AskBlue

About Health Care Reform

Your Guide to Health Care Reform

REVISED ›
August 2013
*Includes Employer Mandate Delay

NEBRASKA

AskBlue
About Health Care Reform

Navigating Health Care Reform…

It's Not Getting Any Easier

We knew that health care legislation was going to drastically change the U.S. health care system—2013 and 2014 will begin to show us just how much. While some provisions of the Affordable Care Act went into effect starting in 2010, the bulk of the legislation will be implemented this year and into 2014, as Health Insurance Marketplaces (Exchanges), tax-credit subsidies, Essential Health Benefits and multiple taxes and fees reshape the system.

Blue Cross and Blue Shield of Nebraska (BCBSNE) has updated *Your Guide to Health Care Reform* to help brokers and employer-group clients learn more about major health insurance changes, the opportunities and the challenges that lay ahead.

On the following pages you will find a summary of provisions that will be implemented in 2013 and 2014, and brief explanations of those provisions and previous statutes that are already in place.

GROUNDBREAKING LEGISLATION

The president signed the Patient Protection and Affordable Care Act (PPACA) into law on March 23, 2010. Additionally, he signed the Health Care and Education Reconciliation Act of 2010 on March 30, 2010, which made amendments to the PPACA law.

The president's signature on the reform bills triggered a series of major changes to the health care system that will affect every American. Several changes became effective upon President Obama's signature. We know much more about changes that are being implemented in 2013 and into 2014; and many other changes are being finalized as federal government entities finalize rules and regulations.

2013-2014 PPACA Provisions

PPACA Provision	SMALL GROUP SHOP	SMALL GROUP OFF-SHOP	INDIVIDUAL MARKET-PLACE	INDIVIDUAL OUTSIDE-MKTPLACE	LARGE GROUP	SELF-INSURED LARGE GROUP	SELF-INSURED SMALL GROUP
Essential Health Benefits (EHB)	●	●[1]	●	●[1]	N/A	N/A	N/A
EHB Out-of-Pocket Maximums	●	●[1]	●	●[1]	●[1]	●[1]	●[1]
EHB Deductible Limits	●	●[1]	N/A	N/A	N/A	N/A	●[1]
Actuarial Value Requirements	●	●[1]	●	●[1]	N/A	N/A	N/A
No Pre-existing Condition Exclusions	●	●	●	●	●	●	●
Maximum 90-day Waiting Period	●	●	N/A	N/A	●	●	●
Transitional Reinsurance Fee (paid by the issuer on behalf of self-insured and fully-insured groups)	●	●	N/A (receives payments)	N/A (receives payments)	●	● TPA collects from employer and remits	● TPA collects from employer and remits
Health Insurance Tax (paid by the issuer based on market share of health insurance premium)	●	●	●	●	●	N/A Awaiting regulations on applicability to stop loss.	N/A
Patient Centered Outcomes Research Trust Fund (PCORI) Fee (paid by the issuer for fully-insured plans)	●	●	●	●	●	●	●

1 These provisions apply to non-grandfathered plans and coverage only.

PPACA Provision	SMALL GROUP SHOP	SMALL GROUP OFF-SHOP	INDIVIDUAL MARKET-PLACE	INDIVIDUAL OUTSIDE-MKTPLACE	LARGE GROUP	SELF-INSURED LARGE GROUP	SELF-INSURED SMALL GROUP
Employer Shared Responsibility ("Pay or Play")	Penalties for applicable large employers with 50 or more full-time employees/full-time equivalents. **DELAYED until 2015**						
Minimum Value Requirements	Penalties for applicable large employers with 50 or more full-time employees/full-time equivalents. **DELAYED until 2015**						
Coverage of Preventive Health Services (expanded)	●	●[1]	●	●[1]	●[1]	●[1]	●[1]
Catastrophic Plan (for individuals under 30 years of age)	N/A	N/A	●	●	N/A	N/A	N/A
Child-Only Plan (required)	●	●	●	●	N/A	N/A	N/A
Single Risk Pool	●	●	●	●	N/A	N/A	N/A
Modified Community Rating ("Fair Health Insurance Premiums")	●	●[1]	●	●[1]	N/A	N/A	N/A
Employer W-2 Reporting[2]	●	●	N/A	N/A	●	●	●
Non-Discrimination Based on Health Status	●	●[1]	●	●[1]	●[1]	●[1]	●[1]
Clinical Trials Coverage	●	●[1]	●	●[1]	●[1]	●[1]	●[1]

2 Currently only for groups issuing 250+ W2s.

Source: Blue Cross and Blue Shield Association

Blue Cross and Blue Shield of Nebraska is an Independent Licensee of the Blue Cross and Blue Shield Association.

