Straight Answers on Health Care Reform
A Tool for Implementing the Affordable Care Act

[For small employers]

From Blue Cross—Your Trusted Advisor
Your questions deserve straight answers.

On March 23, 2010, President Obama signed the Affordable Care Act into law. And with the unprecedented changes of health care reform has come uncertainty, challenges, and numerous questions.

As your trusted advisor, no one is more prepared to guide you through the implementation of the health reform law and give you straight answers to all your questions than Blue Cross. Straight Answers on Health Care Reform: A Tool for Implementing the Affordable Care Act gives you an overview of the key provisions and how they impact your business.

Timeline of Key Provisions

Many of the Affordable Care Act provisions are already in effect, but others are set to roll out in 2014 and beyond.

Already in Place

- Preventive care coverage at no cost share
- Dependent care coverage expanded to age 26
- Rebates from health plans that spend less than the minimum amount of premium revenue on medical claims and activities to improve health care quality
- Small business tax credits and early retiree re-insurance programs
- Employee health plan documents provided annually with definitions and explanations

Coming in 2014

- Health insurers cannot deny coverage or charge higher premiums for any reason, including health status and gender
- Most individuals will be required to have health insurance
- Small businesses and individuals without affordable employer coverage can buy coverage through a state exchange

In the Future

- 2015–Large employers may pay penalties for employees who get premium tax credits
- 2016–The small group category will be expanded to include businesses with 51–100 employees by 2016
- 2017–Large groups can participate in a state exchange
- 2018–A 40 percent excise tax for issuers of employer-sponsored health plans with aggregate values that exceed $10,200 for individual coverage and $27,500 for family coverage (certain exceptions apply)

To Learn More

We have transformed our existing health care reform website into a dynamic, user-friendly site with everything you need to prep for the next phase of health care reform. It now offers a customized experience by audience type, so you can quickly see the provisions and new requirements that matter most to you.

Visit www.bluecrossma.com/straight-answers for more information on health care reform.

The information provided in this document is not legal advice. It is only a summary of our business understanding of select provisions of the law, which may change as the appropriate agencies publish additional guidance. As such, we suggest that employers and individuals consult with their legal counsel and/or tax advisors about how health care reform may impact them.
## Small Employer

