Medical Mutual of Ohio®

Carolina Care Plan | Consumers Life

2010

Healthcare Re-forum

Issues No. 1 through No. 33

Healthcare Re-forum 2010

Table of Contents

Issue No. 1: Introduction to Healthcare Reform . . . 3

Issue No. 2: Individual and Group Market Reforms . . . 4

Issue No. 3: Early Retiree Reinsurance Program . . . 5

Issue No. 4: Extension of Dependent Age . . . 7

Issue No. 5: State Ombudsman Program . . . 9

Issue No. 6: Small Employer Health Insurance Tax Credits . . . 11

Issue No. 7: Healthcare Implementation: A Congressman's Perspective . . . 12

Issue No. 8: The Mutual Advantage with Healthcare Reform . . . 14

Issue No. 9: Definition of Terms Utilized in Healthcare Reform Law . . . 16

Issue No. 10: Prohibition of Discrimination Based on Salary . . . 18

Issue No. 11: High Risk Pool Program . . . 20

Issue No. 12: Maintaining the Status of a Granfathered Plan . . . 22

Issue No. 13: Should My Plan Stay Grandfathered? . . . 24

Issue No. 14: Web Portal—New Consumer Sit for Viewing Coverage Options . . . 26

Issue No. 15: Preventive Services and the New Interim Final Regulations (IFR) . . . 27

Issue No. 16: Healthcare Terminology Definitions (Part II) . . . 29

Issue No. 17: New Regulations Overhaul the Appeals Process . . . 31

Issue No. 18: New Regulations and Appeals Process . . . 33

Issue No. 19: Patient Protections . . . 34

Issue No. 20: Consumer Driven Health Plans Under the New Law . . . 36

Issue No. 21: Healthcare Reform and Self-Insured Plans . . . 38

Issue No. 22: Simple Cafeteria Plans . . . 40

Issue No. 23: Reform Clarifies Rescission Rule . . . 42

Issue No. 24: A First Look at Accountable Care Organizations . . . 44

Issue No. 25: Additional Guidance Issued for Mandates Taking Effect September 23, 2010 . . . 46

Issue No. 26: Additional Guidance Issued for Mandates Taking Effect September 23, 2010 Part II) . . . 48

Issue No. 27: How Do Collective Bargaining Agreements Impact Grandfathered Status? . . . 50

Issue No. 28: Another Look at High-Risk Pools . . . 52

Issue No. 29: An Overview of the American Health Benefit Exchanges . . . 54

Issue No. 30: Types of Plans Sold on the Exchanges . . . 56

Issue No. 31: Co-Ops and Multi-State Plans on the Exchanges . . . 58

Issue No. 32: States' Construction of the American Health Benefit Exchanges . . . 60

Issue No. 33: Updates to Grandfathering Legislation . . . 62

Healthcare Re-forum No. 1

Introduction to Healthcare Reform

Medical Mutual and its Family of Companies are dedicated to bringing a better understanding of Healthcare Reform to you and your customers. We know it is very difficult to decipher and, in order to help you gain a greater understanding, we have developed this forum to provide information and updates, as well as address questions or topics that you can submit.

Over the coming months we will address different aspects of the law and update you about any progress regarding the development of rules and regulations. We will provide clear guidance and understanding where possible. We hope you will pass this information along to others who work for you and your clients. If you have a question or topic you would like us to address, please send it to MarkComm@mmoh.com and include your contact information in case we have questions.

Overview

It is important to understand that when Healthcare Reform legislation is discussed, two bills were signed into law, and the regulations that will contain many of the details have not yet been issued. It is also important to understand that the intent of the laws is to provide health insurance to 32 million currently uninsured Americans. In striving to achieve this objective, these laws address dozens of provisions. Our initial focus will be on those of more immediate impact and interest to group health plans.

Grandfathered Plans

A "grandfathered health plan" is any insured or self-insured plan that was in existence on March 23, 2010. These plans are exempt from certain provisions of the new reform laws. The laws are not yet clear on whether changing plan benefits or switching carriers will cause a plan to lose its grandfathered status. However, adding or removing employees or dependents will not cause a plan to lose its status. It is important to note that collectively bargained plans ratified prior to March 23, 2010, do not have to comply with the Healthcare Reform provisions listed below until the current collective bargaining agreement expires.

For grandfathered plans, the law requires specific changes that must be incorporated into the plan beginning with renewals on or after September 23, 2010. These are listed below:

- The law prohibits plans from imposing lifetime benefit limits or caps and unreasonable annual limits on select benefits yet to be defined by the federal government.
- The law prohibits the use of pre-existing condition exclusions for covered children under the age of 19.
- The law prohibits the rescission of healthcare coverage except in cases of fraud or material misrepresentation.
- The law permits dependent adult children to remain on a parent's coverage until the age of 26, provided that the child does not have employer-sponsored coverage available. Note: Ohio enacted a similar provision in 2009 which is scheduled to take effect on the group's first renewal on or after July 1, 2010. Ohio's provision extends coverage to unmarried adult children until the age of 28.

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Healthcare Re-forum No. 2

Individual and Group Market Reforms

Welcome to our second issue of *Healthcare Re-Forum*. In our first issue we defined "grandfathered plans" and provided key provisions of reform for grandfathered plans. In this issue we address reforms that apply to insurers and groups offering group or individual health insurance plans that have gone into effect after March 23, 2010 (non-grandfathered). The first five provisions also apply to grandfathered plans (plans in existence on or before March 23, 2010).

These provisions are effective for plan years that begin on or after September 23, 2010.

1. Lifetime limits on the dollar value of essential benefits will be eliminated. Essential benefits will be defined by the Secretary of Health and Human Services (HHS).

2. Only "reasonable" annual dollar limits on essential benefits can be set. Medical Mutual currently has annual limits on certain benefits. We will adjust these limits when the Secretary of HHS issues the regulations.

3. Coverage may only be rescinded if an individual performs an act that constitutes fraud or makes an intentional misrepresentation of material.

   FACT: Medical Mutual does not rescind coverage unless we have a strong indication of fraud or intentional misrepresentation.

4. There can be no pre-existing exclusion for covered children under the age of 19.

5. Dependents up to age 26 may remain on their parent's coverage, unless the dependent has employer-based coverage available. Plans are not required to cover children of dependent children. Ohio enacted a similar provision in 2009 that takes effect on July 1, 2010. The Ohio law extends coverage to unmarried dependents to age 28. (We will provide greater detail about the dependent age provision in a future issue.)

6. The nondiscrimination provisions that apply to self-funded plans are now extended to fully insured plans. These provisions prohibit discrimination in favor of a highly compensated individual regarding eligibility and benefits provided by the plan. Compliance with this mandate occurs at the group level as opposed to the insurer level.

7. A number of "patient protections" have been established around provider selection and approval of care. a) If a plan requires a participant to select a primary care provider, the plan must allow each participant to designate any in-network primary care provider who is accepting patients. b) No prior authorization is required for emergency care services, even if the services are out-of-network. No penalties can be applied to out-of-network emergency care. c) Parents are able to designate a network pediatrician as the primary care provider for a child if the plan requires a primary care provider. d) Women must be able to receive the care of a participating OB/GYN physician without a referral.

   FACT: Medical Mutual is already in compliance with these proposed patient protection reforms.

8. All plans must implement an effective internal appeal and external review process. The internal process must provide notice to the enrollees of both an internal and external claims appeal process. A plan will be in compliance with the appeals process if it follows the ERISA claims and appeals regulations. A plan must also comply with the state's external review process that meets the requirements of the National Association of Insurance Commissioners (NAIC) model law on external review. If a state does not have an external review requirement, or if the plan is self-insured, it must establish an external review process that complies with regulations issued by HHS.

   FACT: The current internal appeals process administered by Medical Mutual for all of its group customers is in compliance with the Department of Labor claims and appeals procedures.

9. Plans may not impose any cost-sharing requirements on preventive health services. This includes certain services that are included in the recommendations of the U.S. Preventive Services Task Force.

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Healthcare Re-forum No. 3

Early Retiree Reinsurance Program

The Patient Protection and Affordable Care Act (PPACA) provides a $5 billion reinsurance program to partially reimburse sponsors of employment-based plans that are providing health coverage to early retirees and their eligible spouses, surviving spouses and dependents. This provision goes into effect June 1, 2010. The program will be administered by the Department of Health and Human Services (HHS).

The program provides reimbursement to sponsors of employment-based health plans that provide benefits to early retirees. An employment-based plan is a group health plan maintained by a private employer, state or local government, employee organization, voluntary employee beneficiary association or a committee or board of individuals appointed to administer a group plan. ERISA-defined multi-employer plans are also eligible. An "early retiree" must be age 55 or older and cannot be eligible for Medicare. The early retiree cannot be an active employee of an employer maintaining or contributing to the employment-based plan or of any employer that has made substantial contributions to the plan. Claims for dependents of the early retiree are eligible for reimbursement as well, without regard to the age of the dependent.

Plan sponsors can apply and become certified for the program through HHS. The applications will be reviewed in the order in which they are received and plan sponsors must submit one application for each group health plan they maintain. It is important that the application be correct, as there is no way to correct a submitted application. A new application would then have to be submitted, leaving a risk that funds may have run out by that time. The application must include, among other items, the following information:

- The projected reimbursement amount expected for the first two plan-year cycles with specific amounts for each plan year
- A notation acknowledgement that federal funds will be received by the plan sponsor and that all information in the application is being used to obtain federal funds
- Assurance that the plan sponsor has entered into a written agreement with the health insurance issuer or group health plan that appropriate information, as defined by the program, may be disclosed to HHS
- Verification that written procedures are in place to detect and reduce fraud, waste and abuse
- A summary detailing how reimbursements will be used

Eligible plans must also document programs and procedures that are in place to generate cost savings for participants with chronic and high-cost conditions. The regulations define a chronic and high-cost condition as one for which $15,000 or more in health benefit claims are likely to be incurred during a plan year by an individual.

The amount of reimbursement available is up to 80 percent of annual paid claims that fall between $15,000 and $90,000 per person. Amounts paid to a participating plan through the reinsurance program must be used for either of the following purposes:

- To reduce the sponsor's health benefit premiums or health benefit costs
- To reduce health benefit premium contributions, co-payments, deductibles, coinsurance or other out-of-pocket costs for plan participants—the reimbursement cannot be used as revenue for the plan sponsor

All claims for the retiree, even those below the $15,000 threshold, must be submitted and should include any cost-sharing amounts paid by the retiree. The actual paid amounts, net of any provider discounts, must be submitted.

Payments are retroactive for a plan year, so plan sponsors will be able to take advantage of reimbursements for costs incurred on or after June 1, 2010. Any expenses incurred for early retirees prior to June 1, 2010, will apply toward the $15,000 threshold, but not the reimbursement.

The program ends on January 1, 2014, when early retirees will be able to obtain their coverage through the health insurance exchanges. The program may also end if the funding is exhausted, which many analysts believe will occur prior to 2014.

Note: Medical Mutual is developing processes and standard formats for providing information that groups will need if they plan to submit an application, as well as for submitting claims for reimbursement once they have become certified.

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Healthcare Re-forum No. 4

Extension of Dependent Age

The Patient Protection and Affordable Care Act (PPACA) requires insurers and groups offering group or individual health insurance plans to provide coverage for dependent children up to age 26. The Department of Health and Human Services (HHS) recently issued regulations that specify a dependent is eligible for coverage even if he or she is no longer living with a parent, is not a dependent on a parent's tax return or is no longer a student. Both married and unmarried dependents can qualify for the coverage, although it does not extend to the dependent's spouse or children. Plans that do not cover dependents are not required to comply with the dependent coverage extension.

The dependent coverage extension is effective for plan years beginning on or after September 23, 2010. Parents must receive written notice of the opportunity to re-enroll their eligible dependents into a plan. Insurers and groups must provide the written notice of the special enrollment period and give the eligible dependents a minimum of 30 days from the first day of the new plan year to decide to enroll in the plan.

The benefits offered to newly eligible dependents must be the same as for those dependents who were already covered prior to the effective date of the new legislation. If a plan's structure distinguishes only between self and family coverage, and family coverage is in place, the newly eligible dependent must be added with no additional premium. However, if a plan's cost of coverage increases with each dependent, an additional premium may be charged for each dependent added, provided the cost is no greater than what is charged for other covered dependents. (For example, additional premium may be charged if the type of plan has to change from two-person coverage to family coverage with the addition of the dependent.)

Grandfathered plans—those in existence prior to March 23, 2010—have slightly different rules for the dependent coverage extension. If a young adult under the age of 26 is eligible to purchase employer-based health insurance, the law does not require a grandfathered plan to enroll this newly eligible dependent. This exception for grandfathered plans only applies until January 1, 2014.

The IRS has issued guidance that the coverage provided to these young adult dependents is not taxable income to the employee. This favorable tax treatment is effective on March 30, 2010 and extends until the end of the year in which the dependent turns 26. This means that if plans cover children until the end of the month or end of the year in which they turn 26, those extra months of coverage beyond the 26th birthday will not be considered taxable income.

State vs. Federal Law

Some states have different dependent age requirements than the federal standards created in PPACA. State laws that are more generous than the federal mandate must be followed and the federal law will take precedence over any state law that is less generous. All states require insured plans to cover certain disabled dependents without regard to age. We are not addressing the details of those laws in this communication. Information provided below pertains to the states where Medical Mutual and its Family of Companies provide coverage.

The States of Georgia, Indiana, Michigan, South Carolina and West Virginia have laws that are less generous than the federal mandate and will follow the federal law in order to provide dependent coverage up to age 26.

States that exceed the federal mandates for providing coverage up to age 26 include: Ohio, Pennsylvania and Wisconsin. The federal law applies up to age 26, along with any state provisions that are more generous than the federal mandate.

- Ohio dependent age mandates go into effect for the first renewal on or after July 1, 2010. Ohio law allows an unmarried, dependent child that is an Ohio resident or a full-time student to remain covered up to age 28, provided the child is not eligible for employer or government-sponsored coverage. Once the child turns 26, if he or she meets the requirements of the Ohio law, he or she can remain covered until turning age 28. Additional costs for covering dependents age 26 and 27 can be charged to the parent. The state law does not apply to self-insured plans that are governed by ERISA; this includes most self-insured private employers.
- Pennsylvania law allows an unmarried child, who is a Pennsylvania resident or a full-time student and has no dependents, to remain covered up to age 30, provided the child is not covered under another group or individual plan and is not eligible for government-sponsored coverage.
- Wisconsin law allows an unmarried child to remain covered up to age 27, provided the child is not eligible for employer-sponsored coverage. Full-time students called to active duty in the armed forces can be covered beyond age 26 depending on various factors.

