Healthcare Reform
2010 Near-Term Insurance Market Reform
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Annual/Lifetime Limits

- **Lifetime Limits.** Prohibits lifetime dollar limits on essential benefits, effective for plan years starting 6 months after enactment. Applies to all markets, including grandfathered group and individual plans.
- **Annual Limits.** Prohibits annual dollar limits on essential benefits, effective for plan years starting 6 months after enactment. Before 1/1/14, restricted annual limits may be permitted, as determined by HHS, to ensure minimal impact on premiums. Effective 1/1/14, prohibits annual limits on the dollar value of all essential benefits. Applies to new plans in all markets and to grandfathered group plans.
- **“Per beneficiary”** annual or lifetime limits are permissible for items and services that are not part of the essential health benefits (PPACA §§ 1001, 10101(a); HCERA § 2301(a)(4); PHSA § 2711).

Rescissions

- Permits rescissions only for fraud or intentional misrepresentation of material fact and with prior notice to the enrollee. Applies to all markets, including grandfathered plans. Effective for plan years starting 6 months after enactment (PPACA § 1001; HCERA § 2301(a)(4)(A)(iii); PHSA § 2712).

Preventive Health Services

- Requires coverage of the following preventive health services with no cost-sharing:
  - Evidence-based items/services with a rating of “A” or “B” in the current recommendations of the U.S. Preventive Services Task Force (USPSTF).
  - (Current USPSTF recommendations for breast cancer screening, mammography and prevention will be considered the most current, other than those issued in or around 11/09.)
  - Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC).
  - Evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services.
  - Administration (HRSA) for infants, children and adolescents.
  - With respect to women, additional preventive care and screenings provided for in guidelines supported by HRSA.
- Directs HHS to establish a minimum interval – of no less than one year – between the date on which a recommendation or guideline is issued and the plan year with respect to which the requirement is effective.
- Permits HHS to develop guidelines permitting plans to utilize “value-based insurance designs.”
- Applies to all markets (but not grandfathered plans). Effective for plan years starting 6 months after enactment (PPACA § 1001; PHSA § 2713).
Dependent Coverage

- Requires plans that provide dependent coverage to continue to make coverage available until an adult child (married or unmarried) turns 26.
- Does not require plans to make coverage available to a child of a child receiving dependent coverage.
- Directs HHS to define by regulation the dependents to which this applies.
- Applies to all markets. Applies to grandfathered group and individual plans. For grandfathered group health plans, not applicable prior to 1/1/14 if the dependent is eligible to enroll in an employer-based plan.
- Effective for plan years starting 6 months after enactment (PPACA § 1001; HCERA §§ 2301 (a)(4)(A), 2301(b); PHSA § 2714).

Uniform Explanation of Coverage and Transparency Requirements

- Uniform Coverage Summaries
  - No later than 24 months after enactment, requires plans to provide a summary of benefits and coverage explanation that meets standards developed by HHS. Such documents must be provided at the time of application or enrollment and at policy/certificate delivery.
  - Standards Development. Directs HHS, within 12 months of enactment, to develop such standards, in consultation with the NAIC and a working group composed of representatives of health insurance-related consumer advocacy organizations, health insurers, health professionals, patient advocates and other qualified individuals. Provides for periodic reviews and updates of such standards.
    - Standards:
      - Must be in a uniform format no longer than 4 pages and using print no smaller than 12-point font.
      - Must be presented in a culturally and linguistically appropriate manner and using terminology that average enrollees can understand.
      - Contents. Must include:
        - Uniform definitions of standard insurance and medical terms.
        - Insurance related terms to be defined include at least: premium; deductible; coinsurance; copayment; OOP limit; preferred and non-preferred provider; out-of-network copayments; UCR fees; excluded services; and grievance and appeals.
        - Medical terms to be defined include at least: hospitalization; hospital outpatient care; emergency room care; physician services; Rx drug coverage; DME; home health care; skilled nursing care; rehabilitation services; hospice services; and emergency medical transportation.
        - A description of coverage, including cost-sharing for each of the categories of essential benefits (and other benefits identified by HHS).
        - Exceptions, reductions and limitations on coverage.
        - Cost-sharing provisions.
- Renewability and continuation of coverage provisions.
- A “coverage facts label” that includes examples to illustrate common benefits scenarios, including pregnancy or chronic medical conditions and related cost-sharing (with scenarios based on recognized clinical practice guidelines).
- A statement of whether the plan provides minimum essential coverage and ensures that the plan’s share of total allowed costs is not less than 60%.
- A statement that the outline is a summary of the policy and that the coverage document itself should be consulted for contractual provisions.
- A contact number for consumers and an Internet web address where a copy of the actual coverage policy or certificate of coverage can be reviewed and obtained.
  - Notice of Mid-Year Changes. Requires at least 60 days notice in advance of any material modification in plan or coverage not reflected in most recent summary.
  - Allows summaries to be paper or electronic.
  - Preempts related state standards that provide less information to consumers than is required under this provision.
  - Provides for penalties for willfully not providing of up to $1,000 per failure.
  - Applies to all markets, including to grandfathered plans. Effective 24 months after enactment (PPACA §§ 1001, 10103(d)(3); PHSA § 2715).

