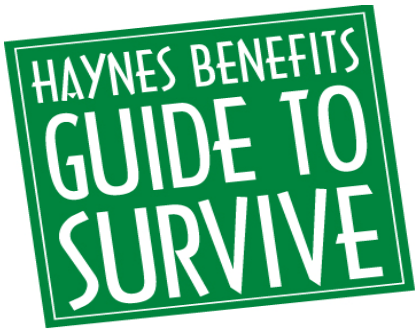

. . . Health Care Reform 2010

Week 2: Health Insurance Market Reforms

Our second alert will discuss the so-called health insurance market reforms in the Patient Protection and Affordable Care Act (the "Act"), which mandates massive change for health and welfare plans. These reform provisions add additional mandated benefits and directly address premiums, availability and renewability.

> *The title of this email alert mirrors the title of this section of the Act. The title is misleading. While the title refers to "health insurance market reforms," the statute in some cases is directed at insurers, but in other cases is applicable to both health insurance issuers and group health plans. To add to the complexity, some insurer rules are further limited by the markets in which the carrier offers products.*

These reform provisions generally are effective for plan years beginning on or after January 1, 2014. In other words, these provisions are effective contemporaneously with initial implementation of the exchange rules.

Again, the Act contains 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.*

Preexisting conditions. Plans may not impose any preexisting condition exclusion or limitation for enrollees.

> *The individual and group market provisions discussed in week 1 only applied to those under the age of 19. In 2014, preexisting conditions will be history.*

Annual limits. Plans may not impose "unreasonable annual 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.

The individual and group market reforms discussed in week 1 limited the initial prohibition to lifetime limits. In 2014, both lifetime and annual limits will be prohibited.

Clinical trials. Plans may not deny participation to, impose additional conditions on, or discriminate against an individual who participates in approved clinical trials. Likewise, plans may not deny participation or impose additional requirements on routine care in clinical trials, and may not discriminate against an individual's participation in such trials.

The term "approved clinical trial" includes Phases I through IV clinical trials that are conducted in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition, or other federally funded trials. The term "routine care" refers to services and expenses typically covered for an individual who is not enrolled in a clinical trial, and excludes investigational services, data collection and analysis, and services clearly inconsistent with established standards of care.

The new clinical trial rules expand the requirements for fully insured plans in some states that already have mandated benefits for clinical trials. The new rules will greatly expand the coverage of these trials and experimental procedures for many self funded plans not currently subject to the state mandates.

Discrimination based on health status. Plans may not establish rules for eligibility or continued eligibility based on health status related factors. The health status related factors list draws from similar provisions in the current HIPAA nondiscrimination rules.

Wellness. The nondiscrimination rules directly address wellness plans, but the Act does not vary much from the current wellness regulations. The major difference is that the maximum reward based on achieving a health standard is increased from 20% to 30% of the cost of employee (and participating dependent) coverage under the plan. The Secretaries of Labor, HHS and Treasury may increase the reward to 50% if they deem appropriate. The Act also requires the Secretary to establish a wellness demonstration project.

The increased rewards should increase implementation of wellness programs by plan sponsors, and participation by employees and dependents.

Excessive waiting periods. Plans shall not apply any waiting period that exceeds 90 days.

Provider discrimination. Plans may not discriminate with respect to participation under the plan against any provider acting within the scope of that provider's license. This rule does not require plans to contract with any providers willing to abide by the terms and conditions for

participation, or prevent a plan from establishing varying reimbursement rates based on quality or performance measures.

Cost sharing limitations. Plans must limit cost sharing to the deductible and out of pocket limitations provided for HSA-related high deductible health plans. These rules provide for a maximum deductible of $2000 single and $4000 family. The out of pocket limits are determined annually.

> *Due to some imprecise language, it is unclear whether the cost sharing limitation rule applies to self funded plans.*

Errata on firearms. Several special rules relating to firearms apply to plans, insurers, and wellness plans, effective for plan years beginning after September 23, 2010. Wellness plans may not collect data relating to the lawful ownership, possession, use or storage of a firearm or ammunition. Likewise, the Secretary may not collect such data. In addition insurers may not base premium rates or wellness rewards on such factors.

> *Plans still may ask questions related to dangerous hobbies and activities such as SCUBA diving, but may not ask about firearms.*

The following provisions apply only to fully insured plans.

Essential health benefits package. Health insurers in the individual and small group market must ensure that coverage includes the essential health benefits package required for qualified health plans in an exchange.

> *We will discuss the exchange rules governing essential health benefits and qualified health plans in week 4.*

Child only plans. Health insurers who offer the essential health benefits package required for qualified health plans in an exchange must offer coverage for child only plans in which the enrollees are individuals who have not yet reached age 21.

Fair health insurance premiums. Insurers in the individual and small group markets may vary rates only by individual or family coverage, rating area, age (not more than 3 to 1 for adults) and tobacco (not more than 1.5 to 1). Each state shall establish 1 or more rating areas, subject to review by the Secretary. The Secretary shall define permissible age rate bands. The rating factors for age and tobacco shall be applied on an individual basis, i.e., the tobacco rate will apply only to those who are tobacco users. If states allow large groups into an exchange, the above provisions will apply to all coverage in the large group market also.

Guaranteed availability. Health insurers in the individual or group markets must accept every employer and individual in the state that applies for such coverage. The insurer may restrict enrollment to open or special enrollment periods.

Guaranteed renewability. Insurers in the individual or group markets must renew or continue in force coverage at the option of the plan sponsor or individual, as applicable.

> *These insurer only rules may further steer fully insured plans to self funding of benefits.*
>
> *With respect to the guaranteed availability and guaranteed renewability provisions, the Act is not clear whether it supersedes the limited HIPAA exceptions to the guaranteed availability and guaranteed renewability rules for bona fide association plans.*

Our next alert will address the new rules addressing grandfathered plans—which will greatly impact all current plans.

April 30, 2010