ACTION: Medical Mutual and its Family of Companies are providing continuous coverage for currently enrolled dependents up to age 26 who would have otherwise lost coverage due to their age or loss of student status on or after May 1, 2010. This extension will not be retroactive for those who lost coverage prior to May 1, 2010. Large groups can choose to opt out of this early adoption of the law.

ACTION: Medical Mutual will provide guidance in the coming weeks for adding newly eligible dependents onto existing health plans. The provisions for adding dependents under the state law go into effect in Ohio with renewals on or after July 1, 2010, and with plan years beginning on or after September 23, 2010, for the federal law and in other states where Medical Mutual provides coverage.

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Healthcare Re-forum No. 5

State Ombudsman Program

The Patient Protection and Affordable Care Act (PPACA) provides for grants to states to establish, expand or provide support for offices of health insurance consumer assistance or health insurance ombudsman programs. To be eligible, a state must designate an independent office to operate an ombudsman program directly or in coordination with state health insurance regulators and consumer assistance organizations. This office will handle questions and complaints concerning health insurance coverage under both federal and state laws with respect to federal health insurance requirements.

States receiving the grant must require their ombudsman program office to:

- Assist with the filing of complaints and appeals
- Collect, track and review problems and questions encountered by consumers
- Educate consumers on their rights and responsibilities with respect to group health plans and health insurance coverage
- Assist consumers with enrollment in a group health plan or health insurance coverage by providing information, referral and assistance
- Resolve problems regarding obtaining premium tax credits for small businesses under section 36B of the Internal Revenue Code of 1986 (as added by PPACA)

To ensure proper linkages between states and the federal government, states receiving the grant must collect and report the types of problems and questions received to the Secretary of Health and Human Services (HHS). HHS would then share the information with state insurance regulators and the Secretaries of Labor and Treasury for follow up if necessary.

Each state will decide whether or not to participate in this program. No list of participating states has been released.

The total grant pool is $30 million for the first fiscal year for which this section applies. Additional monies will be allotted by the Secretary of HHS in subsequent fiscal years to support the state ombudsman program office. This provision went into effect March 23, 2010.

Summary of past Healthcare Re-Forum Issues

- **Issue 1, Grandfathered Plans**
  Defines the reform regulations that apply to insured and self-insured grandfathered plan—those plans in existence prior to the passage of the March 23, 2010, Patient Protection and Affordable Care Act (PPACA).
- **Issue 2, Individual and Group Market Reforms**
  Outlines market reforms that apply to group or individual health insurance plans that have gone into effect after March 23, 2010, (non-grandfathered).
- **Issue 3, Early Retiree Reinsurance Program**
  Explains the early retiree subsidy program that will provide reimbursements to sponsors of employment-based health plans that provide benefits to early retirees.
- **Issue 4, Age of Dependents**
  Reviewed regulations regarding adding dependent children up to age 26 and states that exceed the federal mandate.

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Small Employer Health Insurance Tax Credits

The Patient Protection and Affordable Care Act (PPACA) provides eligible small business employers a tax credit on health insurance premiums paid on behalf of their employees. The tax credit is available beginning tax year 2010 and allows for a tax credit up to 35 percent. The credit increases to 50 percent by 2014.

To qualify for the small employer tax credit, employers must:

- **have fewer than 25 full-time equivalent (FTE) employees**
- **have average annual employee wages less than $50,000 per year, per FTE worker**
- **maintain a qualifying arrangement (requirements are in the IRS notice 2010-44)**

Eligible Employees

With certain exceptions, employees who perform services for the employer during the taxable year are taken into account for the credit. Sole proprietors, partners in a partnership, shareholders owning more than two percent of an S Corporation and any owners of more than five percent of other businesses are not taken into account as employees for purposes of the credit. Certain family members of these owners and partners are also not considered employees for this credit. Companies that are affiliated through common ownership may be treated as a single entity under this tax credit provision.

IRS notice 2010-44 outlines three separate methods an employer can use to determine whether an employee is full time. The IRS website will provide formulas and examples for the calculation of FTEs. One of the means provided for definition of an FTE is arrived at by dividing the total number of hours an employee works in a year by 2,080 and rounding down. Any over-time hours worked by the employee cannot be calculated into the formula. This definition is important to note, because an employer with 25 or more employees could possibly qualify for the credit if some of the employees work part time. Typically, seasonal workers are not counted in determining FTEs and average annual wages, unless the seasonal worker works for the employer more than 120 days during the tax year.

Average Annual Wages

FICA wages are used for this calculation without the wage base limitation. The average annual wage is determined by dividing the total wages paid to qualified employees by the number of FTEs for the year. The result is rounded down to the nearest $1,000 or multiple of $1,000.

Qualifying Arrangement

Only premiums paid by the employer under a qualifying arrangement are counted in the credit calculation. Under this qualifying arrangement, the employer pays premiums for each employee enrolled in healthcare coverage offered by the employer in an amount equal to a uniform percentage (not less than 50 percent) of the premium cost of the coverage. Also, small businesses can receive the credit not only for traditional health insurance coverage, but also for add-on dental, vision and other limited-scope coverage. The employer must pay at least 50 percent of the premium for all add-on coverage for the tax benefit to apply.

The premium taken into account for this credit is the lesser of the actual premium paid or the percent of the premium paid for their eligible employees multiplied by the average premium for the small group market in the employer's state.

Credit Phase-Out

The credit phases out if the number of FTEs exceeds 10 or if the average annual wages exceed $25,000. The credit reduction for each additional FTE over 10 is equal to a 6.667 percent credit reduction. When the number of employees is 25, the credit is zero. The phase-out for each $1,000 of wages is equal to 4 percent of the credit. When the wages are $50,000, the credit is reduced to zero.

Tax-Exempt Businesses

A credit is also available for tax-exempt businesses, although the rules are different and the available credit is up to 25 percent smaller. Beginning in 2014, a credit of up to 35 percent will be available for two years for coverage purchased by nonprofit entities through an Exchange. Nonprofit entities can claim the credit, but it is limited to payroll tax paid or withheld by the tax-exempt entity.

As with any new law, the federal government may issue more regulations on how these credits will work. The IRS website is a good place to check for the most current information. The White House also released a "Fact Sheet" on the small business tax credits. A tax advisor or attorney should be consulted for questions pertaining to tax law.

For More Information

- **IRS Notice 2010-44**
  http://www.irs.gov/pub/irs-drop/n-10-44.pdf
- **IRS FAQ**
  http://www.irs.gov/newsroom/article/0,,id=220839,00.html
- **Fact Sheet**
  http://www.irs.gov/pub/irs-utl/3_simple_steps.pdf

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Healthcare Re-forum No. 7

Healthcare Implementation: A Congressman's Perspective

The Patient Protection and Affordable Care Act and the Healthcare and Education Affordability Reconciliation Act passed after a heated national dialogue and a politically bruising vote for those who supported the legislation against the wishes of their constituents.

One of the U.S. Representatives who voted for both bills was Earl Pomeroy (D - North Dakota). As a member of the jurisdictional House Committee on Ways and Means, Rep. Pomeroy was active in the crafting of the legislation. He is a member of the "Blue Dog" Democrats, many of whom were surprising last-minute supporters of the reform legislation. Rep. Pomeroy also has a unique perspective as a former state insurance commissioner.

On May 26, Rep. Pomeroy sent a letter to Katherine Sebelius, Secretary of Health and Human Services (HHS), in which he cautions, "…you and I both know that the details of implementation matter greatly. Critical to the success of health reform law is an implementation that is inclusive, careful and measured. Absent that, we are certain to witness near-term premium rate shock, market disruption with exiting companies and the curtailment of private sector efforts to reasonably contain unnecessary costs while protecting patient safety."

In his letter, Rep. Pomeroy clearly states he is "deeply committed" to the success of healthcare reform and carefully outlines the following implementation concerns:

Premium Rate Shock

There are a number of new policies beginning in 2010 that improve healthcare access—age of dependent and no pre-existing condition for children. Pomeroy states, "Recognizing that these policies will not be in sync with the personal coverage requirement and health reform infrastructure until 2014, it is important that the final regulations for these policies be carefully crafted and measured to mitigate near-term premium increases."

Market Disruption

Pomeroy encourages Sebelius and the National Association of Insurance Commissioners (NAIC) to carefully craft the Medical Loss Ratio (MLR) standards. He states, "In a January 6, 2010, letter to Congressional leadership, the NAIC raised concerns that 'a loss ratio of 80% in the individual market may not be readily achievable by many insurers…and (these companies) have expenses…they will not be able to reduce until guaranteed issue requirements and health insurance Exchanges are implemented.' According to the American Academy of Actuaries (AAA), if no consideration is made for special circumstances, some insurers will terminate existing blocks of business in the individual marketplace, leaving the customers they served without health coverage until the new Exchanges are created." Rep. Pomeroy advocates for the AAA recommendation to explore other options to the proposed annual MLR for the individual market in order to assure stability over the next few years until the Exchanges are functioning.

Private Sector Cost Containment and Health Promotion

Rep. Pomeroy continues, "I am troubled by attempts of some well-intentioned Members of Congress and stakeholders to aggressively advocate for unrealistically narrow definitions of MLRs which I believe could have a chilling effect on future innovative programs aimed at restraining unnecessary care that is harmful to patients as well as create adverse incentives to eliminate existing programs that improve patient health." He is adamant that programs designed to create better outcomes for patients—prevention initiatives, chronic disease management, nurse hotlines and activities that reduce hospital readmissions—not be counted against insurers' administrative cost in the MLR calculation.

Rate Review at the State Level

Rep. Pomeroy's final plea to Sebelius is to maintain rate reviews for health insurance companies at the state level. He wants state regulators to be involved in ensuring that the "financial solvency of insurance companies is maintained."

There has not yet been any public response by HHS to the issues raised in this letter. It is important to remember that these concerns are being articulated by a member of Congress who supported the healthcare reform bills and who was present through the committee process where the intent of these provisions was extensively reviewed.

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Healthcare Re-forum No. 8

The Mutual Advantage with Healthcare Reform

The Patient Protection and Affordable Care Act (PPACA) has stimulated many discussions and questions about what might better position a health insurer to manage the requirements and provisions of the new healthcare reform law. Medical Mutual of Ohio® believes its mutual status uniquely positions the Company to navigate and manage reform, as well as provide the best healthcare coverage to the people in the communities it serves.

The Mutual Difference

Medical Mutual has prudently preserved its mutual structure for the last 76 years, while 95 percent of the healthcare insurers in the United States are functioning as for-profit stock entities. As a mutual company, Medical Mutual's primary concern is the policyholder rather than Wall Street or absentee shareholders. Unlike for-profit companies, Medical Mutual can develop and implement long-range strategies without being diverted by periodic price changes and per-share earnings reports. Shareholders of for-profit companies demand higher profit margins, which invariably take precedence over improvement of policy benefits.

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Managing the Challenges of Healthcare Reform

By leveraging the strengths inherent to a mutual company, Medical Mutual can confidently navigate the intricacies and challenges of the changing healthcare delivery system. Medical Mutual's strengths and benefits include:

- The creation and preservation of a financially sound organization, which is able to assure current and future protection for its policyholders:
  - Medical Mutual has a highly funded surplus to manage large claims and losses, which allows the Company to maintain policy benefits at their highest level.
  - Medical Mutual is debt free.
- Being a sizeable company with a mature and well-managed infrastructure to not only handle day-to-day business activities, but also manage business expansion and change as it comes

Additional supporting factors that will see Medical Mutual through healthcare reform include:

- Experienced employees with an average tenure of 13 years
- Strong brand awareness in the market
- Informational technology systems that can handle Exchanges in 2014
- Organizational experience in dealing with healthcare delivery system changes over the last 76 years
- Not being owned by stockholders, which creates an added protection against competitor takeovers and subsequent uncertainty

Compliance with PPACA Provisions

Long before the passage of the healthcare reform bills and subsequent mandates, Medical Mutual has demonstrated its commitment to policyholders by:

- Being a leader in prevention and wellness outreach programs
- Not canceling coverage retroactively, called rescission, except in cases of intentional misrepresentation and documented fraud
- An appeals process that is NCQA [1] and URAC [2] accredited and meets all the requirements for the Centers for Medicare and Medicaid Services

- Any provider in the network that is accepting patients can be designated as a primary care provider, including pediatricians
- No referrals are necessary
- Emergency care requires no prior approval, even out of network

The Mutual Way

Medical Mutual for years has grown and prospered by remaining committed to the philosophies that define a mutual company. Today, Medical Mutual is a strong, financially stable company prepared to navigate the post-reform changes in the healthcare delivery system and it remains focused on providing for the needs of its policyholders and the communities it serves.

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Healthcare Re-forum No. 9

Definition of Terms Utilized in Healthcare Reform Law

The passage of the Patient Protection and Affordable Care Act (PPACA) and the Health Care and Education Reconciliation Act (HCERA) have created significant changes in every part of the healthcare delivery system. There are a number of new terms used within the new healthcare laws that are not well understood. To help minimize confusion, we will dedicate several issues of *Healthcare Re-Forum* to define new or difficult terminology.

The Mutual Difference

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Healthcare Reform Terminology

- **Actuarial justification**
  The demonstration by an insurer that its premiums are reasonable based on the benefits provided and anticipated costs to manage policyholder claims. PPACA requires insurers to publicly disclose the actuarial justifications behind premium increases.
- **Adjusted community rating**
  A way of pricing insurance where premiums are not based on a policyholder's health status. PPACA requires the use of adjusted community rating beginning in 2014, with maximum variation for age of 3:1 and for tobacco use of 1.5:1. For example, the premium for a 50-year-old cannot be more than three times the premium for a 25-year-old. Geographic area and family composition (such as "employee plus spouse" or "employee plus child") may also be considered.
- **Attained age**
  Age at which an individual ceases to qualify for coverage. This term has been commonly used to explain dependent eligibility and the maximum allowable age under federal or state law.
- **Cost sharing**
  Healthcare provider charges for which a patient is responsible under the terms of a health plan. Cost sharing includes deductibles, coinsurance and co-payments. PPACA will cap total cost sharing at $5,950 for an individual and $11,900 per year for a family when the exchanges are operating in 2014. These amounts will be adjusted annually.
- **Essential benefits**
  The basic package of benefits included in a health insurance plan by 2014. General coverage includes: ambulatory patient services; emergency services; hospitalization for maternity and newborn care; mental health and substance abuse; prescription drugs; rehabilitative services and devices; laboratory services; preventive and wellness services; and pediatric services, including oral and vision coverage. Health and Human Services (HHS) is expected to further define "essential benefits."
- **Exchange**
  A program that will be overseen by Health and Human Services that will create a state-level marketplace for individuals and small businesses to purchase insurance. As part of the program allowable benefit structures, actuarial rules and applicable cost sharing will be defined. An essential element of the program will be the ability for a consumer or small business to compare and purchase health coverage. A standardized format will be used for presenting benefit options and each plan will be assigned a rating. Exchanges will also determine who qualifies for subsidies and who makes subsidy payments.

