Healthcare Reform
2010 Major Insurance Market Reform
2010 Major Insurance Market Reform

Table of Contents
Pre-Ex Exclusion Periods ........................................................................................................................................ 2
Rating & Pooling .................................................................................................................................................... 2
Guaranteed Issue ..................................................................................................................................................... 2
Non Discrimination ................................................................................................................................................ 3
Guaranteed Renewability ...................................................................................................................................... 3
Wellness Programs ................................................................................................................................................ 3
Provider Non Discrimination ............................................................................................................................... 5
Clinical Trials Coverage ....................................................................................................................................... 5
Non Excessive Waiting Periods ............................................................................................................................. 6
Transition/Grandfathering ..................................................................................................................................... 6
Level Playing Field ................................................................................................................................................ 6
Reports/Studies ....................................................................................................................................................... 7
Temporary Individual Market Reinsurance ........................................................................................................ 7
Risk Corridors ......................................................................................................................................................... 8
Risk Adjustment ...................................................................................................................................................... 9
State Waiver ......................................................................................................................................................... 9
Benefit Requirements ........................................................................................................................................... 10
Other ..................................................................................................................................................................... 10
Pre-Ex Exclusion Periods
- No pre-ex exclusion periods for new coverage in all markets and grandfathered group health plans starting in 2014 (PPACA § 1201; HCERA § 2301(a)(4)(B)(i); PHSA § 2704).

Rating & Pooling
- **Rating Adjustments.** Permits adjustments only for:
  - Age (3:1 for adults), within standard age bands established by HHS in consultation with NAIC.
  - Family composition (individual or family).
  - Tobacco (1.5:1).
  - Geography (Rating areas to be established by states and reviewed by HHS).
- With respect to family coverage, the rating variations permitted for age and tobacco shall be applied to the portion of the premium attributable to each family member.
- Applies to individual and small group markets (but not grandfathered plans). Effective in 2014 (PPACA § 1201; PHSA § 2701).
- **Market Definitions.** Requires states to include the self-employed and employers up to 100 in their small group markets; however, states have the option to keep small group market at 1-50 in 2014 and 2015 (PPACA § 1304).
- If a state permits large employers to purchase coverage through an Exchange (which they can do starting in 2017), the rating rules would extend to insured large employers as well (PPACA §§ 1312(f)(2)(B), 10103(a)).
- **Separate Pools.** Requires separate pools for individual and small group, but permits states to merge the markets. Requires these pools to include policies from both inside and outside Exchange (except for grandfathered coverage; specifies that state laws requiring grandfathered plans to be included in a pool shall not apply) Effective 2014 (PPACA § 1312(c)).

Guaranteed Issue
- Requires guaranteed issue during annual open enrollment and special enrollment periods for qualifying events in accordance with regulations promulgated by HHS consistent with ERISA §603 (COBRA special enrollment periods). Modifies current HIPAA provisions requiring guaranteed issue in the small group market (current PHSA § 2711, re-designated as PHSA § 2731) but eliminates current small group law exceptions for failure to meet participation/contribution requirements and exceptions for association coverage).
- Applies to individual and group markets (but not to grandfathered plans) (PPACA §§ 1201, 1562(c)(8)(D)-(E); PHSA § 2702).
Non Discrimination

- Extends current HIPAA rules (at PHSA § 2702(a)) prohibiting group health plans from establishing rules for eligibility to enroll in coverage based on specified status-related factors (health status, medical condition, claims experience, receipt of health care, medical history, generic information and evidence of insurability) to the individual market. To this list, adds “any other health status-related factor determined appropriate” by HHS (PPACA § 1201; PHSA § 2705).
- Extends current HIPAA rules prohibiting group health plans from charging enrollees higher premiums based on health status (current PHSA § 2702(b)) to the individual market (PPACA § 1201; PHSA § 2704(B)).

Guaranteed Renewability

- Requires guaranteed renewability starting in 2014 (Note: Unlike the guaranteed issue provision, this does not eliminate the HIPAA group participation/contribution requirements). Applies to all insured markets (but not to grandfathered plans) (PPACA § 1201, PHSA § 2703).

