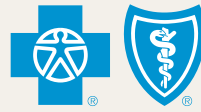

BlueCross BlueShield of Nebraska

An Independent Licensee of the Blue Cross and Blue Shield Association.

YOUR GUIDE TO HEALTH CARE REFORM

bcbsne.com/hcr

1 Introduction to the Law

2 Immediate Reforms

3 Reforms in Effect September 2010

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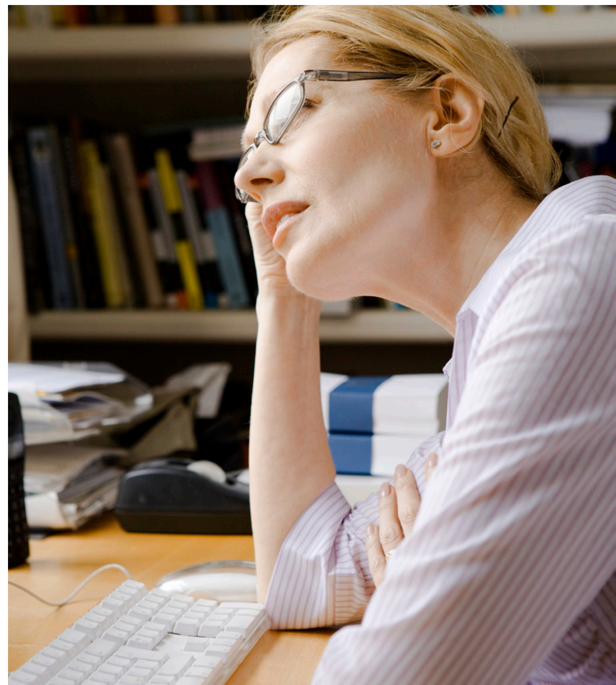
MAKING SENSE OF THE NATION'S NEW HEALTH CARE REFORM LAW IS NO EASY TASK.

It's a complex process, as the new law is thousands of pages long and will drastically change our health care system.

While no one has all of the answers, we do have a talented team ready to help our customers and community navigate the complexities and achieve the end goal: quality and affordable health care for everyone.

We know you're interested in learning how health care reform will affect you, your family and your business. That's why Blue Cross and Blue Shield of Nebraska (BCBSNE) is introducing *Your Guide to Health Care Reform* to help you learn more about major health insurance changes, the opportunities and challenges.

Visit **bcbsne.com/hcr** for more resources and tools to assist you as you navigate through the new health reform law.



Background

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. There were several changes that became effective upon President Obama's signature. The rest of the changes are scheduled to become effective at varying times over the next several years.

The law is wide-reaching and encompasses more than 2,700 pages and many more pages of expected new regulations. Many of the specific details are yet to be finalized by federal agencies and state officials.

This guide outlines some of the major sections of the law, and we've indicated when guidelines are pending from the United States Department of Health and Human Services (HHS) and other federal or state agencies. These guidelines will help all health insurance companies comply more completely with the reforms. Check back on **bcbsne.com/hcr** for updated information.

2010
Immediate Reforms

Grandfathering ("Keep the Plan You Are On"): President Obama said that if you like the insurance you have, you can keep it. To this end, the law "grandfathers" existing individual and group policies. This means policies that were in effect on March 23, 2010, are exempt from many of the health care reforms.

Some of the reforms that do apply to grandfathered policies include:
- Extended dependent coverage to age 26 (see p. 3)
- Rescission restrictions (see p. 4)
- Annual limits and lifetime limits (see p. 4)
- Pre-existing condition limitations for children (see p. 4)

A policy can lose its grandfathered status. If it does, it becomes subject to most of the health insurance reforms set forth in the law. Nongrandfathered plans must:
- Provide coverage for preventive services as defined by HHS with no cost sharing*
- Document certain coverage and cost sharing information
- Comply with external review requirements for appeals process
- Allow direct access to OB-GYNs and pediatricians as primary care physicians**
- Process out-of-network emergency services the same as in-network***
- Comply with annual quality reporting requirements
- Provide coverage for clinical trials
- Small groups must provide coverage for "essential benefits" as defined by HHS