- **Grandfathered plan**
  Any insured or self-insured plan in existence on March 23, 2010. These plans are exempt from certain provisions of the new law. Details regarding maintaining a "grandfathered" status have just been released. A future issue of *Healthcare Re-Forum* will be dedicated to the details of the provision.
- **Group health plan**
  Any plan, fund or program established or maintained to provide medical care to members, employees or their dependents (as defined by the plan) directly through insurance or reimbursement. A plan under this provision is established or maintained by an employer, an employee organization or both. "Group health plans" generally include self-insured and fully insured plans.
- **Health insurance issuer**
  A company, service or organization (including a health maintenance organization) that is licensed and regulated by a state to engage in the business of insurance. An issuer does not include a group health plan.
- **Job lock**
  The situation where individuals remain in their current jobs because they have an illness or condition that may make them unable to obtain health insurance coverage if they leave their jobs. PPACA would eliminate "job lock" by prohibiting insurers from refusing to cover individuals due to health status. For children under 19, the effective date is September 23, 2010. For adults, this protection goes into effect in 2014.
- **Medical loss ratio**
  The percentage of health insurance premiums that is spent by the insurance company on healthcare services. PPACA requires that large group insurance plans spend 85 percent of premiums on clinical services and other activities for enrollees' quality of care. Small group and individual market insurance plans must devote 80 percent of premiums to coverage of medical claim costs. The National Association of Insurance Commissioners (NAIC) is currently working on refining the qualifications.
- **Open enrollment period**
  A specified period during which individuals may enroll in a health insurance plan each year. In certain situations, such as a birth, death or divorce, a special enrollment may be allowed outside the usual open enrollment period.
- **Plan year**
  The year that is designated within the plan document of a group health plan that defines the timeframe for benefit coverage. If a plan is governed by ERISA, the plan year will be set forth in the plan's 5500 reporting form that is filed annually with the Department of Labor.

  If there is no plan document, "plan year" can be defined as follows:
  - The deductible timeframe or limit year (maximum allowable coverage) used under the plan
  - If the plan does not impose deductibles or limits on a yearly basis, the plan year is the policy year
  - If the plan does not impose deductibles or limits on a yearly basis, and either the plan is not insured or the insurance policy is not renewed on an annual basis, the plan year is the employer's taxable year
  - In any other case, the plan year is the calendar year
- **First plan year**
  This is when a provision (regulation) in the healthcare reform law goes into effect for a group or insurer. In 2010, group plans have many provisions that will go into effect on the first day of the first plan year or after September 23. If the group uses a calendar year, the first plan year would begin on January 1, 2011.
- **Pre-existing condition clause**
  The period of time that an individual cannot receive benefits after enrollment in a healthcare plan due to an illness or medical condition for which medical advice, diagnosis, care or treatment was received during a period of time prior to enrollment. For example, plans may exclude coverage for 12 months for a condition that a person received treatment for during the six months prior to enrolling in the plan. All pre-existing condition limitations will be eliminated from plans in 2014 under the PPACA.
- **Qualified health plan**
  A health insurance policy that will be sold through an Exchange in 2014. Exchanges require certification of qualified health plans to ensure minimum standards are met, as specified in PPACA.

As information is made available and requirements are defined under the healthcare reform law, we will cover any new terminology in *Healthcare Re-Forum*.

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Prohibition of Discrimination Based on Salary

Prior to passage of the Patient Protection and Affordable Care Act (PPACA) and Health Care and Education Reconciliation Act (HCERA), tax rules for employer-sponsored health plans permitted employers to offer exclusive plans designed for highly compensated individuals on a tax-favored basis. Under these rules, only self-insured plans were prohibited from discriminating in favor of highly compensated individuals. Beginning September 23, 2010, the PPACA and HCERA extend this prohibition to fully insured plans.

Background

Provisions under the new laws now require fully insured plans to comply with non-discrimination rules, which ensure there is no favoritism in benefit structure toward highly compensated individuals. Companies that are affiliated through common ownership must be treated as a single entity for purposes of non-discrimination testing.

Highly Compensated Individuals

For purposes of non-discrimination testing, a highly compensated individual is:

- One of the five highest paid officers
- A shareholder owning more than 10 percent of the company's stock
- Among the 25 percent highest-paid employees

These requirements are not mutually exclusive. For example, if one of the five highest-paid officers is not among the 25 percent of highest-paid employees, he or she must still be included as a highly compensated individual.

Eligibility Testing

For a plan to be considered non-discriminatory with respect to eligibility, it must pass one of three coverage tests:

- Seventy percent of all employees benefit under the plan
- The plan benefits 80 percent of eligible employees and at least 70 percent of all employees are eligible to participate
- The plan benefits must not discriminate based on employee classification

Certain employees may be excluded from the eligibility tests, including:

- Employees with less than three years of service at the beginning of the plan year
- Employees who are younger than age 25 at the beginning of the plan year
- Employees who are part-time or seasonal
- Employees who are covered under a collective bargaining agreement
- Non-resident aliens who receive no income from a U.S. source

Penalties for Non-discrimination

While both fully insured and self-funded plans will now be subject to non-discrimination rules, the penalties for failure to meet these requirements vary by type of plan. For self-funded plans, failure to meet non-discrimination requirements will make the benefits taxable to the highly compensated employees.

The new rules applicable to fully insured plans impose an excise tax on the employer if it fails to meet non-discrimination requirements. The IRS penalty is $100 each day per highly compensated participant. This excise tax for unintentional failures (i.e., the plan sponsor did not know of the violation and would not have discovered the violation) is capped at $500,000 per year. The new law also gives the Secretary of Health and Human Services (HHS) the authority to impose additional civil fines on employers for up to $100 per day for each highly compensated participant for violations of the law.

Applying the Rules to Health Plans

- The new rules do not apply to grandfathered health insurance plans—those in existence on or before March 23, 2010.
- Fully insured plans established between March 23, 2010, and September 23, 2010, will be subject to the new rules as of the group's first plan year beginning on or after September 23, 2010.
- Fully insured plans established after September 23, 2010, must comply immediately with the new rules.
- The changes a plan can make and still retain grandfathered status have been clarified by the final interim grandfathered plan rules as released June 14, 2010, by HHS, the IRS and the Department of Labor.
- Grandfathered plans can comply with the new provisions in the PPACA and HCERA without losing their grandfathered status.
- Employers and health insurance issuers are given a grace period up to their next plan year on or after September 23, 2010, during which they can revoke or modify any changes made that caused them to lose their grandfathered status.

Medical Mutual will provide a summary of the final interim grandfathered plan rules in an upcoming issue of Healthcare Re-Forum.

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High-Risk Pool Program

The Patient Protection and Affordable Care Act (PPACA) establishes temporary national high-risk pools for those with pre-existing medical conditions. These high-risk pools are also referred to as the Pre-Existing Condition Insurance Plans.

Each state was given the option to operate a temporary high-risk pool or to have the U.S. Department of Health and Human Services (HHS) run the program. According to HHS, 29 states and the District of Columbia will run their own pools, and the federal government will run the high-risk pools in 21 states. PPACA requires HHS to supervise the program in each state.

Purpose of the Pre-Existing Condition Insurance Plan

- Health insurance will be provided to qualified individuals who have been denied coverage because of pre-existing medical conditions until the American Health Benefit Exchanges begin in 2014.
- Individuals with pre-existing medical conditions will receive a range of benefits, including primary and specialty care, hospital care and prescription drug coverage.
- The plan will establish a cost-sharing program in which enrollees will make a monthly contribution that has been set for a standard population in the individual market. Cost will not be based on the health status of enrollees. However, contributions may vary by a 4:1 ratio for age and by a 1.5:1 ratio for tobacco use. Geography may also be factored in.
- At least 65 percent of the cost of services provided will be covered by the plan.

Who Is Eligible?

Individuals must meet specific eligibility criteria to apply for coverage through a temporary high-risk pool program. They must:

- Be a citizen or national of the U.S. or lawfully present in the U.S. (documentation will be required).
- Be uninsured for six months prior to application date.
- Be ineligible for coverage under the federal Medicare program, Medicaid program, Children's Health Insurance Program or an employer-sponsored group health plan, unless the individual is subject to a mandatory initial waiting period.
- Have a qualifying pre-existing condition as evidenced by a denial of coverage by two insurers or by documentation from a health professional.

Application Process

- The 21 states where the federal government is running the high-risk pools will begin taking applications July 1, with an effective date of August 1, 2010, according to the HHS Web site.
- Each state will have a Web site to provide guidance for enrollment. However, the HHS Web site currently has limited information about the program.
- States are allowed to develop an application that fits their needs and requirements.
- States operating their own high-risk pools may not meet the August 1 date for coverage and are working out those details individually with HHS.
- Individuals need to obtain an application through the state under which they are applying for coverage. There is no centralized process for obtaining or submitting applications through the federal government.

Funding

- The federal government's $5 billion allocation will pay the healthcare claims and administrative costs that exceed the monthly contributions collected from enrollees.
- Each state will receive a specific amount based on the formula used to calculate Children's Health Insurance Program (CHIP) funds.

- In states where Medical Mutual of Ohio and its Family of Companies do business, the estimated temporary high-risk pool funding for the program duration is as follows:
  – Georgia: $177 million
  – Indiana: $93 million
  – Michigan: $141 million
  – Ohio: $152 million
  – South Carolina: $74 million
  – Pennsylvania: $160 million
  – Wisconsin: $73 million
  – West Virginia: $27 million.
- HHS intends to reallocate monies within two years, based on an assessment of actual state enrollment and expenditure experiences.
- Michigan, Ohio, Pennsylvania, West Virginia and Wisconsin have elected to administer the federal high-risk pool program at the state level. Georgia, Indiana and South Carolina will allow HHS to run the program in their respective states.

2014—American Health Benefit Exchanges

In 2014, individuals enrolled in the high-risk program will likely transition into the state-based American Health Benefit Exchanges, where pre-existing condition exclusions are prohibited. The Secretary of HHS is expected to develop procedures to ensure there is no lapse in coverage during the transition.

Medical Mutual to Administer Ohio's Pre-Existing Condition Insurance Plan

The state of Ohio selected Medical Mutual to administer the plan through an Administrative Services Only (ASO) arrangement with the federal government. Ohio Department of Insurance (ODI) Director Mary Jo Hudson expressed extreme confidence that we are the right company to administer this important program.

We will promote the program, process all applicants, manage all claims and provide customer service support. We will receive a modest administrative fee and, along with the state, will not take on any financial risk.

All members will have access to our statewide provider network. The Ohio program will offer two Preferred Provider Organization benefit plans, one with a $1,500 deductible and the other with a $2,500 deductible. Coverage offered must have an out-of-pocket limit no greater than $5,950 for an individual, excluding contributions. There will be no pre-existing condition exclusions or waiting periods. Rates for non-smokers are expected to be in the range of $188 to $545 per month depending on the age of the enrollee and the benefits selected. Rates for smokers will be higher. The benefit plans will encourage the use of in-network providers, though out-of-network benefits will also be available.

- We will begin accepting applications August 1, with an effective date of September 1, 2010.
- Ohio is developing its own application, which will be available later in July.
- ODI will provide enrollment information on its Web site, http://www.ohioinsurance.gov. Medical Mutual is also working on a Web site for applicants.

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Healthcare Re-forum No. 12

Maintaining the Status of a Grandfathered Plan

New regulations released on June 14, 2010, address what changes can be made to a plan that existed on March 23, 2010, without causing the plan to forfeit grandfathered status.

The Interim Final Rule (IFR) from the U.S. Departments of Treasury, Labor and Health and Human Services (the Departments) is still subject to amendment and elaboration after a 60-day public comment period.

Changes that Cause the Loss of Grandfathered Status

The following changes will cause individual and employer plans to no longer be grandfathered:

- A merger, acquisition or similar business restructuring, if the principal purpose of the action is to cover new individuals under the grandfathered plan
- A substantial elimination of benefits to diagnose or treat a particular condition
- Any increase in cost-sharing percentage requirements (e.g., coinsurance) above the level in effect as of March 23, 2010
- An increase in the fixed-amount, cost-sharing requirements (e.g., deductible or out-of-pocket limits) above the level in effect on March 23, 2010, other than copayments, that exceeds the sum of medical inflation plus 15 percent
- An increase in copayments above the level in effect on March 23, 2010, by an amount that exceeds the greater of the sum of medical inflation plus 15 percent or $5, adjusted annually by medical inflation
- A contribution rate decrease by an employer or employee organization of more than 5 percent below the contribution rate on March 23, 2010, for any tier of coverage and any class of similarly situated individuals
- The addition of an overall annual limit on the dollar value of benefits if the plan was not imposing an overall annual or lifetime limit on the dollar value of benefits on March 23, 2010
- The addition of an overall annual limit on the dollar value that is lower than the dollar value of the lifetime limit on March 23, 2010
- Any decrease in dollar value of the overall annual limit (regardless of whether the plan had an overall lifetime limit on March 23, 2010), if the plan imposed an overall annual limit on the dollar value of all benefits
- A change in health plan carriers in the individual market

Changes that Do Not Impact Grandfathered Status

The following changes will not cause a plan to lose its grandfathered status:

- The addition of family members of an individual who is a member or participant of a grandfathered plan; or the addition of new employees by an employer that maintains a grandfathered plan
- One or more individuals enrolled on March 23, 2010, cease to be covered by the plan (provided that the plan or coverage has continuously covered at least one person since March 23, 2010)
- Plan premium adjustments that do not affect relative contribution levels (for example, if an employer contributes 50 percent of an employee's premium, an increase in the employee's premium contribution is permitted as long as the employer's contribution is increased accordingly)
- Voluntary compliance with any provision of the Patient Protection and Affordable Care Act (PPACA)
- Entering into a new group policy or plan with a health plan issuer (either the same or a new issuer) as long as no changes are made to the plan's benefit structure that violate other rules for maintaining granfathered status (effective November 15, 2010)

- Plan changes effective after March 23, 2010, if the changes were made after:
  - A legally binding contract was entered into on or before March 23, 2010
  - A filing with a state insurance department was made on or before March 23, 2010, or
  - A written plan amendment was adopted on or before March 23, 2010, even if the amendment went into effect after March 23, 2010

The IFR notes there may be other changes in a plan that could trigger a forfeiture of grandfathered status. In the regulations, the Departments have requested comments about whether the following changes should result in the loss of grandfathered health plan status:

- Changes to plan structure (e.g., switching from a health reimbursement arrangement to major medical coverage)
- Changes in a provider network
- Changes to a prescription drug formulary and the magnitude of any changes
- Any other substantial change to overall benefit design

Additional Points to Consider:

- Plans intending to remain grandfathered must include a statement in plan materials provided to participants or beneficiaries that the plan or coverage is to be grandfathered within the meaning of section 1251 of the PPACA. The IFR includes a model statement that may be used.
- The IFR requires that plans maintain records documenting the terms of the plan that were in effect on March 23, 2010, as well as any records necessary to verify or clarify the plan's grandfathered status. These documents include: plan materials; health insurance policies, certificates or contracts of insurance; summary plan descriptions; premiums or the cost of coverage and required employee contribution rates. The plan or issuer must make the records available to participants and governmental entities for review.
- Employers and health plan issuers are provided with a grace period within which they can revoke or modify any changes made between March 23, 2010, and June 14, 2010, where the changes might result in the loss of grandfathered status. To benefit from the grace period, plans must revoke any changes that would cause a loss of grandfathered status by the start of the next plan year on or after September 23, 2010.
- Grandfathered plan rules apply separately to each benefit package under a group health plan or health insurance coverage.
- For an explanation of the reform provisions grandfathered plans are exempt from, reference *Healthcare Re-Forum, Issue No. 1*.

