BlueCross BlueShield of Alabama

An Independent Licensee of the
Blue Cross and Blue Shield Association

2011 Healthcare Reform

Blue Cross and Blue Shield of Alabama Health Plans

Reporting Health Coverage Costs on Form W-2

Requires employers to disclose the value of the benefit provided by the employer for each employee's health insurance coverage on the employee's annual Form W2.

Cafeteria Plan Changes

Creates a Simple Cafeteria Plan to provide a vehicle through which small businesses can provide tax-free benefits to their employees. This would ease the small employer's administrative burden of sponsoring a cafeteria plan. The provision also exempts employers who make contributions for employees under a simple cafeteria plan from nondiscrimination requirements applicable to highly compensated and key employees.

Non-Prescription Drugs

Payments for Over-the-Counter (OTC) drugs not eligible for nontaxable reimbursement from employer-provided plans (e.g. FSAs, HRAs, HSAs). Exception for insulin and OTC drugs prescribed by a physician.

Tax for Withdrawals from HSAs and Archer Medical Savings Account Funds for Non-Qualified Medical Expenses

Increases the additional tax for HSA withdrawals prior to age 65 that are not used for qualified medical expenses from 10 to 20 percent. The additional tax for Archer MSA withdrawals not used for qualified medical expenses would increase from 15 to 20 percent.

Medical Loss Ratio

Beginning no later than 1/1/2011, insurers are required to meet medical loss ratio requirements or provide rebates to members.

Changes to Medicare Advantage Plans

Limits to Cost Sharing (Medicare Advantage)

Requirements reduce the flexibility to design benefit packages that meet beneficiary needs by prohibiting MA plans from charging higher cost-sharing greater than that in traditional Medicare for: chemotherapy, dialysis, skilled nursing care, and such other services CMS deems appropriate.

Medicare Advantage Disenrollment

Permits MA enrollees to disenroll and return to traditional Medicare at any time within the first 45 days of the year.

Donut Hole and Generic Drugs (Medicare Advantage)
Provides for MA-PD and PDP sponsors to waive cost-sharing for the first fill of a generic medication in order to promote greater use generic substitution and implements a 93% coinsurance rate for generics in 2011 (down from 100% today). Also, provides a 50 percent discount on all brand-name drugs in the donut hole and begins phasing in additional discounts on brand-name and generic drugs to completely close the donut hole by 2020 for all Part D enrollees.

Protected Drug Classes (Medicare Advantage)
Beginning in 2011, requires all Part D sponsors to cover all drugs in the six protected classes.

Funding to Medicare Advantage Plans
Medicare Advantage payments set at 2010 levels.

Medicare Advantage Bids
Gives CMS authority to deny MA and PDP plan bids if it proposes "significant increases in cost sharing or decreases in benefits."

Government

Report on 5500 Forms
Annual DOL reports to Congress on self-funded plans.

HHS Report on Group Market
HHS study of large group market including evaluation whether the insurance reforms cause adverse selection in the large group market or encourage smaller employers to self-fund.

Report on Denial of Coverage
GAO study on denials of coverage and enrollment.

Standardizing the Definition of Qualified Medical Expenses
Conforms the definition of qualified medical expenses for HSAs, FSAs, and HRAs to the definition used for the itemized deduction. An exception to this rule is included so that amounts paid for over-the-counter medicine with a prescription still qualify as medical expenses.

Reduced subsidies
Reduces subsidies for income-related Part D premiums.

Reimbursement for Primary Care
Provides a 10 percent Medicare bonus payment for primary care physicians and general surgeons.

Training Support for Primary Care
Establishes a Graduate Medical Education policy allowing unused training slots to be re-distributed for purposes of increasing primary care training at other sites.

Health Care Quality and Efficiency
Establishes a new Center for Medicare & Medicaid Innovation to test innovative payment and service delivery models to reduce health care costs and enhance the quality of care provided to individuals.

Preventive Health Coverage
Provides a free, annual wellness visit and personalized prevention plan services for Medicare beneficiaries and requires new plans to cover preventive services with little to no cost sharing. Creates incentives for State Medicaid programs to cover evidence-based preventive services with no cost sharing, and requires coverage of tobacco cessation services for pregnant women.

Consumer Assistance
Requires the Secretary of HHS to award grants to States to establish health insurance consumer assistance or ombudsman programs to receive and respond to inquiries and complaints concerning health insurance coverage.

Transitional Care for Medicare Beneficiaries
Establishes the Community Care Transitions Program to provide transition services to high-risk Medicare beneficiaries.

Expanding Primary Care, Nursing, and Public Health Workforce
Increases access to primary care by adjusting the Medicare Graduate Medical Education program. Primary care and nurse training programs are also expanded to increase the size of the primary care and nursing workforce. Seeks to ensure public health challenges are adequately addressed.

Access to Home and Community Based Services
The new Community First Choice Option, which allows States to offer home and community based services to disabled individuals through Medicaid rather than institutional care, takes effect on 10/01/2011.

Transitioning to Reformed Payments in Medicare Advantage
Freezes 2011 Medicare Advantage payment benchmarks at 2010 levels to begin transition. Continues to reduce Medicare Advantage benchmarks in subsequent years relative to current levels. Benchmarks will vary from 95% of Medicare spending in high-cost areas to 115% of Medicare spending in low-cost areas. Changes are phased-in over 3, 5 or 7 years, depending on the level of payment reductions.

DME Claims
HHS may hold payment of DME supplier's claims for 90 days if HHS determines there is a significant risk of fraudulent activity among DME suppliers or in a geographic area or within a category of DME.

Medicaid
State option to provide coverage to childless adults and to coordinate care through health homes for chronically ill individuals.