PPACA identifies the factors that will cause a plan to lose its grandfathered status. In summary, these changes include:
- Eliminating all (or substantially all) benefits to diagnose or treat a particular condition
- Increasing coinsurance by any amount above the level at which it was set on March 23, 2010
- Increasing fixed amount cost-sharing (e.g., deductibles and out-of-pocket maximums) more than the sum of medical inflation plus 15 percentage points from the level of March 23, 2010
- Increasing copays by an amount that exceeds the greater of: (1) a total percentage (measured from March 23, 2010) that is more than the sum of medical inflation plus 15 percentage points, or (2) $5 increased by medical inflation
- Reducing employer or employee organization contributions based on the cost of coverage or a formula by more than 5 percentage points below the contribution rate on March 23, 2010
- Reducing an overall annual dollar limit or adding a new overall annual dollar limit, compared to what was in effect on March 23, 2010

The regulation generally provides that grandfathered status applies separately to each benefit option offered under a group health plan.

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.

A federal rate review is designed to prevent unreasonable rate increases. At this time, it is unclear what defines unreasonable. BCBSNE is working with regulators to better understand this provision. We will continue to set our premiums using sound actuarial analysis that incorporates health care trend data and utilization patterns.

■ *continued on page 3*

**Many BCBSNE plans already offer coverage for some preventive services*
***All BCBSNE plans allow direct access to these providers without referral*
****All BCBSNE plans allow out-of-network emergency room services to be paid at the in-network level*

■ *continued from page 2*

2010 Immediate Reforms

Small business tax credits: The federal government is using tax credits to encourage small, low-wage businesses to offer their employees health insurance. In 2014, when fully phased in, the tax credits will be worth up to 50 percent of the premium. A business can qualify for the credit for up to two years.

To qualify, a business must have fewer than 25 full-time equivalent employees (based on a 2,080-hour year), pay an average annual salary of less than $50,000 and pay at least 50 percent of the employee premium. More information about these tax credits can be found at **www.irs.gov**.

Temporary high-risk pool: People with pre-existing conditions who have been uninsured for at least six months will be able to apply for coverage in a new national high-risk pool, established by the federal government. The high-risk pool is intended to provide coverage until January 2014 when, under the law, health insurance coverage will be available on a guaranteed issue basis on health insurance exchanges. More information about the high-risk pool can be found at **www.pcip.gov**.

HHS Web Portal: In July 2010, HHS made a new website available for insurance plan comparison.

The website was designed to help small businesses and individuals compare policies and shop for insurance.

The website has begun with a modest amount of information but will become more comprehensive in future years. In 2014, the site will be replaced by a more robust health insurance exchange.

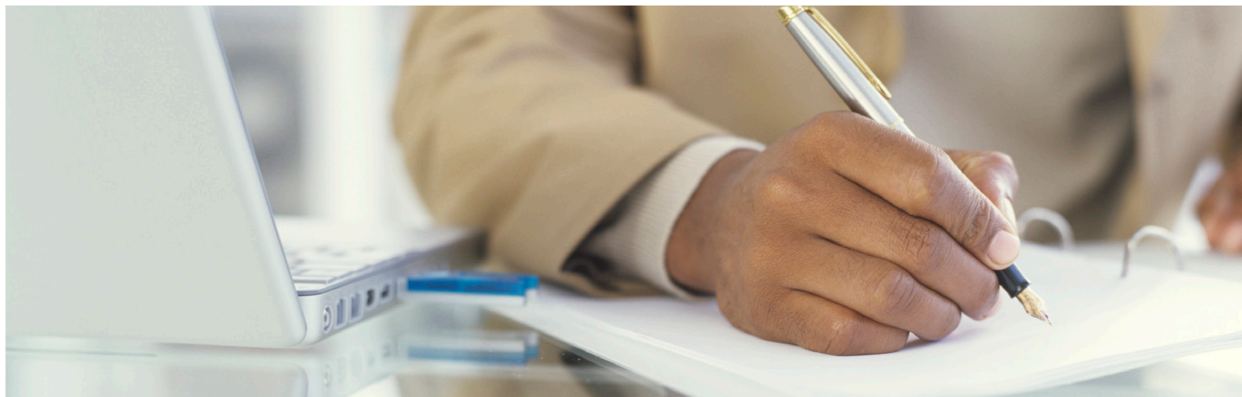
To visit the HHS portal, go to **www.healthcare.gov** and select your state from the drop-down box under "Explore your coverage options."