Now that these regulations are in place, the next question is, "How will these rules impact my coverage and what should I do?" In an upcoming *Healthcare Re-Forum*, we will address the potential impact of this IFR on the grandfathered status of individual and group plans.

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Healthcare Re-forum No. 13

Should My Plan Stay Grandfathered?

In past Re-Forum issues on grandfathering, we explained the different coverage changes groups or individuals may make without impacting the grandfathered status of a plan. In this issue, we look at the provisions that grandfathered plans are exempted from and the provisions with which they must comply.

[**Please Note:** The Interim Final Rule (IFR) from the U.S. Departments of Treasury, Labor, and Health and Human Services (HHS) is still subject to amendment and elaboration after a 60-day public comment period that ends on August 16.]

When Will Changes to Health Plans Occur?

Reforms take effect on a plan's first plan year beginning on or after September 23, 2010. The plan year is not necessarily when benefits change or when coverage renews. For many plans, the first plan year will be January 1, 2011. As noted in *Healthcare Re-Forum: Issue No. 12*, a grandfathered plan is one that was in existence on or before March 23, 2010.

Grandfathered Plans Are Exempt from the Following:

- The requirement that preventive services be covered without cost-sharing
- The prohibition of discrimination in favor of highly compensated individuals
- The requirement that plans provide their enrollees internal and external appeals of claims denials (many group health plans must already provide internal appeals under ERISA, and most states require that fully insured plans offer external review of denied claims)
- New HHS reporting requirements about claim payment policies, enrollment/disenrollment, claim denials and cost-sharing (effective 2010)
- New HHS reporting requirements about plan efforts to improve participant health, safety and wellness, and quality-of-care improvement activities (effective 2012)
- Coverage for adult children with other employment-based coverage available
- Patient protection requirements:
  - Mandating coverage of emergency services without prior approval and in-network requirements
  - Allowing the designation of a participating primary care provider and pediatrician
  - Prohibiting the required approval or referral to see an OB-GYN
- The requirement that individual and small group plans cover federally defined "essential health benefits" (effective 2014)
- The limit on out-of-pocket expenditures to the amounts now permitted for high-deductible health plans offered with a health savings account ($5,950 for individual coverage and $11,900 for family coverage) (effective 2014)
- The requirement that small group health plans limit deductibles to $2,000 for single coverage and $4,000 for family coverage (effective 2014)
- The requirement for coverage of certain clinical trials (including cancer clinical trials) (effective 2014)
- The restrictions on varying premiums charged for health plan coverage in the individual or small group market only by individual or family coverage, rating area, age and tobacco use, subject to certain restrictions (effective 2014)
- Non-discrimination based on a provider who is acting within his/her license (e.g., if an OB-GYN is covered, a plan may also have to cover midwives under this provision) (effective 2014).

Provisions that Apply to Grandfathered Plans and New Plans

- Compliance with medical loss ratio requirements (fully insured plans only)
- The prohibition against waiting periods in excess of 90 days (effective 2014)
- The prohibition of lifetime limits
- The ban on rescissions except in the case of fraud
- The requirement that plans cover adult children up to age 26 (however, grandfathered group plans do not need to cover adult children if they are eligible for coverage under another employer-sponsored group health plan)
- Prohibition of pre-existing condition exclusions for those under age 19
- Elimination of restricted annual limits on essential benefits

The agencies responsible for the IFR on grandfathering estimate that about 66 percent of small employers (fewer than 100 employees) and 45 percent of large employers (100 or more employees) will relinquish grandfathered status by 2013. In the individual market, the agencies estimated that between 40 percent and 67 percent of health plans will relinquish grandfathered status by 2013.

Next Steps for Plan Sponsors

Plan sponsors should consider the following:

- Plan sponsors should evaluate their current plan to determine whether the benefits of maintaining grandfathered plan status outweigh the restrictions on plan design and cost-sharing changes imposed by the regulations.
- Plan sponsors may want to consider alternative combinations of changes that may effectively control costs while maintaining grandfathered status. For example, an increase in a deductible over the allowed amount may cause a loss of grandfathered status. However, a plan sponsor might consider increasing the deductible by a lesser amount and increasing the out-of-pocket maximums or co-payments, or decreasing the employer's share of the premium in a way that recognizes the prescribed limitations, but does not relinquish grandfathered status.
- Plan sponsors that decide to retain the grandfathered status of their group health plan should carefully document the plan in effect on the grandfather date (March 23, 2010) and include the notice about grandfathered status in plan materials distributed to participants. (A model notice is included as part of the IFR.)

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Healthcare Re-forum No. 14

Web Portal—New Consumer Site for Viewing Coverage Options

The Patient Protection and Affordable Care Act (PPACA) required the Secretary of Health and Human Services (HHS) to establish an Internet site for individuals and small businesses to identify available health coverage in each state. The small business definition varies from state to state but is typically defined as 1 to 50 employees. The Web portal (portal) will help consumers evaluate their private health insurance options and allow them to determine if they may be eligible for a variety of public programs, including existing state high-risk pools (available in some states), new pre-existing condition insurance plans (temporary high-risk pools), Medicaid, Medicare and the Children's Health Insurance Program (CHIP).

The portal will be implemented in phases, with July 1 marking the launch of the first phase. During this phase, the portal includes information about small business tax credits and the Early Retiree Reinsurance Program, which provides reinsurance payments to approved businesses offering coverage to their non-Medicare retirees age 55 and older. The portal also includes a consumer education component to help people better understand the new healthcare reform laws, insurance terminology and their choices in coverage, and provides an overview of the operation of insurance in the current marketplace. To help consumers evaluate their insurance options in both the private and public sectors, a detailed overview of these options is also included, offering a preview of the American Health Benefit Exchanges.

The portal currently provides the following information:

- Plan names and types (e.g., HMO, PPO)
- Summary of services offered
- List of network providers
- Formulary, if available
- Links to each available plan's Web site and customer service contact information
- An overview of the PPACA
- Contact information for consumers to obtain more information and to enroll

Consumers will be directed to Medicare Web sites and call centers for information about the Medicare program. For Medicaid and CHIP programs, the portal will provide the following information for each state:

- Eligibility information
- Summary of the level of Medicaid services available
- Links and contact information for benefit information, to determine eligibility on an individual basis and to enroll

The following information about high-risk pools (Pre-Existing Condition Insurance Plan) will be available by state:

- Name of the plan and contact information
- Enrollment instructions
- Eligibility criteria
- Coverage limitations
- Enrollee contribution/premiums

In October, the portal's second phase will offer more detailed pricing and benefit information for both public and private insurance options. Consumers will be able to compare cost-sharing amounts, deductibles and contributions/premiums. Greater detail about the high-risk pool program will also be available.

HHS will schedule an annual update for the portal as well as periodic adjustments from carriers to keep the information accurate. More information about the portal is available in the Interim Final Rule from HHS: http://www.hhs.gov/ociio/regulations/webportal.html

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Healthcare Re-forum No. 15

Preventive Services and the New Interim Final Regulations (IFR)

The Patient Protection and Affordable Care Act (PPACA) requires group health plans and health insurance issuers offering group or individual health insurance coverage to provide recommended preventive services without cost sharing. The Departments of Health and Human Services (HHS), Labor and the Treasury published new interim regulations in the Federal Register on July 19, 2010, that provide further guidance on this requirement.

The Basics of the Provision

For plan years beginning on or after September 23, 2010, non-grandfathered group health plans must cover the preventive services outlined below. Additionally, plans may no longer charge patients a copayment, coinsurance or deductible for these services when delivered by a network provider. The term "group health plan" includes both insured and self-insured group health plans.

What Preventive Services Does the Rule Cover?

- Evidence-based items or services that have a rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF).
- Immunizations for routine use in children, teenagers and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC) with respect to the individual involved. A recommendation of the Advisory Committee is considered to be "in effect" after it has been adopted by the Director of the CDC. A recommendation is considered to be for routine use if it appears on the Immunization Schedules of the CDC.
- With respect to infants, children and teenagers, evidence-based preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).
- With respect to women, evidence-based preventive care and screening provided for in comprehensive guidelines supported by HRSA (and not otherwise addressed by the recommendations of the USPSTF). HHS is developing these guidelines and expects to issue them no later than August 1, 2011.

IFR Clarify the Cost-Sharing Requirements for Office Visits

- If a recommended preventive service is billed separately (or is tracked separately as individual encounter data) from an office visit, a plan or issuer may apply cost-sharing requirements to the office visit.
- If a recommended preventive service is not billed separately (or is not tracked separately as individual encounter data) from an office visit and the primary purpose of the office visit:
  – is for that preventive item or service, a plan or issuer may not apply cost-sharing requirements to the office visit.
  – is not for the preventive item or service, a plan or issuer may apply cost-sharing requirements to the office visit.

Additional Points to Note

- Plans that cover preventive services beyond those required under the new law may apply cost-sharing requirements for the additional services.
- The regulations clearly indicate that group health plans may require cost-sharing for recommended preventive services delivered by an out-of-network provider.
- When newly recommended preventive services are identified under the law, there is an interval of not less than one year between the issuance of recommendations or guidelines under Public Health Services Act Section 2713(a) and the plan year for which coverage of the services addressed in the recommendations or guidelines must go into effect.

- Plans and issuers can use reasonable medical management techniques to determine coverage limitations if a recommendation or guideline for a recommended preventive service does not specify the frequency, method, treatment or setting for the provision of that service.
- A plan or issuer is not required to provide coverage or waive cost-sharing requirements for any item or service that ceases to be a recommended preventive service.

A complete list of preventive services recommendations and guidelines that must be covered under the IFR can be found at:

http://www.HealthCare.gov/center/regulations/prevention.html

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Healthcare Re-forum No. 16

Healthcare Terminology Definitions (Part II)

As we discuss and review provisions in the Patient Protection and Affordable Care Act (PPACA) and the companion Health Care and Education Reconciliation Act (HCERA) there are still terms that create confusion. This issue of Re-Forum focuses on defining terminology that may be new or confusing, or that has new elements or additional requirements through the healthcare reform laws.

Healthcare Reform Terminology:

- **Co-op plan** - A health insurance plan that will be sold by member-owned and operated non-profit organizations through the American Health Benefit Exchanges (Exchanges) when they begin operations in 2014. PPACA provides grants and loans to help co-op plans enter the marketplace, and there must be at least one co-op plan available in each state.
- **Cost sharing** - Healthcare provider charges for which a patient is responsible under the terms of a health plan. Cost sharing includes deductibles, coinsurance and copayments. PPACA will cap total cost sharing at $5,950 for an individual and $11,900 per year for a family when the Exchanges are operational in 2014. These amounts will be adjusted annually. (Grandfathered plans are exempt from this requirement.)
- **Deductible** - A dollar amount that a patient must pay for healthcare services each year before the insurer will begin paying claims under a policy. PPACA limits annual deductibles for small group policies to $2,000 for policies that cover an individual and $4,000 for other policies. These amounts will be adjusted annually to reflect the growth of premiums. (Grandfathered plans are exempt from this requirement.)
- **External review** - Part of the health insurance claims denial process. External review typically occurs when an independent third party reviews a claim to determine whether the insurer is obligated to pay. It is one of several steps that comprise the appeal and review process, and is performed after the member has exhausted the insurance company's internal review process without success. The Department of Health and Human Services (HHS) has recently issued rules to standardize the external review process. (Grandfathered plans are exempt from this requirement.)
- **Guaranteed issue** - A requirement that health insurers sell a health insurance policy to any person who requests coverage. Beginning in 2014, PPACA requires that the physical condition (past or present) of the applicant is not considered for coverage.
- **High risk pool** - A temporary federal high-risk pool program created by PPACA, also called the Pre-Existing Condition Insurance Plans, which will be administered at the state level to provide coverage to individuals with pre-existing conditions who have been uninsured for at least six months. The temporary high-risk pool will be administered in Ohio by Medical Mutual. This program is intended to function until the Exchanges are operational in 2014 or until the allocated funds are exhausted.
- **Individual mandate** – A mandate for most individuals to have health insurance or pay a penalty for each month of noncompliance, beginning in 2014. Individuals will be required to maintain minimum essential coverage for themselves and their dependents.
- **Internal review** – The guarantee that enrollees in non-grandfathered plans can receive an internal evaluation of a denied claim. Enrollees who still face refusal will then be able to move the case to an independent, external review (see "External review" above). New Interim Final Rules standardize the appeals process for both internal and external appeals.
- **Medical loss ratio (MLR)** - The percentage of health insurance premiums that are spent by the insurance company on healthcare services. PPACA requires large group plans to spend 85 percent of premiums on clinical services and other activities for

the quality of care for enrollees. Small group and individual market plans must devote 80 percent of premiums to these purposes. Further clarification on the MLRs is expected from the National Association of Insurance Commissioners.

