



HEALTH CARE REFORM update



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Summary of Key Provisions

On March 23, 2010, President Obama signed into law the “Patient Protection and Affordable Care Act” (PPACA). A reconciliation bill making changes to the Act was signed by the President on March 30, 2010. The PPACA as amended by the reconciliation bill is collectively referred to as the Act in this summary.

This is not intended to be a comprehensive overview of the Act.

Key highlights

The Act purports to extend coverage to 94% of non-elderly Americans and to reduce the number of uninsured Americans by 32 million. The Congressional Budget Office estimates that the healthcare provisions of the Act will reduce the budget deficit by an estimated \$130 billion over 10 years. Generally, the Act maintains the employer based system and allows, through complicated grandfathering rules, individuals to retain their current plans. The Act includes a somewhat stronger individual mandate than what was contemplated in prior proposals. A requirement that employers with at least 50 employees offer coverage to employees is also included. Individuals and small employers will be eligible for subsidies to help defray the cost of complying with these coverage mandates. The Act establishes significant new requirements relating to rating, product design, how plans will be marketed and sold, and consumer protections as well as numerous new taxes. In addition, new government sponsored options, such as multi-state plans, are established. Some provisions went into effect immediately, though these were predominantly obligations of regulatory agencies, while others began to take effect 6 months after enactment and still others are phased in through 2018. This summary provides an overview of certain key provisions of the Act.

New competition

- **Multi-State Plans.** The federal government, through the Office of Personnel Management, will contract with at least two private plans (including at least one non-profit) to offer multi-state plans through the Exchange in each state, with states retaining regulatory authority over multi-state plans.
- **Consumer Operated and Oriented Plan (Co-Op).** The Act provides \$6 billion in start-up funding for non-profit co-op plans. However, a subsequent Appropriations Bill reduced the amount to \$3.8 billion. Co-Ops can apply for start-up or solvency loans in exchange for meeting certain requirements, including doing substantially all of their business in the individual and small group markets. Existing insurers are prohibited from qualifying.
- **Interstate Compacts.** States may voluntarily allow the purchase of insurance across state lines, subject to HHS approval and federal regulations. It is believed that the state where the consumer resides would retain the ability to require licensure, regulate market conduct, and handle consumer complaints.

New taxes

- **Insurer Fee.** The Act imposes an assessment of \$8 billion on insurers in 2014 that increases annually to \$14.3 billion in 2018, and indexed thereafter. An insurer’s liability is based on its ratio of net premiums written (insured business). Tax exempt insurers pay only 50% (e.g. HMOs).



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- **Tax on “Cadillac” Health Plans.** There is an excise tax of 40% on the value of coverage over \$10,200 for individual and \$27,500 for family coverage, beginning in 2017 (indexed for inflation thereafter); high-risk industries would have a higher trigger. The tax would apply to insured and self-funded plans in the group market but not to plans sold in the individual market.
- **§ 833(b) Deduction.** The § 833(b) deduction for Blue Plans is preserved only if a Plan’s medical loss ratio is not less than 85%. It would apply to taxable years beginning after 12/31/09.
- **Comparative Effectiveness Research Assessment (Patient-Centered Outcomes Research Trust Fund Fee).** Insurers and self-funded plans will be assessed \$1 per year for each covered life to fund CER beginning in 2013 and increasing to \$2 for 2014-2019. For additional information, please see the *Summary of Employer Taxation Provisions* fact sheet.

New marketplace – the Exchange, HHS web portal and High Risk Pools

- **The Exchange.** The Act and subsequent proposed rules include a highly regulated, state-based Exchange model that must be established by 2014 or there would be a federal fallback. States may receive grants to help fund the establishment of their Exchange. The Exchange will consider the reasonableness of premium increases when deciding to permit a plan to participate.
 - The Exchange is limited to individuals and small groups from 2014-2016, then to groups of up to 100. States may expand eligibility to groups over 100 starting in 2017.
 - Employers can establish a level of benefits, with employees then free to make an individual choice among plans in the Exchange at that level (e.g., any Bronze plan).
 - Subsidies will be available only through the Exchange.
 - Coverage may still be offered outside the Exchange, but the benefits must meet certain requirements.
- **HHS Web Portal.** On July 1, 2010, HHS established a web based portal where individuals and small employers can obtain information about affordable coverage options in their state. HHS issued standardized templates for information.
- **High Risk Pool.** HHS established temporary high risk pools within 90 days of enactment that remain in effect until Exchanges are operational. These pools provide coverage for individuals who have not had coverage for 6 months and have certain pre-existing conditions.

Individual and Employer Mandates - Penalties & Subsidies

- **Individuals:**
 - **Penalty.** Starting in 2014, individuals will be required to obtain and maintain “minimum essential coverage.” The penalty is the greater of a flat dollar amount or percent of income level: \$95 in 2014, growing to \$695 in 2016 (and indexed to the cost of living thereafter), or .5% in 2014 growing to 2.5% of income in 2016, but in any event capped at the national average premium for the lowest cost plans.
 - **Subsidy.** Tax credits would subsidize premiums so that the costs would be limited to 2% of income for those at 100% of the Federal Poverty Level (FPL) and gradually increase to 9.5% of income for those at 400% of FPL. Tax credits are also available to offset portions of cost-sharing.
- **Employers:**
 - **Penalty.** Employers with at least 50 employees that do not offer affordable minimum essential coverage will be fined \$2,000 for each full-time employee (but the fine calculation will not count the first 30



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employees). If the employer does offer coverage but an employee receives a subsidy through the Exchange, then the penalty is the lesser of \$3,000 for each employee receiving a subsidy or \$2,000 for each full-time employee. There is no minimum contribution requirement.

