



BlueCross BlueShield of Alabama

An Independent Licensee of the
Blue Cross and Blue Shield Association

2010 Healthcare Reform

Blue Cross and Blue Shield of Alabama Health Plans

Changes to Health Plans on or after October 1, 2010

Eliminating Lifetime Limits

Prohibits lifetime limits on benefits in all group health plans and in the individual market.

Restricting Use of Annual Limits

Prohibits annual limits on essential benefits. Secretary of HHS may allow annual limits on restricted benefits through 1/1/14. Applies to grandfathered and new group health plans and new individual health plans.

Prohibiting Rescissions

Prohibited unless fraud or intentional misrepresentation. Applies to all group and individual health plans.

Extending Dependent Coverage

Requires any group health plan or plan in the individual market that provides dependent coverage for children to continue to make that coverage available up to age 26. Applies to all group and individual health plans.

Eliminating Pre-Existing Condition Exclusions for Children

Bars health insurance companies from imposing pre-existing condition exclusions on children's coverage (under 19 years of age). Applies to all group and individual health plans, except grandfathered individual plans.

Preventive Health Services

All new group health plans and plans in the individual market must provide first dollar coverage for preventive services specified by USPSTF and CDC. Secretary of HHS will issue regulations defining the scope of the preventive benefits. Applies to new group and individual health plans.

Non-discrimination Based on Salary

Requires insured group health plans to meet current IRC section 105(h)(2) requirements for self-funded group health plans that prohibit discrimination of favor of highly compensated individuals. Applies to new group health plans.

Primary Care Physician Choice (Pediatricians and OB/GYNs)

Members must be provided a choice of participating primary care providers, including choice of pediatrician for children and direct access to OB/GYNs (for plans that require designation of a PCP). Applies to new group and individual plans.

Emergency Care

No prior authorization, equivalent cost-sharing for non-network and network providers, and a “prudent layperson” definition of emergency medical conditions. Applies to new group and individual plans.

Appeals Process

Requires that any new group health plan or new plan in the individual market implement an effective appeals process for coverage determinations and claims. Applies to new group and individual plans.

Transparency/Disclosure Requirements

Requires insurers to comply with transparency requirements applicable to Exchange-participating plans (e.g. claim payment policies, financial disclosure, rating practices, cost-sharing, enrollee rights, etc.).

Provisions**Temporary High Risk Pools (July 2010)**

Provides eligible individuals (without creditable for 6 months and have a pre-existing condition defined by HHS guidelines) access to coverage that does not impose any coverage exclusions for pre-existing health conditions. This provision ends when Exchanges are operational.

Reinsurance for Early Retirees

Creates a new temporary reinsurance program to help companies that provide early retiree health benefits for those ages 55-64 offset the expensive cost of that coverage.

See Administration Fact Sheet.

Rebates for the Part D “Donut Hole”

Provides a \$250 government issued rebate for all Part D enrollees who enter the donut hole. Currently, the coverage gap falls between \$2,700 and \$6,154 in total drug costs. Section 1101.

Rate Review

Beginning with the 2010 plan year, requires HHS, in conjunction with states, to establish a process for review of unreasonable premium increases. Insurers must submit justifications for increases prior to implementation and post such information on their websites. State Departments of Insurance (DOIs) must provide HHS with information about trends in premium increases. Applies to all individual, small group, and large group insured coverage.

Medical Loss Ratio Reporting

Health plans, including grandfathered plans, must annually report on the share of premium dollars spent on medical care. NAIC shall establish uniform definitions, standard methodologies and reporting by December 31, 2010. Rebates for excessive (large group – 85% and individual and small group – 80%) medical loss ratios shall begin in 2011. Applies to all group and individual health plans.

Tax Implications**Small Business Tax Credit**

Initiates the first phase of the small business tax credit for qualified small employers for contributions to purchase health insurance for employees. The credit is up to 35 percent of the employer's contribution to provide health insurance for employees. There is also up to a 25 percent credit for small nonprofit organizations. See IRS Guidance at <http://www.irs.gov/newsroom/article/0,,id=220809,00.html>.

