Selected Insurance Provisions in the 2010 Health Care Reform Legislation

By James T. Nyeste

The health care reform legislation passed by Congress and signed by President Obama in March consists of "The Patient Protection and Affordable Care Act" (Pub. L. 111-148)[1], enacted March 23, 2010, and "The Health Care and Education Reconciliation Act of 2010" (Pub. L. 111-152)[2], enacted March 30, 2010. The two laws must be read together because the Reconciliation Act makes several amendments to the first law, including effective dates for certain provisions. This article focuses on the legislation's major changes to the private health plan and insurance system.

The biggest changes in private coverage made by the legislation will take effect in 2014 and include guaranteed issue and renewability of insurance; essential health benefit requirements; limitations on deductibles and other cost-sharing; the creation of health benefit exchanges to facilitate the purchase of coverage by individuals and small businesses; and the individual mandate to maintain coverage. Prior to 2014, numerous other changes take effect, in whole or in part.

In reading the legislation (and this summary), it is crucial to understand certain jargon. The term "health plan" means a "group health plan" as well as "health insurance coverage." A "group health plan" is an ERISA-governed employee welfare benefit plan that provides medical care. Most people with health care coverage have it through a health plan established by their employer and, thus, are part of a "group health plan." For purposes of the insurance reforms discussed below, "health plan" and "group health plan" do not include self-insured plans unless stated otherwise. The terms "health insurance coverage" and "health insurance issuer" refer to insurance (individual or group) and HMO coverage, whether or not issued in connection with an employer's ERISA plan. If you have an individual health insurance policy for you and your family, it is not governed by ERISA, but it is "health insurance coverage" within the legislation. Some of the insurance reforms under this legislation do not apply equally to all health plans; sometimes ERISA-governed group health plans are treated differently from health insurance coverage outside the ERISA context.

The following are some of the insurance provisions pertaining to health plans in the new legislation:

Existing plans are not affected by most changes. Existing health plans are grandfathered and are not subject to most of the insurance changes in the legislation, regardless of renewals occurring after enactment. Pub. L. 111-148, §1251(a)(2). Thus, unless noted otherwise, the provisions below do not apply to grandfathered plans.

No lifetime or annual limits on benefits: For plan years beginning on or after September 23,

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[1] The text of the Act and information as to Congressional actions, Congressional Budget Office cost estimates, and other matters relating to the legislation can be found at http://thomas.loc.gov/cgi-bin/bdquery/z?d111:HR03590:.
[2] See http://thomas.loc.gov/cgi-bin/bdquery/z?d111:HR04872:.

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2010, the legislation prohibits lifetime limits on benefits in all health plans, both new plans and grandfathered plans, both group health plans and health insurance coverage. With respect to plan years beginning on or after September 23, 2010 and prior to January 1, 2014, group health plans (both new and grandfathered) and health insurance coverage may only have annual limits that are "restricted" or reasonable, as determined by the Secretary of Health and Human Services, for "essential health benefits" (as defined in the legislation). For plan years beginning on or after January 1, 2014, group health plans (new and grandfathered) and health insurance coverage may not impose annual limits on benefits. However, all health plans may place annual or lifetime limits on specific covered benefits that are not essential health benefits to the extent that such limits are otherwise permitted by Federal or State Law. Pub. L. 111-148, §§ 1004(a), 10101(a); Pub. L. 111-152, §2301(a).

Prohibition on rescissions: The legislation prohibits rescission as to a covered individual unless that individual has performed an act or practice that constitutes fraud or makes an intentional misrepresentation of material fact as prohibited by the terms of the plan or coverage. The prohibition applies to all health plans, both new plans and grandfathered plans, and takes effect with plan years beginning on or after September 23, 2010. Pub. L. 111-148, §§ 1001, 1004(a); Pub. L. 111-152, §2301(a).

