Immediate Insurance Reforms of the Accountable Care Act & Exchanges

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Immediate Insurance Reforms

Effective September 23, 2010

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- Lifetime and Annual Limits

  (PPACA § 1001 / PHSA § 2711)

  - Insurers may not establish lifetime limits on the dollar value of essential benefits on any plan of health insurance coverage.
  - Insurers may establish annual limits on the dollar value of essential benefits until January 2014.
  - Insurers must provide a special enrollment period for individuals who lost coverage under a plan due to reaching the lifetime limit.

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- Lifetime and Annual Limits (cont.)
  - Lifetime limit prohibition applies to all plans.
  - Annual limit rules apply to all plans except grandfathered individual market plans.
  - DHHS issued regulations on June 21, 2010.

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- Rescissions

  (PPACA § 1001 / PHSA § 2712)

  - Rescission – a cancellation or discontinuance of coverage that has a retroactive effect.
  - An insurer may only rescind coverage for fraud or intentional misrepresentation of material facts.
  - Insurer must give the individual a 30-day advance notice before cancellation.
  - Applies to all plans.
  - DHHS issued regulations on June 21, 2010.

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- Coverage for Preventive Services

  (PPACA § 1001 / PHSA § 2713)

  - Plans must provide coverage without cost sharing for:
    - Services recommended by the US Preventive Services Task Force
    - Immunizations recommended by the Advisory Committee on Immunization Practices of the CDC
    - Preventive care and screenings for infants, children and adolescents supported by the Health Resources and Services Administration
    - Preventive care and screenings for women supported by the Health Resources and Services Administration
  - Applicable to all non-grandfathered plans.
  - DHHS issued regulations on July 19, 2010.

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Extension of adult children coverage

(PPACA § 1001 & HR 4872 § 2301 / PHSA § 2713)

- Plans that provide dependent children coverage must extend coverage to adult children up to age 26.
- Plans are required to provide a 30-day enrollment period for any child whose coverage ended, or who was denied coverage due to age.
- Applicable to all plans, although grandfathered plans may limit access to only adult children who are not eligible for their own employer-sponsored coverage.
- DHHS issued regulations on May 13, 2010.

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Preexisting condition exclusions

(PPACA § 1201 & 10103 / PHSA § 2704)

- Plans may not impose any exclusion of benefits (including denial of coverage) or limit coverage based upon a preexisting condition for an individual under age 19, if the plan provides coverage to dependent children.
- Applicable to all plans except grandfathered individual market plans.
- DHHS issued regulations on June 21, 2010.

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Uniform Explanation of Coverage Documents and Standardized Definitions

(PPACA § 1001 / PHSA § 2715)

- The Secretary must develop a summary of benefits and coverage explanation to be provided to all potential policyholders and enrollees.
- Applicable to all plans except grandfathered plans.
- A subgroup of the National Association of Insurance Commissioners (NAIC) B Committee is developing these standards and will present them to DHHS.
- Standards are to be developed by March 2011 and implemented by March 2012.

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Provision of Additional Information

(PPACA § 1001 / PHSA § 2715A)

- All plans must submit to the Secretary and the State Insurance authority and make available to the public certain information in plain language.
- Some of the information required includes claims payment policies and practices, periodic financial disclosures, data on enrollment/disenrollment, number of claims denied, and rating practices.
- Applicable to all non-grandfathered plans.

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Bringing Down the Cost of Health Care

(PPACA § 1001 / PHSA § 2718)

- Insurers must report to the Secretary the ratio of incurred losses (incurred claims) plus loss adjustment expense (change in contract reserves) to earned premiums.
- Insurers must provide a "rebate" to consumers if the ratio is less than 85% for the large group market and 80% for the small group and individual markets.
- Effective January 1, 2011.
- Applicable to all plans.
- DHHS requested input and guidance from the NAIC on this issue. The NAIC has several subgroups working on the issue.

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Appeals Process

(PPACA § 1001 / PHSA § 2719)

- Internal claims appeal process must follow the federal Department of Labor's claims and appeals procedures as adopted previously and as augmented by the recently issued regulations from DHHS.
- Rescissions will be subject to internal appeal procedures.
- If a state has adopted the NAIC's model External Review Act , then plans must comply with the state's external review law. Otherwise, plans must comply with the recently issued regulations from DHHS.
- Applicable to all non-grandfathered plans.
- DHHS issued regulations on July 23, 1010.

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Patient Protections

(PPACA § 1001 / PHSA § 2719A)

- Plans that provide for a PCP must allow a pediatrician to be designated.
- If a plan provides coverage for emergency services, must do so without prior authorization.
- Plan may not require authorization or referral for a female patient to receive obstetric or gynecological care.
- Applicable to all non-grandfathered plans.
- DHHS issued regulations on June 21, 1010.

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Ensuring Consumers Get Value

(PPACA § 1003 / PHSA § 2794)

- Secretary in conjunction with the states shall develop a process for the annual review of "unreasonable" premium increases.
- NAIC subgroups are working on developing a standardized format for the information which must be provided to the Secretary, the states, and made available to the public about the premium increase.
- Applicable to all non-grandfathered plans.

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Other Provisions

(PPACA § 1003 / PHSA § 2794)

- Consumer Assistance Offices (PPACA § 1002)
- Temporary High Risk Pool Program (PPACA § 1101)
- Temporary Reinsurance Program for early retirees (PPACA § 1102)
- Web portal to identify affordable coverage options (PPACA § 1103)

Exchanges

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What is an Exchange?

- An organized marketplace for the purchase of health insurance coverage.
- Intended to encourage competition by offering a choice of plans and by providing consumers with information that will allow for comparison shopping.
- Such competition and choice is hoped to reduce the growth of health care spending by encouraging competition on price and quality.
- An exchange can function in one of three ways:
  - Market Organizer and Distribution Channel
  - Selective Contracting Agent
  - Active Purchaser

- Market Organizer & Distribution Channel offers all plans and all carriers and serves as an impartial source of information.
- Selective Contracting Agent offers standard choices from several plans and insurers and promotes competition but does not “negotiate” premiums.
- Active Purchaser sets benefits and package and procures and negotiates the terms of insurance (including price) on behalf of enrollees .
  - It is not clear if this type of exchange model would comply with the requirements in ACA since rules applying to rating of insurance plans must be the same inside and outside the Exchanges.

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An Exchange is expected to:

- Make available (only) qualified health plans to individuals and employers.
- Offer consumers choices of health plans by focusing competition on rates and quality.
- Provide information to consumers.
- Create an administrative mechanism for enrollment – with "no wrong door" features.
- Be the sole location for an individual who qualifies for insurance subsidies to receive those subsidies.
- Establish navigators to assist consumers in health care purchasing decisions.

- Nothing in the ACA prohibits the sale of health insurance outside of the exchange. Rules however must be consistent inside and outside the exchanges in order to offset anti-selection issues.
- An exchange must be established for the individual and small employer group markets. That may be a single exchange (if the two market places are merged) or two separate exchanges.
- Exchanges may open to large employers at the option of the State.

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