Essential Health Benefits

The Essential Health Benefits (EHB) provision establishes a core package of items and services for the individual and small group markets—both inside and outside Health Insurance Marketplaces—in ten categories:

EHB regulations include special standards and options for coverage of benefits not typically covered by individual and small group policies today, including habilitative services and standards for prescription drug coverage.

TRUE COSTS

Because the EHB statute requires "richer" health plans than were typically offered to individuals and small groups, this provision is expected to increase costs for most everyone in the health care system.

- 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 and chronic disease management
- Pediatric services, including oral and vision care

EHB Out-of-Pocket Maximums

Non-grandfathered plans—including self-funded and large group employer plans—sold both inside and outside the Health Insurance Marketplaces must meet cost-sharing limitations.

Beginning in 2014, individual, small group and large group plans that offer the essential health benefits package must limit annual cost-sharing (deductible, coinsurance and copayments) to the amounts allowed for high-deductible health plans (HDHPs) coordinated with health savings accounts (HSAs). In 2013, these amounts are $6,350 for individuals and $12,700 for families.

**Cost sharing for this purpose includes deductibles, coinsurance, and copayments for in-network providers. It does not include premiums, non-covered services, balance billing amounts, or cost sharing for out-of-network providers.

EHB Out-of-Pocket Maximums

Deductible Limits

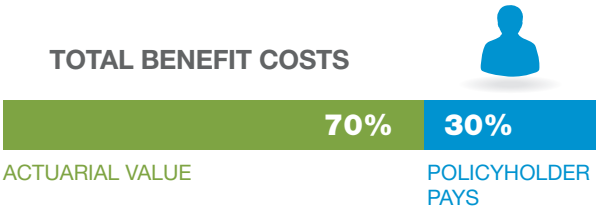
Small group EHB plans are also subject to a limit on the amount of their annual deductibles. In 2014, these limits will be $2,000 for individual coverage and $4,000 for families. Federal departments considering this provision confirmed in final rules that deductible limits only apply to small group plans, but they intend to engage in future rulemaking on this issue.

EHB Deductible Limits

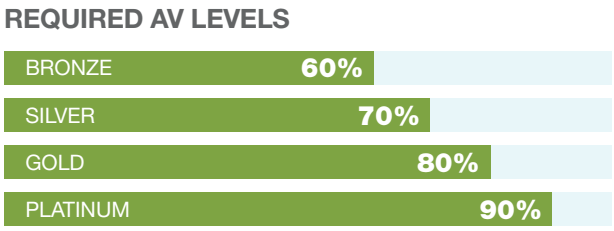
Actuarial Value Requirements

Actuarial value (AV) represents the amount the insurer pays for an average claim versus the amount the customer pays in the form of cost sharing, such as deductibles and copays.

For example, if a plan has an AV of 70 percent, on average a consumer could expect to be responsible for 30 percent of the costs of all covered benefits in that plan. The base level, or Bronze product, inside and outside the Marketplace, is established at 60 percent actuarial value. Richer benefit packages will also be available.



An insurer must offer Silver and Gold plans to participate in the Health Insurance Marketplace. Issuers may offer catastrophic-only coverage to eligible individuals. Standardized "metallic" plans will allow consumers to compare plans with similar levels of coverage.



To streamline and standardize the calculation of AV for health insurance issuers, HHS provides a publicly available AV Calculator, which issuers will use to determine health plan AVs based on a standard population, as required by law. In 2014, the AV Calculator will use a national standard population. Beginning in 2015, HHS will accept state-specific data sets for the standard population if states choose to submit alternate data for the calculator.

HHS finalized that a plan can meet a particular metal level if the AV is within +/- 2 percentage points of the standard. For example, a Silver plan may have an AV between 68 percent and 72 percent. In addition, the final rule provides flexibility for issuers in the small group market regarding annual deductible limits, if necessary, to achieve a particular metal level.