Coverage of preventive health services: For plan years beginning on or after September 23, 2010, all health plans must include coverage for certain preventive health services without any deductible, co-pay or co-insurance requirements. These include: immunizations recommended by the CDC; services rated A or B by the U.S. Preventive Services Task Force; and for women, infants, children, and adolescents such additional preventive care and screenings as provided for in guidelines supported by the Health Resources and Services Administration ("HRSA"). Pub. L. 111-148, §§ 1001, 1004(a).

Extension of dependent coverage to age 26: For plan years beginning on or after September 23, 2010, all health plans, both new and grandfathered, must extend coverage for dependent children until the child turns 26, subject to regulations to be promulgated by the Secretary of HHS further defining the dependents for whom coverage shall be extended. For grandfathered group health plans and plan years beginning before January 1, 2014, this extension for adult children applies only if the child is not eligible to enroll in other employer-sponsored coverage. Pub. L. 111-148, §§ 1001, 1004 (a); Pub. L. 111-152, §2301(a), (b).

Elimination of exclusions for pre-existing conditions: For plan years beginning on or after September 23, 2010, health plans cannot exclude coverage for pre-existing conditions in children under the age of 19. For plan years beginning on or after January 1, 2014, group health plans (new and grandfathered) and health insurance coverage cannot impose any pre-existing condition exclusion on anyone. Pub. L. 111-148, §§ 1201, 1253, 10103(d); Pub. L. 111-152, §2301(a).

Uniform explanation of coverage documents and standardized definitions: Within 12 months of enactment, the Secretary of Health and Human Services is to consult with the NAIC and develop standards for health plans to compile and provide to enrollees a summary of benefits and coverage, using uniform definitions of insurance and medical terms, and describing the coverage, cost-sharing provisions, exceptions and limitations on coverage, and continuation and renewability provisions. Not later than 24 months after enactment, all health plans (including

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self-insured plans) shall begin using these summaries of benefits and coverage, employing the standardized terms. Pub. L. 111-148, § 1001.

Portals for Comparative Information: Not later than July 1, 2010, the HHS Secretary shall establish a mechanism, including an internet website, through which a resident of any State may identity health insurance coverage options in that State. The information provided shall include, at a minimum, the percentage of premium revenue spent on non-clinical costs and information on eligibility, availability, premium rates, and cost-sharing and be consistent with the standards for the uniform explanation of coverage. Pub. L. 111-148, § 1103.

Public disclosure and justification of unreasonable premium increases: Beginning in 2010, the Secretary of HHS in conjunction with the States will establish a process for the annual review of premium increases in health insurance coverage. That process shall require health insurance issuers to submit a justification to the Secretary and relevant State for any unreasonable rate increase before implementation of the increase. Such increase and justification must be prominently and publicly disclosed on the Internet website of the health insurance issuer. Health insurance issuers with excessive or unjustified premium increases may not be allowed to participate in the new Health Benefit Exchanges that are to begin operation in 2014. Pub. L. 111-148, §§1003, 1311(e).

Insurance premium rebates: Beginning not later than January 1, 2011, health insurance issuers (including grandfathered health plans) must make annual premium rebates to enrollees if the percentage of revenue spent on health care, as opposed to administration, is less than 85% for coverage in the large group market (employment-based groups of more than 100 employees) and less than 80% for coverage in the small group and individual markets. Pub. L. 111-148, § 10101(f).

Appeals process: For plan years beginning on or after September 23, 2010, health plans must offer internal and *independent, external* appeal processes for coverage determinations and claims. Pub. L. 111-148, § 10101(g).

Temporary high risk insurance pool: The HHS Secretary is to establish a temporary national high risk insurance pool program to provide health care coverage to individuals with pre-existing conditions who have been uninsured for at least 6 months. The program is to go into effect in June, 2010 and is to expire January 1, 2014. Benefit coverage offered by the pools must be at least 65%; out-of-pocket costs may not exceed the applicable amount in Internal Revenue Code § 223(c)(2) (presently $5,950); premium rates must be based on age, may not vary by a factor greater than 4:1, and must be established at a standard rate for a standard population. The legislation appropriates $5 billion to subsidize the pools for claims and administrative costs that are in excess of the amounts premiums collected. There are sanctions to discourage health plans from dumping high risk individuals who already have coverage. The HHS Secretary is to develop procedures to transition persons covered by the temporary high risk pools into coverage with the Health Benefit Exchanges which are to become operational in 2014. Pub. L. 111-148, § 1101.