Wellness Programs

- Premium Variation for Participation in Employer Wellness Programs. Permits employers to vary premiums by as much as 30% for employee participation in certain health promotion and disease prevention programs. Effective 1/1/14.
- Programs Not Subject to Requirements
  - Programs where participation is not based on a health status factor.
  - Programs that do not link rewards to a standard related to a health status factor – so long as participation is made available to all “similarly situated individuals.”
  - Programs that do not provide rewards – so long as participation is made available to all “similarly situated individuals.” Specific programs listed as not subject to requirements:
    - Programs that reimburse some/all of fitness membership costs.
    - Diagnostic testing programs that provide rewards for participation and do not base any rewards on outcomes.
    - Programs that encourage preventive care through waivers of cost-sharing (e.g., for well baby care).
    - Programs that reimburse the costs of smoking cessation programs, regardless of whether the individual quits smoking.
    - Programs that provide rewards to individuals for attending a periodic health education seminar.
• **Requirements.** The following requirements apply to programs that condition rewards based on satisfying a standard related to a health status factor:
  
  o **30% Limit.** Rewards for such programs may not exceed 30% of the cost of employee-only coverage, determined based on the total amount of employer and employee contributions (or, if dependents are eligible for the program, 30% of the cost of coverage in which an employee and any dependent are enrolled). Allows HHS to increase this ceiling to 50%.
  
  o **Awards**
    - Allows the reward to take the form of premium discounts or rebates, the absence of a surcharge, a waiver of cost-sharing mechanisms or the value of a benefit that would not otherwise be covered under the plan.
    - Plan shall give individuals eligible for the program the opportunity to qualify for the award at least once a year.
    - The full reward must be available to all similarly situated individuals.
    - Plans must provide a reasonable alternative standard (or waiver of the applicable standard) for obtaining the reward for an individual for whom it is unreasonably difficult due to a medical condition or for whom it is medically inadvisable to attempt to satisfy the standard. Permits plans, “if reasonable under the circumstances,” to seek verification, such as a statement from an individual’s physician, that a health status factor makes it medically inadvisable or unreasonably difficult for the individual to satisfy or attempt to satisfy the program standard. Requires plans to disclose in all plan materials that describe the terms of the wellness program the availability of any alternative standard or the possibility of a waiver of the program standards (plan materials that disclose the availability of a wellness programs without describing its terms do not require such disclosure).
  
  o **Program Design.** Requires the wellness program to be “reasonably designed to promote health or prevent disease” – that is, it must have a “reasonable chance” of improving health or preventing disease in participating individuals; must not be overly burdensome; must not be a subterfuge for discriminating based on a health status factor; and is not “highly suspect” in the method chosen to promote health/prevent disease.
  
  o **Grandfather Clause.** Grandfathers all existing wellness programs established prior to the date of enactment of this section and that complied with all applicable regulations.

• **Individual Market Wellness Program Demonstration.** By 7/1/14, directs HHS, in consultation with Treasury and DOL, to establish a 10-state demonstration project under which participating states apply the wellness provisions described above (for the group market) to individual market. Permits expansion of the demonstration starting on 7/1/17, if the demonstration efforts are found to be effective. To participate in the demonstration, requires participating states to: 1) design their projects to avoid any coverage decreases or any increase in federal costs related to available individual tax credits; 2) ensure that consumer protection standards are met; 3) ensure that premium discounts under the program do not create undue burdens for individuals, do not lead to cost-shifting and are not a subterfuge for discrimination.
• **Reporting.** Requires HHS to report to Congress on the effectiveness of wellness programs within 3 years of the date of enactment, including collecting data from employers on their wellness programs (PPACA § 1201; PHSA § 2705).

**Provider Non Discrimination**

• Prohibits discrimination against providers acting within the scope of the license or certification with respect to participation under a plan. Specifies that this provision is not an “any willing provider” requirement and that the provision does not prohibit reimbursement based on quality or performance. Applies to all markets (but not to grandfathered plans). Effective 1/1/14 (PPACA § 1201; PHSA § 2706(a)).

**Clinical Trials Coverage**

• Requires coverage of routine costs for and prohibits discrimination against clinical trial participants. Applies to insured plans in all markets and self-funded plans (but not grandfathered plans).

• **Routine Patient Costs.** Defines these costs to include all items and services consistent with the coverage provided that is typically covered for a qualified individual who is not enrolled in a clinical trial. Specifically excludes: the investigational item/device/service itself; items and services provided solely to satisfy data collection and analysis needs; and services clearly inconsistent with widely accepted and established standards of care for a diagnosis.

• **Use of In-Network Providers.** Permits plans to require enrollees to participate in the trial through a participating provider, if such providers are participating in the trial and will accept the individual as a trial participant.