Actuarial Value Calculator
cciio.cms.gov

All Blue Cross and Blue Shield of Nebraska group plans offered in the market for 2014 comply with **actuarial value standards.**

No Pre-existing Condition Exclusions/Guaranteed Issue

PPACA requires health plans to permit a person to enroll in health care coverage regardless of health status, age, gender, or other factors that might predict the use of health services. Except in some states, guaranteed issue doesn't limit how much you can be charged if you enroll.

The law's guaranteed issue requirements will result in greater changes for the individual market than for the small group market. Beginning January 1, 2014, insurance companies are required to guarantee issue all policies to all residents. In most states, this will require legislative or regulatory changes by 2013.

In addition, high-risk pools may become obsolete as states pass laws requiring insurers to cover these individuals in the private market. In the small group market, the PPACA reaffirms the 1996 HIPAA law, requiring insurance companies to guarantee issue and renew coverage to small groups.

Maximum 90-day Waiting Period

For plans or policies that take effect on or after January 1, 2014, a group health plan and issuer may not impose waiting periods that exceed 90 days for benefits.

Taxes and Fees

Transitional Reinsurance Fee

PPACA imposes a new per-enrollee fee on group health plans of all sizes to fund a transitional reinsurance program that will operate from 2014 through 2016.

Congress mandated the program and fee to help offset the anticipated instability in the individual health insurance market caused by the upcoming introduction of state and federal Marketplaces, the requirement that all Americans be covered by health insurance and the removal of medical underwriting.

Federal government revenue from Transitional Reinsurance Fee

2014	2015	2016
$12 BILLION	**$8 BILLION**	**$5 BILLION**

$63 per covered person

$5.25 per month

Department of Health and Human Services (HHS) estimated annual fee for each group health plan in 2014.

The fee applies to all group health plan participants, including dependents.

TRUE COSTS

Most employers expect to pass-through this per person cost to employees and their dependents.

The transitional reinsurance fee applies to all plans providing major medical coverage. The fee does not apply to the following types of plans:

- Stand-alone dental or vision plans
- Health Savings Accounts (HSAs)
- Health reimbursement arrangements (HRAs) that are integrated with a group health plan
- Health flexible spending arrangements (FSAs)
- Employee assistance programs that do not provide major medical coverage
- Disease management and/or wellness programs that don't provide major medical coverage
- Stop-loss and indemnity reinsurance policies

Insurers are directly liable for the fee on insured groups. Self-insured groups are liable for the fee, but third party administrators (TPAs) are required to collect and remit the fee on behalf of the self-insured plan. Insurers and plan administrators (or their TPAs) will be required to send plan enrollment counts to HHS by Nov. 15, 2014. HHS then will send out bills for the first quarterly installment by Dec. 15, 2014, with payments due 30 days later.

For fully insured groups, the fee will be included in the premiums charged.

For self-funded groups, the fee will be illustrated on the invoice, but will be collected beginning in either December 2014 or early January 2015.

Health Insurance Tax

This tax is being implemented to help fund the cost of implementing PPACA provisions. All health insurers will be responsible for paying this fee, which will be assessed on fully-insured medical, dental and vision plans (both grandfathered and non-grandfathered), and is an industry-wide assessment based on market share. The tax does not apply to self-funded plans, and it will be divided proportionally among all health insurers.

In 2014 the fee will represent a total of $8 billion collected from insurers, eventually increasing to $14.3 billion by 2018. After 2018, the Health Insurance Tax will be calculated based on the annual rate of premium growth.

TRUE COSTS

All of these taxes and fees will be passed on to consumers in the form of higher health insurance premiums. The Health insurance tax alone is estimated to increase insurance premiums by as much as 2.5% annually.

2013

REFORMS IN EFFECT STARTING 2013

- **Flexible spending account limits:** The maximum amount an employee may contribute to a flexible spending account is $2,500 in 2013. This limit does not include employer contributions.
- **Medicare tax:** The hospital insurance tax increased 0.9 percent for high-income earners and extends to investment income. Single taxpayers with income exceeding $200,000 and married taxpayers who file joint returns with income exceeding $250,000 are considered upper income.
- **Medical expense deductibility:** Increases the threshold for deducting medical expenses from 7.5 percent to 10 percent of adjusted gross income.
- **Medicaid expansion:** The legislation expands Medicaid eligibility nationwide to those earning up to 133 percent of the federal poverty level (FPL). However, Nebraska's legislature opted to NOT expand Medicaid for 2014.