**Transparency/ Disclosure Requirements**
- Requires plans in all markets to comply with transparency and disclosure requirements applicable to Exchange-participating plans:
  - **Transparency in Coverage.** Submit the following information to HHS and the state insurance commissioner, and make it available to the public: claims payment policies and practices, periodic financial disclosures, enrollment/disenrollment data, data on claims denial and rating practices, information on cost-sharing and payments for non-network coverage and information on enrollee rights.
  - **Cost-Sharing Transparency.** Permit individuals to learn the amount of cost-sharing with respect to specific items or services by a participating provider upon request; at minimum, such information must be available through an Internet website.
- Effective for plan years beginning on or after 6 months after enactment. Applies to plans in all markets (but not to grandfathered plans) (PPACA §§ 10101(c), 10104(f); PHSA § 2715A).

**Salary Non Discrimination**
- Requires insured group health plans (other than grandfathered plans) to meet current IRC § 105(h)(2) requirements prohibiting discrimination in favor of highly compensated individuals in terms of eligibility and benefits. Effective for plan years starting 6 months after enactment (PPACA §§ 1001, 10101(d); PHSA § 2716).
Quality of Care Reporting

- **Quality Reporting.** Requires all group and individual plans (except grandfathered plans) to comply with annual quality reporting requirements to be established by HHS within 2 years of enactment. Plans must submit annual reports to HHS and to enrollees during each open enrollment period on whether the plan’s benefits meet the elements of a required quality program, and HHS must make the reports available through an Internet website. Allows HHS to develop penalties for noncompliance. Also allows HHS to provide exceptions to the reporting requirements for plans that “substantially meet the goals” of this provision. Required elements of a quality program:
  - Improve health outcomes through activities such as quality reporting, effective case management, care coordination, case management and medication and care compliance initiatives, including through the use of the medical home model.
  - Implement activities to prevent hospital readmissions through a hospital discharge program that includes patient-centered education and counseling, comprehensive discharge planning and post-discharge reinforcement by an appropriate health professional.
  - Implement activities to improve patient safety and reduce medical errors, through use of best clinical practices, evidence-based medicine and HIT.
  - Implement wellness and prevention programs, which may include the following:
    - Smoking cessation or weight management
    - Stress management
    - Physical fitness or nutrition
    - Heart disease or diabetes prevention
    - Healthy lifestyle support
- **NOTE:** This section does not require that plans report outcomes, only that they report that they support these quality-related activities. A separate section, PPACA §10329, directs HHS to develop a method to assess health plan value.
- **Study and Report.** Within 180 days of the promulgation of the HHS regulations, requires the GAO to review the regulations, and report to Congress on the impact of these activities on the quality and cost of health care (PPACA § 1001; PHSA § 2717).