2010

Reforms in Effect on and after Sept. 23, 2010

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. The adult child does not have to live at home or be a student and can be married. According to the PPACA, this goes into effect at the start of your policy's next plan year on or after Sept. 23, 2010.

In recognition that many students could lose coverage upon graduation this year, BCBSNE decided to extend coverage for existing dependents who may be losing coverage, effective June 1, 2010, in advance of the new law. This dependent coverage extension was implemented for all individual and small group policies and was optional for large employer groups.



Early retiree reinsurance: Employers may apply to receive reinsurance coverage if they provide health insurance coverage to early retirees, ages 55 to 64. The reinsurance covers 80 percent of claims between $15,000 and $90,000. The program expires in 2014 or when the $5 billion appropriation is exhausted. To be eligible, the employer's plan must generate cost savings for people with chronic conditions, provide claim documentation, and apply to HHS.

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 may appeal certain coverage or payment decisions and have them reviewed by an independent review organization not affiliated with BCBSNE. This requirement is new for insured and self-funded business in Nebraska.

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

Preventive services: The law prohibits cost sharing (deductibles, copays, coinsurance, etc.) for certain recommended preventive services provided by an in-network provider.

Rescissions: Insurers may not rescind – or void – a policy without a showing of fraud or intentional misrepresentation. BCBSNE has controls and safeguards in place to prevent unwarranted rescissions. Our rigorous review process involves medical services and legal specialists as well as a two-level appeals process for the policyholder.

Lifetime limits: Insurance policies will no longer be 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. Specific guidelines for what is defined as essential benefits are pending from HHS.

Medical loss ratio: Health plan administrative costs will be limited to 15 percent for large group products and 20 percent for individual and small group business. Beginning in 2011, plans will have to issue rebates to customers if they exceed these administrative expense caps. HHS will develop the definitions and calculations to determine the administrative cost after consulting with state insurance commissioners.

2011

Reforms in Effect Starting in 2011

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 discounts: Allows employers to offer wellness premium discounts up to 30 percent of employee-only premium and provides grants to small employers to establish wellness programs.

Employer obligations: Must disclose the aggregate value of benefits on W-2 form.

2012

Reforms in Effect Starting 2012

Uniform coverage documents: Health plans will be required to publish a description of the policy in a uniform format and provide it to enrollees upon enrollment and renewal. The document must be no more than four pages, use 12-point font and include definitions and examples.

Quality: Insurers must report to HHS and enrollees on their ability to promote quality of care. For example, insurers must provide incentives for hospitals to reduce the number of readmissions. Consumers will also find it easier to compare how well their health plan is performing in the areas of promoting quality health care and wellness.

2013

Reforms in Effect Starting 2013

Flexible spending account limits: The maximum amount of flexible spending accounts becomes $2,500.

Medicare tax: The hospital insurance tax will increase 0.9 percent for high income earners and will extend 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).

Comparative effectiveness research: Research will begin on assessing the best treatments for certain conditions and disseminating that information to health care providers. To fund this research, a fee of $2 ($1 until 2014) per insured life will be assessed to the policyholder.

2014

Reforms in Effect Starting September 2014

Guaranteed issue: The new law prohibits pre-existing condition exclusions for all applicants.

Community 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.

Exchange: The federal government creates a new health insurance marketplace to enable individuals and small businesses (and large businesses, if a state elects) to compare and purchase policies and apply for subsidies. There will be a fee for using the exchange. A person must buy insurance through the state-based exchange to be eligible for subsidies (described below).

Individual mandate: Almost all Americans will be required to have health insurance, whether it is through an employer, a government program or the individual insurance market. The law penalizes people who fail to carry insurance. The penalty is phased in. When it is fully implemented in 2016, a person who fails to buy insurance will be subject to a penalty of $695 or 2.5 percent of their income, but not more than the cost of the lowest cost policy sold through the exchange. Penalties for uninsured children are half the adult penalty.

