BlueCross BlueShield of Alabama

An Independent Licensee of the
Blue Cross and Blue Shield Association

2014 Healthcare Reform

Blue Cross and Blue Shield of Alabama Health Plans

Provisions

Insurer Fee

Imposes aggregate annual tax apportioned among health insurers based on relative market share assessed beginning in 2014 ($8 billion in total for 2014) as to premiums written 2013 and thereafter.

Individual Mandate

Becomes effective, with penalty for noncompliance the greater of $95 per individual in 2014 (capped at 300% of the flat dollar amount for a family) OR 1% of household income in 2014. For any dependent under age 18, penalty is one half the individual amounts. Exemption for affordable coverage not available (cost exceeds 8% of household income indexed thereafter by the amount which premium growth exceeds income growth). Penalty is counted as an additional amount of federal tax owed and enforced through the federal tax system.

Employer Provisions

- Employer reporting requirements. Requires employers providing qualifying coverage to report specified information to the Treasury Department.
- Employer mandate. Employer must offer minimum essential coverage that satisfies the individual mandate. No minimum contribution requirement. Mandate only applies to employers with at least 50 full-time employees. Penalties range from $2,000-$3,000 depending on whether the employer offers coverage and if an employee receives a tax credit or cost-sharing subsidy through the Exchange.
- Free Choice Vouchers. Employers that offer coverage and provide any contribution are required to give “vouchers” to qualified employees whose premium contributions are between 8.0-9.8% of income. Vouchers can be used to purchase coverage through an Exchange.

Insurance Reforms

- Guaranteed issue. Requires guaranteed issue during open and special enrollment periods for qualifying events in accordance with regulations promulgated by HHS.
- Guaranteed renewal. Requires guaranteed renewability for all insured markets.
- Modified community rating. Permits rating adjustments for Age (3:1 for adults), family composition, tobacco (1.5:1) and geography.
- No preexisting condition exclusions. No pre-ex for new coverage in all markets and grandfathered group health plans. (*Note: this provision is effective for plan years beginning 6 months or after the date of enactment for enrollees under 19 years of age*).
- No annual limits on the dollar value of essential benefits.

- No eligibility waiting periods of more than 90 days for group coverage.
- Coverage of essential benefits package in individual and small group markets.
- Uniform application of rating rules.
- Individual market reinsurance program (from 2014-2016). Requires aggregate contribution amounts for all states to equal $10 billion in 2014, $6 billion in 2015 and $4 billion in 2016.
- Risk adjustment for individual and small group markets. *No actual effective date is provided for this provision, but HHS is given authority to issue regulations.*
- Risk corridors for individual and small group markets. Risk corridors will be modeled after those used to adjust payments to regional PPOs in Medicare Part D. (2014-2016)

Consumer Protections/PBOR

- Provider nondiscrimination. Prohibits discrimination against providers acting within the scope of their license or certification with respect to participation under a plan. Specifies that this provision is not an "any willing provider" requirement and that the provision does not prohibit reimbursement based on quality or performance. Applies to all markets.
- Coverage of routine costs for clinical trial participants. Requires coverage of routine costs for and prohibits discrimination against clinical trial participants in all markets.

Health Insurance Exchange

- States must establish exchanges. Exchange must be a nongovernmental agency or nonprofit entity to offer qualified health plans to individuals and small employers. Provides for the federal government to implement an Exchange in states that either elect not to establish their own exchange or states for which HHS determines by 1/1/2013, that state will not have an operational Exchange by 1/1/14. Exchanges will be voluntary, with insurers allowed to sell coverage in the outside market. Further, switching to a non-Exchange plan carries no penalties.
- Requirements for qualified health plans. This includes marketing requirements, sufficient provider networks, accredited clinical quality measures and implementing and reporting on quality improvement strategies. Any Exchange plan must, before raising premiums, submit justification to the Exchange and post such justification on their website(s).
- Coverage of essential benefits package. Essential benefits include the following services: Ambulatory, Emergency, Hospitalization, Maternity and Newborn, Mental Health, Rehabilitative, Laboratory, Preventive and Wellness, Pediatric and Prescription drugs.
- Offering of Multi-state Plans through Exchange. Requires HHS, in consultation with NAIC, to issue regulations for the creation of compacts to provide for the sale of individual insurance across state borders.
- Other coverage requirements inside the exchange.
  - Equal in scope to typical employer-sponsored plan
  - Cost-sharing limits (*plan years beginning in 2014)*
  - Requirements for different benefit levels/actuarial values
- Coverage requirements outside the exchange. Participating plans must agree to offer at least one QHP in the silver level and at least one plan in the gold level in the Exchange.
  - Preventive benefits
  - Coverage of essential benefits for individual and small group plans
  - Cost-sharing limits for group health plans

Offering of Exchange-Participating QHBPs through Cafeteria Plans

State Basic Health Plan Option

Individual Subsidies *Effective for taxable years beginning after 12/31/13.*

- Premium credits. Premium credits will be based on a defined percentage of household income and the cost of the Exchange-participating health plan.
- Cost-sharing subsidies. Makes individual premium credits available only to individuals enrolled in an Exchange-participating health benefits plan.

Small Group Subsidies Tax credits for small employers.

Medicaid

- Expansion to 133% FPL
- Requires Medicaid benchmark benefits to consist at least of minimum essential coverage.
- Requires states to provide premium assistance to any Medicaid beneficiary with access to employer-sponsored insurance if cost-effective for the state.

CHIP

Requires states to enroll CHIP-eligible children in exchange plans if coverage is unavailable in the state CHIP plan because of a funding shortfall. *No specific effective date is provided for this provision, but Exchanges effective by 1/1/14*.

Medicare Advantage

- Requires coding intensity adjustment to be no less than 2010 plus 1.3%.
- Requires 85% minimum medical loss ratio.

Employer-Sponsored Wellness Program Discounts and HHS Reports

Permits employers to vary premiums by as much as 30% for employee participation in certain health promotion and disease prevention programs. HHS has authority to increase discount ceiling to 50%. HHS will also issue a report on the effectiveness of wellness programs for which premium discounts are allowed in promoting health, etc.

Wellness Demonstration

Premium variation for participation in wellness programs for the individual market in 10 states.

Pilot Testing of Pay-for-Performance in Medicare

Applies to psychiatric, LTC, rehab, and PPS- exempt cancer hospitals, as well as hospice programs.

GAO study on Health Insurance Competition and Market Concentration

Deadline for first report; biennial reports required thereafter.