Medical Loss Ratios

- **Loss Ratio Reporting.** Requires loss ratio reporting for plan years starting 6 months after enactment. Makes required reports available on the HHS website.
- **Rebates.** Requires rebates for MLRs below required levels starting in 2011. Sets MLRs of 80% in the individual and small group markets and 85% in the large group market. Permits states to set higher percentages. Allows HHS to set an MLR below 80% for the individual market in particular states if HHS determines that a higher level could “destabilize” the individual market in that state. Also allows HHS to adjust the individual market if appropriate on account of volatility due to the establishment of state Exchanges.
**MLR Calculation**
- Requires plans to calculate the ratio of total premium revenue (after accounting for risk adjustment, reinsurance and risk corridor payments) spent on:
  - “Reimbursement for clinical services” and costs for “activities that improve health care quality” to
  - All other non-claims costs, excluding federal and state taxes and licensing or regulatory fees.
- By 12/31/10, requires the NAIC (subject to certification by HHS) to establish uniform definitions of these terms and standardized methodologies for calculating MLRs, taking into account the special circumstances of smaller plans, different types of plans and newer plans.
- Bases calculations on 3 years of data starting in 2014.
- Applies to all insured plans (individual and group), including grandfathered plans (PPACA §§ 1001, 10101(f), 10103(d)(3); PHSA § 2718).

**Patient Protections**

- **PCPs.** Requires plans that require or provide for designation of a participating primary care provider (PCP) to permit individuals to select any participating PCP available to accept such individuals. Applies to all markets (but not to grandfathered plans). Effective for plan years starting 6 months after enactment (PPACA § 10101(h); PHSA § 2719A(a)).
- **Access to Pediatric Care.** Requires plans that require or provide for designation of a participating primary care provider (PCP) for a child to permit individuals to select any participating pediatrician. Applies to all markets (but not to grandfathered plans). Effective for plan years starting 6 months after enactment (PPACA § 10101(h); PHSA § 2719A(c)).
- **Emergency Care**
  - Requires plans to cover emergency services without prior authorization or regardless of whether the provider participates in the plan’s network.
  - Requires equivalent cost-sharing for network and non-network providers, and prohibits any limitations more restrictive than those imposed on services provided by network providers.
  - Uses a “prudent layperson” definition of emergency medical condition.
  - Applies to all markets (but not to grandfathered plans).
  - Effective for plan years starting 6 months after enactment (PPACA § 10101(h); PHSA § 2719A(b)).
- **Direct Access to OB/GYN.** Requires plans in all markets (but not grandfathered plans) to provide direct access to participating OB/GYNs. Effective for plan years starting 6 months after enactment (PPACA § 10101(h); PHSA § 2719A(d)).
Appeals

- **Internal Appeals**
  - Requires group plans to have in effect an internal claims and appeals process that initially incorporates the existing DOL claims and appeals procedures, updated as necessary with any standards established by DOL. Requires nongroup plans to have in effect an internal claims and appeals process that initially incorporates claims and appeals procedures under existing law, updated in accordance with any standards set by HHS for this market.
  - Provide notice to enrollees of available internal and external appeals processes, and the availability of any applicable office of health insurance consumer assistance or ombudsman to help enrollees with the appeals processes.
  - Allow enrollees to review their files, present evidence and testimony and receive continued coverage pending the appeals outcome.

- **External Reviews.** Requires all plans to:
  - Comply with state external review requirements that, at minimum, include the protections in the NAIC’s External Review Model Act; or
  - For states without an external review process that meets these requirements and for self-funded plans, implement an external review process that meets minimum standards established by HHS through guidance.

- Permits HHS to deem an external review process of a group plan or insurer in operation as of the date of enactment as
- Applies to insured plans in all markets and self-funded plans (but not to grandfathered plans).
- Effective for plan years starting 6 months after enactment (PPACA §§ 1001, 10101(g); PHSA § 2719).