- Subsidy. Employers with up to 25 workers and an average payroll of less than \$50,000, and which contribute at least 50% of total premium cost, may be eligible for a tax credit in 2010-2013 of up to 35% of the employer's costs and up to 50% in 2014 and beyond. An employer can only use the credit for 2 years.

Rating Rules

- Insurers must guarantee issue of coverage during open enrollment and special enrollment periods, starting in 2014.
- Plans may not impose pre-existing condition exclusions in any market for children under 19, starting for plan years beginning September 23, 2010. Pre-existing condition exclusions are prohibited regardless of age starting in 2014. Group plans can impose a maximum waiting period of 90 days starting in 2014.
- Rating adjustments are limited to: age at 3:1, family size, tobacco at 1.5:1, and geographic area as established by the states and HHS. These rules apply in the individual and small group market. If a state allows large groups to purchase in the Exchange (starting in 2017) then the rating rules will apply to large groups both in and out of the Exchange.
- Beginning September 1, 2011, rate increases that are filed or become effective will be affected by the Unreasonable Rate Review rule. All increases over 10 percent will be reviewed during the first review period. After that period, the Department of Health and Human Services' Center for Consumer Information and Insurance Oversight (CCIIO) will provide state specific thresholds for review of the rate increases.
- Insurers are required to meet a MLR of 80% in the individual and small group market and 85% in the large group market. Insurers will be required to provide rebates to consumers by August 2012 for 2011 MLR experience. MLR is based on reimbursement for clinical services and costs for activities that improve health care quality; administrative costs exclude state and federal taxes.

Product Design

- All individual and small group market insured plans must meet the requirements of the "essential health benefits package" which will be defined by HHS:
 - Essential health benefits will include coverage for some benefits in the following categories listed in the Act: ambulatory, emergency, hospitalization, maternity and newborn care, mental health/substance abuse/behavioral care, prescription drug coverage, rehabilitative services and devices, lab services, preventive/ wellness services, chronic disease management, and pediatric services including oral and vision. These are to be comparable to typical employer plan as certified by CMS and HHS will periodically review the list.
 - Cost sharing limits tied to the HDHP limits, and small group annual deductibles generally are limited to \$2,000/\$4,000.
 - Meeting one of four actuarial value tiers (determined by standard population, not plan's actual population): Bronze (60%); Silver (70%); Gold (80%); and Platinum (90%). An employer's HSA contributions may be taken into account in determining the actuarial value. A catastrophic plan can be



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offered to individuals under 30 or meeting a hardship exemption and a child-only plan can be offered to those up to age 21.

- Large group health plans must follow the cost sharing limits specified above.
- Dependents will be covered to age 26, starting for plan years beginning six months after enactment of the reconciliation bill. Dependents may be married or unmarried. Applies to group (fully-insured or self-funded) and individual markets.
- Preventive services must be covered without cost sharing, in all markets, starting in plan years beginning six months after enactment.
- Lifetime and annual maximums on essential health benefits are prohibited starting in plan years beginning six months after enactment.
- Grandfathering. Coverage in existence at the time of enactment, so-called grandfathered plans, may be exempt from some of the rating, benefit, and consumer protection rules.

Delivery System Reforms/Provider Payments

- **Comparative Effectiveness (Patient-Centered Outcomes Research).** An independent, public-private Comparative Effectiveness Research (CER) Center is established in 2010.
- **Medicare Quality/Value-based purchasing:**
 - The Act establishes budget neutral (presumably counteracting penalties and bonuses) value-based purchasing (“VBP”) for hospitals for discharges after October 1, 2012; creates VBP demonstration programs for inpatient critical access hospitals in 2012; refines physician quality reporting initiatives and makes bonuses of .5% available; imposes penalties for failure to report quality to be followed by pay-for-performance (“P4P”) programs for an extend list of providers; and directs HHS to implement plans for value-based purchasing for skilled nursing facilities, home health and ambulatory surgical centers.
 - The Act phases in physician P4P in 2015, using a budget-neutral payment modifier.
 - Payment reductions are imposed on hospitals with preventable readmissions and high rates of hospital acquired conditions.
 - Groups of providers could organize as Accountable Care Organizations to share in Medicare cost savings.

Medicare Advantage (“MA”)

- The Act cuts MA funding by approximately \$131 billion. Fee for Service (“FFS”) cuts total \$70 billion. MA benchmarks are phased-down to a level of county FFS spending. In 2011, MA rates would be set at the 2010 level (without legislation to avert cuts in Medicare payments, this will result in a significant reduction in funding). In 2012, the rates would be ½ current benchmark and ½ local FFS, and in 2013 and beyond it would be 100% of the local FFS rate, although certain alternative calculations could be triggered. The FFS benchmarks are adjusted to give additional money to plans in areas with lower than average FFS spending, and vice-versa.
- Plans scoring four stars or higher on the system developed by HHS would be eligible for bonuses.
- Starting in 2012, plans must have a minimum MLR of 85%, or pay a rebate to HHS.



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Medicare Part D

- The government issued a \$250 rebate to beneficiaries reaching the gap in 2010. The coinsurance rate in the gap is phased down. Brand name drugs are available at a discount during the gap, with the discount paid by the manufacturer counted towards the catastrophic limit.
- The first generic fill for Medicare Part D participants is to be available without cost-sharing, not earlier than January 1, 2011.
- The retiree drug subsidy program is made less attractive. Beginning in 2011, the Act eliminates the tax exclusion for subsidy payments made when employers offer qualifying retiree drug coverage.

This summary is provided for informational purposes only and is not intended as legal advice. This summary does not reflect any guidance or federal regulations that may have been issued after the passage of PPACA. Please consult your legal advisor for additional information.