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<u>Changes effective in 2014 and after</u>:

Guaranteed availability and renewability of coverage: Each health insurance issuer that offers coverage in the individual or group market (large or small) in a State must accept every employer and individual in the State that applies for coverage and must renew or continue in force such coverage at the option of the plan sponsor or individual. Pub. L. 111-148, § 1201(4).

Fair health insurance premiums: Premiums in the individual and small group market (employer-based groups of up to 100 employees) may vary only by whether the coverage is for an individual or a family, by rating area, by age (subject to a 3:1 maximum ratio), and by tobacco use (subject to a maximum ratio of 1.5:1). Pub. L. 111-148, § 1201(4).

Prohibition on discrimination based on health status: A group health plan and a health insurance issuer may not establish rules for eligibility based on health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, disability, or any other health status-related factor determined by the HHS Secretary. Pub. L. 111-148, § 1201(4).

Qualified Health Benefit Plans: The legislation provides for a certification or stamp of approval for health plans meeting certain conditions. The legislation does not require that every non-grandfathered health plan meet these conditions, but the availability of various credits and subsidies turns on certification. Pub. L. 111-148, §§ 1301, 1302, 1303.

1. **Certification:** A "certified" or "qualified" health benefit plan is one that provides a certain essential health benefits package and is offered by a health insurance issuer that offers Silver and Gold level plans in the State Health Benefit Exchange and that agrees to charge the same premium whether the plan is offered through an Exchange or outside the Exchange. A qualified plan may also be offered by a non-insurer Co-Op, and it may be a Multi-State plan.

2. **Essential health benefits requirement:** A qualified plan for individual or small group coverage must include an essential health benefits package regardless whether the coverage is offered in a Health Benefit Exchange or outside the Exchanges. That package shall be defined by the HHS Secretary and include at least:

    a. ambulatory patient services
    b. emergency services
    c. hospitalization
    d. maternity and newborn care
    e. mental health and substance abuse disorder services
    f. prescription drugs
    g. rehabilitative services and devices
    h. laboratory services
    i. preventive and wellness services
    j. pediatric oral and vision care

    To meet the essential health benefits requirement, the qualified plan must also meet the cost-sharing limitations and level of coverage requirement (as below).

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3. **Cost-sharing:** Beginning January 1, 2014, cost-sharing under a health plan (whether or not it is a qualified plan) may not exceed the applicable amount in Internal Revenue Code § 223(c)(2) in 2014 (presently $5,950 for single coverage and $11,900 for family coverage). In following years, the limitation on cost-sharing is indexed to the rate of average premium growth.

   Additionally, for plans in the small group market, deductibles are limited to $2,000 individual/$4,000 family, indexed to average premium growth. This amount may be increased by the maximum amount of reimbursement available to an employee under a flexible spending arrangement.

4. **Levels of coverage (Bronze, Silver, Gold, and Platinum)**: The levels of coverage applicable to qualified plans are defined as follows:

   Bronze – Must provide coverage that provides benefits that are actuarially equivalent to 60% of the full actuarial value of benefits under the plan.
   Silver – 70%
   Gold – 80%
   Platinum – 90%

5. **Catastrophe plan (exception to the "level of coverage" requirement for qualified plans):** Individuals under 30 years of age or those exempt from the individual mandate because no affordable plan is available to them or because of a hardship may purchase a catastrophic plan providing the essential benefits package with a deductible equal to the total limitation on cost-sharing above and first-dollar coverage of at least three primary care visits.

6. **Child-only plans:** Qualified plans offered through an Exchange must also be available as a plan available only to individuals under the age of 21.