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<th>Provision</th>
<th>How This Will Impact You</th>
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<tr>
<td><strong>Administrative Requirements</strong></td>
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<tr>
<td>Uniform explanation of coverage documents</td>
<td>Insurance companies and employers are required to provide consumers in the private health insurance market with a brief summary of what a health insurance policy or employer plan covers, called a Summary of Benefits and Coverage. It must be provided to subscribers during an open enrollment period, upon enrollment, at renewal or upon request. Blue Cross is revising the Summary of Benefits and Coverage to comply with new requirements in 2013.</td>
<td>Employer/Health Plan</td>
<td>9/23/2012</td>
</tr>
<tr>
<td>Waiting period limitation, not greater than 90 days</td>
<td>The Affordable Care Act provides that “a group health plan and a health insurance issuer offering group or individual health insurance coverage shall not apply any waiting period that exceeds 90 days.” This means employers cannot have waiting periods greater than 90 calendar days.</td>
<td>Employer</td>
<td>2014 plan year</td>
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<tr>
<td>Exchange notification for employees</td>
<td>Open enrollment for health insurance coverage through the health insurance exchange or marketplace begins October 1, 2013. The Affordable Care Act creates a new requirement for employers to notify employees of available coverage options. This is a one-time notice that must be provided to all current employees as of October 1, 2013 and to new employees as they are hired. For 2014, if the notice is provided within 14 days of an employee’s start date, the notice will be considered as having been provided at the time of hiring. Employers must provide a notice to all full-time and part-time employees, regardless of whether the employee is enrolled in an employer-sponsored medical plan. The notice does not have to be provided to employees’ dependents. Notices must be in writing and can be delivered electronically by the employer if the Employee Retirement Income Security Act standards for electronic delivery are met.</td>
<td>Employer</td>
<td>10/1/2013</td>
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<td>Expanded employer-based wellness programs</td>
<td>The Affordable Care Act creates new incentives and builds on existing wellness program policies to promote employer wellness programs and encourage opportunities to support healthier workplaces. This provision increases the maximum permissible reward under a health-contingent wellness program from 20 percent to 30 percent of the cost of health coverage, and further increases the maximum reward to as much as 50 percent for programs designed to prevent or reduce tobacco use.</td>
<td>Employer</td>
<td>2014</td>
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<tr>
<td>$2,500 employee contribution limit for Flexible Spending Accounts</td>
<td>This provision limits employee contributions to Flexible Spending Accounts. Effective January 1, 2013, salary reductions by an employee for a taxable year for the purposes of coverage under a cafeteria plan are limited to $2,500. In addition, for taxable years beginning after December 31, 2013, the dollar amount shall be increased by a cost-of-living adjustment.</td>
<td>Employer</td>
<td>2013</td>
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<tr>
<td>Automatic enrollment</td>
<td>This does not apply to small employers.</td>
<td>Employer</td>
<td>To be determined/ 2015</td>
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<td><strong>Benefit Changes</strong></td>
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<td>Coverage of pre-existing health conditions (regardless of age)</td>
<td>Beginning in 2010, group health plans cannot exclude enrollees (employees, spouses, or dependents) under age 19 based on pre-existing conditions. Beginning in 2014, all pre-existing condition exclusions must be removed.</td>
<td>Insurer</td>
<td>2014 plan year</td>
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<td>Annual limit on plan deductibles—$2,000 individual or $4,000 family</td>
<td>Under the Affordable Care Act, annual deductible limits are $2000 per individual and $4000 per family for the merged markets (indexed with inflation) and apply to all essential health benefits. Where applicable, Blue Cross is currently implementing this for 2014 plan designs.</td>
<td>Insurer</td>
<td>2014 plan year</td>
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<td>Essential health benefits</td>
<td>Beginning in 2014, all non-grandfathered health plans sold in the individual and small group markets (inside and outside the Massachusetts Health Connector) must cover all ten essential health benefits categories. In 2012, each state was required by the federal government to select an essential health benefits benchmark plan. The benchmark plan defines the essential health benefits that must be covered by plans in the state. In MA, Blue Cross HMO Blue® with Deductible is the benchmark plan. All benefits in this plan at the time it was selected are considered essential health benefits in MA. Where applicable, Blue Cross is currently implementing this for 2014 plan designs.</td>
<td>Insurer</td>
<td>2014 plan year</td>
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<td>Eliminate annual and lifetime dollar limits on essential health benefits</td>
<td>Beginning in 2014, all health plans sold in the individual and small group markets (inside and outside the Massachusetts Health Connector) must eliminate annual and lifetime dollar limits on essential health benefits. Where applicable, Blue Cross is currently implementing this for 2014 plan designs.</td>
<td>Insurer</td>
<td>2014 plan year</td>
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| Essential health benefit—Pediatric dental coverage                                                                                | Pediatric dental benefits (to age 19) is one of the essential health benefit categories required to be included as part of health coverage in the individual and small group market in 2014. These benefits will include:  
  • Preventive and diagnostic services, including oral exams, X-rays, and routine dental care  
  • Basic restorative services, including fillings, root canals, stainless steel crowns, periodontal care, oral surgery, and dental prosthetic maintenance  
  • Major restorative services, including tooth replacement, resin crowns, and occlusal guards  
  • Medically necessary orthodontic care that has been pre-authorized for a qualified member  
Where applicable, Blue Cross is currently implementing this for 2014 plan designs. | Insurer          | 2014 plan year |
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<td>Maximum out-of-pocket limits on member cost sharing—$6,350 individual or $12,700 family</td>
