

New Requirements for Health Insurers - 2010

The Patient Protection and Affordable Care Act (ACA) contains a number of provisions that are designed to improve access to health coverage. This document provides an outline of health insurance reform provisions that were implemented in 2010.

Grandfathered Plans

A number of new requirements may not apply to grandfathered plans. In general, a grandfathered plan is an insurance plan that existed prior to March 23, 2010. To meet the definition of grandfathered, an insurance plan must also meet a number of other requirements outlined in a regulation released by the federal government. If an insurance plan no longer qualifies as grandfathered, the insurer or employer will have to abide by insurance rules established in the law required of new insurance plans written after March 23, 2010.

Among the grandfathered status rules, a health plan or insurer:

- Cannot eliminate all or most benefits to diagnose or treat a particular condition;
- Cannot increase or alter cost-sharing beyond a designated limit (e.g. if a health plan increases cost-sharing after March 23, 2010 by the greater of the rate of medical inflation plus 15 percent or 5 dollars, the plan is no longer considered grandfathered);
- Cannot raise co-insurance;
- Cannot significantly increase deductibles; and,
- Cannot add or alter the annual limit on the dollar value of what the health plan will cover.

Employers are permitted to change health insurance companies as long as the terms of the new plan abide by the cost and benefit rules listed above.

Additional Resources

- *Healthcare.gov: Questions and Answers Keeping the Plan You Have: Information on how insurance plans can qualify as a grandfathered plan.*

<http://www.healthreform.gov/about/grandfathering.html>

Coverage for Dependents up to Age 26:

Young adults are often unable to access affordable, comprehensive health insurance and make up a significant portion of the uninsured. According to the Commonwealth Fund, nearly 14 million young people aged 19 to 29 were without health insurance in 2006. In most cases, once young adults reach age 18 or 19, they are no longer eligible for coverage through their parent or guardian's health insurance unless they enroll in college full-time. Once a young person graduates college, they are usually unable to enroll in their parent or guardian's health plan. A number of states have addressed this problem by requiring health insurers to cover dependents until they reach a certain age, but not all states have taken such action.

As of March 2010, the ACA required individual and new group health plans (including self-insured plans where an employer directly pays for the health benefits of its employees) that provide dependent coverage to allow children or dependents to remain on their parent's health insurance plan until they turn 26 years of age. The federal government estimates that requirement has helped 6.6 million young adults receive coverage under their parents' insurance plans, including 3.1 million young adults who are newly insured because of the provision.

Dependents can enroll in their parent's group plans that existed prior to March 23, 2010 only if they do not have access to group coverage elsewhere. This restriction phases out in 2014.

How does this work?

- Married and unmarried children can qualify for coverage.
- The requirement took effect for plan years that began on or after September 23, 2010.
- It is still unclear how the dependent coverage requirement will affect existing plans' premiums or whether dependents with pre-existing conditions will have services for such conditions covered. One estimate suggests that premiums will increase by less than 1 percent.
- The cost of the dependent's insurance will be excluded from the employee's income through the end of the taxable year when the child turns 26. This tax exclusion applies to workplace, retiree, and self-employed individuals who apply the self-employed health insurance tax deduction.
- For young adults seeking to enroll in their parent's coverage, plans and insurers are required to offer a minimum 30-day open enrollment period to allow dependents an opportunity to enroll. Insurers and employers are required to provide notice of the open enrollment period.
- Those interested in seeking dependent coverage should contact their human resources department for enrollment information.