• **Non-Network Coverage.** Applies the general requirements of this provision to enrollees participating in approved trials being conducted out-of-state, unless that plan does not otherwise cover out-of-network benefits.

• **Qualified Individuals.** Enrollees who are eligible to participate in an approved trial according to the trial protocol for cancer or other life-threatening diseases, the individual provides medical and scientific information establishing that his/her participation would be appropriate.

• **Approved Clinical Trial.** Defined as a phase I, II, III or IV clinical trial for the prevention, detection or treatment of cancer or other life-threatening disease or condition, that is also one of the following:
  o A federally funded trial sponsored by: the NIH, the CDC, AHRQ, CMS, a cooperative group or center of any of the previous entities or the Departments of Defense (DOD) or Veterans Affairs (VA); a qualified non-governmental research entity identified in guidelines issued by the NIH for center support grants; or the DOD, VA or Department of Energy if the study has been reviewed and approved through a peer review system.
  o A study conducted under an investigational new drug application reviewed by the FDA or a drug trial that is exempt from having an investigational new drug application.
• **FEHBP.** Applies this provision to health plans offered under the FEHBP.
• **Treatment of State Clinical Trials Laws.** Does not preempt state clinical trials laws that go beyond the requirements of this provision.
• Effective 1/1/14 (PPACA § 10103(c)).

### Non Excessive Waiting Periods
- Limits waiting periods under all group health plans (periods before which an employee is eligible for coverage) to 90 days starting in 2014. Applies to all markets, including all grandfathered coverage (PPACA §§ 1201, 10103(b); HCERA § 2301 (a)(4)(A)(i); PHSA § 2708).

### Transition/Grandfathering
- Grandfathers existing coverage under rating, benefit and certain other rules as long as such coverage is renewed. Subjects new coverage to new rules.
- Permits family members of current enrollees and new employees to enroll in grandfathered coverage.
- Applies grandfathered status to coverage maintained under an insured collective bargaining agreement (until the date that such agreement terminates).
- Grandfathered status is indefinite; the provision is silent regarding changes in terms or conditions of such coverage; however, grandfathered status applies to coverage in effect on date of bill’s enactment – not in 2014 when major reforms go into effect
- (PPACA §§ 1251, 10103(d), 101 03(e)(1)).

### Level Playing Field
- Requires any state regulation or amendment adopted under PPACA to apply uniformly to all health plans in each insurance market to which it applies (as of 1/1/14) (PPACA § 1252).
- Appears that self-funded MEWAs would not be subject to insurance market reform rules applicable to insured benefits (i.e., rating restrictions, guaranteed issue/renewability). However, appears that self-funded MEWAs would be subject to general group health plan rules applicable to self-funded plans (at least at employer level), and fully insured MEWAs would be subject to insurance market reform rules applicable to insurers (PPACA § 1301(b)(1)(B)).
Reports/Studies

- **Self-Funded Plans.** Annual DOL reports to Congress on self-funded plans, due 12 months after enactment (PPACA § 10103(f); PHSA § 1253).

- **Large Group Market.** HHS study of large group market including evaluation of extent to which the insurance reforms may cause adverse selection in the large group market or encourage smaller employers to self-fund, due one year after enactment (PPACA § 10103(f); PHSA § 1254).

- **Denials.** GAO study on denials of coverage and enrollment (and the reasons for such denials) by insured and self-funded group plans (including both qualified and nonqualified health plans), due one year after enactment to HHS and DOL. Directs GAO to include data on denials that were later approved by a plan. Requires the report to be made available by HHS and DOL on a public Internet website (PPACA § 10107(b); § 1562).

- **Health Plan Value.** HHS to develop methodology, in consultation with relevant stakeholders (including insurers, consumers, employers and providers) to measure health plan value. Requires such methodology to consider overall costs to enrollees; quality of care; efficiency of the plan in providing care; relative risk of plan enrollees; and actuarial value (or other comparative measure of covered benefits). Report due to Congress 18 months after enactment (PPACA § 10329).

Temporary Individual Market Reinsurance

- **Overview.** Mandatory state-run reinsurance program (2014-2016) for the individual market. Requires non-profit state-run reinsurance entities to collect payments and use amounts collected to make reinsurance payments to health insurance issuers that cover high-risk individuals for any plan year beginning in such 3-year period. (PPACA § 1341)

- **Eligible Coverage.** Individual market coverage, except for grandfathered coverage.

