Healthcare Reform

Guidance for Groups
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Overview of the Patient Protection and Affordable Care Act

Passed in March 2010, the Patient Protection and Affordable Care Act (PPACA) was intended to reform the nation’s healthcare system. The law was designed to expand coverage and change the way insurance works, particularly for small businesses and individuals. It sets minimum standards for health coverage and provides financial help for some small groups and individuals to buy health insurance.

Many of the law’s provisions became effective immediately, or within months of enactment. Other parts, such as new coverage rules, taxes and insurance exchanges, will be phased in for 2014. It’s important to note: this new law is complicated, and many elements are still being interpreted. In addition, federal agencies will be issuing many more new regulations that we expect to expand the scope of the statutes even further. Additionally, Louisiana state law still applies to the extent that it is not preempted by PPACA.

Blue Cross and Blue Shield of Louisiana is committed to being a resource on reform. We will continue to play a leadership role in the health insurance industry in Louisiana, no matter what changes healthcare reform brings to our state. Our commitment to providing affordable access to quality healthcare for our 1.2 million members will not change.

Key PPACA reform provisions include:

- **Grandfathered plans.** Group employer plans existing on March 23, 2010 will be “grandfathered” from certain provisions of the law. (See details and conditions inside.)
- **Dependent coverage to age 26.** Dependents on an employer plan will be able to maintain coverage until age 26, regardless of marital status, health status, and financial dependency on their parents. (Dependents eligible for their own employer sponsored coverage may not qualify.)
- **No lifetime dollar-value limits on benefits.** The law prohibits lifetime and annual dollar-value limits on essential benefits.
- **No exclusions for pre-existing conditions.** Group plans issued or renewed after Sept. 23, 2010 may no longer deny eligibility or benefits for covered members under age 19 based on pre-existing conditions.

Our commitment to providing affordable access to quality healthcare for our 1.2 million members will not change.
• **State-run insurance exchanges.** By 2014, states will establish separate exchanges to offer access to affordable individual and small-group coverage.

• **Mandated insurance.** Beginning in 2014, individuals will be required to maintain health insurance, and certain employers with more than 50 full-time equivalent employees (FTEs) will be required to provide their workers with insurance or pay a penalty. (Some exceptions apply.)

• **Tax credits to pay for insurance.** Beginning in 2010, tax credits will be available to help eligible small businesses pay for insurance for their employees. In 2014, certain individuals with incomes below 400 percent of the federal poverty level may qualify for credits toward their premium costs and for subsidies towards their cost-sharing. This financial assistance will be available through the state-run exchanges.

• **Elimination of coverage rescissions.** Rescission — that is, the insurer’s ability to revoke a policy after the policy has been issued — is permitted only for fraud or intentional misrepresentation of a material fact.

**Immediate Group Market Reforms**

PPACA makes a number of reforms in the group market, leading up to major reforms in 2014.

Some of the more important reforms, effective 2010-2011, include the following:

- **Tax credits.** Eligible small-group employers and small nonprofit organizations are eligible immediately for tax credits for premium contributions to purchase health insurance for employees.
  
  *(See more details on tax credits for small businesses on page 7.)*

- **High-risk pool.** The Department of Health and Human Services (HHS) has created a temporary national high-risk health insurance pool to provide eligible individuals with immediate access to coverage that does not impose any coverage exclusions for pre-existing health conditions. This is called the Pre-Existing Condition Insurance Plan. It is not the same plan as the Louisiana Health Plan, Louisiana’s high-risk pool or the HIPAA pool.
• **New internet portal.** HHS launched an internet-based portal on July 1, 2010, to offer individuals and small groups information on major medical insurance plans in their markets. The portal also includes eligibility information about a variety of existing public programs including Medicaid, Medicare and the Children’s Health Insurance Program (CHIP). The portal is designed as an information resource until the state exchanges become active in 2014. At that time, individuals and small businesses will be able to use the portal to shop for and purchase health insurance in their markets. Residents of any state will be able to identify affordable health insurance coverage options in their state.

• **Coverage for preventive services.** All non-grandfathered group and individual health plans must provide first-dollar coverage for specified preventive services rendered by in-network providers. Plans can no longer require a copayment, coinsurance or deductible for these services. This coverage is not required for services rendered by out-of-network providers, and copayments, coinsurance and deductibles may be required for the out-of-network services. Effective date: Plan years beginning on or after Sept. 23, 2010 (Jan. 1, 2011, for calendar-year plans). Grandfathered plans are not subject to this requirement.