Additional Resources

- *CNNMoney: Without health care reform, 20-somethings out of luck. An article regarding the effect of the dependent care rule.*
<http://money.cnn.com/2012/04/16/pf/health-care-young-adults/index.htm>
- *Department of Health and Human Services – Young Adults and the Affordable Care Act Fact Sheet. Information on the dependent care coverage provision.*
http://cciio.cms.gov/resources/files/adult_child_fact_sheet.html

Temporary High-Risk Pools:

Oftentimes, people with pre-existing conditions are unable to find affordable coverage through the individual and small business health insurance market. Many states have established high-risk pools for individuals unable to acquire coverage elsewhere. Since the cost of coverage for people with complex health care needs can be significantly burdensome, high-risk pools often provide some premium and cost-sharing subsidies. Unfortunately, many existing high-risk pools are underfunded and unable to meet the growing demand. In July 2010, the Department of Health and Human Services began providing assistance to states to establish or expand high-risk pools for people who are unable to find coverage in the health insurance market.

The high-risk pool program is temporary; in 2014, states will be required to establish health insurance exchanges and individuals covered in the high-risk pool will be transitioned to an exchange-based plan. Further, beginning in 2014, insurance companies will be required to accept all applicants regardless of health status and will only be allowed to vary premiums based on a person's age; whether they are applying for family or

individual coverage; whether they use tobacco; and whether they live in a high, medium, or low cost area of the country. There will be limits to how much premiums can vary based on age and tobacco use.

In July 2010, the ACA authorized \$5 billion to fund the establishment or expansion of high-risk pools. The Department of Health and Human Services is working with states to facilitate the process or operate its own high-risk insurance program if a state fails to do so.

Who is eligible for coverage through a temporary high-risk pool?

- Must be a U.S. citizen or legal resident.
- Not have been covered by creditable coverage (e.g. employer-based coverage) for the previous 6 months prior to applying for high-risk pool coverage.
- Must have a pre-existing condition.
- Individuals already enrolled in their state's existing high-risk pool are prohibited from enrolling in the new temporary high-risk pool program unless they discontinue coverage and remain uninsured for 6 months.

Are there any rules related to the type of coverage offered in the high-risk pool?

- Health insurance plans must cover a minimum of 65 percent of health care costs.
- Out-of-pocket (excluding premiums) costs cannot exceed \$5,950 for an individual.
- There can be no pre-existing condition exclusions.
- Premiums can vary based on a person's age (but cannot be greater than a ratio of 4 to 1).
- Premiums must reflect the standard rate for a standard population, rather than for a high-risk population.
- New high-risk pools may be required to cover a minimum benefit package.
- If the plan is operated by the federal government, prospective enrollees may present a letter from their physician or other health practitioner to the insurer stating that they have a pre-existing condition, thus partially fulfilling the eligibility requirements. Some state-operated plans also accept this type of verification.

The ACA prohibits states from reducing their existing high-risk pool programs that were established prior to the health reform law. Uninsured individuals who are currently unable to receive coverage because of a pre-existing condition should contact their state insurance commission (or other relevant entity) to determine how they can enroll in the temporary high-risk pool in their state.

Additional Resources

- *Pre-Existing Condition Insurance Program home page.*
<https://www.pcip.gov/Default.html>
- *Kaiser Family Foundation: Questions about Temporary High-Risk Pool.*
<http://www.kff.org/healthreform/upload/8066.pdf>

Pre-existing Conditions Exclusions Banned for Children:

In September 2010, the ACA prohibited new individual and group plans (including self-insured plans) as well as group plans established on or before March 23, 2010, from excluding coverage of pre-existing conditions for

children younger than age 19. While the law bans pre-existing condition exclusions for children under age 19, it does not require that health plans enroll children into coverage. Insurers may allow children with pre-existing conditions to enroll only during specified periods, also known as open enrollment periods, if permitted by state law. If a state requires health insurers to cover all applicants (guaranteed issue) or has laws regulating open enrollment periods, those laws will not be preempted by this provision.