Consumer Information

- Provides state grants to establish, expand or support offices of health insurance consumer assistance or health insurance ombudsman programs.
  - **Eligibility.** To be eligible for a grant, a state must designate an independent office of health insurance consumer assistance or an ombudsman that receives and responds to inquiries and complaints concerning health insurance coverage with respect to federal health insurance requirements and under state law.
  - **Duties.** Such office or ombudsman must: 1) help file complaints and appeals and provide information about the external appeal process; 2) collect, track and quantify problems and inquiries; 3) educate consumers on their rights and responsibilities; 4) help with enrollment in coverage by providing information, referral and assistance; and 5) resolve problems with obtaining premium tax credits.
  - **Data Collection and Secretarial Action.** Requires such office or ombudsman to collect and report data to HHS on the types of problems and inquiries they receive from consumers. Directs HHS to use such data to identify areas where more enforcement action is needed and to share the data with state insurance regulators and Labor and Treasury for their enforcement activities.
- **Funding.** Appropriates $30 million for the first fiscal year and “such sums as may be necessary” for subsequent years.
- **Effective Date.** Enactment. (PPACA § 1002; PHSA § 2793)

**Hospital Charge Data.** Requires all hospitals to disclose annually a list of its standard charges for items and services, including for Medicare DRGs. Effective 6 months after enactment (PPACA § 10101(f); PHSA § 2718(e)).

**Rate Review**

- Beginning with the 2010 plan year, requires HHS (in conjunction with states) to establish a process for review of unreasonable premium increases. Requires:
  - Insurers to submit a justification for increases prior to implementation and post such information on their websites.
  - State insurance commissioners to provide HHS with information about trends in premium increases in different rating areas and make recommendations as to whether issuers should be excluded from Exchange participation due to patterns of excessive or unjustified premium increases.
  - Starting with plan years beginning in 2014, requires HHS (in conjunction with states) to monitor premium increases both inside and outside of exchanges.
  - Direct states, in considering whether to allow large employers to purchase coverage through the Exchange (see PPACA § 1312(f)(2)(B)), to take into account any excess of premium growth outside of the Exchange as compared to premium growth inside the Exchange.
  - Provides $250 million in state grants during 2010-2014 to help states carry out this provision. Limits grants to individual states to no less than $1 million and no more than $5 million for a grant year.
  - Applies to all individual and group health insurance coverage. Effective for plan years beginning 6 months after enactment (PPACA § 1003; PHSA §2794).

- Establishes **Medical Reimbursement Data Centers** at academic or other nonprofit entities to collect medical reimbursement data from insurers, to organize and analyze such information and to make it available to insurers, providers, researchers, policymakers and the general public. Directs centers to:
  - Develop (and update) fee schedules and other database tools that reflect market rates for medical services and geographic differences in those rates.
  - Make health care cost information available to the public through an Internet website.
  - Publish information on methodologies used to analyze health charge data and make such data available to researchers and policymakers.
  - Specifically notes that insurers are not required to provide data to these Centers (PPACA § 10101(i)).
High Risk Pools

- Directs HHS to establish temporary, national high-risk pool program, within 90 days after enactment. Allows states or non-profit entities to be given responsibility to administer the program. Sunsets the program on 1/1/14, when the state Exchanges become effective.

- **Risk Pool Requirements.** Requires qualified high risk pools to:
  - Provide coverage to all eligible individuals without any preexisting condition restrictions.
  - Provide coverage for at least 65% of plan costs.
  - Limit OOP costs to those for HDHPs.
  - Require premiums to be set at 100% of standard rates, and allow premiums to vary only according to the adjusted community rating rules under this bill (PPACA § 1201; PHSA § 2701), except that rates can vary by age in a range of 4:1 (vs. 3:1 under PPACA § 2701).

- **Eligibility.** Defines eligible individuals as those without creditable coverage in past 6 months and who have a pre-existing condition as determined by HHS guidelines.

- **Anti-Dumping.** Requires HHS to establish criteria for determining whether insurers and group health plans have discouraged individuals from remaining enrolled in prior coverage based on health status. Requires issuers and employers who engage in such behavior to reimburse the program for such individuals who subsequently enroll in the program. Such determinations are to be based on criteria established by HHS and must include at least the following circumstances:
  - Offering of money or other financial considerations for disenrolling from prior coverage.
  - In cases where the premium for prior private coverage exceeds the premium under the new HHS program: 1) the prior coverage is a policy no longer being actively marketed by the insurer; or 2) the prior coverage is one for which duration or health status can be considered in determining renewal premiums.

- **Oversight.** Requires HHS to establish an appeals process to enable individuals to appeal determinations under this provision as well as procedures to protect against fraud and abuse.