<td>Beginning with 2014 plan years, non-grandfathered employer group health plans must comply with a single maximum out-of-pocket amount for all plan coverage, including medical, prescription-drug, and mental-health and substance-use disorder benefits. Plans currently using multiple claim payers, such as separate pharmacy benefit management, have until the 2015 plan year to design a single maximum out-of-pocket limit and coordinate vendor arrangements. Where applicable, Blue Cross is currently implementing this for 2014 plan designs.</td>
<td>Insurer</td>
<td>2014 plan year</td>
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| Specified actuarial value requirements (Metallic tier) | The Affordable Care Act establishes four levels of coverage based on actuarial value, which represents the share of health care expenses the plan covers for a typical group of enrollees. All merged market plans sold inside and outside an exchange will be required to conform to limited ranges of actuarial values associated with metallic tiers. Metallic tiers are a way of classifying health insurance products which have similar actuarial value. For example, if a plan has an actuarial value of 70 percent, on average, a consumer would be responsible for 30 percent of the costs of all covered benefits. The metallic tiers and corresponding actuarial value calculation are as follows:  
  • Platinum (AV: 88%–92%)  
  • Gold (AV: 78%–82%)  
  • Silver (AV: 68%–72%)  
  • Bronze (AV: 58%–62%)  
Where applicable, Blue Cross is currently implementing this for 2014 plan designs. | Insurer | 2014 plan year |
| Clinical trials coverage | If a group health plan or health insurance issuer in the group and individual health insurance market provides coverage to a qualified individual, then such plan or issuer: (1) may not deny the qualified individual participation in an approved clinical trial with respect to the treatment of cancer or another life-threatening disease or condition; (2) may not deny (or limit or impose additional conditions on) the coverage of routine patient costs for items and services furnished in connection with participation in the trial; and (3) may not discriminate against the individual on the basis of the individual's participation in the trial. Where applicable, Blue Cross is currently implementing this for 2014 plan designs. | Insurer | 2014 plan year |
| Rating restrictions | According to final regulations for implementing the Affordable Care Act, beginning in 2014, a health insurance issuer's rate offering non-grandfathered health insurance coverage may only vary by:  
  • Whether the plan covers an individual or family  
  • Geographic area  
  • A 3:1 age rating band, and  
  • Tobacco use  
However, for the calendar years 2014 and 2015 only, a transition period has been granted in Massachusetts to allow the partial use of these additional rating factors: Industry, Participation Rate, Group Size, Intermediary Discount and Group Purchasing Cooperatives. | Insurer | 2014 plan year |
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<td>Minimum creditable coverage</td>
<td>Under Massachusetts law, minimum creditable coverage-compliant plans must provide coverage for a broad range of medical services and have certain limits on what a subscriber will pay for in-network services. There can be no limits or caps on certain benefits such as prescription drug benefits. The broad range of medical services must be available to all people covered by the plan. An individual must have minimum creditable coverage to avoid the Massachusetts individual mandate tax penalty. Although employers are not directly affected by the minimum creditable coverage rules, employees, retirees, and family members enrolled in an employer plan that does not satisfy the minimum creditable coverage requirements may be subject to tax penalties.</td>
<td>Insurer and employer</td>
<td>Ongoing</td>
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<td><strong>Fees and Assessments</strong></td>
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| Patient-Centered Outcomes Research Institute fee payment | The Affordable Care Act authorized the Patient-Centered Outcomes Research Institute, an organization tasked with funding research that will provide clinicians with evidence-based information. It is funded by a fee assessed on insured plans and self-insured plans. The fee is based on the average number of lives covered per year. The fee increases over time until it ends in 2019. Blue Cross will file and pay the fee.  
• $1 per covered life for plan or policy years ending on or after October 1, 2012 and before October 1, 2013  
• $2 per covered life for plan or policy years ending on or after October 1, 2013 and before October 1, 2014  
• On or after October 1, 2014, the amount of the fee will be adjusted for inflation until the fee ends on October 1, 2019 | Insurer                     | 2013            |
| Transitional re-insurance program fee         | The Affordable Care Act created the transitional re-insurance program to help stabilize premiums in the individual health insurance market, as the new exchanges and insurance market reforms take effect in 2014. The fees from fully insured and self-funded plans will support this transitional re-insurance program until 2016, when the program ends. For the benefit year 2014, the Department of Health and Human Services expects the per capita contribution rate to be $5.25 per month (or $63 per year). This amount is an estimate and could change when the department publishes a final amount. The annual contribution amounts for 2015 and 2016 decline to approximately $8 billion and $5 billion, respectively. The annual per-covered-life contribution rates for the final two years of the program should have similar decreases. Blue Cross will report and pay the re-insurance fee for fully-insured small groups. | Fully Insured—Blue Cross  
Self-insured—Plan Sponsor | 2014            |
Health insurance industry fee

The insurer fee, also called the health insurance industry tax, is an annual fee on certain health insurers beginning in 2014. This annual fee will help fund the federal and state exchanges that will be launching in 2014. The fee does not apply to self-insured accounts. Health insurers will pay a fee based on their percentage of market share. The total industry fee is estimated to be $8 billion in 2014, increasing to $14.3 billion by 2018. After that, the amount will increase in proportion to overall premium growth. For our insured plans that are subject to the health insurance industry fee, the fee will be included as part of the health plan premium and will be spread out over the months the plan is in effect.

Employer Shared Responsibility

Large employer (50+ full-time employees) must offer benefits to all full-time equivalent employees working 30+ hours per week

This does not apply to small employers.

Minimum employer value standard (60 percent actuarial value test)

This does not apply to small employers.

Affordability test (9.5 percent) of income

This does not apply to small employers.

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