Additional Resources

- *Kaiser Health News: Article Regarding Child Coverage of Pre-Existing Conditions.*

<http://www.kaiserhealthnews.org/daily-reports/2010/march/31/kids-stuff.aspx?referrer=search>

- *U.S. Department of Health and Human Services: Q & A regarding the ban on pre-existing condition exclusions for children under age 19.*

<http://www.hhs.gov/ociio/regulations/children19/factsheet.html>

Restricting Annual or Lifetime Dollar Limits on Coverage:

Some health insurance plans place limits on the dollar amount of coverage they will provide. For instance, a health plan may cover up to \$5 million in health care services over a patient's lifetime. Some health plans restrict the dollar amount of coverage an enrollee can receive in a year. Beginning in September 2010, new and existing group health plans (including self-insured plans, where an employer directly pays for the health benefits of its employees) and individual plans were prohibited from establishing lifetime limits on the dollar value of essential health benefits for any participant or beneficiary.

Additionally, new and existing group plans and new individual plans are allowed to impose only a restricted annual limit on the benefits that are deemed "essential health benefits" as determined by the federal government. The federal government is required to ensure that there is access to needed services available with minimal impact on premiums. Group health plans and health insurance issuers are permitted to 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 and state law. Essential benefits include preventive and wellness services and chronic disease management, ambulatory patient services, emergency services, hospitalization, mental health services, among others. The lifetime and annual dollar limitation has been waived for some plans, particularly "mini-med" insurance plans, which provide fewer benefits and require higher cost-sharing than traditional coverage.

Additional Resources

- *Healthcare.gov: Lifetime and Annual Limits. An outline of the ACA provision.*

<http://www.healthcare.gov/law/features/costs/limits/>

Prohibiting Coverage Rescissions:

The ACA also restricts the controversial practice of rescission, which refers to the practice of canceling medical coverage after policyholders have become sick or injured. As of September 2010, all insurers were prohibited from rescinding coverage policies. Rescissions are still permitted in cases where the covered individual

committed fraud or made an intentional misrepresentation as prohibited by the terms of the plan or coverage. A cancellation of coverage in this case would require prior notice to the enrollee.

Justifying Premium Increases:

In 2010, the federal government began distributing grants to states to assist them in their efforts to review premium rate hikes implemented by health insurance plans. Starting in September 2011, non-grandfathered individual and small group market health insurers were required to submit to the federal government and relevant State regulators a justification for premium increases deemed unreasonable before implementation of the premium increase. An insurer seeking to raise premiums by more than 10 percent is now required to submit a justification to the government and such information is made public. In 2012, states were given the option to propose new thresholds for rate reviews. States are also required to submit information to the Secretary regarding premium trends in their state. Once the health insurance exchanges are operating, premium increase information will be considered when determining whether an insurer should be allowed to participate. The federal government has distributed funding to States to assist them in their premium rate review efforts.

Additional Resources

- *Healthcare.gov: Fact Sheet on the Premium Rate Review provision.*

<http://www.healthcare.gov/news/factsheets/ratereview05192011a.html>

- *Kaiser Health News: Insurers Must Justify Double-Digit Rate Increases.*

<http://www.kaiserhealthnews.org/daily-reports/2011/may/20/rate-review-rule.aspx?referrer=search>

Covering Core Preventive Services:

Beginning in September 2010, the ACA required individual and group market plans (including self-insured plans) established after March 23, 2010 to cover – at a minimum – evidence-based items and services that have a rating of “A” or “B” in the recommendations of the U.S. Preventive Services Task Force (USPSTF) if they are provided by an in-network physician or other health care professional. Cost-sharing for these services is prohibited and such services are exempt from deductibles. Insurers are allowed to cover additional preventive benefits beyond those given a rating of “A” or “B” by the USPSTF. Plans that existed on or before March 23, 2010 and meet the definition of a grandfathered plan are **not** required to abide by this provision.

What do these ratings mean?

- An “A” rating means that the service is recommended and that there is a high level of certainty that it will yield substantial benefit to the patient.
- A “B” rating indicates that the service is recommended and that there is a high level of certainty that the services will yield at least a moderate benefit to the patient.

