

Health Care Reform

April 2012 Update



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Status of Challenges to Health Care Reform

- Supreme Court finalized oral arguments on March 28, 2012.
- The two final questions argued before the justices were:
 - If the requirement that most Americans purchase health insurance or pay a fine (the individual mandate) is dismantled by the Court, must the rest of the law fall with it?
 - Is the federal government's major expansion of the state-based Medicaid program -- which is expected to bring 16 million low-income Americans into the health insurance marketplace -- allowed under the U.S. Constitution?
- If individual mandate fails, what could happen?
 - Supreme court could rule that the whole Affordable Care Act would go down if the individual mandate did.
 - US Court of Appeals for 11th Circuit ruled that the individual mandate was unconstitutional but that the rest of ACA could stand
 - The Supreme Court's final decision will be released in June of 2012
- The Employer Mandate provision, which requires all large employers to provide affordable minimum essential coverage, is not being challenged.



Exchanges



Exchanges

- On March 12, 2012 the Department of Health and Human Services (HHS) issued a final rule on Exchanges.
- The Patient Protection and Affordable Care Act (PPACA) provides for the establishment of state and Federal Exchanges to allow individuals and small business to shop for and enroll in health insurance.
- The Exchanges will provide consumers with information on qualified health plans, determine their eligibility for federal assistance or premium subsidies, and facilitate their enrollment in plans.

Final Rules

- Provides broad state flexibility, allows States to determine the requirements and participation for qualified health plans (QHPs) and allows exchanges to coordinate and sub-contract with State regulatory entities (FL OIR).
- Tightens grace period requirements to prevent subsidy eligible people from gaming the system.
- Requires SHOP exchanges to set the employee choice of health plans as the default and employers can select a level of coverage (e.g., bronze) for employees.
- The initial open enrollment will begin from Oct 1st 2013 through March 31st 2014.
- States have the option to permit agents and brokers to enroll individuals and employers in qualified health plans in the Exchange.
- Market reforms such as rating factors, tiered rating structure, pricing issues on and off the Exchange have been deferred and will be addressed in subsequent guidance.



Exchanges (cont.)

Florida:

- Has not accepted Federal funds.
- At this point in time, it is unlikely that Florida will have enough time to develop an Exchange.
- If Florida has a Federal Exchange implemented, it will have regulations included that the State may not have chosen
- States with Federal Exchanges will have the opportunity to transition to a State Exchange in the future



Types of Exchanges

State

- By Jan. 1, 2014, each state shall establish and operate two Exchanges to facilitate the purchase of certified qualified health plans that offer essential health benefits, one for the Individual market (American Health Benefits Exchange) and one for the Small Group market (Small Business Health Options [SHOP] Exchange).
- Only Qualified Health Plans (QHPs) that provide coverage for essential benefits can be sold through the Exchange. States may mandate additional benefits, but must cover any additional expenses.
- HHS has not yet clarified how it will assess financial liability for state benefit mandates.
- Four levels of coverage will be available on the Exchange – Bronze, Silver, Gold, and Platinum – that provide benefits equivalent to set percentages of the plan's full actuarial value.
- Individuals who purchase insurance through the Exchange may be eligible to receive premium subsidies or tax credits.



Types of Exchanges (cont.)

Federal (fallback)

- The Federal government will establish an Exchange on behalf of any State that fails to create a State Exchange by Jan. 1, 2014 and on behalf of any state that does not receive HHS approval of their Exchange by Jan. 1, 2013.
- The Federal Exchange must comply with all of the provisions and rules applicable to State Exchanges.
- States with Federal Exchanges will have the opportunity to transition to a State Exchange in the future.

Private (optional)

- Provide a non-governmental, non-subsidized platform for employers to offer defined contribution support to employees/retirees and allows consumers to compare options and enroll in/or maintain their private insurance.
- Are independent of State/Federal Exchanges and not subject to Exchange provisions/rules but plans offered must be HCR compliant.
- Can offer coverage of narrow geographic areas (cities and counties) or wide geographic areas (multi-state).
- Private exchanges are expected to appeal to employers that want to offer a more robust benefit package, have concerns about the stability or plans offered in the Federal Exchanges, or will not qualify for the tax credits offered by the Federal Exchange.



Current Impactful Provisions - Update



Women's Preventive Services

- Under the Affordable Care Act, women's preventive health care services are covered with no cost sharing for new health plans.
- Women's preventive health services are intended to provide a comprehensive set of preventive services that include contraceptive coverage.
- On August 1, 2011 they were expanded to include:
 - Human Papillomavirus (HPV) Testing
 - Counseling for sexually transmitted infections
 - Counseling and screening for human immune-deficiency virus (HIV)
 - Screening and counseling for interpersonal and domestic violence
 - Screening for gestational diabetes
 - Contraceptive methods and counseling (see next page for details)
 - Breastfeeding support, supplies and counseling
 - Annual Well Woman Visits
- These are mandated to be available to women at a \$0 cost share effective Aug. 1, 2012. For groups, these expanded benefits must be added to non-grandfathered plans and available upon the group's renewal date on or after Aug. 1, 2012.
- Many are already included in our benefits but several (i.e., screening for gestational diabetes, breastfeeding counseling, etc.) will be added.
- On March 16, 2012, HHS released an Advanced Notice of Proposed Rulemaking outlining contraceptive coverage exemptions for religious employers - see next page for details.