Some of these preventive services include:
- Blood pressure, diabetes and cholesterol tests
- Many cancer screenings
- Counseling from your healthcare provider on such topics as quitting smoking, losing weight, eating better, treating depression and reducing alcohol use
- Routine vaccines for diseases such as measles, polio or meningitis
- Flu and pneumonia shots
- Counseling, screening and vaccines for healthy pregnancies
- Regular well-baby and well-child visits from birth to age 21
• **Prohibiting rescissions.** Fully insured group health plans and individual policies may not be rescinded, except in the cases of fraud or intentional misrepresentation of material fact. This includes coverage for an individual under a group health plan or individual policy. Effective date: Plan years beginning on or after Sept. 23, 2010 (Jan. 1, 2011 for calendar year plans). There are no exceptions for grandfathered or self-insured plans.

• **Extending dependent coverage.** All individual policies and group health plans that provide dependent coverage for children must continue to make that coverage available up to age 26. The age of the dependent is the only qualifier. It makes no difference if the child is a student, married, single, employed, living in the same household or financially dependent upon the parent. This provision is effective for plan years beginning Sept. 23, 2010. For plan years before 2014, grandfathered plans may restrict this extended coverage only to children under the age of 26 who are not eligible for other group coverage.

Under new Louisiana state law, the extended eligibility age is also made applicable to grandchildren in the custody of and living with a grandparent.

All Blue Cross and Blue Shield companies agreed to allow covered dependents up to age 26 to remain on their parents’ medical policies effective June 1, 2010 — in advance of the law.

– For most standard fully insured group policies, as of May 31, 2010, existing dependents under age 26 are now allowed to remain on their parents’ policy if they wish.

– Employees may add an eligible dependent to their insurance policies during a one-time 30 day special enrollment period beginning Sept. 23, 2010, and thereafter during an annual enrollment period at their group’s anniversary.

– Employees with non-covered dependents under age 26 may also add them to their insurance policies during their annual open enrollment period beginning with June 1, 2010, anniversaries.
• **Prohibiting benefit limits.** The law prohibits certain types of annual or lifetime limits on the dollar value of “essential health benefits” coverage in grandfathered and non-grandfathered employer plans. This provision is effective for plan years beginning on or after Sept. 23, 2010.

“Essential health benefits” as currently defined by PPACA are:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance abuse treatment
- Prescription drugs
- Rehabilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including vision and dental care

Additional essential health benefits will be defined in future regulations. In the interim, HHS will take into account an insurer’s good-faith efforts to comply with a reasonable interpretation of the term “essential health benefits.”

In a good-faith effort to comply with the law, Blue Cross and Blue Shield of Louisiana has identified a list of essential benefits and removed the lifetime and or annual dollar limits on each. Some of the essential benefits identified that will no longer have annual limits include, but are not limited to, physical therapy, occupational therapy, speech therapy, durable medical equipment and prosthetics.

If an individual lost coverage due to reaching a lifetime limit, he or she may be allowed to re-enroll via an open enrollment period if he or she is still otherwise eligible for coverage on the group plan.
This regulation does not apply to individuals who reached a lifetime limit while covered by a contract that was not renewed or is no longer in effect.

It does apply to family members who lost coverage due to reaching a lifetime limit if other members of the family are still covered by an active policy.

Plans must notify these individuals how and when they are eligible to re-enroll.

- **Expanding access to coverage.** Plans are barred from denying coverage on imposing pre-existing condition exclusions on coverage for anyone under age 19. This is effective for new groups and renewals beginning on or after Sept. 23, 2010. These regulations apply to both grandfathered and non-grandfathered group health plans.

Beginning in 2014, group health plans and insurers will be prohibited from applying any pre-existing condition limitation to any covered participant, regardless of age or health status.

- **Coverage of emergency services.** The law requires group health plans that provide benefits for emergency services in hospital emergency departments to do so even if the services are provided out of network. In addition, out-of-network emergency services must be covered at the same cost-sharing requirements (i.e., copayments or coinsurance) that apply to in-network emergency room services and no prior authorization can be required.

An out-of-network emergency services provider can still bill patients for the difference between the provider’s charges and the amount collected from the plan, as well as the member’s in-network cost share amount.

This provision is effective for new groups and renewals of non-grandfathered group plans on or after Sept. 23, 2010.

- **Temporary re-insurance program to support coverage for early retirees.** The law establishes an early-retiree reinsurance program that dedicates $5 billion to help employers that offer group health coverage to early retirees, ages 55 through 64, who are not
Medicare-eligible. The goal of the program is to help employers maintain their early-retiree coverage until the new state-run insurance exchanges become operational in 2014. Any business receiving reimbursements must use the funds to lower plan costs. The program began June 21, 2010, and will run until Jan. 1, 2014, or until funds run out. According to the interim final regulation, companies do not need to reapply each year.