- **Multi-state plan** - The requirement for the Office of Personnel Management (OPM), which administers the federal employees' health benefit plan (FEHBP), to contract with at least two health insurers (one of which must be non-profit) to offer insurance in the individual and small group markets in multiple states through the Exchanges. This provision is intended to create nationwide coverage: insurers may phase in coverage, with 60 percent of the states in year one, 70 percent in year two, 85 percent in year three, and 100 percent in year four and each subsequent year.
- **Risk adjustment** - A process through which insurance plans that enroll a disproportionate number of sick individuals are reimbursed for that risk by other plans that enroll a disproportionate number of healthy individuals. PPACA requires states to conduct risk adjustment for all non-grandfathered health insurance plans.
- **Risk corridor** - A temporary provision in PPACA that requires plans whose costs are lower than anticipated to make payments into a fund that reimburses plans whose costs are higher than expected. This mandatory federal risk corridor program will be in place from 2014 – 2016 for qualified health benefit plans in the individual and small group markets, excluding grandfathered plans.
- **Small group market** - The market for health insurance coverage offered to small businesses with between 2 and 50 employees. PPACA will broaden the small group market definition to businesses with between 1 and 100 employees on January 1, 2016.
- **Waiting period** - A period of time that an individual must wait either after becoming employed or submitting an application for a health insurance plan, before coverage becomes effective and claims may be paid. Premiums are not collected during this period. Plans may not impose a waiting period in excess of 90 days. Grandfathered plans will need to comply with their plan year beginning on or after January 1, 2014.

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Healthcare Re-forum No. 17

New Regulations Overhaul the Appeals Process

On July 23, 2010, the Departments of Health and Human Services, Labor and the Treasury (the Departments) released interimfinal regulations (IFR) to help create a uniformprocess for the internal and external appeals processes of health insurance claims. The IFR requires group health plans and insurers offering group or individual health insurance coverage to establish a comprehensive,well-defined process for patientswho appeal decisions on coverage, services and claim payments. These regulations also apply to self-funded health plans, but not to grandfathered plans. Changes are effective for plan years beginning on or after September 23, 2010 (January 1, 2011, for calendar year plans). The IFR is subject to amendment and elaboration until September 21, 2010.

Internal Appeals

The IFR sets forth six new requirements—in addition to those in the existing Department of Labor regulations—for the internal claims and appeals process. The new rules for internal appeals:

- Expand the definition of "adverse benefit determination" to include rescissions of coverage.
- Shorten the timeframe for urgent care benefit determinations to 24 hours (previously 72 hours) after the receipt of the claim by the health plan or insurer.
- Allow for a "full and fair review" of the denial by requiring a health plan or insurer to:
  1. Allow the claimant to review the claim file and present evidence and testimony, and
  2. Provide to the claimant, free of charge and with reasonable opportunity to respond, any new or additional evidence or rationale considered by the health plan or insurer in connection with the claim.
- Require a health plan or insurer to avoid conflicts of interest by making decisions about hiring, compensation, termination and promotion independent of a claim reviewer's or medical expert's record of denial of benefits.
- Require a health plan or insurer to provide notice of adverse benefit determinations to enrollees in a culturally and linguistically appropriate manner and in a way that sufficiently identifies the claim involved (model notices will be issued clarifying these requirements).
- Establish that a health plan's or insurer's failure to strictly follow the requirements of the internal claims and appeals process will indicate that the claimant has exhausted the internal claims and appeals process. The claimant may then initiate an external review and pursue judicial review.

Three additional requirements apply to individual health insurance plans:

- The definition of "adverse benefit determination" is expanded to include any decision to deny coverage in an initial eligibility decision.
- An insurer must provide for only one level of internal appeal before issuing a final determination.
- An insurer must maintain records of all claims and notices associated with the internal claims and appeals process for six years.

The Patient Protection and Affordable Care Act requires health plans and insurers to provide continued coverage pending the outcome of an internal appeal. The IFR clarifies that health plans and insurers may not reduce or terminate an ongoing course of treatment without providing advance notice and an opportunity for advance review. Claimants in an urgent care situation or those receiving an ongoing course of treatment may proceed with an internal review and an expedited external review concurrently.

External Review

The IFR also provides detailed directions for the external review process by clarifying which health plans and insurers must comply with either the state or federal external review procedures. The IFR specifies that, after a transition period, states' external review processes will need to meet the standards established in the National Association of Insurance Commissioners' Uniform Health Carrier External Review Model Act (Model Act). The Model Act includes requirements for:

- External review of an insurer's or plan's decision to deny coverage for care based on medical necessity, healthcare setting, level of care or effectiveness of a covered benefit.
- Clear information to be provided to individuals about their right to external review. This must be available in the plan materials and in a notice at the time the claim is denied.
- Expedited external review in some cases, including urgent care claims and emergency services.
- Exhaustion of the internal appeals process to be unnecessary in certain situations, such as when a health plan or insurer waived the exhaustion requirement or when the health plan or insurer did not strictly follow the rules established in the internal appeals process.
- Payment of the cost of the external review by the health plan or insurer. Under state law, states may not require consumers to pay more than a nominal fee of $25.
- Review by an independent review organization (IRO) randomly assigned by the respective state. The state must also ensure the IRO meets certain standards, keeps appropriate written records and is not affected by a conflict of interest.
- A process to review claims involving experimental or investigational treatments.
- External review of final decisions to be binding on the health plan or insurer. If the patient wins the appeal, the health plan or insurer is expected to pay for the denied benefit.
- No minimum dollar amount for a claim to be eligible for external review.

If State laws do not meet these standards, consumers in those states will be entitled to comparable federal external review standards. The Departments will issue more guidance soon about the federal external review process. These new standards are expected to be similar to those in the Model Act. Insurers and health plans will need to review the Model Act standards, which must be implemented in states prior to July 1, 2011, the end of the transition period. The IFR about appeals can be accessed at http://edocket.access.gpo.gov/2010/pdf/2010-18043.pdf.

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Healthcare Re-forum No. 18

New W-2 Reporting Requirements

The Patient Protection and Affordable Care Act (PPACA) includes a provision requiring employers to calculate and report the aggregate cost of applicable employer-sponsored health benefit coverage on employee W-2 forms. Employers must report this value on all W-2 forms issued for the 2011 tax year. All employers who offer employer-sponsored health insurance coverage must comply with this new legislation. Grandfathered plans are not exempt from this requirement.

Definition of Employer-Sponsored Coverage

In this provision, employer-sponsored coverage includes major medical coverage, amounts contributed to Health Reimbursement Accounts (HRAs), Medicare supplemental coverage, employer-provided Medicare Advantage plans, the value of on-site medical clinics and so-called mini-medical (or limited benefit) plans.

Types of Coverage that Are Excluded

Certain types of employer-sponsored coverage are specifically excluded from the new W-2 form reporting requirements, including:

- Any salary-reduction contributions made to a health flexible spending arrangement (health FSA)
- Stand-alone vision or dental insurance coverage
- Long-term care coverage
- Hospital indemnity or other fixed indemnity insurance (if paid for with employee after-tax dollars)
- Specific disease or illness coverage (if paid for with employee after-tax dollars)
- Accident-only coverage
- Disability income insurance
- Workers' compensation insurance

How Is the Cost of Coverage Determined?

This new provision requires employers to determine the value of employer-sponsored coverage under rules similar to those that apply when determining COBRA continuation coverage premiums, including the special rules that apply for self-insured arrangements. For fully insured plans, the premium will likely be the aggregate cost.

Another challenge for employers is that some of the plans covered by the new reporting requirement are not plans that previously would have been valued for COBRA purposes, such as on-site medical clinics. With the PPACA provision, employers are now required to determine reportable values for such programs. Regulatory guidance is expected on this new requirement.

The value of employer-sponsored coverage will appear on employees' W-2 forms for informational purposes, but will not be considered taxable income. It is believed the intent behind this provision is to sensitize both employers and employees to the value of employer-sponsored healthcare coverage in anticipation of both the Exchanges, scheduled to begin in 2014, and the imposition of the "Cadillac" excise tax in 2018. The excise tax is intended for employers who provide health plans with values that exceed $10,200 for single coverage or $27,500 for family coverage.

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Healthcare Re-forum No. 19

Patient Protections

On June 28, 2010, the Departments of Health and Human Services (HHS), Labor and Treasury (the Departments) issued interim final regulations (IFR) entitled "Patient Protection and Affordable Care Act: Pre-existing Condition Exclusions, Lifetime and Annual Limits, Rescissions and Patient Protections." This IFR defines several mandates that will take effect for non-grandfathered plans on or after September 23, 2010 (for calendar year plans, the rules will take effect January 1, 2011). This issue of *Healthcare Re-Forum* reviews the reform rules involving the Patient Protections mandate. All non-grandfathered group health plans, both fully insured and self-insured, as well as non-grandfathered individual health plans, must comply with the guidelines listed below. Grandfathered group and individual plans are exempt from the Patient Protections mandate.

The Patient Protections mandate will have a significant impact on provider selection for plan members. The IFR clarifies requirements about how plan members can choose primary care providers, including the ability to choose pediatricians as primary care providers for children and required access to obstetric and gynecological care for women. In- and out-of-network emergency services are also reviewed.

Primary Care Provider Selection

If a plan requires members to choose a primary care provider (PCP), the plan will need to notify each member (or in the individual market, the primary subscriber) about his or her right to choose:

- Any participating PCP who is accepting new patients
- Any participating physician specializing in pediatrics as the PCP for a child (the pediatrician must be accepting new patients)

The ability to choose a pediatrician as a child's PCP does not change the general terms of insurance coverage for pediatric care. If there is a certain benefit not covered by the plan, the plan will not be required to cover that service even if the pediatrician recommends it as part of a treatment plan.

In addition, plans that provide coverage for obstetrical or gynecological care and require members to choose a PCP must notify members that there is no requirement to obtain prior approval or a referral for such care by in-network healthcare professionals in those specialties. As defined by the IFR, a healthcare professional who specializes in obstetrics or gynecology is any individual who is authorized under applicable state law to provide obstetrical or gynecological care.

While a female member will not need prior approval to see an OB/GYN, the OB/GYN must still follow the plan's policies on referrals to other providers and, if required, prior approvals for specific services.

Emergency Services Provision

Plans that currently provide benefits for emergency services in hospital emergency departments need to be aware of the following requirements:

- Plans must provide coverage for emergency services without prior approval, whether those services are received from in- or out-of-network providers.
- The cost-sharing amounts (e.g., deductibles and coinsurance) for both in- and out-of-network emergency services must be the same, with members not being charged more for out-of-network emergency services.
- Out-of-network emergency services providers may sometimes bill patients for the difference between their charges and the amount collected from the plan (i.e., the allowed amount) and from the patient (i.e., copayment or coinsurance).

- The IFR establishes a formula to ensure plans pay an "appropriate amount" to non-network providers of emergency services (the formula's calculation should be reviewed in the IFR, along with the examples provided for further clarification).
- Cost-sharing requirements that plan members pay, such as deductibles or out-of-pocket maximums, may only apply for out-of-network emergency services in the same way they apply for all other out-of-network services.

Summary

The new IFR makes it clear that health plan members who are required to designate a PCP are able to select any available participating PCP, and that parents may choose any available participating pediatrician to be their children's PCP. The IFR also prohibits the requirement of a referral for obstetrical or gynecological care. The IFR sets specific requirements on how health plans should reimburse out-of-network providers for emergency services. Plans and insurers will need to charge the same cost-sharing amounts for emergency services that are obtained either in or out of a plan's network. These changes apply only to non-grandfathered individual market and group health plans, both fully insured and self-insured.

The "Patient Protection and Affordable Care Act: Pre-existing Condition Exclusions, Lifetime and Annual Limits, Rescissions and Patient Protections" IFR can be accessed through the following link:

http://www.dol.gov/federalregister/HtmlDisplay.aspx?DocId=23983&AgencyId=8&DocumentType=2

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Healthcare Re-forum No. 20

Consumer-Driven Health Plans Under the New Reform Law

The Patient Protection and Affordable Care Act (PPACA) imposes a number of new rules and restrictions on consumer-driven health plans (CDHP) such as health savings accounts (HSAs), health flexible spending accounts (health FSAs) and health reimbursement arrangements (HRAs). This issue of *Healthcare Re-Forum* provides a brief overview of these arrangements and the PPACA provisions that affect them.

Overview: HSAs, Health FSAs, HRAs and Related "Insurance" Arrangements

HSAs are individual accounts that pay routine healthcare expenses directly. An HSA is designed to function with (and can only accept contributions when paired with) a high-deductible health insurance plan (HDHP), which protects the individual from catastrophic medical expenses. This system of healthcare is referred to as "consumer-driven healthcare" because non-catastrophic medical expenses can be paid using a consumer-controlled account. Health FSAs and HRAs are similar to HSAs, but are not directly established by an individual. However, all three types of arrangements give employees and employers the opportunity to pay for covered medical expenses on a pre-tax basis, while encouraging enrolled individuals to become actively involved in making their own healthcare decisions.

HSA Paired with an HDHP[1]

- An HSA is used for general medical expenses; an HDHP protects against catastrophic medical bills
- An HDHP is purchased by either an individual or an employer (as a group health plan)
- An HSA is owned by the individual, even when an employer sponsors the HDHP
- Individuals may make annual contributions up to a pre-determined limit; employers may also contribute under limited circumstances
- Individuals may withdraw funds tax-free to pay for qualified medical expenses until reaching the HDHP deductible
- Funds remaining at the end of each year grow on a tax-deferred basis
- Individuals cannot have access to other forms of medical insurance including certain health FSAs and HRAs (subject to limited exceptions)

Health FSA

- An FSA is an employer-sponsored, employee-funded healthcare spending account
- Employees elect pre-tax contributions to pay for qualified medical expenses not otherwise covered by their health plan
- Funds remaining at the end of each year may not be rolled over into the next year
- Can be used in conjunction with other types of insurance plans, as a component of a cafeteria plan (Internal Revenue Code Section 125) or as stand-alone vehicles (there are some restrictions on types of health FSAs that can be used if a person contributes to an HSA)

HRA

- An HRA is an employer-sponsored, employer-funded healthcare spending account
- Provides covered employees with benefits through individual accounts to help meet annual deductibles or pay for other qualified medical expenses
- Employer determines the amount of money set aside; employees cannot contribute
- Employer determines if funds remaining at the end of each year may be carried over or must be forfeited
- Can be used in conjunction with any type of health plan offered by the employer, including an HDHP, or as stand-alone vehicles (there are some restrictions on the types of HRAs that can be used if a person also contributes to an HSA)

1. Archer Medical Savings Accounts (Archer MSAs) are the precursor to HSAs and operate very similarly. Effective January 1, 2008, new Archer MSAs may not be established; however, contributions to and distributions from Archer MSAs established prior to that date may continue.

