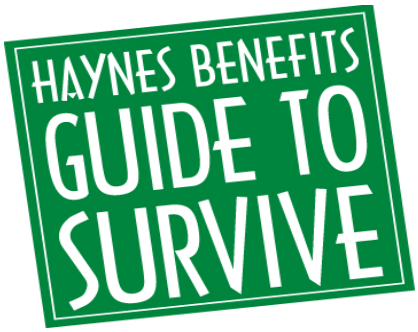

. . . Health Care Reform 2010

Week 1: Market and Access Provisions Apply Almost Immediately

President Obama recently signed the Patient Protection and Affordable Care Act (the "Act"), which mandates massive change for health and welfare plans. The effective dates for these changes are staggered between enactment and 2018. Benefits professionals will spend the next weeks, months and years deciphering and planning under the new structure. Due to the number of inconsistent and incomplete provisions in the Act, we can expect modifications through either legislation or regulation over that same time period.

To rebuff criticisms that the original timetable would not benefit individuals until 2014, the White House pushed to make certain provisions of the Act effective almost immediately. These changes primarily set forth new individual and group market reforms, and provisions to preserve and expand coverage.

This alert will discuss the provisions which have an almost immediate effective date for plan years beginning after September 23, 2010 (January 1, 2011 for calendar year plans), unless otherwise noted below.

The Act also follows through on the President's often repeated campaign promise that "if you like your coverage, you can keep it" by providing an exception to many (but not all) of the mandates for "grandfathered plans." We will fully discuss grandfathered plans in our third alert.

> *These email alerts provide a summary of the Act and our comments, which are written in italics. The provisions below apply to both group health plans and health insurers except where specifically noted.*

Preexisting condition exclusions. Plans may not impose any preexisting condition exclusion or limitation for enrollees that are under the age of 19.

> *HIPAA originally placed limits on preexisting condition exclusions. The Act places a prohibition on those exclusions, but the implementation was accelerated for individuals under age 19.*

High risk pools. To further ease the burden on those with preexisting conditions, the Secretary of Health and Human Services must create a temporary high risk pool to provide coverage for individuals with a preexisting condition that have not been covered under creditable coverage for the 6 month period before the date the individual is applying for coverage. The Secretary is to create this pool by June 21, 2010, and these provisions terminate on January 1, 2014.

Dumping of participants. To protect the high risk pools, the Act prohibits dumping of participants by discouraging enrollment based on health status. If a plan has dumped a high risk individual, that plan must reimburse the high risk pool for the cost of the medical expenses.

Lifetime limits. Plans may not impose lifetime limits on the dollar value of essential health benefits. Plans that are not required to provide essential health benefits under the Act may place lifetime limits on specific covered benefits.

Rescissions. Plans may not retroactively rescind coverage of a participant. However, a plan may prospectively cancel coverage if the individual engages in fraud or intentional misrepresentation of a material fact, pursuant to the terms of the plan.

> *Plans will not be able to invoke the fraud and misrepresentation provisions unless specifically spelled out in the plan documents, and plan sponsors therefore need to review and possibly amend their documents to allow cancellation.*

Preventive health services. Plans must provided coverage without any cost sharing requirements (first dollar coverage) for certain services, immunizations, preventive care screenings, women's health care and screenings, and well child care. The Secretary will determine the required interval, to be not less than one year.

Choice of provider. If a plan requires or provides designation of a participating primary care provider, the plan must permit each participant to designate any participating PCP who is available to accept the participant.

Emergency services. If a plan covers services for an emergency medical condition in the emergency department of a hospital, the plan must cover emergency services without a preauthorization requirement; regardless of whether the provider is a participating provider; without any requirements that are more restrictive for out of network providers than for in network providers; and with the same cost sharing requirements as for an in network provider.

Pediatric care. Plans that provide for the designation of a participating primary care provider for a child must permit the designation of a pediatrician who is in network. Plans may still exclude coverage and conditions of pediatric care.

Obstetrical and gynecological care. Plans may not require preauthorization or referral for female patients who seek coverage for obstetrical or gynecological care provided by a participating Ob/Gyn. Plans must also treat Ob/Gyn care and authorizations the same as PCP care and authorizations. The Act does not prohibit exclusions or limitations on obstetrical or gynecological care.

> *The provider, emergency services, pediatric care and Ob/Gyn provisions enhance the ability of participants to pick their own provider.*

Adult children to age 26. While the Act does not require coverage of dependents, plans that cover dependent children must provide that coverage until the age 26, even if such child is not a tax dependent. The Act does not require coverage of grandchildren.

Discrimination based on salary. The Act extends the nondiscrimination rules applicable to self funded plans to fully insured plans, which now may not discriminate in terms of eligibility based on compensation. Plans may provide for the payment of lower dollar or percentage contributions by lower paid workers.