Executive Compensation

Limits deductibility of compensation to officers, directors, employees, and service providers of health insurance to \$500,000 per employee per year.

IRC Section 833

Requires that non-profit BCBS organizations have a medical loss ratio of 85 percent or higher in order to take advantage of the tax benefits provided to them under Internal Revenue Code (IRC) Section 833, including the deduction for 25 percent of claims and expenses and the 100 percent deduction for unearned premium reserves.

Government Initiatives

Consumer Information through the Web (July 2010)

Requires the Secretary of HHS to establish an Internet website through which residents of any State may identify affordable health insurance coverage options in that State. The website will also include information for small businesses about available coverage options, reinsurance for early retirees, small business tax credits, and other information of interest to small businesses. So-called "mini-med" or limited-benefit plans will be precluded from listing their policies on this website.

Medical Reimbursement Data Center

Establishes centers to develop fee schedules and other tools that reflect market rates for medical services and geographic differences in those rates to make health care cost information available to the public. Does **NOT** require insurers to provide data.

Public Health Prevention Efforts

Creates an interagency council to promote healthy policies at the federal level and establishes a prevention and public health investment fund to provide an expanded and sustained national investment in prevention and public health programs.

Quality Program Infrastructure

Additional resources provided to HHS to develop a national quality strategy and support quality measure development and endorsement for the Medicare, Medicaid and CHIP quality improvement programs.

Payments to Rural Providers

Extends Medicare payment protections for small rural hospitals, including hospital outpatient services, lab services, and facilities that have a low-volume of Medicare patients, but play an important role in their communities.

Patient-Centered Outcomes Research Institute

Establish a private, non-profit institute to identify national priorities and provide for research to compare the effectiveness of health treatments and strategies.

Medicaid Flexibility for States

A new option allowing States to cover parents and childless adults up to 133 percent of the Federal Poverty Level (FPL) and receive current law Federal Medical Assistance

Percentage (FMAP).

Non-Profit Hospitals

Establishes new requirements applicable to nonprofit hospitals beginning in 2010, including periodic community needs assessments.

Expanding the Adoption Credit and Adoption Assistance Program

Increases the adoption tax credit and adoption assistance exclusion by \$1,000, makes the credit refundable, and extends the credit through 2011. The enhancements are effective for tax years beginning after December 31, 2009.

Investment in New Therapies

A two-year temporary credit subject to an overall cap of \$1 billion to encourage investments in new therapies to prevent, diagnose, and treat acute and chronic diseases. The credit would be available for qualifying investments made in 2009 and 2010.

Tax Relief for Health Professionals with State Loan Repayments

Excludes from gross income payments made under any State loan repayment or loan forgiveness program that is intended to provide for the increased availability of health care services in underserved or health professional shortage areas. This provision is effective for amounts received by an individual in taxable years beginning after December 31, 2008.

Excluding from Income Health Benefits Provided by Indian Tribal Governments

Excludes from gross income the value of specified Indian tribal health benefits. The provision is effective for benefits and coverage provided after the date of enactment.

Establishing a National Health Care Workforce Commission

Establishes an independent National Commission to provide comprehensive, nonbiased information and recommendations to Congress and the Administration for aligning federal health care workforce resources with national needs.

Health Care Workforce

Expands and improves low- interest student loan programs, scholarships, and loan repayments for health students and professionals to increase and enhance the capacity of the workforce to meet patients' health care needs.

Indoor Tanning Services Tax

Imposes a ten percent (10%) tax on amounts paid for indoor tanning services. Indoor tanning services are services that use an electronic product with one or more ultraviolet lamps to induce skin tanning. The tax would be effective for services on or after July 1, 2010.

Health Care Fraud

Requires enhanced screening procedures for health care providers to eliminate fraud and waste in the health care system.

Community Health Centers and the Primary Care Workforce

Provides funds to build new and expand existing community health centers, and expands funding for scholarships and loan repayments for primary care practitioners working in underserved areas.