Compliance Advisory:

MEADE & ROACH LLP

Health Care Reform Impact During the First Year of Enactment

March 2010

Impact for Group Health Plans and Health Insurers

PART I

The President enacted into law the Patient Protection and Affordable Care Act, H.R. 3590 (the "Act") on March 23, 2010. The Health Care and Education Reconciliation Act of 2010, H.R. 4872 (the "Reconciliation Act") was passed by the U.S. House of Representatives on March 25, 2010 and amends the Act. As of this writing, the Reconciliation Bill is due to be enacted by the President on March 30, 2010. The purpose of this Client Advisory is to describe those sections of the Act that will directly impact group health plans (GHPs) and health insurers during Calendar Year 2010. With the exception of Section 1003 of the Act, these provisions go into effect 6 months after the Act's enactment date (January 1, 2011 for calendar year plans). Section 1003 of the Act entitled "Ensuring That Consumer Get Value for Their Dollars is effective for plan year 2010.

> "It will be up to every GHP and health insurer to take immediate steps to insure compliance with the Act. In addition to the establishment of new policies and procedures, each health insurer and GHP will need to start assessing its capabilities to make the new additional financial reporting requirements."

Because of the scope of these provisions, we have divided the Client Advisory into two parts.

Part I will cover sections relating to: Ensuring that Consumers Get Value for Their Dollars; No Lifetime or Annual Limits; Prohibition on Recessions; Coverage of Preventive Health Services, Extension of Dependent Coverage; Prohibition of Discrimination Based On Salary; Bringing Down the Cost of Health Care Coverage; Appeals Process; and Immediate Access to Insurance For Uninsured Individuals With A Preexisting Condition.

Part II will address the following provisions: Development and Utilization of Uniform Explanation of Coverage Documents and Standardized Definitions; Ensuring the Quality of Care; Health Insurance Consumer Information; Reinsurance for Early Retirees; Immediate Information That Allows Consumer to Identify Affordable Coverage Options; and Administrative Simplification. Part II will also address the "Medicare Donut Hole" provision as well as the Tax Credit for Small Business.

Sec 1003 ENSURING THAT CONSUMERS GET VALUE FOR THEIR DOLLARS (Effective Federal Fiscal Year 2010)

Beginning with federal fiscal year 2010, HHS, in conjunction with each State's department of insurance ("DOI") must establish a process for the annual review of increases in premiums for health insurance coverage to detect unreasonable increases in premiums.

Step I: Grants Awarded To States for Purposes of Determining Unreasonable Premium Increases

The Government will appropriate $250,000,000 for the purpose of awarding grants to States to assist it in reviewing, approving, and monitoring the reasonableness of premium increases for health insurance coverage. HHS will award grants to States during the 5-year period beginning with fiscal year 2010.

As a condition of receiving a grant, each State, through its DOI must provide HHS with information about trends in premium increases in health insurance coverage in the State's premium rating areas. Later, when health care benefit exchanges (the "Exchanges") are created, each State's DOI will also be required to make recommendations whether particular health insurance issuers should be excluded from participation in the Exchange due to excessive or unjustified premium increases.

Step II. Insurers will be required to justify rate increases to HHS and the State

Beginning with plan year 2010, health insurers will be required to submit a justification for an unreasonable premium increase prior to the implementation of an increase. The determination of what is an unreasonable increase is not set forth in the statute. Health insurers include those participating in the individual and/or group markets.

In addition, health insurers will be required to prominently post the justification for any unreasonable premium increases "considered" unreasonable on their Internet websites.

Comment: There appears to be confusion as to the implementation of Section 1003. Some commentators have suggested that the obligation of the federal and state governments to establish a rate review process must start immediately because the Federal fiscal year began October 1, 2009. In addition, other commentators have stated that the actual rate review process for the 2010 Plan Year will begin on October 1, 2010. Once we have clarification on this issue, we will update our report.

Sec. 2711. NO LIFETIME OR ANNUAL LIMITS (Effective 6 months after enactment)

A GHP and a health insurance issuer offering group or individual health insurance coverage may not establish with respect to "Essential Benefits"--

1. lifetime limits on the dollar value of benefits for any participant or beneficiary; or

2. unreasonable annual limits on the dollar value of benefits for any participant or beneficiary based on limits set forth for deductions for health savings accounts.

Until HHS further defines the term "Essential Benefits," such benefits must include: (A) ambulatory patient services; (B) emergency services; (C) hospitalization; (D) maternity and newborn care; (E) mental health and substance use disorder services, including behavioral health treatment; (F) prescription drugs; (G) rehabilitative and habilitative services and devices; (H) laboratory services; (I) preventive and wellness services and chronic disease management; and (J) pediatric services, including oral and vision care.