Reinsurance for early retirees. By June 21, 2010, the Secretary must establish a temporary reinsurance program to reimburse employment-based plans for a portion of the cost of providing coverage to early retirees, their eligible spouses and dependents. Early retirees are individuals age 55 or older who are not eligible for Medicare and are not active employees of an employer maintaining an employment-based plan or contributing to such plan. Plans may apply to the Secretary to participate in the program.

> *Early retirees tend to be a very expensive sub-group for most plans. Many plan sponsors may take advantage of this reinsurance option.*

Uniform explanations and standardized definitions. By March 23, 2011, the Secretary must develop a uniform summary of benefits and coverage that can accurately describe the benefits and coverage under a plan. The standards must be in a uniform format that does not exceed 4 pages and uses at least 12 point font. The language must be written in a "culturally and linguistically appropriate manner" and utilize "terminology understandable to the average plan enrollee." The explanation must include uniform definitions, description of the coverage and cost sharing, exceptions and limitations, renewability and continuation provisions, examples of common benefit scenarios, and other required statements.

How are plans to fit all that into 4 pages?

The Secretary also is required to develop standards for the definitions of terms used in "health insurance coverage" and "insurance-related terms," such as deductible, coinsurance and copayment.

It is interesting to note that several of these provisions refer specifically to a policy or certificate, health insurance coverage, and insurance-related terms. While we do not think this was intended to exempt self funded plans from these requirements, the use of insurance terms opens the door for this argument.

The Act also requires notice of summaries of material modifications (SMMs) to participants at least 60 days prior to the effective date of the modification.

The Act provides a penalty for failure to provide these notices of $1000 per participant for each failure.

Appeals process. Plans must have an effective appeals process which, at a minimum: has an internal claims appeal process; provides notice to enrollees, in a culturally and linguistically appropriate manner, of available internal and external appeals processes; allows enrollees to review their files and provide evidence and testimony and to receive continued coverage pending the outcome of the appeals process; and provides an external review process that includes at least the consumer protections under the Uniform External Review Model Act promulgated by the NAIC.

Many self funded plans currently do not have an external appeal process. The new appeals rules will add significant new layers to most self funded plans current appeals process. The allowance for continuation of coverage will encourage participants to appeal claim denials.

Cost reporting and rebates. Health insurers must submit reports concerning the percentage of total premium revenue that such coverage expends on reimbursement for clinical services; for activities that improve health care quality; and on all other non-claim costs. The insurer must provide an annual rebate to each enrollee on a pro-rata basis to the extent by which the non-claims costs exceed 15% in the group market, and 20% in the individual market (or lower percentages as states may determine). These provisions terminate after 2013, when the exchanges begin.

These cost reporting and rebate rules may steer plans from fully insured to self funded arrangements. Sound fiduciary planning involves the need to properly

fund reserves. The Act presently leaves unaddressed whether reserves are deemed to be claims costs, but it would be impossible to meet the ratio standards if reserves are not included.

Premium review process. Beginning with the 2010 plan year, insurers will be subject to review of unreasonable increases in premiums for health insurance coverage. Insurers must submit justification for an unreasonable premium increase and post such information on the insurer's website. The federal government will provide grants to states to monitor increases through 2013, and the Secretary also will monitor thereafter.

The premium review process also may steer fully insured plans to self funding.

Transparency. Plans must provide transparency disclosures required of exchange plans, including the following: claims payment policies and data, periodic financial disclosures, enrollment and disenrollment data, number of denied claims, rating practices, cost sharing and payment data with respect to out of network providers, information on participant rights under the Act, and other information required by the Secretary. The data must be provided to the Secretary, applicable state department of insurance, and the public.

Affordable coverage options. By July 1, 2010, the Secretary must establish a mechanism, including a website, to allow individuals to identify affordable coverage options. These affordable coverage options shall include health insurance coverage, Medicaid, Medicare, and state high risk pools. The Secretary also must develop a standard format for presenting the information.

Reports. By March 23, 2011, the Secretary must issue three reports. First, the Secretary must issue an aggregate annual report on self funded plans, including number of participants, benefits offered and funding arrangements. Second, the Secretary must issue a report on the study of the large group market, including the extent to which self funded plans can offer less costly coverage, claim denial rates, and any potential conflicts of interest. Third, the Secretary must issue a report regarding the rate of denials of coverage and enrollment by group health plans and health insurance issuers.

Reporting the quality of care. By March 23, 2012, the Secretary shall develop reporting requirements for benefit and reimbursement structures that improve health outcomes through management and coordination of care and compliance initiatives; prevent hospital readmissions through discharge planning, patient education, and reinforcement; improve patient safety and reduce medical errors; and implement wellness and health promotion activities.

Electronic transaction standards. Plans must meet and certify compliance with certain electronic transaction standards. The Secretary is to develop operating rules. The effective dates of these standards vary according to the type of transaction. For example, the standards will have different effective dates for eligibility and health care payment and remittance.

Our next alert will address the new rules identified in the statute as health insurance market reforms.

April 20, 2010