VIVA HEALTH

A Member of UAB Health System

HEALTH REFORM

The Affordable Health Care for America Act will certainly change the health landscape over the next several years. The law's numerous provisions are effective at different times between now and 2020 and some provisions are phased in over a number of years.

What does the new law mean for VIVA, our members, and our providers? While there are many unanswered questions that should be addressed in the regulations being written now, below is a brief summary of the law's key provisions for health plans.

2010 changes (take effect 6 months from the date the law was signed for new groups and at the first renewal thereafter for existing groups)

Commercial:

- Dependent children may stay on a parent's health plan until age 26. Children are not required to be students and can be married although the child's spouse is not eligible. The definition of "dependent" is not yet known.
- Elimination of lifetime coverage and benefit limits.
- Rescissions (retroactive coverage terminations) are prohibited except in cases of fraud or intentional misrepresentation.
- Pre-existing condition exclusions may not be applied to children under age 19.

Medicare

- $250 government rebate check for Medicare beneficiaries who fall into the Part D coverage gap.

2011 changes.

Commercial:

- Commercial plans required to spend 85% of large group and 80% of small group/individual premiums on claims or quality improvement activities.
- Government to develop templates for health plans to use in describing benefits such as model schedules of benefits and certificates of coverage.

Medicare:

- Drug manufacturers provide a 50% discount for brand-name drugs and plans offer at least 7% coverage of generic drugs in the Part D coverage gap. Coverage in the gap continues to increase until 2020 when the gap is closed.

- The January - March Medicare Advantage open enrollment period (OEP) is eliminated and replaced with an opportunity for members to move to original Medicare from January 1 - February 15.
- Medicare plans must have an out-of-pocket maximum of $6,700 or less and meet other benefit requirements such as no member cost sharing for preventive services.

2012 changes.

Medicare:

- Phase down of plan payment rates to 100% of fee-for-service begins.
- Phase-in of quality bonuses based on a five star rating system begins.
- The annual election period (AEP) is moved up to October 15 - December 7.
- Medicare Special Needs Plans must be NCQA accredited.

2014 changes.

Commercial:

- Exchanges open where small business (up to 100 employees) and individuals may purchase health insurance.
- Premium rating based on health status no longer allowed.
- Annual benefit limits and pre-existing condition exclusions prohibited.
- Penalties imposed on certain uninsured individuals and certain employers who do not offer health insurance to their employees.

Medicare:

- Medicare plans required to spend 85% of premiums on claims or quality improvement activities.

The staff at VIVA HEALTH is working hard to be sure we understand and comply with the new law and to evaluate the specific opportunities and challenges it presents for VIVA. We expect much more detailed information will be made available to us in the coming months. We will provide periodic updates as information becomes available.