- May not be offered as a component of a cafeteria plan (Internal Revenue Code Section 125)

Reform Provisions Affecting HSAs, Health FSAs, HRAs and Archer MSAs

- Effective January 1, 2011, the PPACA limits the types of medical expenses that can be paid for by an HSA or an Archer MSA and reimbursed under a health FSA or HRA. Over-the-counter medications no longer qualify as eligible medical expenses for HSA and Archer MSA distribution or health FSA and HRA reimbursement, other than two exceptions:
  1. Over-the-counter insulin
  2. Over-the-counter items prescribed by a physician
- The PPACA also requires employers to provide information on the aggregate cost of an individual's employer-sponsored health coverage for the previous year on the individual's W-2. This requirement is effective for tax years starting on or after January 1, 2011. Contributions to a health FSA are not included as part of the aggregate cost of an individual's employer-sponsored health coverage. The existing W-2 reporting requirement for an employer's contributions to an individual's HSA or Archer MSA remains unchanged under the PPACA.
- Effective January 1, 2011, there is an increase in the tax penalty on distributions from HSAs and Archer MSAs that are not used for qualified medical expenses. The current 10 percent tax on non-qualified distributions from HSAs and 15 percent tax on non-qualified distributions from Archer MSAs will both increase to 20 percent.
- Effective January 1, 2013, PPACA imposes a new $2,500 annual limit on the contribution an employee can make to a health FSA. The new limit will be indexed to inflation for future years.
- Effective January 1, 2018, an excise tax of 40 percent will be levied on employer-sponsored coverage that has an aggregate actuarial value in excess of $10,200 for single coverage and $27,500 for family coverage (indexed annually). This is the so-called "Cadillac Tax." Employer-sponsored coverage includes the value of the employer's contributions to an employee's HSA or Archer MSA and the cost of coverage (as defined in the Internal Revenue Code) provided under a health FSA or HRA. The tax will be imposed on coverage providers, which can include insurers, employers and plan administrators, depending on the funding arrangement for the coverage.

Other Points to Note:

- HDHPs in existence on or before March 23, 2010, must observe the rules established for grandfathered plans if they seek to maintain their grandfathered status for plan years beginning on or after September 23, 2010.
- Annual or lifetime limit restrictions do not apply to HSAs, health FSAs, HRAs or Archer MSAs that are integrated with a group health plan that otherwise complies with the annual and lifetime limit prohibition. These limits also do not apply to retiree-only HRAs, though the status of stand-alone HRAs is unclear. The Department of Health and Human Services is requesting comments on the application of annual limit restrictions to stand-alone HRAs that are not retiree-only HRAs.

This article is not intended to provide tax or legal advice. As always, it is important for employers to consult with a tax and/or legal advisor when evaluating the effect of the PPACA provisions reviewed above.

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Healthcare Re-forum No. 21

Healthcare Reform and Self-Insured Plans

Self-insured employers and other self-funded group health plan sponsors have historically enjoyed very broad discretion with respect to the scope and design of the benefits covered by their plans. This is no longer the case. The Patient Protection and Affordable Care Act (PPACA) amends the Public Health Services Act (PHSA), the Employee Retirement Income Security Act of 1974 (ERISA) and the Internal Revenue Code, and therefore applies to all self-insured group health plans, including those governed by ERISA. The PPACA imposes a number of new requirements regarding both the eligibility for plan membership and the scope of benefits that self-insured plans must provide. Self-insured plans, which typically use the administrative services of an insurer or third-party administrator, will be required to follow most of the same rules set forth in the PPACA that apply to fully insured plans.

Rules for self-insured plans were clarified in the preamble to the interim final regulations about grandfathering issued June 14, 2010. A portion of the preamble clearly defines self-insured plans as "group health plans" on par with fully insured plans, with the subsequent responsibilities defined in the PPACA. In addition, the preamble clarifies the PPACA does not provide self-insured, non-government plans the exceptions granted to such plans by HIPAA and certain other federal employee benefit plans.

Provisions Not Affecting Self-Insured Plans

The PPACA imposes a variety of detailed obligations on all group plans. However, the following reforms **do not apply to self-insured plans:**

- **Ensuring Consumers get Value for their Dollars –** Effective in 2010, insurers are required to have their premium increases approved by both the applicable states and the Secretary of Health and Human Services (HHS).
- **Medical Loss Ratios (i.e., the percentage of every premium dollar spent on medical benefits) –** Effective for plan years on or after January 1, 2011, Medical Loss Ratios (MLRs) are set at 80 percent in the small group and individual markets and 85 percent in the large group market. Self-insured groups do not have the same reporting requirement that fully insured groups have to substantiate compliance with the MLRs.
- **Fair Health Insurance Premiums –** Effective for plan years on or after January 1, 2014, insurers will be restricted in their use of rating factors as defined by states and HHS. The factors that can be used by underwriters to calculate a premium include geography (to be defined), age (3:1 ratio) and tobacco usage (1.5:1 ratio).
- **Guaranteed Availability and Renewability of Coverage –** Effective January 1, 2014, insurers must cover or renew all applicants for both new and renewing policies.
- **Annual Tax on Net Premiums –** A new annual tax on net premiums divided by market share is established by the PPACA effective January 1, 2014, that will apply to fully insured plans and raise a total of $14.3 billion (increasing on an annual basis). Each issuer of health insurance will be assessed a fraction of this yearly, phased-in, non-deductible fee. Self-insured plans and their administrators are exempt from this tax.

Provisions Affecting Self-Insured Plans

Grandfathering

It is important for both fully insured and self-insured groups to study the ramifications of maintaining grandfathered plan status.

Under the rules for grandfathered plans, health insurance coverage maintained pursuant to a collective bargaining agreement is grandfathered through the expiration date of the last agreement relating to the coverage in effect on March 23, 2010. The special grandfathering rule for collectively bargained plans does not apply to self-insured plans.

Self-insured plans that decide to maintain grandfathered status will be exempt from new requirements for an internal appeal/external review process. However, the PPACA does not change the ERISA requirement for self-insured plans to provide an internal appeal procedure to plan enrollees who have experienced an adverse benefit determination.

Taxes and Fees

There are a number of new taxes and fees established by the PPACA. These taxes and fees apply to both self-insured and fully insured plans, with the exception of the annual tax on net premiums, as noted above.

Stop-Loss Coverage

While employers who self-insure take on the financial risk of their employees' healthcare coverage, they are able to limit their risk through the purchase of stop-loss insurance policies. The stop-loss policy is one of the most crucial elements of a self-insured plan. Under the PPACA, after September 2010, employers will be prohibited from capping the lifetime limits for "essential health benefits." It will be important for employers to discuss the impact of this change with their stop-loss carriers. Employers will also need to review their stop-loss policies carefully to determine what caps, if any, exist on stop-loss coverage, both aggregate and specific.

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Healthcare Re-forum No. 22

Simple Cafeteria Plans

The Patient Protection and Affordable Care Act of 2010 (PPACA) modified cafeteria plan regulations to create Simple Cafeteria Plans, which allow qualified employers with 100 or fewer employees to offer cafeteria plans as long as they meet minimum eligibility, participation and contribution requirements defined in the law. This change is effective for plan years beginning after December 31, 2010

Prior to the passage of PPACA, IRS rules governing cafeteria plans did not include self-employed individuals in the definition of "employee." As a result, sole proprietors, partners, shareholders of 2 percent or more in S-corporations and members of limited liability companies were unable to participate in cafeteria plans. The PPACA created a "safe harbor" for qualified small employers from Internal Revenue Code Section 125, which prevents discrimination in favor of highly compensated employees for eligibility or specific qualified benefits. With Simple Cafeteria Plans, owners of small businesses may now participate as individuals, making it more likely they will offer these plans to their employees.

Other than this safe harbor provision and specific qualification provisions, cafeteria plans and Simple Cafeteria Plans are the same.

Types of Cafeteria Plans

Cafeteria plans enable employees to reduce their salaries on a pre-tax basis to pay for qualified benefits, thus reducing their overall tax liability. Qualified benefits include dependent care and healthcare benefits such as certain medications, health insurance premiums, copayments and deductibles.

There are three types of cafeteria plans, which apply to Simple Cafeteria Plans as well:

- **Premium-Only Plan (POP)** – In a POP, after-tax contributions made by employees to their employer-provided group insurance are converted to pre-tax contributions. This results in tax savings for both the employee (federal, FICA and sometimes state) as well as the employer (FICA and sometimes Workers' Compensation). This is the most commonly used type of cafeteria plan.
- **Flexible Spending Account (FSA)** – Employees may elect to deposit pre-tax earnings into an FSA to use for medical and/or dependent care expenses. FSAs function like a checking account in that the cafeteria plan administrator actually writes checks to reimburse participants for the medical and dependent care expenses they submit.
  - **Dependent care FSAs**–allow participants to pay up to $5,000 in qualified dependent care expenses using pre-tax dollars.
  - **Healthcare FSAs**–enable participants to fund individual accounts to use pre-tax dollars to pay for out-of-pocket healthcare expenses such as deductibles, coinsurance and fees for services that are not covered under their health insurance plans.
- **Full flex plan** – Through a full flex plan, employers can contribute a defined amount for benefits and employees can choose which benefits to purchase from a menu of options.

Employers of all sizes can offer cafeteria plans. Most employers offer a POP because of the ease of establishing the plan and the available tax benefits. FSAs are popular with all types of employers, while only large employers (1,000+) typically offer full flex plans due to the increased administration and communication requirements.

Note: Many employers add FSAs or a full flex plan to the core POP to provide further tax-favored benefits for their employees.

Simple Cafeteria Plan Regulations

As defined by the PPACA, employers with 100 or fewer employees must meet the following minimum eligibility, participation and contribution requirements to qualify for a Simple Cafeteria Plan:

- **Eligibility**
  - Employers who averaged 100 or fewer employees in the previous two years can qualify for a Simple Cafeteria Plan. A company not in existence for the previous two years must reasonably expect to average 100 or fewer employees on business days during the current year.
  - Special rules were created for a "growing employer." If the employee population exceeds 100 employees in the subsequent years, the employer can continue to sponsor a Simple Cafeteria Plan. However, once the employer exceeds 200 employees, the plan must be converted to another type of cafeteria plan to continue receiving tax advantages.
  - Aggregation rules are used to prevent an employer from creating additional subsidiaries to avoid the limitation on the number of employees. In addition, leased employees have applicable regulations to calculate employer eligibility.

- **Participation**
  - Employees who worked at least 1,000 hours in the previous year must be eligible to participate.
  - Every eligible employee must have the ability to elect any benefit available under the plan.
  - Employees under age 21, employees who have yet to complete one year of service with the company and employees covered under a collective bargaining agreement may be excluded from participating.

- **Contributions**

  Plans will need to make qualified benefit contributions for eligible employees. The contribution amount must be determined based on one of the following calculations:
  - A standardized percentage that is at least 2 percent of the employee's compensation; or
  - An amount not less than the lesser of:
    (a) 6 percent of the employee's compensation for the plan year, or
    (b) an amount that is twice the amount of the salary reduction contributions of each qualified employee for the plan year.

If the employer relies on the satisfaction of (b), it will not be treated as compliant if the rate of contributions with respect to any salary reduction contribution of a highly compensated or key employee is greater than that of any other employee.

The IRS has provided a Frequently Asked Questions (FAQ) website for Cafeteria Plans, which is available at http://www.irs.gov/govt/fslg/article/0,,id=112720,00.html.

Employers should consult with their tax advisor before establishing a Simple Cafeteria Plan.

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Healthcare Re-forum No. 23

Reform Clarifies Rescission Rule

The Patient Protection and Affordable Care Act of 2010 (PPACA) includes language specifying new rescission restrictions that apply to group and individual markets, fully insured and self-insured plans, and grandfathered and non-grandfathered plans. On June 28, 2010, and July 23, 2010, the Departments of Health and Human Services, Labor and the Treasury (the Departments) released interim final regulations (IFR) to help further define the rules that apply to rescission.

What is Rescission?

Rescission is any discontinuance of coverage that has a retroactive effect, such as a cancellation that considers a policy void from the time of enrollment. A distinction is made for non-payment of premiums—a health plan is allowed to cancel coverage retroactively if a participant fails to pay required premiums or contributions in a timely manner. This type of cancellation is not considered rescission. In addition, cancellations with only future effect are not rescissions and are still permissible.

Rescission Rules Issued by PPACA

The PPACA's new rescission rules build on existing protections for individuals offered by the Public Health Service Act's regulations governing the cancellation of coverage and non-discrimination rules set forth by the Health Insurance Portability and Accountability Act (HIPAA). The PPACA establishes a floor for other health coverage rescission laws—all state laws and any other federal laws may only provide a standard that is at least as strict as the PPACA rescission standard. If a state's rescission law is less favorable to an individual than the standard established under PPACA, then the state law is superseded. Effective for plan years beginning on or after September 23, 2010, health plans may not rescind coverage of an enrolled individual unless the individual committed fraud or intentionally misrepresented material information as prohibited by the terms of the policy. The burden is now on the plan to not just prove misrepresentation of information, but also to prove the individual's intent to deceive. Rescissions for reasons other than fraud or intentional misrepresentation are not allowed.

Rescissions are now considered adverse benefit determinations under the PPACA's new claims and appeals rules, and are therefore subject to internal and external reviews. According to the new rescission rules, a plan or health insurance issuer must provide written notice of a rescission at least 30 days in advance,* giving the individual the opportunity to dispute the decision. When the rescission does occur, the individual will have the right to appeal. Notice must be provided to each participant who would be affected, regardless of whether the rescission applies to an entire group or only to an individual within the group. The IFR states plans must keep coverage in effect pending an appeal of a rescission.

PPACA's guaranteed availability mandate takes effect January 1, 2014, eliminating eligibility decisions based on health status, medical history, claims experience, disability, genetic information and evidence of insurability. The prohibition of these underwriting factors will effectively end disputes about misrepresentation of an individual's medical history and therefore make rescissions even less likely.

*Advance notice is not required for cancellation due to non-payment of premiums.

Examples of Using the Rescission Regulations

Example 1

An individual is covered by an employer-sponsored group health plan providing coverage for employees who work at least 30 hours per week. The employer moves the individual to a part-time position, and he or she is no longer eligible for coverage. The plan fails to account for the position change and continues to provide healthcare coverage. During a routine audit, the plan discovers the individual no longer works the required hours for coverage. Under PPACA, the plan cannot rescind the individual's coverage because there was no fraud or intentional misrepresentation of material fact. The plan may only cancel coverage prospectively, subject to other applicable

federal and state laws. Because this is not a rescission, the 30-day notice is not required.

