting requirements

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

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

Requirements for minimum coverage

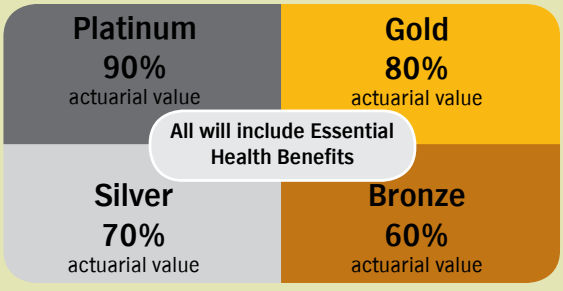
To be considered minimum coverage, a plan must:

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

Requirements for exchange plans

To be offered in an exchange, a plan must:

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



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

The benefit requirements listed above for exchange plans will also apply to small group fully insured plans sold outside of the exchanges.

FAQs

Answering common questions about health care reform

What preventive care services were added for nongrandfathered plans?

Most of the services required by HHS were already included in our preventive care guidelines; however, we did add several additional screening tests and certain services associated with previously covered screenings and vaccines. Also, we added counseling related to aspirin use, tobacco cessation, obesity and alcohol.

What services are considered essential health benefits?

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

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

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

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

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

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

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

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

Find more questions and answers on our website

If you have a question about health care reform that isn't answered here, be sure to visit anthem.com/healthcarereform.

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

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