Patient-Centered Outcomes Research Fee

The Patient-Centered Outcomes Research Institute (PCORI) fee was implemented to help fund research on the best health care treatments for certain conditions and disseminate this information to health care providers. The IRS began assessing employer group plans a $1 per covered person fee effective for plan years ending on or after October 1, 2012 (increasing to $2 starting October 1, 2013).

The fee applies to group health plans for active or former employees, as well as some health reimbursement arrangements and health flexible spending arrangements. Fees do not apply to excepted benefits (stand-alone dental or vision plans and most health FSAs), expatriate medical plans, and stop-loss insurance or indemnity reinsurance policies.

PCORI fee:

2012 **$1** PER COVERED LIFE

2013 **$2** PER COVERED LIFE

Blue Cross and Blue Shield of Nebraska files reports and pays the fees for our fully insured groups. However, the IRS stipulates that self-insured plan sponsors must report and pay the fee themselves and cannot delegate this work to third parties or vendors. Plan sponsors will file IRS Form 720 to report the fees and make annual payments. The fee is due by July 31 of each year.

The fee is calculated as the average number of covered lives under a plan multiplied by $1. The multiplier increases to $2 for the next plan year and is indexed for inflation through plan years ending before October 1, 2019.

Employer Shared Responsibility ("Pay or Play"): DELAYED until 2015

Beginning in 2015, PPACA's Employer Shared Responsibility mandate—also referred to as Employer "Pay or Play"—goes into effect. Employers with 50 or more full-time employees (or a combination of full- and part-time employees that is equivalent to at least 50 full-time employees) are subject to this mandate.

Under the Shared Responsibility mandate, employers may be assessed penalties if one or more of their employees receives a subsidy or premium tax credit for purchasing individual coverage in the Marketplace and any of the following apply:

- Coverage is not provided to at least 95 percent of full-time employees and their dependents;
- Coverage is provided, but does not meet federal guidelines regarding minimum essential benefits value;*
- The coverage provided is deemed "unaffordable," meaning the employee's share of premium exceeds 9.5 percent of household income.

* The IRS and HHS have developed a minimum value calculator [cciio.cms.gov] which employers can use to determine whether their plan provides minimum value.

Employers will determine each year, based on their current number of employees, whether they will be considered a large employer under this provision for the next year. For the purposes of this mandate, "full-time" is defined as working an average of at least 30 hours a week. Part-time employees are calculated by taking the hours worked in a month divided by 120. Seasonal employees are not counted if they work less than 120 days/year *(see example at right)*.

Companies with a common owner must be combined for purposes of determining whether or not they are subject to this provision. If the companies' combined total is 50 or more full-time equivalent employees, then each company is subject to the Employer Shared Responsibility mandate, even if those companies separately do not employ 50 or more full-time equivalent employees.

"SAFE HARBORS"

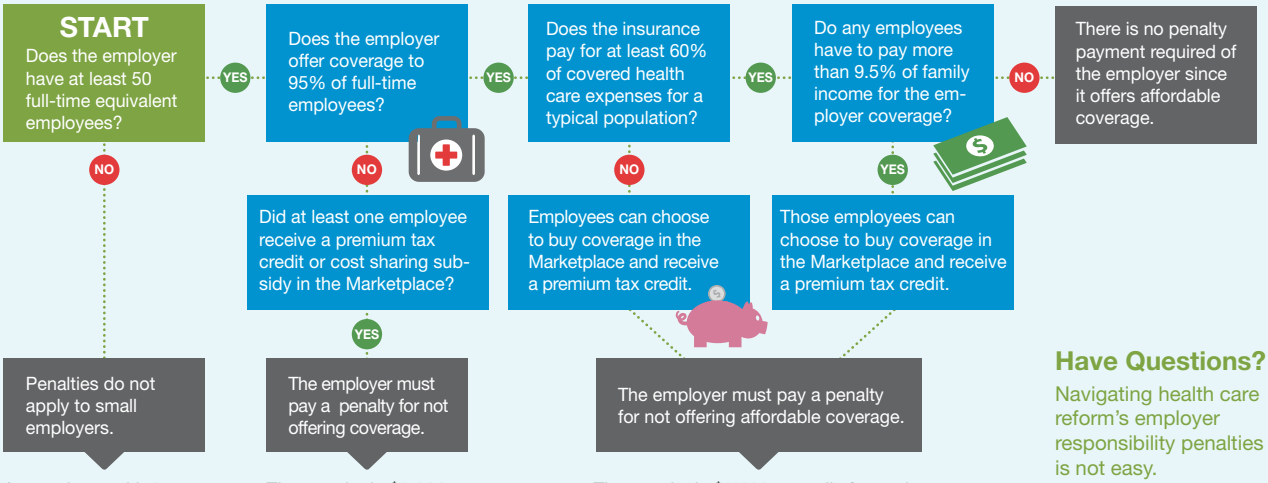
Because employers generally will not know their employees' household incomes, employers can take advantage of one of the affordability safe harbors in the proposed regulations.