Women's Preventive Services (cont.)

Contraception Coverage

- Beginning August 1, 2012 all non-grandfathered (group and IU65) plans must provide contraceptives at \$0 member cost share for in-network providers beginning in the first plan year (in the individual market, policy year) on or after August 1, 2012.
 - Group plans are required to provide them to current and new members on the group renewal date beginning on or after August 1, 2012.
 - IU65 plans are required to provide them to new members beginning August 1, 2012 and to current members beginning on the individual plan anniversary date (e.g., BlueOptions 6/1, Hospital Surgical Plus 8/1).
- In order to qualify for \$0 cost-share, Federal guidelines require the contraceptive method or sterilization procedure to be approved by the FDA and prescribed by a physician.
- We are limiting women's preventive oral contraceptives to generics at \$0 cost share. A woman can still receive brand oral contraceptives, but a cost share may be required.
- Religious organizations can request a permanent contraceptive exemption if they meet the required criteria.
- Non-profit organizations can request a temporary contraceptive safe harbor exemption (up to one year).



Summary of Benefits and Coverage

- The final rules for the Summary of Benefits and Coverage (SBC), Coverage Examples, and Uniform Glossary, along with related templates and completion instructions, were released on February 9, 2012.
- The SBC and Uniform Glossary are used by group health plans and health insurance issuers to provide clear language in a uniform format that helps consumers better understand and compare their health coverage options.

Final Rules

- The requirement to provide an SBC and uniform glossary applies to all individual and group health plans, regardless of plan size or funding arrangement.
 - For individual coverage, the SBC and uniform glossary must be provided beginning on September 23, 2012.
 - For group coverage, the SBC and uniform glossary must be provided to participants on the first day of the first open enrollment period that begins on or after September 23, 2012.
 - For participants enrolling through a special enrollment period (such as new hires), the SBC and uniform glossary must be provided on the first day of the first plan year that begins on or after September 23, 2012.
 - Florida Blue is currently working to define an approach for providing the SBC to ASO groups
- The SBC must be provided at no charge:
 - To a group health plan or individual upon application for health coverage.
 - By the first day of coverage (if there are any changes to the application SBC).
 - Upon renewal of existing coverage, either with the renewal application materials (written renewals) or 30 days prior to the first day of the new plan year (automatic renewal).
 - Upon request by a group health plan, group employee, or individual.



Annual Limits on Essential Health Benefits

- Restricts and phases out the annual dollar limits that can be placed on essential benefits for group and individual health insurance:

Plan Years	09/23/2010-09/22/2011	09/23/2011-09/22/2012	09/23/2012-12/31/2013	01/01/2014-Forward
Annual Limit	\$0.75M	\$1.25M	\$2.0M	\$0

- As a result, the per-day maximum Ambulance Benefit Maximum on many plans must be increased, effective August 1, 2012

Pharmacy Benefits

- HCR and Medical Cost Management initiatives will require pharmacy changes related to Retinoids and Compounds, affecting both access and member cost share



Employer W-2 Reporting

- HHS requires employers to report the aggregate cost of their employer-sponsored group health plan coverage for informational purposes on their employee's W-2 form beginning with the 2012 W-2 form issued in January 2013.
- Employers who file less than 250 W-2 forms have a transitional relief period and are not required to report the cost of their employer-sponsored group health plan until January 2014.
- Employers must provide a written statement within 30 days of receipt of a written request from a former employee. The former employee must submit their written request prior to January 2nd and must have been employed during the preceding year.
- Employers are not required to report the cost of health coverage on any forms required to be furnished to employees prior to January 2013; however, employers are allowed to report the 2011 aggregate health care cost in January of 2012.
- Employers are responsible for complying with this provision.
 - Since employers have the total aggregate cost of employer-sponsored health plan coverage, it is incumbent upon them to provide to their employees.



Florida Blue and Health Care Reform



Florida Blue and HCR

- Our HCR staff is currently working on further analysis of all provisions and the final rules as available to determine steps to ensure compliance by the effective dates.
- Our Take Part website is being updated very soon
 - The Take Part website can be visited any time of day for information on health care reform and the provisions
- Communications continue to keep you informed
- Use outside resources such as the Kaiser Family Foundation, America's Health Insurance Plans (AHIP) and HealthCare.gov to stay informed