However, the prohibition on setting limits does not appear to apply to "excepted benefits" offered by a GHP to the extent that such limits are otherwise permitted under federal or state law.

Comment: It appears a GHP can establish lifetime or annual limits on what are known as "excepted benefits." Certain benefits are excepted in all circumstances: accident only (including AD&D); disability insurance; liability insurance; liability supplement policies; workers' compensation; auto medical payment coverage; credit only; and coverage for on-site medical clinics. However, some benefits are only excepted in certain instances (such as limited scope dental, limited scope vision, long-term care benefits and benefits provided under a health flexible spending arrangement).

Sec. 2712 PROHIBITION ON RESCISSIONS (Effective 6 months after enactment)

Recessions will no longer be permitted, except in those instances in which a covered individual has performed a fraudulent act or has made an intentional misrepresentation of material fact. However, it appears that the terms of the plan or coverage must specify actions that are deemed to result in recession. In addition cancellation of a policy may not take place without prior notice to the enrollee under procedures for appeals discussed below.

Comment: Many state insurance codes already limit recission to occur only in the event of an individual's misrepresentation or fraud with respect to an application for coverage. It is unknown on what basis a health insurer will be able to rescind a policy once the Act's prohibitions on denials on the basis of preexisting conditions go into effect. For example, presumably health insurers will still be undertaking underwriting activities. Will a health insurer still have the ability to rescind a policy on the basis of an individual's intentional failure to advise of a preexisting illness on an application to the extent it effects the health insurer's underwriting of such individuals?

Sec. 2713 COVERAGE OF PREVENTIVE HEALTH SERVICES (Effective 6 months after enactment).

Preventive health services must be provided at no cost to the covered individual, including any cost sharing requirements. Preventative health services include:

1. Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force. With respect to women, additional preventive care and screenings must be provided to the extent they are included in comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA"). In addition, the current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention will be considered the most current other than those issued in or around November 2009.

2. Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved.

3. With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the HRSA.

In the event new guidelines or recommendations are established, HHS must establish a minimum time frame before applying any new requirements. However, the minimum time frame must be less than one year.

Sec. 2714. EXTENSION OF DEPENDENT COVERAGE (Effective 6 months after enactment)

To the extent that dependent coverage is provided, dependent coverage of children must be made available for an adult child until the child turns 26 years of age. However, coverage is not required to be made available for a child of a child receiving dependent

coverage. The Reconciliation Act removed the exclusion of married dependents from the Act.

The Reconciliation Act also requires grandfathered GHPs to eliminate pre-existing condition exclusions for children within six months of enactment.

Comment: The Act has left it up to HHS to define the term "dependent." Thus, it is unclear whether HHS will broaden the definition of "dependent" to include domestic partners or same sex spouses if included in the Plan's definition of "dependent."

Sec. 2716 PROHIBITION OF DISCRIMINATION BASED ON SALARY (Effective 6 months after enactment)

Rules basing eligibility for any full-time employee under the terms of the plan may not be based on the total hourly or annual salary of the employee or any other rules that have the effect of discriminating in favor of higher wage employees.

However, the law does not prohibit a plan sponsor from establishing contribution requirements for enrollment in the plan or coverage that provide for the payment by employees with lower hourly or annual compensation of a lower dollar or percentage contribution than the payment required of similarly situated employees with a higher hourly or annual compensation.

SEC. 2718. BRINGING DOWN THE COST OF HEALTH CARE COVERAGE (Effective 6 months after enactment)

Starting with plan years beginning in 2010, a health insurance issuer offering group or individual health insurance coverage will be required to report to HHS each plan year's percentage of total premium revenue that such coverage expends--

1. on reimbursement for clinical services provided to enrollees under such coverage ("clinical costs");

2. for activities that improve health care quality ("health care quality costs"); and

3. on all other non-claims costs, including an explanation of the nature of such costs, and excluding state taxes and licensing or regulatory fees ("administrative costs").

Under the Act clinical costs and health care quality costs are included in "medical costs" The Act requires that health insurance issuers pay to enrollees on a pro rata basis a rebate in the amount that premium revenue exceeds 25% of administrative costs for GHPs and 20% of administrative costs for individual coverage. (Beginning January 1, 2011).

HHS will publish on its Internet website health insurers' financial reports of clinical, health care quality and administrative costs.