Under the safe harbors, an employer can avoid a penalty if the cost of the coverage to the employee would not exceed 9.5 percent of the wages the employer pays the employee that year, as reported in Box 1 of Form W-2, or if the coverage satisfies either of two other design-based affordability safe harbors.

More information about the Employer Shared Responsibility mandate: FAQ section at www.irs.gov

Employer Penalty Scenarios

Determining penalties for employers not offering affordable coverage



An employer with 25 or fewer employees and average wages up to $50,000 may be eligible for a health insurance tax credit for up to two years.

The penalty is $2,000 annually times the number of full-time employees minus 30. The penalty is increased each year by the growth in insurance premiums.

The penalty is $3,000 annually for each full-time employee receiving a tax credit, up to a maximum of $2,000 times the number of full-time employees minus 30. The penalty is increased each year by the growth in insurance premiums.

Have Questions?

Navigating health care reform's employer responsibility penalties is not easy.

Contact a Blue Cross and Blue Shield of Nebraska representative or your broker or agent for further guidance.

Large Employer (50+) or Not?

Minor League Baseball Inc.

40 full-time employees → Calendar Year

Jan — Dec

30 part-time employees →

May — Sept

10x100 hours/month

20x120 hours/month

1 Aggregate Hours

10 x 100 = 1,000
20 x 120 = 2,400 > 3,400 aggregate hours/month

2 Divide by 120 →

3,400 ÷ 120 = 28.33 FTE/month May - Sept

3 Add Full-Time Employees

4 Add up the numbers for each month

Month	Total Counted Employees (Full-Time + FTE)		
January	40	July	68.33
February	40	August	68.33
March	40	September	68.33
April	40	October	40
May	68.33	November	40
June	68.33	December	40
		Total for Year	621.65

5 Divide the yearly total by 12 →

621.65 (Total Counted Employees) ÷ 12 = 51.80

Disregard the fraction
Minor League Baseball Inc. has 51 counted employees (full-time plus FTE)—subject to Pay or Play regulations

Minimum Value Requirements: DELAYED until 2015

Minimum Value Calculator
cciio.cms.gov

Although large group health plans do not have to cover Essential Health Benefits as outlined in the PPACA, those employer-based plans must satisfy "minimum value" requirements to avoid potential liability and incur shared responsibility penalties. In addition, they cannot impose any annual or lifetime dollar limits on EHB.

Beginning in 2015, if an employer does not offer a health plan that has a "minimum value" (MV) of at least 60%, its employees who enroll in an Exchange plan may be eligible to receive a federal premium subsidy or qualify for reduced cost sharing. Under PPACA's "shared responsibility" provisions, the employer could be subject to a $3,000 penalty for each full-time employee who receives subsidized Exchange coverage.

However, it is based on claims data for typical self-funded employer plans.

All Blue Cross and Blue Shield of Nebraska group plans offered in the market for 2015 will comply with **minimum value standards.**

Coverage of Preventive Health Services (expanded in 2012)

Since the law was passed in 2010, it has prohibited cost sharing (deductibles, copays, coinsurance, etc.) for certain recommended preventive services provided by an in-network provider.

In August 2011, the U.S. Department of Health and Human Services (HHS) announced new guidelines to ensure women receive preventive health services at no additional cost to them, with 100% coverage for expanded services such as well-woman visits, various screenings and contraceptive services.

CONTRACEPTIVE SAFE HARBORS:

Non-profits based on religious beliefs

Religiously-affiliated groups

Self-insured religious-affiliated organizations

Non-grandfathered plans and issuers must include these services without cost sharing for insurance policies with plan years beginning on or after August 1, 2012.