7. **Special rules relating to abortion:** A state may prohibit qualified plans offered through an Exchange from covering abortions.

   A qualified plan is not required to cover abortion services as part of the essential benefits package. If a plan covers elective abortion services, it may not use any funds attributable to federal subsidies provided through the Exchange to pay for them and must collect a separate payment from enrollees for the actuarial value of those services. State insurance commissioners shall insure that health plans segregate funds for abortion services.

Health Benefit Exchanges: The Exchanges are the "big idea" or centerpiece of the insurance provisions in the legislation. The idea is to facilitate the purchase of health insurance by individuals and small businesses. Government credits and subsidies will be provided to individuals and families of limited means. Small employers will get the benefit of pooling together their employees to spread the risk over larger groups and lower the cost of insurance. Many small employers will also receive tax credits to help cover the cost of coverage. Pub. L. 111-148, §§ 1311, 10104.

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1. **HHS grants to States:** Grants will be made available to States in amounts to be specified by the Secretary of HHS for planning and activities related to establishing an Exchange. Grants may be renewed if the State is making progress in establishing an Exchange and the market reforms. Exchanges must be self-sustaining beginning in 2015, and may generate revenue through assessments, user fees, or other means.

2. **Individual and SHOP Exchanges**: Each state must establish, as a governmental agency or nonprofit entity, an exchange for individuals and an exchange for Small Business Health Options Programs ("SHOP" exchange), or it may provide a single exchange to service both individuals and small employers. States may jointly form regional exchanges or may form multiple subsidiary exchanges if each one serves a distinct geographic area.

3. **Exchange functions**: Exchanges may only sell plans that are Qualified Health Benefit Plans, except for stand-alone dental plans meeting certain conditions. A State may require that plans provide additional benefits if the State defrays the additional cost of these benefits. Exchanges must provide for an initial open enrollment period, annual open enrollment periods after the initial period, special enrollment periods under circumstances similar to those for Medicare Part D plans, and special enrollment periods for Native Americans.

   An Exchange must also, at a minimum:

   - Certify, recertify, and decertify qualified plans consistent with guidelines developed by the Secretary of HHS
   - Require health plans seeking certification to submit to the Exchange, the HHS Secretary, and the public, accurate and timely disclosure of the following information:
     - Claims payment policies and practices
     - Periodic financial disclosures
     - Data on enrollment
     - Data on disenrollment
     - Data on the number of claims that are denied
     - Data on rating practices
     - Information of cost-sharing and payments with respect to any out-of-network coverage
     - Information on enrollee rights
     - Other information specified by the Secretary
   - Require health plans seeking certification to permit individuals to learn the cost-sharing under their plan for furnishing a specific item or service by a participating provider upon request through a website
   - Operate a toll-free consumer assistance hotline
   - Maintain a website to provide standardized comparative information on qualified plans
   - Assign a rating based upon relative quality and price to each qualified plan
   - Use a standardized format for presenting coverage options under the Exchange, including use of the uniform outline of coverage

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- Inform individuals of eligibility requirements for the State's Medicaid program, CHIP program and any applicable state or local public program and screen and enroll eligible individuals in these programs
- Certify exemptions from the individual mandate
- Transfer information to the Secretary of Treasury on exemptions from the individual mandate, as well as on employees receiving subsidies through the Exchange because the employer failed to provide sufficient affordable coverage.
- Provide information to employers on employees who cease coverage in a qualified plan
- Establish a Navigator program under which the Navigators will:
    - Conduct public education activities
    - Distribute information concerning enrollment in plans and subsidy availability
    - Facilitate enrollment in plans
    - Provide referrals to health insurance consumer assistance offices or ombudsmen to enrollees with grievances, complaints or questions
    - Entities eligible to become Navigators include:
        - Trade, industry, and professional associations
        - Commercial fishing industry organizations
        - Community and consumer-focused nonprofit entities
        - Chambers of commerce
        - Unions
        - Resource partners of the Small Business Administration
        - Licensed insurance producers
        - Other entities that are not insurers and do not receive any direct or indirect compensation from insurers in connection with plan enrollments or disenrollments.