Plans must carefully monitor employee eligibility for coverage as errors by the employer or third-party administrator in monitoring an employee's or dependent's eligibility for coverage can no longer result in a retroactive cancellation of coverage.

Example 2
An entire group's health coverage can be rescinded if the carrier later discovers the group sponsor made intentionally misleading statements while applying for group coverage. Under PPACA, the insurer could terminate coverage of the group retroactive to the issuance of the contract, but must provide 30 days of advance notice for the group to shop for new coverage. Coverage must stay in effect pending the outcome of any appeal.
Similarly, after an individual is enrolled, a carrier's discovery of fraudulent omissions by the individual or their representative could lead to rescission of the individual's health coverage retroactive to the policy's effective date. A 30-day advance notice is required, and coverage must stay in effect pending the outcome of any appeal.

The Federal Register: June 28, 2010 (Volume 75, Number 123) Interim Final Regulations in part addresses rescissions: http://edocket.access.gpo.gov/2010/2010-15278.htm

Draft model language for rescissions can be reviewed at the National Association of Insurance Commissioners website: http://www.naic.org/committees_b_regulatory_framework.htm

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Healthcare Re-forum No. 24

A First Look at Accountable Care Organizations

The Patient Protection and Affordable Care Act (PPACA) calls for the creation of an Accountable Care Organization (ACO) program by January 1, 2012, to be administered by the Centers for Medicare & Medicaid Services (CMS). ACOs will be responsible for the quality, cost and overall care of Medicare patients, and will be expected to meet specific organizational and quality performance standards to be eligible to receive a percentage of the expected cost savings. ACOs will also be able to contract with private health carriers.

What are Accountable Care Organizations?

ACOs predate the PPACA as a healthcare model, but have been limited to a small number of healthcare systems across the country. The concept has recently drawn attention after being identified by the PPACA as one of Medicare's pilot programs. Providers who participate in ACOs strive to improve care outcomes, as well as reduce waste, duplication and inefficiencies. ACOs offer participating providers the infrastructure to integrate care and embrace emerging reimbursement methods such as bundled payments, medical homes, gainsharing (i.e., cost and revenue sharing) and pay for performance. Because the ACO model is designed to help providers work together to improve care and reduce medical costs, state Medicaid programs and private health insurers may join Medicare in supporting the ACO model. The reality is there are fewer dollars available for healthcare, and ACOs may help the healthcare dollar go farther.

Medicare's Shared Savings Program

Helping to fuel growth of ACOs is the Medicare Shared Savings Program, which allows providers within ACOs to share both accountability for treating Medicare patients, and any realized cost savings if they meet defined quality standards. ACO networks must include primary care providers, employ evidence-based medicine and achieve levels of integration such as sharing patient information and joint governance.

Who Can Become an Accountable Care Organization?

The PPACA specifies the types of groups that can become an ACO:

- Physicians and other professionals in group practices or networks of practices
- Partnerships or joint venture arrangements between hospitals and physicians/professionals
- Hospitals employing physicians/professionals
- Other forms that the Secretary of Health and Human Services may determine appropriate

The PPACA also specifies the requirements for an ACO, which must:

- Participate for a minimum of three years
- Provide an adequate number of primary care providers to service enrolled patients (minimum of 5,000 per ACO)
- Maintain a defined legal structure to receive and distribute shared savings
- Have a formal management structure for both clinical and administrative services
- Have sufficient recordkeeping to account for patients and determine appropriate payments (patients are not “locked in” to a provider)
- Have defined processes to:
  – Promote evidenced-based medicine
  – Coordinate care
  – Report the necessary data to evaluate quality and cost measures, including the Physician Quality Reporting Initiative (PQRI), Electronic Prescribing (eRx) and Electronic Health Records (EHR)

Further definition of the requirements is expected to be forthcoming.

Other delivery system changes are specified in the PPACA that will ultimately impact ACOs, such as:

- Creating a demonstration project for a pediatric ACO
- Expanding CMS' initiative to bundle payments around episodes of care (i.e., periods of care by a healthcare facility or provider for a patient's specific medical problem or condition)
- Funding the Patient-Centered Outcomes Research Institute to develop evidence-based medical treatments
- Extending the existing Gainsharing Demonstration Project (January 1, 2007, through December 31, 2009), which involved arrangements between hospitals and providers under which the hospital shared savings with a provider due to collaborative efforts to improve quality and efficiency of services, through 2014
- Establishing the new Center for Medicare and Medicaid Innovation to test new payment and delivery models (funded by $10 billion over the next decade)

ACOs and Private Carriers

Private health plans are encouraging physicians and hospitals to work together as ACOs by experimenting with bundled payments for episodes of care. Bundled payments can create additional revenue for providers if they make their healthcare delivery system more efficient through controlling the use of resources and measuring clinical outcomes. Because providers who participate in an ACO look for ways to reduce costs and improve outcomes, they will ultimately serve the best interests of the ACO, patient and carrier.

The September 17, 2010, *Federal Register Notice* includes a request for input about the direction in which ACOs will evolve within the framework of established regulations and the oversight of responsible federal agencies: http://oig.hhs.gov/authorities/docs/2010/FR9-17-10.pdf

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Healthcare Re-forum No. 25

Additional Guidance Issued for Mandates Taking Effect September 23, 2010

On September 20, 2010, the Department of Labor (DOL) issued new guidelines pertaining to mandates in the Patient Protection and Affordable Care Act (PPACA) that took effect September 23, 2010. The DOL's guidance includes new frequently asked questions (FAQs) posted to its website, reflecting its ongoing effort to clarify the new rules brought about by healthcare reform, as well as to address some of the issues exposed by implementation of these mandates (http://www.dol.gov/ebsa/faqs/faq-aca.html).

Grandfathered Plans FAQs

Until the federal government issues final regulations, fully insured group health plans will not be treated as having lost grandfathered status due to a change in employer contribution rates if the issuer and plan sponsor complete the following actions:

- Upon renewal, the issuer requires the plan sponsor to clearly indicate both its contribution rate for the new plan year and its rate as of March 23, 2010.
- The issuer's policies, certificates or contracts of insurance clearly disclose that plan sponsors must notify the issuer if they change contribution rates during the plan year.

These actions must be completed by January 1, 2011, for policies renewed prior to that date. The respective plan will lose grandfathered status once the issuer learns of a contribution rate reduction of more than 5 percent (or earlier if another change is made causing the loss of grandfathered status).

An issuer could require a plan sponsor to provide advanced notice (e.g., 30 or 60 days in advance) of a change in contribution rates, since nothing in the PPACA prevents it.

Claims, Internal Appeals and External Review FAQs

The Departments of Health and Human Services (HHS) and the Treasury, as well as the DOL (the Departments), released additional Interim Final Regulations (IFR) on July 22, 2010, to standardize the process by which consumers can appeal medical coverage or claim denials by their non-grandfathered health plans. The DOL FAQs make the following points:

- The new external review provisions of PPACA do not apply to grandfathered health plans.
- The Departments have provided transitional relief from the new federal requirements for external review that may allow non-grandfathered, fully insured plans to use an existing state external review process in a state in which they are doing business, instead of complying with the new federal requirements. This transitional relief applies regardless of whether the plan existed on March 23, 2010, or is a new plan.
- Non-grandfathered, self-insured plans may also qualify for transitional relief under the rules of DOL Technical Release 2010-01. It provides a safe harbor if these plans either follow the procedures described there (based on the National Association of Insurance Commissioners (NAIC) Uniform Health Carrier External Review Model Act) or voluntarily comply with a state external review program (http://www.dol.gov/ebsa/pdf/ACATechnicalRelease2010-01.pdf). When a self-insured plan does not strictly comply with all standards set forth in the Technical Release, compliance will be determined on a case-by-case basis.

For example:

– A self-insured plan that fails to contract with at least three independent review organizations (IROs), but demonstrates its external review process is independent and without bias, may still be considered compliant

– A self-insured plan does not have to contract directly with an IRO and may satisfy the standards by contracting with a third-party administrator that contracts with an IRO

- The IFR shortened the time requirement for making initial benefit determinations only with respect to urgent care claims. Therefore, the Departments have revised the model notice. (http://www.dol.gov/ebsa/IABDModelNotice2.doc)
- The DOL also issued Technical Release 2010-02 (http://www.dol.gov/ebsa/newsroom/tr10-02.html) on September 20, 2010, providing an enforcement grace period until July 1, 2011, for non-grandfathered plans that will have difficulty making all of the required changes in time for the new claims and internal appeals mandates. The grace period applies to:
  - Making urgent care claims decisions within a 24-hour period
  - Providing notices in a "culturally and linguistically appropriate" manner
  - Providing diagnosis and procedure codes and other content on notices of adverse determination
  - Allowing claimants to initiate external review or litigation if the plan or issuer fails to adhere to all requirements of the IFR

Coverage of Dependent Children FAQs

The DOL's FAQs clarify a plan's or issuer's option of limiting coverage for dependent children up to age 26 to only those children described in IRS Code Section 152(f)(1), which defines children as sons, daughters, stepchildren, adopted children, children placed for adoption and foster children. A plan may choose to impose additional eligibility conditions, such as student status, financial dependency or co-residence, for children who do not fall within the Section (such as grandchildren, nieces and nephews). This aligns the extended coverage definition of adult child with the extended tax exclusion.

Out-of-Network Emergency Services FAQs

The DOL's FAQs further clarify that under the PPACA, health plans and insurers are required to cover both in-network and out-of-network emergency services and cannot impose greater cost-sharing amounts such as copayments or coinsurance on a member if the emergency services are received from out-of-network providers or facilities. However, the PPACA does not require health plans and insurers to pay amounts that out-of-network providers may balance bill a member. Instead, the law establishes minimum payment standards to prevent a health plan or insurer from making a low reimbursement to an out-of-network provider while knowing that a patient will in turn be balance billed. In addition, the FAQs reinforce that these minimum payment rules do not apply where state law or a contract prohibits balance billing.

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Healthcare Re-forum No. 26

Additional Guidance Issued for Mandates Taking Effect September 23, 2010 (Part II)

The Departments of Health and Human Services, Labor and the Treasury (the Departments) released additional Frequently Asked Questions (FAQs) on October 8, 2010, addressing issues pertaining to the implementation of the Patient Protection and Affordable Care Act (PPACA). This most recent guidance continues the Departments' clarification of various PPACA provisions and interim final regulations (IFRs).

Maintaining Grandfathered Status

As specified in the Departments' FAQs, plans that are continuing to provide the same coverage that was in place as of March 23, 2010, will only lose their grandfathered status if they make one or more of the following changes:

1. Substantially eliminate benefits to diagnose or treat a particular condition
2. Raise coinsurance requirements
3. Increase a deductible or out-of-pocket maximum by an amount that exceeds medical inflation plus 15 percentage points
4. Increase copayments by an amount that exceeds medical inflation plus 15 percentage points (or $5 plus medical inflation if greater)
5. Decrease the employer's contribution rate by more than 5 percentage points
6. Impose annual limits on the dollar value of essential benefits below allowable amounts

A plan's grandfathered status applies on a benefit package-by-benefit package basis. If a plan offers a PPO, a POS and an HMO, and makes changes that cause only one of these benefit options to lose its grandfathered status, the remaining unchanged options are still grandfathered plans. In addition, rules in the IFR about grandfathering state that employer contributions apply on a tier-by-tier basis. If a group health plan modifies the tiers of coverage it had in effect on March 23, 2010 (i.e., from self-only and family to a multi-tiered structure of self-only, self-plus-one, self-plus-two and self-plus-three-or-more), the employer contribution for any new tier would be evaluated for compliance by comparing it to the corresponding tier that was in effect on March 23, 2010. The employer contribution for self-plus-one, self-plus-two and self-plus-three-or-more would need to be within 5 percent of the family coverage that was in effect on March 23, 2010. If a grandfathered plan had a self-only coverage tier and added a family coverage tier, the level of employer contribution toward the family coverage would not cause the plan to lose its grandfathered status.

Grandfathered plans that exceed allowable copayments in one category of services (i.e., specialty care) while keeping it the same in another (i.e., primary care) would lose grandfathered status.

Group health plans may continue to offer premium discounts or additional benefits as an incentive for wellness. The use of cost-sharing surcharges as penalties in wellness programs should be closely evaluated to ensure compliance with the rules for maintaining grandfathered status. Plans also need to closely monitor ERISA and applicable state and federal laws when offering wellness incentives to make sure they are in compliance with any applicable non-discrimination rules.

Dental and Vision Benefits

Dental or vision benefits structured as exempt benefits under the Health Insurance Portability and Accountability Act (HIPAA) are not subject to PPACA reforms. Dental and vision benefits are considered to be exempt under HIPAA if they are offered under a separate policy, certificate or contract of insurance, or are not integral parts of the group health plan. Dental and vision benefits are not considered to be an integral part of the plan if a participant has the right to elect not to receive the coverage, or they must pay an additional premium if they elect to recieve the coverage.

Rescissions

The Departments' FAQs clarify that, in some instances, retroactive termination of coverage is permitted for administrative reasons. The Departments' FAQs ask, "What about retroactive terminations of coverage in the normal course of business?"

1. Rules about rescission included in the IFR clarify that a plan error (such as mistakenly covering a part-time employee) may be cancelled prospectively once identified, but not retroactively rescinded unless there was evidence of fraud or intentional misrepresentation by the employee.
2. If a plan covers only active employees, and a terminated employee does not pay premiums for COBRA coverage but has a continuation of coverage due to a delay in administrative recordkeeping, the retroactive elimination of coverage back to the date of employment termination is not considered a rescission.
3. If a plan does not cover ex-spouses and COBRA continuation premiums (if required) are not paid by the employee or ex-spouse, and the plan is not notified of a divorce, the plan's termination of coverage retroactive to the divorce is not considered to be a rescission of coverage.

Preventive Health Services

Some of the recommendations and guidelines of the United States Preventive Services Task Force (USPTF) and other relevant federal committees do not provide definitive guidelines that specify the scope, setting or frequency of the preventive items or services to be covered. The Departments' FAQs state that the plan or issuer, in the absence of definition, can use reasonable medical management techniques to determine the frequency, method, treatment or setting for providing a recommended preventive health service.