**How it works:** A temporary reinsurance program will reimburse employment-based group health plans up to 80 percent of an early retiree’s plan-year costs between $15,000 and $90,000. HHS will administer the reimbursements.

**Eligibility:** Employer group health plans are eligible if they provide health benefits to retirees and also use procedures to generate cost-savings for those participants with chronic and high-cost conditions. Those eligible include fully insured and self-insured ERISA plans, state and local government plans, church plans, MEWAs and VEBAs. The program covers claims of the early retiree’s covered spouse, surviving spouse, children and other dependents of the retiree, and claims for each are counted separately for purposes of calculating the cost threshold and cost limit. Groups apply for the program directly to HHS. For more information, visit the HHS website at [www.healthcare.gov](http://www.healthcare.gov).

Blue Cross and Blue Shield of Louisiana will provide administrative services for the early retiree reinsurance program if requested. A group must notify Blue Cross and Blue Shield of Louisiana if it is applying for the program and sign an agreement to receive services.

**Tax credits.** Effective with the tax year beginning Jan. 1, 2010, many small employers may qualify for a tax credit to provide health insurance coverage to employees. The credit is designed to encourage small employers to offer health insurance coverage for the first time or maintain coverage they already offer.

- The maximum credit is up to 35 percent of premiums paid in 2010 by eligible small business employers and up to

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For more information on this tax credit, visit [www.IRS.gov](http://www.IRS.gov) or [www.bcbsla.com/reform](http://www.bcbsla.com/reform).
25 percent of premiums paid by eligible employers that are tax-exempt organizations. Beginning in 2014, the maximum credit is 50 percent of a for-profit employer’s contribution toward premiums and 35 percent of employer contributions.

- The credit is specifically targeted to help small businesses and tax-exempt organizations that primarily employ low- and moderate-income workers. A qualifying employer must have less than the equivalent of 25 fulltime workers and pay wages averaging less than $50,000 per employee per year. The employer must also contribute at least 50 percent of the employees’ premiums based on the single rate.

- For more information on this tax credit, visit www.IRS.gov or www.bcbsla.com/reform.

**Management carve-out plans.** PPACA requires that non-grandfathered insured group health plans now comply with nondiscrimination rules that previously applied only to self-funded plans. Non-grandfathered groups with more than 50 employees may have management-only plans, but they may be subject to significant tax penalties. The penalty does not apply to groups size 2-49, although it appears that they may still be subject to nondiscrimination testing. (Special counting rules apply.) Grandfathered groups can keep their management carve-out and not be subject to a tax penalty. Groups should seek advice from their tax counsel before they change insurers or set up a management carve-out plan.

**Consumer-directed account options:** There will be some big changes in 2011 to health savings accounts (HSA), flexible spending arrangements (FSA) and the high-deductible health plans (HDHP) that are paired with them.

For instance, the penalty for non-qualified purchases from HSAs will increase to 20 percent. Also, beginning Jan. 1, 2011, PPACA will no longer permit the use of HSA and FSA funds to purchase certain items, including some over-the-counter drugs. In 2013 FSA contributions will be limited to $2,500 per year, though the amount will be adjusted yearly for inflation.
**Grandfathered Health Plans**

A grandfathered health plan is an existing group health plan or health insurance coverage (including coverage from the individual health insurance market) in which a person was enrolled on the date of PPACA’s enactment, March 23, 2010. **By definition, any policy effective April 1, 2010, or later is not a grandfathered health plan because no member was enrolled on March 23, 2010.**

Note: The definition for “group health plan” includes both self-insured and fully insured health plans.

Grandfathered health plans are exempt from the majority of the new insurance reforms. However, grandfathered plans are subject to a handful of requirements with different effective dates. Family members of current enrollees are allowed to enroll in the grandfathered plan, even after enactment, if such enrollment is permitted under the terms of the plan in effect on the date of enactment. New employees (and their families) may also enroll in group grandfathered plans.

The new regulations on “grandfathering” explain how employers with health coverage in place on March 23, 2010, can keep their current plan and under what circumstances they could lose grandfather status.

**Changes that WILL NOT cause a loss of Grandfather Status:**

- Increasing or decreasing premiums
- Changing policy benefits as required to comply with federal or state law
- *Increasing* benefits or reducing deductibles, coinsurance or copayments
- Making changes to provider networks (future regulations may change this)
- Making changes to drugs listed on a prescription drug formulary or moving drugs between drug tiers (future regulations may change this)
Changes to an existing group due to mergers and/or acquisitions, unless the principal purpose of the restructuring is to move employees to a grandfathered plan.