Eligibility and consumer choice: Only citizens and lawful residents may purchase coverage through the Exchange. Incarcerated individuals may not enroll through the Exchange. Individuals enrolling in the Exchange may choose any plan for which they are eligible. Small employers may offer one or more small group plans to employees through the Exchange. They may specify a level of coverage for which they will provide support, and employees may choose any plan that offers coverage at that level. Nothing prohibits eligible individuals and employers from purchasing coverage outside the Exchange. No individual or employer shall be compelled to purchase coverage through the Exchange. However, members of Congress and their personal staff will no longer be eligible for the Federal Employees Health Benefit Plan and must purchase coverage through the Exchanges in order to receive coverage through the federal government. Nothing prohibits an insurer from offering insurance outside of the Exchange. However, insurers must consider all enrollees in all non-grandfathered plans in the individual and small group markets, respectively, to be members of the same risk pools, whether they purchase coverage through the Exchange or outside the Exchange. States may require the individual and small group markets to be merged, but may not require that grandfathered plans be pooled together with non-grandfathered plans. Beginning in 2017, states may allow insurers to offer large group plans through the Exchange. Pub. L. 111-148, § 1312.

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State failure to establish Exchange or implement requirements: If a State fails to have an operational Exchange by January 1, 2014 or has not taken the actions the HHS Secretary determines are necessary, the Secretary shall establish and operate the Exchange within the State. Pub. L. 111-148, § 1321(c).

Nonprofit, member-run health insurers: The legislation also establishes the Consumer Operated and Oriented Plan ("Co-Op") program to foster the creation of qualified nonprofit health insurance issuers to offer Qualified Health Plans in the individual and small group markets. To be eligible to receive loans and grants from the HHS Secretary, an organization must not be an existing health insurer or sponsored by a state or local government; substantially all of its activities must consist of the issuance of Qualified Health Benefit Plans in each State in which it is licensed; governance of the organization must be subject to a majority vote of its members and must avoid insurance industry involvement and interference; and any profits must be used to lower premiums, improve benefits, or improve the quality of health care delivered to its members. Pub. L. 111-148, §§ 1322, 10104(l).

Basic health plan option: States are given the option to create a Basic Health Plan for uninsured individuals with incomes between 133-200% of the federal poverty level (FPL) who would otherwise be eligible to receive premium subsidies in the Exchange. States opting to provide this coverage will contract with one or more standard plans to provide at least the essential health benefits of an Exchange plan and must ensure that eligible individuals do not pay more in premiums than they would have paid in the Exchange and that the cost-sharing requirements do not exceed those of the Platinum plan for enrollees with income less than 150% FPL or the Gold plan for all other enrollees. States will receive 95% of the funds that would have been paid as federal premium and cost-sharing subsidies for eligible individuals to establish the Basic Health Plan. Individuals with incomes between 133-200% FPL in States creating Basic Health Plans will not be eligible for subsidies in the Exchanges. Pub. L. 111-148, §§ 1331, 10104(o).

Individual mandate: The legislation will require most U.S. citizens and legal residents to have health coverage beginning January 1, 2014. The required coverage can include grandfathered coverage. Those without coverage must pay a tax penalty of the greater of $695 per year up to a maximum of three times that amount ($2,085) per family or 2.5% of household income. The penalty will be phased-in according to the following schedule: $95 in 2014, $325 in 2015, and $695 in 2016 for the flat fee, or 1.0% of taxable income in 2014, 2.0% of taxable income in 2015, and 2.5% of taxable income in 2016. Beginning after 2016, the penalty will be increased annually by the cost-of-living adjustment. Exemptions will be granted for financial hardship, religious objections, American Indians, those without coverage for less than three months, undocumented immigrants, incarcerated individuals, those for whom the lowest cost plan option exceeds 8% of an individual's income, and those with incomes below the tax filing threshold (in 2009 the threshold for taxpayers under age 65 was $9,350 for singles and $18,700 for couples). Pub. L. 111-148, §§ 1501(b), 10106(b); Pub. L. 111-152, § 1002.