- **Funding.** Appropriates $5 billion to pay claims and administrative costs of the high risk pool that are in excess of premiums collected. Allows HHS to stop taking applications for participation in the program to comply with this funding limit. Also provides for HHS to make “such adjustments as necessary” to eliminate any remaining deficit after such funds are spent.

- **Transition to Exchange.** Requires HHS to develop procedures to provide for the transition of program enrollees into plans offered through an Exchange, including allowing for an extension of coverage after the risk pool provision is terminated, if HHS deems this necessary to avoid a lapse in coverage.

- **Relation to State Law.** Supersedes existing state laws or regulations (other than state licensing laws or laws relating to plan solvency) with respect to qualified high risk pools established in accordance with this provision (PPACA § 1101).
Early Retiree Reinsurance

- Directs HHS to establish a temporary reinsurance program within 90 days of enactment to assist employment-based plans with the costs of providing health benefits to early retirees and their dependents. Sunsets the program on 1/1/14.
- **Eligible Employers.** Eligible retirees must be 55 or older, not Medicare-eligible and not active employees.
- **Eligible Coverage.** To participate in the program, employment-based health plans must:
  - Implement programs/procedures to generate cost-savings for individuals with chronic and high-cost conditions.
    - Implement programs/procedures to generate cost-savings for individuals with chronic and high-cost conditions.
    - Provide documentation of the actual cost of medical claims involved.
    - Submit an application and be certified by HHS.
- **Payments/Claims**
  - Reimburses 80% of claims between $15,000 and $90,000, subject to annual increases based on the medical care component of the CPI.
  - Plans must submit claims charges (including both plan share and enrollee cost-share). Requires claims to be based on the actual amount expended by the plan, taking into account negotiated price concessions (e.g., discounts, rebates, etc.).
- **Use of Payments.** Requires reinsurance payments be used to lower costs for the plan, including employer costs and retiree costs (e.g., premiums, cost-sharing). Payments cannot be sued as general revenues for employers. Direct HHS to monitor the use of such payments by employers.
- **Other.** Requires HHS to: 1) establish an appeals process to permit employment-based plans to appeal claims determinations; 2) establish procedures to protect against fraud and abuse; and 3) conduct annual audits of claims data.
- **Funding.** Appropriates $5 billion for this provision. Allows HHS to stop taking applications for participation in the program to comply with this funding limit (PPACA §§ 1102, 10102(a)).

Internet Portal

- Requires HHS (in consultation with states) to establish a mechanism (including an Internet website) through which individuals and small employers can identify affordable coverage options, effective by 7/1/10.
  - **Required Information.** Requires websites to provide information on at least the following coverage options (to the extent practicable): private insurance coverage; Medicaid and CHIP coverage; state high risk pool coverage; coverage under the new high risk pool program; and coverage within the small group market, including reinsurance for early retirees (PPACA § 1102) and small business tax credits (PPACA § 1421).
Standardized Formats. Directs HHS to develop a standardized format for presenting this information within 60 days of enactment. Requires such format to require information on MLRs, eligibility, availability, premiums and cost-sharing, and to be consistent with the standards adopted for uniform coverage explanations under PHSA § 2715. Permits HHS to contract out this requirement (PPACA §§ 1103(a), 10102(b)).

Children’s Pre-exclusions Period

- No pre-exclusion periods for individuals under age 19. Applies to all markets and grandfathered group health plans. Effective plan years beginning 6 months after date of enactment. (PPACA § 10103(e)(2)) (In a 3/29/10 letter, HHS announced its intent to issue regulations clarifying: (1) children with pre-existing conditions could not be denied access to their parent’s coverage; and (2) insurers would not be allowed to insure a child, but exclude coverage for the child’s pre-existing condition).

Conforming Amendments to PHSA, ERISA, and IRC

- Makes a number of conforming amendments throughout the PHSA to further consistency with new PPACA substantive provisions, and reorders and renumbers PHSA subparts and sections. Conforming amendments include applying mental health parity to the individual market, eliminating small group market guaranteed issue exceptions for lack of association membership or failure to meet contribution/participation requirements, and making small group market size 1-100. Also incorporates PHSA requirements into ERISA and IRC (PPACA § 1563).