- **Health Plan Contributions.** Requires all health insurance plans (individual and group markets) and third-party administrators (on behalf of group plans) to contribute $25 billion over this 3-year period to a reinsurance program for individual policies.

- **Model Regulation.** Requires HHS, in consultation with the NAIC to establish a model regulation to carry out this provision. The model regulation must address:
  - Identification of High-Risk Individuals. Requires regulations to establish a method for determining high-risk individuals including a list of at least 50 but not more than 100 high-risk medical conditions or any other comparable objective method recommended by the American Academy of Actuaries.
  - Payments. Requires the formula for determining payment amounts to issuers to provide for the equitable allocation of available funds through reconciliation. Such formula may be designed to provide a schedule of payments that specifies the amount that will be paid for each of the specified conditions or may use any other comparable method recommended by the American Academy of Actuaries.
  - **Required Contributions:**
    - Method. Permits contributions to be based on: 1) the percentage of revenue of each issuer and the total costs of providing benefits for self-
funded plans; or 2) a specified amount per enrollee that may be required to be paid in advance or periodically throughout a plan year.

- Proportionality. Requires contributions for issuers to proportionally reflect their fully insured commercial book of business for all major medical products and the total value of all fees charged and the costs of coverage administered by the issuer as a TPA. However, each issuer’s contribution must also reflect its proportionate share of an additional $2 billion for 2014 and 2015 and an additional $1 billion in 2016.

- Administrative Fee. Contributions also can include an amount to fund the administrative expenses of the reinsurance entity.

- Aggregate Amounts. Requires aggregate contribution amounts for all states to equal $10 billion for 2014, $6 billion for 2015 and $4 billion for 2016.

- **Relation to State High Risk Pools.** Requires states to eliminate or modify their high risk pools to the extent necessary to carry out the reinsurance program. Permits states to coordinate their high risk pools with this program, to the extent not inconsistent with this provision (PPACA §§ 1341, 10104(r)).

### Risk Corridors

- **Overview.** Mandatory federal risk corridor program (2014-2016) for qualified health benefit plans in the individual and small group markets (excluding grandfathered coverage). (While not entirely clear, the intent may be to apply this section only to “qualified health benefit plans” within the Exchange.

- **Medicare Part D Model.** Requires the risk corridors to be modeled after those used to adjust payments to regional PPOs in Medicare Part D.

- **Payments**
  - **Payments Out.** If a participating plan’s allowable costs are >103% but not >108% of a target amount, the plan would be paid 50% of the amount in excess of 103% of the target amount. If the allowable costs are >108%, the plan would be paid 2.5% of the target amount plus 80% of allowable costs >108% of the target amount.
  
  - **Payments In.** If a participating plan’s allowable costs are <97% but not <92% of a target amount, the plan would pay in 50% of the excess of 97% of the target amount over the allowable costs. If the allowable costs are <92%, the plan would pay in 2.5% of the target amount plus 80% of the excess of 92% of the target amount over the allowable costs.
  
  - **Allowable Costs.** Defined as the total costs (other than administrative costs) of the plan in providing covered benefits. Allowable costs are reduced by any risk adjustment and reinsurance payments received under § 1341 and § 1343.
  
  - **Target Amount.** Defined as total premiums (including any premium subsidies), less administrative costs (PPACA § 1342).
Risk Adjustment

- **Overview.** Mandatory, state-run risk adjustment programs for the individual and small group markets (developed by HHS in consultation with states), excluding grandfathered coverage, starting in 2014. Applies to insured business only.

- **Program design.** Requires HHS to establish criteria and methods for carrying out such risk-adjustment activities. Allows HHS to utilize criteria and methods similar to those utilized under the Medicare Advantage and the Medicare Part D Programs.

- **Assessments.** Requires states to assess a charge on “low actuarial risk plans,” defined as plans whose enrollees’ actuarial risk for one year is less than the average actuarial risk of all enrollees in all plans or coverage in the state for the same year.

- **Payments.** Requires states to provide payment to “high actuarial risk plans,” defined as plans whose enrollees’ actuarial risk for one year is greater than the average actuarial risk of all enrollees in all plans in the state for the same year (PPACA § 1343).

State Waiver

- States can apply for waivers to opt out of the following requirements if they implement programs that ensure their residents have coverage that is at least as comprehensive as the coverage required under Exchange plans. HHS will determine the scope of the waiver based on a state’s application.