What are insurers required to cover?

- Recommended immunizations;
- Preventive care for infants, children and adolescents;
- And additional services for women outlined in comprehensive guidelines supported by the Health Resources and Services Administration.

A plan or issuer is permitted to cover or deny additional services not recommended by the USPSTF. The current recommendations of the USPSTF regarding breast cancer screening, mammography, and prevention are considered the most current other than those issued in or around November 2009.

The provision also requires HHS to update required services following the release of recommendations issued by the relevant entity, e.g. USPSTF.

When are patients eligible for free preventive services?

In addition to the requirement that physicians be in-network, a regulation issued by the federal government in July 2010 established a number of other rules that influence whether or not an insurer is required to cover a preventive service without cost-sharing:

- If the recommended preventive service is not billed separately (or is not tracked as individual encounter data separately) from an office visit and the primary purpose of the office visit is the delivery of such an item or service, then a plan or issuer **may not** impose cost-sharing requirements with respect to the office visit;
- If a recommended preventive service is billed separately (or is tracked as individual encounter data separately) from an office visit, then a plan or issuer **may** impose cost-sharing requirements with respect to the office visit;
- If a recommended preventive service is not billed separately (or is not tracked as individual encounter data separately) from an office visit and the primary purpose of the office visit is not the delivery of such an item or service, then a plan or issuer **may** impose cost-sharing requirements with respect to the office visit;
- An insurer is permitted to use "reasonable medical management" to determine frequency, method, treatment, or setting for a recommended preventive item or service if such information is not provided in the USPSTF's (or other relevant entity) recommendation; and,
- If a service/item is no longer recommended by USPSTF, HRSA, etc., insurers are no longer required to provide such service without cost sharing. Insurers are required to alert enrollees of revision of benefit plans.

Additional Resources

- *Healthcare.gov – Recommended Preventive Services.*

<http://www.healthcare.gov/center/regulations/prevention/recommendations.html>

Health Coverage Assistance for Early Retirees:

Ineligible for Medicare coverage and potentially facing receding employer-based retiree health benefits, many early retirees have trouble finding affordable health insurance. Early retirees may seek out coverage in the individual market, but without strong negotiating power and rules that require insurers to accept all applicants, such insurance may be out of reach.

To reduce the rate of uninsurance among early retirees – a demographic with higher health care costs than younger workers – the ACA authorizes \$5 billion to provide financial assistance in the form of reinsurance to employers who provide coverage for early retirees.

What is reinsurance?

- Reinsurance is like an insurance plan for insurance plans. Employers who face rising health care costs because of early retiree health coverage can safeguard against significant cost increases by using reinsurance.
- The program would protect insurance devoted to retirees age 55-64.

How does it work?

- Beginning in June 2010, the program reimbursed employers for 80 percent of the cost of providing health insurance for an early retiree if costs are between \$15,000-90,000 a year. These limits will be adjusted in subsequent years.
- Reimbursements must be used by the employer to reduce premium costs or premium contributions and cost-sharing for participants.
- The funds cannot be used for general revenue purposes.
- The federal government is no longer accepting new applications for the reinsurance program. The program is scheduled to end in 2013, but may terminate before then if funding runs out. So far, the program has help protect the health benefits of 19 million individuals.

Additional Resources

- *Healthcare.gov: Early Retiree Reinsurance Program (ERRP). Provides basic program information, participants by state, and relevant web links.*

<http://www.healthcare.gov/law/features/employers/early-retiree-reinsurance-plan/>

Option for Early Medicaid Coverage Expansion:

Beginning in 2010, states were given the option to extend Medicaid coverage to nonelderly, childless adults with incomes up to 133 percent of the federal poverty level and receive the current federal reimbursement rate. Connecticut, Minnesota, and the District of Columbia opted to expand their Medicaid programs under this provision. In 2014, states may expand Medicaid coverage to newly eligible individuals such as low-income childless adults.