Some groups are allowed a temporary safe harbor from the contraceptive services mandate. Nonprofit employers who, based on religious beliefs, do not currently provide contraceptive coverage in their insurance plan, will be provided an additional year – until Aug. 1, 2013 – to comply with the new regulation. This additional year is available to religiously-affiliated groups, such as hospitals, charities and universities that currently do not provide contraceptive services, and allows them to adapt to the new rule.

Additionally, religious-affiliated organizations that are self-insured would instruct their "third-party administrator" to provide coverage through separate individual health insurance policies so they do not have to pay for services to which they morally object.

Some Preventive Services initially covered by the PPACA

- Alcohol and Drug Screening and Counseling
- Blood Pressure Screening
- Colonoscopy
- Depression Screening
- Diabetes (type 2) Screening
- Diet Behavioral Counseling
- Immunizations
- Mammogram
- Obesity Screening
- Pap smear
- Preventive Exam
- Tobacco Cessation and Use Counseling
- Vision Screening

Expanded Preventive Services covered (as of 2012)

- Well-woman visits
- Screening for gestational diabetes
- Human papillomavirus testing
- Counseling for sexually transmitted infections
- Counseling and screening for human immune-deficiency virus
- Contraceptive methods and counseling
- Breastfeeding support, supplies, and counseling
- Screening and counseling for interpersonal and domestic violence

Catastrophic Plans

A catastrophic plan covers essential health benefits established by the PPACA, but only after out-of-pocket cost-sharing reaches a high deductible that will match the level of the PPACA's required out-of-pocket maximum. Recommended preventive services are covered without cost sharing.

Catastrophic plans are for:

Individuals under age 30 before the plan year begins

Or those who have received certification that they are exempt from the individual mandate because they do not have an affordable coverage option, or they qualify for a hardship exemption.

Child-Only Plan

The law states that any qualified health plan offered in the Marketplace at any metallic level of coverage (gold, silver, etc.) must also be offered as a corresponding child-only plan at the same level of coverage. Individuals under 21 at the beginning of the plan year are eligible for child-only plans.

However, according to the definition of "qualifying child," a taxpayer cannot include children age 19 through 20 in determination of the taxpayer's premium tax credit eligibility, unless the 19- or 20-year-old fits the criteria for tax dependent status (e.g. the child is a student).

Single Risk Pool

Beginning in 2014, health insurance issuers will be required to maintain a single statewide risk pool, one for each for their entire individual and small employer markets, unless a state chooses to merge the individual and small group pools into one pool. Premiums and annual rate changes would be based on the health risk of the entire pool.

The claims experience of enrollees in all non-grandfathered individual or small group plans (inside or outside the Marketplace) will be combined so that the premium rate of a plan is not adversely affected by the health status or claims experience of its enrollees. For now, the individual and small group markets will not be merged in Nebraska.

Modified Community Rating (3:1 Age Rating)

Under the new law, insurers can only vary premiums based on where the person lives, family size, smoking status and age. The amount of variation is strictly limited, within a 3:1 ratio for age variation on adults, and within a 1.5:1 ratio for tobacco use (also subject to wellness program requirements in the small group market).

Simply put, premiums can be no more than three times more for older, less healthier populations than they are for younger, healthier consumers. In most cases, this will result in higher premiums for younger insureds, and lower premiums for older populations (see infographic below).

Starting in 2017, states have the option of allowing large employers to purchase coverage through the Marketplace. For states that choose this option, these rating rules also would apply to all large group health insurance coverage.

Impact of 3:1 Age Rating on Health Insurance Premiums

Source: America's Health Insurance Plans

Employer W-2 Reporting

Employers issuing 250 or more W-2 statements must report the cost of their group health coverage on employee W-2s. This rule allows the employer to provide useful and comparable information to employees on the cost of their health care coverage. This information is for reporting purposes only and does not affect tax liability.

Non-Discrimination Based on Health Status

Effective January 1, 2014, group health plans and issuers are prohibited from establishing rules for eligibility based on a person's health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, disability, and any other health-related factor determined by the Department of Health and Human Services.

Clinical Trials Coverage

This PPACA provision prohibits insurers that offer individual or group health products from dropping or limiting coverage for a covered person participating in an approved clinical trial.

It applies to all clinical trials that treat cancer or other life-threatening diseases or conditions. The trial must be one of the following:

- A federally funded or approved trial.
- A clinical trial conducted under an FDA investigational new drug application.
- A drug trial exempt from the requirement of an FDA investigational new drug application.

