Health Insurance Market Reforms Under PPACA:

The Future is Now

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Introduction

- PPACA created numerous market reforms affecting group health plans and health insurance issuers in the group and individual markets.
- Many of these new requirements are effective plan years beginning on or after September 23, 2010.
- The future is **NOW**!

Lifetime and Annual Limits

- Lifetime limits on dollar value of essential health benefits are prohibited.
- Until 2014, plans may impose a restricted annual limit on dollar value of "essential health benefits." Effective 1/1/2014, annual limits on dollar value of such benefits are prohibited.
- Annual or lifetime limits on non-essential health benefits are permitted if allowed under state or federal law.

Prohibition on Rescissions

- Individual and group health issuers may not rescind coverage of enrollee except for:
  - Fraud
  - Intentional misrepresentation
- Prior notice of cancellation required.
- Network plan rules still apply.
- HIPAA exceptions to guaranteed renewability still apply.

Coverage of Preventive Health Services

- Minimum coverage without cost-sharing required for:
  - Preventive services and immunizations recommended by US Preventive Services Task Force and CDC
  - Child preventive services recommended by Health Resources and Services Administration (HRSA)
  - Women's preventive care and screening recommended by HRSA

Extension of Dependent Coverage

- Plans that offer dependent coverage must continue to make dependent coverage available to dependents until age 26 – regardless of marital status.
- Coverage for dependents of adult dependents is not required.

No Discrimination in Favor of Highly Compensated Individuals

- Subjects insured group health plans to rules governing self-insured plans.
- Insured group health plans cannot establish eligibility rules for any full-time employee that are based on total hourly or annual salary of the employee or otherwise establish rules (including benefits) that discriminate in favor of higher wage employees.

Appeals Process

- Plans required to implement effective internal appeals process for coverage determinations and claims.
  - Follow DOL procedures if applicable
  - Otherwise, following state procedures until HHS establishes process
- Plans required to comply with State external review process.
- If no State external process or plan is self-funded, follow HHS-established process.
- Plans' existing external process may be adequate.

Patient Protections

- Enrollees allowed to select their PCP, or pediatrician for children, from among any available participating PCP.
- Prior authorization and increased cost-sharing on emergency services prohibited.
- Plans can't require authorization or referral for OB/GYN services by a participating specialist in these areas.

Temporary High Risk Pool Program

- Within 90 days of enactment, HHS to establish high risk pool program for eligible individuals:
  - US citizen, US national or person lawfully residing in US
  - Has not had creditable coverage during six month period prior to application to program
  - Has preexisting condition
- Program to be run by HHS or contracted non-profit entities.

Minimum Medical Loss Ratios

- Required medical loss ratio reporting for health insurance issuers (including grandfathered plans).
- Report must include premium amount spent on clinical services, activities to improve quality, and all other non-claims costs.
- NAIC to develop definitions and standardized methodologies for calculating measures.

Minimum Medical Loss Ratios (cont'd)

- Beginning 1/1/2011, annual enrollee rebates required by health insurance issuers for:
  - Large group plans that spend less than 85% of premium on clinical services and quality
  - Small group and individual plans that spend less than 80% of premium on clinical services and quality
- States may set higher percentages.

Minimum Medical Loss Ratios (cont'd)

- DOL, Treasury and HHS published request for comments, 75 Fed. Reg. 19297 (April 14, 2010):
  - Actual MLR Experience and Minimum MLR Standards
  - Uniform Definitions and Calculation Methodologies
  - Level of Aggregation
  - Data Submission and Public Reporting
  - Rebates

Other Premium Rate Restrictions

- Beginning with plan year 2010, HHS and States to establish annual premium increase review process.
  - Issuers to submit justification for "unreasonable" premium increase prior to implementation
  - Issuers to post this information on website
  - Increase can be basis for exclusion from Exchange

Grandfathered Plans

- Except for certain requirements, Title I Subtitles A and C don't apply to group health plans and health insurance coverage in which individual was enrolled on date of PPACA's enactment.
- New family members may be added.
- New employees and their families may be added.

Grandfathered Plans (cont'd)

- Requirements applicable to grandfathered plans
  - Medical loss ratio
  - Uniform coverage documents
  - Prohibition on excessive waiting periods
  - Prohibition on lifetime limits
  - Prohibition on rescissions
  - Adult child coverage

Grandfathered Plans (cont'd)

- Additional requirements applicable to group health plans only
  - Prohibition on annual limits
  - Prohibition on pre-existing condition exclusions
  - Adult child coverage but only if dependent is not eligible to enroll under an eligible employer-sponsored health plan (applies to plan years before January 1, 2014)

Focus on Access to Information

- Offices of health insurance consumer assistance or health insurance ombudsman programs.
- Uniform explanation of coverage documents and standardized definitions.
- Plan reporting requirements on benefits and provider reimbursement structures that improve quality.
- Availability of information on health options for individuals and small businesses.

Longer Term Market Reforms

- Establishment of permissible rating factors for individual and small group markets:
  - Family structure
  - Rating area
  - Age (limited to 3:1 for adults)
  - Tobacco use (limited to 1.5:1)
- Limitations also apply to large group issuers offering such coverage through Exchange.

Longer Term Market Reforms (cont'd)

- Guaranteed availability and renewability.
- Prohibition on preexisting condition exclusions and other forms of discrimination based on health status (no pre-ex on kids - effective 9/23/2010).
- Non-discrimination against providers acting within scope of license with respect to plan participation – but not an any willing provider requirement.

Longer Term Market Reforms (cont'd)

- Essential health benefits requirement for issuers in individual and small group markets.
- No group health plan waiting periods greater than 90 days.
- Coverage for participants in approved clinical trials.
- Uniform application of rating reforms.