**Changes that WILL cause a loss of Grandfather Status:**

- Elimination of all or substantially all benefits to diagnose or treat a particular condition
- Increasing the coinsurance percentage members must pay
- An increase in copayments. Grandfathered plans will be able to increase those copayments by no more than the greater of $5 (adjusted annually for medical inflation), plus 15 percentage points. This includes prescription drug changes of increasing copayment amounts across any tier in excess of $5.
- An increase in deductibles. Grandfathered plans can only increase these deductibles by a percentage equal to medical inflation plus 15 percentage points.
- A decrease in employer contributions. Grandfathered plans cannot decrease the percent of premiums the employer pays by more than five percentage points.
- Adding or tightening annual limits
- Changing insurance companies or carriers
- Moving to another product
- Groups that define eligibility to include all full-time employees moving to a management carve-out arrangement (i.e., a custom eligibility arrangement)

If a group has made any benefit changes between April 1, 2010, and June 14, 2010, that resulted in the loss of grandfathering status, the group may be able to regain grandfather status by acting before the group’s next anniversary date.
Requirements for Grandfathered Plans

The insurance reforms with which grandfathered health plans must comply beginning the first plan year after Sept. 23, 2010 are the following:

- Prohibition on lifetime limits on essential health benefits
- Prohibition on health plan coverage rescissions
- Requirement to extend dependent coverage to children until the individual is 26 years old. Prior to 2014, a grandfathered plan may limit enrollment to children up to 26 only if the child is not eligible for employment-based health benefits.

Additionally, grandfathered group health plans will be required to comply with the following reforms:

- Prohibition on coverage exclusions for pre-existing health conditions for dependants up to age 19. For older enrollees, this provision will become effective for plan years beginning on or after Jan. 1, 2014.
- Restriction on annual limits on essential health benefits provided by group health plans for plan years beginning Sept. 23, 2010.

RESOURCES

We suggest the following resources for up-to-date information:

- Spotlight on Issues — Blue Cross and Blue Shield Association: [www.bcbs.com/issues/](http://www.bcbs.com/issues/)
- Blue Cross and Blue Shield Association web page on reform: [www.bcbs.com/issues/uninsured/](http://www.bcbs.com/issues/uninsured/)
2014 Employer Requirements — Insurance Mandates

In 2014, one of the more important provisions of the reform legislation goes into effect – the mandate that individuals have health insurance coverage or pay a penalty.

PPACA does not require an employer to provide employees with coverage, but it does impose penalties on certain employers if they do not. An employer with at least 50 FTEs that does not provide coverage may be subject to a penalty if at least one of its full-time employees receives a premium subsidy. An employer with at least 50 FTEs that provides access to coverage but fails to meet certain requirements may also be subject to a penalty. The number of FTEs excludes those full-time seasonal employees who work for less than 120 days during the year. The penalty for an applicable employer that provides coverage is similar to the penalty assessed against an employer that does not provide coverage. An employer may be subject to a penalty only in relation to its full-time workers, defined as those working an average of at least 30 hours per week. An employer is not subject to a penalty in relation to its part-time workers (those working less than an average of 30 hours per week).

Disclaimer

This information has been compiled from a variety of sources. Please note that interpretations may vary, and you should consult your attorney and/or tax advisor for more specific information. New and existing state laws as well as future federal and state regulations may have an impact on many of these provisions. Please also note that the new law allows for “grandfathering” of certain health plans, making those plans not necessarily subject to portions of the new law.

Sources for this brochure: Congressional Research Service; Private Health Insurance Provisions in PPACA, AHIP; U.S. Chamber of Commerce; Gallagher Benefit Services; Mercer; National Federation of Independent Business
TIMELINE FOR IMPLEMENTATION – SOME HIGHLIGHTS

The following information is based on a document prepared by the committees on Ways & Means, Energy & Commerce, and Education & Labor, April 2, 2010. This is not a complete list of all the changes, but merely some of the most important highlights. Note again that many details will be forthcoming by the IRS, HHS, state departments of insurance and other regulatory agencies.

In addition to some of the immediate changes outlined above that take place in 2010, highlights of the reform timeline include the following:

2011

**W-2 Reporting.** Employers will be required to report employees’ health benefits on W-2s.

**HSA and FSA Limits:** Consumers are not allowed to use HSA and FSA funds to buy non-prescribed items, including over-the-counter medication. Additionally, the penalty for using HSAs for non-qualified purchases increases to 20 percent.