This federal requirement, effective January 1, 2014, will not apply to grandfathered health plans. BCBSNE plans will comply with this provision.

REFORMS IN EFFECT STARTING 2018

"Cadillac plan" tax:
A new tax on high-value insurance policies will become effective in 2018. If the premium for a group insurance policy exceeds $10,200 for a single policy or $27,500 for a family policy, the excess amount will be subject to a 40 percent excise tax.

Reforms Already in Place

2012 Reforms

Uniform coverage documents:
Beginning with plan years on and after September 23, 2012, all health insurance companies were required to produce the same document describing their health care policies. HHS issued a uniform template that must be used (commonly referred to as the Summary of Benefits and Coverage, or SBC). The SBC must be available and provided to "shoppers" prior to purchase, and to individual and group members at enrollment and renewal.

Quality:
Insurers must report to HHS and enrollees in non-grandfathered individual and group health plans and policies, offered both inside and outside the Marketplace, on their ability to promote quality of care. For example, insurers must report on coverage benefits and health care provider reimbursement structures that improve health outcomes and patient safety, reduce the number of hospital readmissions, and reduce medical errors.

More information about SBCs may be found at www.dol.gov/ebsa/healthreform/

Provisions Enacted Before 2012

Grandfathering ("Keep the Plan You Are On"):
PPACA "grandfathered" individual and group policies that were in effect on March 23, 2010, making them exempt from some of the health care reforms. However, a policy can lose its grandfathered status based on a number of factors.

Rate review:
Health insurance companies must file premium rates with HHS. BCBSNE is already required to file its individual policy rates with the Nebraska Department of Insurance.

Small business tax credits:
The federal government is using tax credits to encourage small, low-wage businesses to offer health insurance to employees. In 2014, when fully phased in, the tax credits could be worth up to 50 percent of the premium.

More information about tax credits: www.irs.gov

Coverage of adult children:
Allows children up to age 26 to receive dependent coverage under a parent's policy. Until 2014, grandfathered plans are not required to cover dependents that are eligible for group coverage in their own right. After 2014, dependents age 19 to 26 cannot be excluded from coverage even if the dependent has access to his or her own employer coverage.

Network access:

Emergency room	Out-of-network claim payment amounts must be the same as in-network claim payment amounts for emergency room visits. A requirement for prior approval of emergency room visits is prohibited.
Primary care	Insurance customers must be able to select any network primary care physician they want to see.
OB/GYN	Women must have direct access to their network OB/GYN without requiring a referral from a primary care physician.

Appeals:
Members of non-grandfathered plans may appeal certain coverage or payment decisions and have them reviewed by an independent review organization not affiliated with BCBSNE.

Elimination of pre-existing condition exclusions for children:
The law prohibits pre-existing condition exclusions for children under the age of 19.

Rescissions:
Insurers may not rescind—or void—a policy without showing fraud or intentional misrepresentation. BCBSNE has controls and safeguards in place to prevent unwarranted rescissions.

Lifetime limits:
Insurance policies are no longer allowed to impose a cap on policy benefits at a certain overall amount.

Annual limits:
This provision restricts and later prohibits insurance policies from imposing dollar-amount-based annual limits on essential benefit plan services.

Medical loss ratio:
Health plan administrative costs are limited to 15 percent for large group products and 20 percent for individual and small group business. Insurance companies must issue rebates to customers if they exceed these administrative expense caps.

Health savings accounts and flexible spending accounts:
Penalties for unqualified withdrawals from health savings accounts (HSAs) increase. Spending on over-the-counter products will no longer be permitted for HSAs and flexible spending accounts (FSAs), unless you get a prescription from your doctor (insulin is the exception).

Employer wellness grants:
Provides grants to small employers to establish wellness programs.

Sources for this “Guide” include:

- Blue Cross and Blue Shield Association
- IRS.gov
- Healthcare.gov
- HHS.gov
- Kaiser Family Foundation
- America’s Health Insurance Plans
- nebraskablue.com

This summary is provided for reference only. It is not intended as legal or regulatory advice or interpretation of any law, regulation or guidance issued by the federal or state government. This information is subject to change at any time as regulations or guidance is being issued by the federal government on an ongoing basis.

For more up-to-date information, please refer to nebraskablue.com, healthcare.gov or the United States Department of Health and Human Services at www.hhs.gov.

NEBRASKA

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