- **Requirements that Can Be Waived:**
  - Establishment of qualified health plans. (PPACA §§ 1301-1304).
  - Health benefit Exchanges. (PPACA §§ 1311-1312).
  - Reduced cost-sharing for individuals. (PPACA § 1402).
  - Individual tax credit. (new IRC § 36B).
  - Employer responsibility requirements. (new IRC § 4980H).
  - Individual responsibility requirement. (new IRC § 5000A).

- **State Applications.** Must contain a comprehensive description of state plan that will meet the requirements for a waiver as well as a 10-year budget plan that is budget neutral for the federal government and an assurance that the state has enacted a law providing for state action under a waiver, including implementation of the state plan. Directs HHS to develop a coordinated process permitting states to submit a single application for a waiver under Medicare, Medicaid and/or CHIP. HHS to make determination on waiver applications within 180 days of receipt.

- **Subsidy Pass-Through.** For state waivers under which individuals and small employers would not qualify for the bill’s tax credit/subsidy provisions, provides for the funds that would have been paid on behalf of Exchange participants in the absence of a waiver to be paid to the state to help implement the state plan under the waiver.

- **Criteria for Granting Waivers.** Permits HHS to grant waiver requests if HHS determines that the state plan will:
  - Provide coverage that is at least as comprehensive as the essential health benefits coverage and that has cost-sharing protections against excessive OOP expenditures that are at least as affordable as under this bill.
  - Extend coverage to at least a comparable number of residents as under this bill.
  - Not increase the federal deficit.
**Transparency.** Requires HHS to issue regulations within 180 days of enactment the provide for:
- A process for public notice and comment at the state level as relates to state waivers, including hearings.
- Waiver applications that ensure disclosure of: 1) the provisions of law that the state seeks to waive; and 2) the specific plans of the state to ensure the waiver will be in compliance with the criteria for granting waivers and the requirement to enact a state law to provide for state actions under a waiver.

**Waiver Length.** No waivers can extend longer than 5 years unless such an extension is requested and granted by HHS. Effective for plan years beginning 1/1/17 (PPACA § 1332).

**Benefit Requirements**

**Individual and Small Group Markets.** Requires all insurers in the individual and small group markets to meet the same requirements as Exchange plans with respect to:
- Providing coverage of the essential benefits package.
- Meeting cost-sharing requirements for essential benefits.
- Offering at least one of the Bronze, Silver, Gold or Platinum benefit plans (or a catastrophic plan). (See “Qualified Health Plans” section for more details.)
  Effective 1/1/14 (PPACA § 1201; PHSA § 2707(a)).

**Group Markets.** Requires all group health plans to meet cost-sharing limits required under § 1302(c)(1)-(2), which limit deductibles to $2,000 for individuals and $4,000 for families and limit annual out-of-pocket maximum to HDHP levels for HSA plans.
  Effective 1/1/14 (PPACA § 1201; PHSA § 2707(b)).

**Insured Plans.** Requires insurers who offer any level of coverage (Bronze, Silver, Gold or Platinum) re: the essential benefits package to also offer coverage at that level for child-only plans (PPACA § 1201; PHSA § 2707(c)).
- These requirements do not apply to grandfathered plans.

**Other**

**State Benefit Mandates.** Continues to apply state benefit mandates to coverage outside of Exchanges. (PPACA § 1312(d)(2)). States can mandate additional benefits inside Exchanges but they must make payments to cover the additional costs for such benefits for those that are subsidy eligible. Requires these state payments to be made directly to individual enrollees or to the health plans in which such individuals are enrolled. For the multi-state plans OPM is required to offer through state Exchanges, states are allowed to mandate additional benefits but must cover the costs for all enrollees from that state (including those who are not subsidy eligible). As with single-state plans, such payments could be made directly to individual enrollees or to the health plans in which such individuals are enrolled. Effective 1/1/14 (PPACA §§ 131 1(d)(3), PHSA § 1334; 10104(e), 10104(q); PHSA § 1334).
- Payments to FQHCs. Requires payments by Qualified Health Benefits Plans to FQHCs to be at least as high as payments to FQHCs under Medicaid (PPACA § 101 04(b)(2)).
- Gun Rights Protections. Prohibits any requirements for disclosure of or collection of information on gun ownership under the bill. Prohibits insurers from using such information to increase premiums, deny coverage or reduce or withhold rewards for wellness program participation (PPACA § 10101(e)).