Premium credits and cost-sharing subsidies: To enable lower income individuals and families to fulfill the mandate to maintain health coverage, the legislation provides for advanceable and refundable premium tax credits and cost-sharing subsidies on a declining sliding scale for household income from 133-400% FPL (for a family of four, 400% of the FPL is presently

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$88,200). Employees who are offered coverage by an employer are not eligible for premium credits unless the employer plan does not have an actuarial value of at least 60% or if the employee's share of the premium exceeds 9.5% of income. The Secretary of HHS must establish a program for the advance determination of income eligibility for individuals applying for credits and subsidies through Exchanges. The Secretary of HHS will notify the Exchange and the Secretary of Treasury, and the Secretary of Treasury will make the necessary payments to the insurer, who must reduce the individual's premiums and cost-sharing. States may provide subsidies in addition to the federal subsidies. Pub. L. 111-148, §§ 1401, 1402, 1412.

Small business tax credits: To encourage small employers with fewer than 25 employees to offer health insurance to their employees and to contribute to the costs, the legislation provides for tax credits of up to 35% of the employer's contribution in tax years 2010 through 2013 and up to 50% for tax years 2014 and later. Pub. L. 111-148, §§ 1421, 10105(e).

Employer penalties: Currently, employers are not obligated to offer health benefits to their employees, and the new legislation does not impose any such requirement. However, beginning in 2014, employers with 50 or more employees that do not offer coverage and have at least one full-time employee who receives a premium tax credit will be assessed a fee of $2,000 per full-time employee, excluding the first 30 employees. Employers with more than 50 employees that do offer coverage but still have at least one full-time employee receiving a premium tax credit will pay the lesser of $3,000 for each employee receiving a premium credit or $2,000 for each full-time employee, excluding the first 30 employees.

Employers that offer coverage to their employees are required to provide vouchers to employees with incomes less than 400% FPL whose share of the premium exceeds 8% but is less than 9.8% of their income and who choose to enroll in a plan in the Exchange rather than in the employer's plan. The voucher amount is equal to what the employer would have paid to provide coverage to the employee under the employer's plan and will be used to offset the premium costs for the plan in which the employee is enrolled. Employers will pay the voucher amount to the Exchange. Employers providing vouchers will not be subject to the penalties assessed in connection with employees who receive premium credits in the Exchange. Pub. L. 111-148, § 1513.

Tax changes to increase revenue: The legislation includes many tax provisions related to health insurance or to finance health care reform. They are far too numerous and detailed to summarize here.

Re-cap: The 2010 health care reform legislation makes substantial changes to the private health plan and insurance system, especially to the individual and small group markets, but existing health plans are grandfathered in most respects. There are important changes for new plans taking effect in 2010 through 2013 (and some of these affect grandfathered plans on renewals), but the biggest changes will occur in 2014.

Beginning in 2014, the legislation requires most U.S. citizens and legal residents to have health insurance or pay a tax penalty. The legislation creates State-based benefit Exchanges through which individuals and small employers can purchase coverage, with premium and cost-sharing credits and subsidies available to individuals and families with income between 133-400% of the federal poverty level. To encourage employers to offer affordable qualified health plans to their

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employees, certain small employers (< 25 employees) are given tax credits, and large employers (≥ 50 employees) are assessed penalties if any of their employees receive premium tax credits. Further, the legislation imposes new regulations on health plans in the Exchanges and in the individual and small group markets, including guaranteed issue and renewability, fair premiums, restrictions on cost-sharing, the elimination of lifetime and annual coverage limits, prohibitions on rescission, required coverage of preventive health services, dependent coverage to age 26, elimination of exclusions for pre-existing conditions, and a prohibition on discrimination based on health status. Some of these changes also apply to the large group market and some to grandfathered plans as well.

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