Employers and insurers will report policy information to the Internal Revenue Service, which will play a role in enforcing the mandate.

Subsidies: The law also offers subsidies to people who might have a difficult time buying insurance. Subsidies are available to those with household incomes of up to 400 percent of the federal poverty level (FPL). For a family of four, 400 percent FPL is $88,200.

The subsidy is set up so that a person pays no more than a certain percentage of his or her income for health insurance. Subsidies are also available for cost-sharing expenses such as deductibles and copays. A person must buy insurance through the exchange to be eligible for subsidies.

Employer requirements: The law requires employers to provide minimum essential coverage for full-time employees and dependents. Employers with more than 50 full-time equivalent employees that have any full-time employees receiving subsidized coverage in the exchange are subject to penalties.

- If the employer does not offer coverage, the fine is $2,000 per full-time employee.*
- If the employer does offer coverage, but the coverage has less than 60 percent actuarial value, or the full-time employee's share of premium exceeds 9.5 percent of income, the fine is $3,000 per full-time employee receiving subsidized coverage or $2,000 per full-time employee, whichever is less.*

* The penalties based on overall number of full-time employees exclude the first 30 employees

Other employer obligations include:

- Employers must inform new hires of the exchange and their potential eligibility for subsidies in the exchange.
- Employers with more than 200 employees and who provide health coverage must automatically enroll new full-time employees in coverage.
- Provide free choice vouchers. Requires employers with more than 50 full-time equivalent employees and who provide coverage to issue free choice vouchers to qualifying employees. Qualifying employees have a household income less than 400 percent of the FPL and their share for coverage is 8 percent to 9.8 percent of their household income. The free choice voucher enables the employee to buy coverage in the exchange with the employer's usual contribution amount. Employers issuing free choice vouchers are not subject to penalties.

- Larger employers (50 or more full-time equivalent employees) must report employee coverage information to the government.
- Waiting periods in excess of 90 days are not allowed.

Benefit requirements: Small group and individual policies sold on the exchange will have to meet federal standards. One of these standards is based on the policy's actuarial value. Actuarial value 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.

The base level, or Bronze product, is established at 60 percent actuarial value. Richer benefit packages will also be available as follows:

- Silver – 70 percent actuarial value
- Gold – 80 percent actuarial value
- Platinum – 90 percent actuarial value

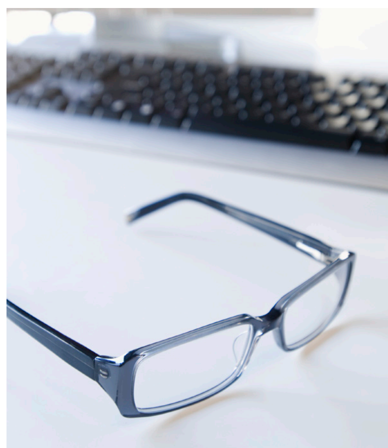
An insurer must offer the Silver and Gold plans if it wants to participate in the exchange.

In addition to the actuarial value requirements, all policies, whether offered through the exchange or not, will have to cover "essential benefits." The policies must contain specific coverage provisions, including:

- Mental health benefits comparable to health benefits
- Policies cannot deny participation in certain clinical trials or associated routine patient costs
- The rest of the major provisions in the essential health benefits list, which are pending clarification from HHS

Even products that are not sold through the exchange must meet cost-sharing limitations. They cannot exceed $2,000 for single coverage and $4,000 for family coverage. These amounts will increase with inflation.

Insurer tax: Insurers will be assessed a new phased-in tax. This is an industry-wide assessment based on market share. When fully implemented in 2018, the tax is expected to cost the insurance industry $14.3 billion. Similar taxes will apply to drug and device manufacturers. Name-brand drug manufacturers will pay, on average, a $2.8 billion per-year assessment beginning in 2011. Medical device manufacturers will pay a 2.3 percent tax on non-retail sales beginning in 2013. All of these assessments will add to the costs of health care for consumers.



2018

Reforms in Effect Starting September 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.

bcbsne.com/hcr

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 **bcbsne.com/hcr** or the United States Department of Health and Human Services at **www.hhs.gov**.