SEC. 2719. APPEALS PROCESS (Effective 6 months after enactment)

Many GHPs and health insurers have already established appeals processes for denial of coverage. However, health insurers must now include in its appeals procedures for coverage determination and claims the following:

1. an internal claims appeal process;

2. notices to enrollees, in a culturally and linguistically appropriate manner, of available internal and external appeals processes and the availability of any applicable State DOI's office of health insurance consumer assistance or ombudsman program to assist such enrollees with the appeals processes;

3. an opportunity for an enrollee to review their file, to present evidence and testimony as part of the appeals process, and to receive continued coverage pending the outcome of the appeals process; and

4. an external review process that, at a minimum, includes the consumer protections set forth in the Uniform External Review Model Act promulgated by the National Association of Insurance Commissioners.

SEC. 1101. IMMEDIATE ACCESS TO INSURANCE FOR UNINSURED INDIVIDUALS WITH A PREEXISTING CONDITION (Effective 90 days after enactment)

Appropriation and Transition

Congress has appropriated $5 billion to pay claims against (and the administrative costs of) a high risk pool. If HHS estimates for any fiscal year that the aggregate amounts available for the payment of the expenses of the high risk pool will be less than the actual amount of such expenses, then the Secretary shall make such adjustments as are necessary to eliminate that deficit.

By June 25, 2010, HHS must establish a temporary high risk health insurance pool program to provide health insurance coverage for eligible individuals until January 1, 2014.

Thereafter, HHS must develop procedures to transition eligible individuals enrolled in health insurance coverage offered through a high risk pool established under State Insurance Exchanges and must ensure that there is no lapse in coverage with respect to the individual.

Who is eligible for the high risk pool?

"Eligible individuals" must:

1. be a citizen or national of the United States or lawfully present in the United States;

2. not have had coverage in an employer group health (or certain

other GHPs) plan for a period of 6 months and 63 days:

3. have a pre-existing condition that will be defined by guidance issued by HHS.

Who may administer the risk pool?

"Eligible entities" are entities that:

1. are a State agency or nonprofit private entity?

2. submit an application to HHS in a manner to be determine by HHS; and

3. agree to utilize contract funding for the establishment and administration of a high risk pool.

In addition, an eligible entity must be in a state that agrees not to reduce the annual amount the state expends for the operation of its state high risk pools during the year preceding the year in which the eligible entity enters into a contract with HHS to administer the risk pool.

High Risk Pools Eligibility and Coverage Requirements

High risk pools:

1. may not impose any preexisting condition exclusion with respect to such coverage;

2. (i) must provide coverage in which the issuers share of costs is not less than 65 percent of such costs; and (ii) that has an out of pocket limit not greater than those established for health savings accounts for the year involved,

The Secretary has the flexibility to modify such limit if necessary to ensure the pool meets the actuarial value limit required under the Act.

The requirements for premium rates are set forth in Section 2701 of the Public Health Service Act. However, rates may vary on the basis of age by a factor of not greater than a ratio of 4 to 1. Rates must also reflect a standard rate for a standard population.

Protection Against Dumping Risk by Insurers

Based on criteria to be developed by HHS, health insurers and GHPs will be required to reimburse individuals in the event it is determined such individuals have been discouraged from remaining enrolled in prior coverage by the insurer or GHP based on that individual's health status.

An issuer or employment-based health plan will be required to reimburse an individual's medical expenses if HHS has determined the individual was encouraged by the issuer or GHP to disenroll from health benefits coverage prior to enrolling in coverage through the high risk pool. The criteria shall include at least the following circumstances:

1. In the case of prior coverage obtained through an employer, any financial consideration for disenrolling from the coverage provided by the health insurer, the employer or GHP.

2. In the case of prior coverage obtained directly from an issuer or under an employment-based health plan--(i) the provision by the issuer or plan of money or other financial consideration for disenrolling from the coverage; or (ii) in the case of an individual whose premium for the prior coverage exceeded the premium required by the program (adjusted based on the age factors applied to the prior coverage)--(a) the prior coverage is a policy that is no longer being actively marketed (as defined by the Secretary) by the issuer, or (b) the prior coverage is a policy for which duration of coverage from issue or health status are factors that can be considered in determining premiums at renewal.

NEXT STEPS:

It will be up to every GHP and health insurer to take immediate steps to insure compliance with the Act. In addition to the establishment of new policies and procedures, each health insurer and GHP will need to start assessing its capabilities to make the new additional financial reporting requirements. Health insurers will also have to re-evaluate administrative costs in light of the establishment of rebates for enrollees. Significantly, information systems will need to be evaluated and updated to reflect the changes in benefits and claims administration required by the Act.

We plan to follow up shortly with Part II of our series on the immediate impact of health care reform on GHPs and health insurers.

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