**Strengthening 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.

**Increasing Reimbursement for Primary Care.** Provides a 10 percent Medicare bonus payment for primary care physicians and general surgeons, under certain circumstances.

**Improving 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.
Discounts in the Medicare Part D “Donut Hole.” 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.

Pharmaceutical Manufacturers Fee. Imposes an annual, non-deductible fee on the pharmaceutical manufacturing industry allocated according to market share. This fee does not apply to companies with sales of branded pharmaceuticals of $5 million or less.

2013

Increased Threshold for Claiming Itemized Deduction for Medical Expenses. Increases the income threshold for claiming the itemized deduction for medical expenses from 7.5 to 10 percent. Individuals over 65 would be able to claim the itemized deduction for medical expenses at 7.5 percent of adjusted gross income through 2016.

Medical Device Excise Tax. Establishes a 2.3 percent excise tax on the sale of a medical device by a manufacturer or importer. Exempted from the tax are eye glasses, contact lenses, hearing aids, and any device of a type that is generally purchased by the public at retail for individual use.

Medicare Payroll Taxes. The Medicare payroll tax on wages and self-employment income in excess of $200,000 will increase to 2.3 percent and is not indexed to inflation.

2014

Reforming Health Insurance Regulations. Implements strong health insurance reforms that prohibit insurance companies from engaging in discriminatory practices that enable them to refuse to sell or renew policies due to an individual’s health status. Health plans can no longer exclude coverage for pre-existing health conditions. It also limits the ability of insurance companies to charge higher rates due to health status, gender, or other factors. Premiums can vary only on age (no more than 3:1), geography, family size, and tobacco use.
**Eliminating Annual Limits.** Prohibits health plans from imposing annual dollar value limits on the amount of coverage an individual may receive.

**Establishing Health Insurance Exchanges.** Opens health insurance exchanges in each state to individuals and small employers. This new venue will enable people to comparison shop for standardized health packages. It facilitates enrollment and administers tax credits so that people of all incomes can obtain affordable coverage.

**Ensuring Choice through a Multi-State Option.** Provides a choice of coverage through a multi-state plan, available from nationwide health plans under the supervision of the Office of Personnel Management.

**Providing Health Care Tax Credits.** Makes premium tax credits available through the exchange to ensure people can obtain affordable coverage. Credits are available for people with incomes above Medicaid eligibility and below 400 percent of poverty if they are not eligible for or offered other acceptable coverage. They apply to both premiums and cost sharing.

**Ensuring Choice through Free Choice Vouchers.** Workers who qualify for an affordability exemption to the individual responsibility policy but do not qualify for tax credits can take their employer contribution and join an exchange plan.

**Promoting Individual Responsibility.** Requires most individuals to obtain acceptable health insurance coverage or pay a penalty of $95 for 2014, $325 for 2015, $695 for 2016 (or, up to 2.5 percent of income in 2016), up to a cap of the national average bronze plan premium. Families will pay half the amount for children, up to a cap of up to a cap of $2,250 per family. After 2016, dollar amounts are indexed. If affordable coverage is not available to an individual, they will not be penalized.

**Promoting Employer Responsibility.** Requires employers with 50 or more employees who do not offer coverage to their employees to pay $2,000 annually for each full-time employee over the first 30 as long as one of their employees receives a tax credit. Precludes
employment waiting periods for enrollment in coverage over 90 days. Requires employers who offer coverage but whose employees receive tax credits to pay $3,000 for each worker receiving a tax credit up to an aggregate cap of $2,000 per full time employee.

**Increasing Access to Medicaid.** Medicaid eligibility will increase to 133 percent of the federal poverty level for all non-elderly individuals to ensure that people obtain affordable health care in the most efficient and appropriate manner. States will receive increased federal funding to cover these new populations.

**Small Business Tax Credit.** Continues the second phase of the small business tax credit for qualified small employers.

**Health Insurance Provider Fee.** Imposes an annual, non-deductible fee on the health insurance sector allocated across the industry according to market share. The fee does not apply to companies whose net premiums written are $25 million or less.

Source: Committee on Energy and Commerce
http://energycommerce.house.gov
CONTACT:
800.599.BLUE (2583)

DISTRICT OFFICE PHONE NUMBERS:
Alexandria 318.448.1660
Baton Rouge 225.295.2556
Houma 985.223.3499
Lafayette 337.232.7527
Lake Charles 337.562.0595
Monroe 318.323.1479
New Orleans 504.832.5800
Shreveport 318.795.0573

www.bcbsla.com/reform

5525 Reitz Avenue
Baton Rouge, Louisiana 70809-3802