Clarification Relating to Policy Year and Effective Date of the Affordable Care Act for Individual Health Insurance Policies

Rules in the IFR about coverage of dependent children up to age 26 have led to varying interpretations by states and issuers regarding when a policy year begins for individual policies. The confusion has arisen from the practice of carriers in the individual market designating a policy year of January 1 through December 31 for an individual policy, while the coverage actually begins on October 1. The Departments have sought to clarify this issue in the FAQs by stating that implementation of PPACA begins with the first new period of coverage on or after September 23, 2010, whether this new coverage period is a full or shortened period of coverage. For PPACA, in the example above, the policy year begins with the first new coverage (i.e., October 1, 2010), not when the next 12-month policy year begins.

For more information related to the Departments' FAQs about implementation of the PPACA, please visit http://www.dol.gov/ebsa/faqs/faq-aca2.html.

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Healthcare Re-forum No. 27

How Do Collective Bargaining Agreements Impact Grandfathered Status?

Grandfathered health plans were originally introduced with the passage of the Patient Protection and Affordable Care Act (PPACA) on March 23, 2010. The section of the legislation pertaining to grandfathering attempts to allow plans that were in existence as of March 23, 2010, to retain much of their existing plan structure if they follow a specific set of rules. The rules for grandfathered health plans were defined in Interim Final Regulations (IFR) issued June 17, 2010, by the U.S. Departments of Health and Human Services (HHS), Labor and the Treasury (the Departments). A grandfathered health plan may be provided on a fully insured or self-insured basis.

Previous issues of *Healthcare Re-Forum* (*Should My Plan Stay Grandfathered*? and *Maintaining Grandfathered Plan Status*) have described both the rules grandfathered plans must follow, as well as the exemptions they are allowed by various mandates.

One of the questions that has frequently arisen is: "How does collective bargaining impact a plan's grandfathered status?" The IFR provides most of the answers to this question.

Fully Insured Collectively Bargained Plans (Limited Relief)

Fully insured plans subject to collective bargaining agreements (CBA) in effect March 23, 2010, may:

- Maintain their grandfathered health plan coverage by delaying implementation of non-grandfathered benefits (if such status is lost) until the expiration of the current CBA
- Change insurance carriers during the term of the current CBA without adversely affecting grandfathered status (provided that no changes have been made that would independently affect grandfathered status, such as changes to cost and coverage terms)

If any changes are made that would otherwise cause the plan to lose its grandfathered status (other than a change in carriers) prior to the termination of the last CBA, non-grandfathered status must be implemented once the last provision of the CBA terminates.

If the plan is a fully insured multi-employer plan in which other employers also participate, the plan can delay implementation of non-grandfathered status (if such status is lost) until the last of all the CBAs relating to that plan terminates. Once the last CBA relating to the plan terminates, the plan sponsors must confirm if any changes have been made to the plan that would cause the loss of grandfathered status under the PPACA by comparing all of the changes made to the plan after March 23, 2010, to the terms of the plan as they existed on March 23, 2010.

An example of a common question about the impact of CBAs on grandfathered status is: "Would a fully insured, collectively bargained plan that has a CBA that was ratified February 1, 2010, and expires February 1, 2014, be able to switch carriers without losing its grandfathered status?" The answer is yes, the plan could switch carriers prior to the expiration of the last provision of the CBA and still maintain its grandfathered status. **However, the guidance of legal counsel should always be obtained on these matters.**

Self-Insured Grandfathered Health Plans

Self-insured grandfathered plans subject to CBAs are treated like other grandfathered plans and do not have the special status afforded to fully insured grandfathered plans subject to CBAs.

The grandfathering rules apply on a plan-by-plan basis (i.e., if an employer has one or more plans subject to a CBA and one or more plans not subject to a CBA, the appropriate rules are applied to each plan to determine its grandfathered status independently of any other plans).

Affordable Care Act Amendments to Opt-Out Provisions (Applies Regardless of Grandfathered Status)

Prior to the passage of the PPACA, sponsors of self-insured, non-federal governmental group health plans were permitted to exempt their plans from six requirements of the Public Health Service Act (PHSA). On September 21, 2010, Steve Larsen, Director of HHS' Office of Oversight, issued a memorandum clarifying that with the enactment of the PPACA, these plans have been restricted to opting out of just three PHSA provisions, as demonstrated in the chart below:

PHSA Requirement	Allowed to Exempt Plans?	
	Under PHSA	Under PPACA
Limits on Pre-existing Condition Exclusions	Yes	No
Requirements for Special Enrollment Periods	Yes	No
Prohibition Against Discrimination Based on Health Status	Yes	No
Benefits for Newborns and Mothers	Yes	Yes
Parity in Mental Health and Substance Use Disorder Benefits	Yes	Yes
Coverage for Reconstructive Surgery Following Mastectomies	Yes	Yes

With respect to the opt-out elections, HHS has issued a transitional period and will not take any enforcement actions for plan years that begin before April 1, 2011, to allow plans the opportunity to comply with the changes in the PHSA provision exemptions.

While the restrictions on opting out apply whether or not a plan is grandfathered, it is important to note that if a self-insured, non-federal governmental plan is operating under a CBA ratified prior to March 23, 2010, the plan may still be exempted from all six mandates until the first plan year following the plan year in which the last provision of the CBA has expired.

Plans With Both Union and Non-Union Employees

No formal guidance pertaining to grandfathering was issued regarding whether a plan is classified as collectively bargained if there are both union and non-union employees participating in a single plan. However, the IRS has issued guidance through other federal laws that affect collectively bargained plans. A plan is considered to be collectively bargained if at least 25 percent of the employees participating in the plan are union-represented. If less than 25 percent of the employees in the plan are union-represented, the plan will operate under the rules for non-collectively bargained plans.

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Healthcare Re-forum No. 28

Another Look at High-Risk Pools

The Patient Protection and Affordable Care Act (PPACA) established a temporary national high-risk pool program, also known as the Pre-Existing Condition Insurance Plan (PCIP). The basic rules and structure of the PCIP, including eligibility, were reviewed in *Healthcare Re-Forum: Issue No. 11, High Risk Pool Program*. Through the PCIP, states were given the option to either use federal funding and run their own high-risk pools or be part of the federal PCIP. For example, Ohio did not have an existing high-risk pool and opted to use federal funds to create one.

Prior to the implementation of the PCIP program, states have used several methods for providing coverage to individuals who either could not access group insurance or who had been denied coverage in the individual market for various reasons, including pre-existing conditions. In 35 states, state-run high-risk pools have helped to fill the gap for these individuals, providing coverage to approximately 200,000 people nationwide. Although each state's pool is different, average premiums have ranged from 125 percent to 200 percent of standard market rates, while also requiring significant cost sharing by enrollees. In states without high-risk pools, coverage has been provided through open enrollment periods, guaranteed issue or conversion policies. Eligibility for other government healthcare programs, such as Medicare and Medicaid, has eliminated an individual's eligibility for high-risk pool coverage.

The PCIP was modeled after these state-run high-risk pools; however, the following modifications were made by the PPACA in an attempt to make the PCIP more accessible:

- No waiting periods for coverage of pre-existing conditions, compared with three to 12-month waiting periods for state pools
- Plans must provide a minimum of 65 percent actuarial value for coverage (i.e., the portion of the total cost of covered benefits that is paid by a health insurance plan)
- Out-of-pocket costs are capped at $5,950 for an individual, compared with deductibles in some state high-risk pools of up to $15,000 and no caps on out-of-pocket costs
- Standard rate premiums for the state or its subdivisions that cannot exceed a ratio of 4:1 for age-based tiers
- Portability from one state to another

The PCIP is targeted at a small but significant subset of the population that has difficulty obtaining or maintaining insurance. The PPACA's intent was never to cover a large percentage of the uninsured population with this provision; instead, the intent was to offer a source of immediate coverage for a relatively small group of people with pre-existing conditions who had been without insurance for at least six months and who would not otherwise be able to access insurance until the American Health Benefit Exchanges (the Exchanges) are operational in 2014.

Unlike the Exchanges, the PCIP does not index premiums to income or provide subsidies for those with low incomes and therefore may not be a viable option for people who cannot afford standard market rates. The $5 billion in federal funding provided for the PCIP is being used to offset pool costs, making the premiums comparable to those in the individual market rather than those in the existing state high-risk pools.

States were given considerable flexibility in the design of their PCIP programs. In the 27 states that chose to run their own programs, HHS sent a request for proposals to nonprofit third-party administrators that included a model coverage template indicating the minimum standard for actuarial value, premiums and out-of-pocket expenses. In the remaining 23 states that did not choose to administer their own plans (plus the District of Columbia), HHS awarded the contract to administer the federal PCIP program to the Government Employees Health Association, which also administers the Federal Employees Health Benefits Program.

Insurance reforms in the PPACA, such as changes to age of dependents or requirements to cover preventive services at no cost, do not apply to the PCIPs (or state high-risk pools) because they do not meet the federal definition of a group health plan or a health insurance issuer.

The Interim Final Regulations issued about the PCIP cited estimates of potential enrollment that range from 175,000 to 400,000 individuals nationwide. Government economists projected 375,000 people would gain coverage in 2010. While the PCIP was only implemented recently, there has already been criticism about the lower-than-expected enrollment numbers[1]. On October 4, 2010, the Associated Press published a story titled "Low Enrollment Plagues 'High-Risk Pool,'" in which the reporter pointed out that California has been funded for 20,000 enrollees but has fewer than 450 applicants. In addition, as noted in the article, Texas had just 200 enrollees by mid-September and Wisconsin had only received 300 applications for a program that has room for 8,000 individuals.

In contrast, the Ohio experience has been more positive. Medical Mutual of Ohio® was selected by HHS to administer the Ohio High Risk Pool. With nearly two months of the pool's experience to draw upon, we have seen:

- A strong start with 650+ enrollees (through October), making Ohio one of the top program performers
- Community outreach by Medical Mutual, marketing the program through informational posters and brochures placed at pharmacy counters
- Additional outreach via both free media placement (newspaper articles, television newscasts and public service announcements) and paid media (radio advertisements)
- Communication with the Ohio State Medical Association about needed program support and participation by providers
- Presentations to brokers stressing the role they can play in identifying individuals eligible for the program
- Presentations by Universal Health Care Action Network of Ohio to 70 member associations, providing information about the structure of the Ohio plans and the enrollment process
- Additional marketing efforts by Medical Mutual through an e-newsletter sent to 200,000 current members asking for their assistance in identifying friends or family who may qualify for the program
- Comprehensive information available on Medical Mutual's program website (www.ohiohighriskpool.com), such as background, products, eligibility information, and enrollment applications, with a link to the Ohio Department of Insurance's (ODI) online "Frequently Asked Questions" page
- Extensive outreach via e-mails from ODI to government agencies and support organizations throughout the state

The early success of the Ohio High Risk Pool is a reflection of the positive working relationship Medical Mutual has with the broker and provider communities in Ohio, HHS and ODI, with the common goal of increasing coverage for Ohioans who have been unable to obtain health insurance due to pre-existing conditions. Medical Mutual knows that there is significant work still to be done and recognizes its responsibility to serve as a good steward of the PCIP program and for those whom it is intended to benefit.

[1] Enrollment information is not yet available for all states that chose to have their PCIP programs run by HHS (including Georgia, Indiana and South Carolina).

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An Overview of the American Health Benefit Exchanges

The Patient Protection and Affordable Care Act (PPACA) and the Health Care and Education Reconciliation Act (HCERA) direct the states to establish health insurance exchanges, known as the American Health Benefit Exchanges (the Exchanges), as a new mechanism for individuals and small employers to purchase health insurance coverage beginning January 1, 2014. To assist in the implementation of the state-based Exchanges, federal funding will be available beginning in 2011 and will phase out by 2015, at which time the Exchanges must be self-sustaining.

The PPACA also requires the federal Office of Personnel Management (OPM) to contract with health plan issuers to offer a minimum of two multi-state plans in each Exchange, at least one of which must be non-profit. These multi-state plans will have separate risk pools and will be separate entities from the Federal Employees Health Benefit Program, which the OPM also administers. The Exchanges will also be responsible for offering a co-op, which will be funded nationally by a $6 billion grant.

At a minimum, the PPACA and HCERA authorize each state to create Exchanges through which individuals and small employers* can purchase health insurance coverage. States will have four options to consider as they set up their Exchanges:

- Establish an Exchange to supervise coverage options for both individuals and small employer groups with up to 100 employees
- Establish an Exchange for individuals and a separate Small Business Health Options Program (SHOP) to serve small employer groups with up to 100 employees
- Establish an Exchange allowing multiple states to jointly offer increased coverage options
- Establish multiple Exchanges that serve distinct geographic regions within a state

If a state fails to create an Exchange, or to adequately comply with Exchange regulations set by the Department of Health and Human Services (HHS), HHS will set up and operate the Exchange within that state.

Participation by individuals and employers in an Exchange will be completely voluntary. Employers and individuals may continue to obtain coverage through the non-Exchange health insurance marketplace.

The PPACA requires the state-based Exchanges to:

- Certify health plans as "qualified" before they are offered in the Exchange
- Develop a rating system to classify qualified health plans based on relative quality and price
- Notify the public about eligibility for enrollment in Medicaid, Children's Health Insurance Programs (CHIP) and other similar state programs, as well as coordinate the enrollment process for each
- Use a standard enrollment form and uniform format for presenting understandable health benefit plan options
- Create and maintain a website for consumers to find pricing and other plan information, and include an online calculator to determine the actual cost of a plan's coverage after subsidies
- Operate a toll-free telephone hotline to assist consumers and employers
- Publicly disclose all claims payment policies and practices, finances, enrollment data, denied claims and rating practices
- Publish cost sharing and out-of-network payment information for each plan

*Please note, for purposes of the Exchanges, a small employer is an employer with 100 or fewer employees. States have the option of defining small employers as those with 50 or fewer employees until 2016, when all states will need to comply with the Exchange definition of small group as 100 or fewer. Beginning in 2017, states may choose to allow employers with more than 100 employees to offer coverage for their employees through an Exchange.

Exchanges will employ Navigators, who will provide consumer guidance in the Exchanges' plan options, offer culturally and linguistically appropriate information about enrolling in the plans and provide information about available subsidies. They will also provide referrals for complaints.

Two states currently operate Exchanges—Massachusetts and Utah. Washington (state) is anticipating a January 1, 2011, launch for its Exchange.

Health insurance plans offered through the Exchanges will be referred to as qualified health plans (QHP). While full regulations have yet to be released by the Secretary of HHS, the following requirements are known:

- A QHP must satisfy a minimum threshold of coverage defined by HHS
- A QHP must be offered by a licensed insurer and cannot be a self-insured plan sponsored by an employer and exempt from state regulation under ERISA's preemption rules
- QHPs will vary in cost from least expensive to most expensive: bronze, silver, gold and platinum
- To be included on an Exchange, carriers must agree to offer at least one silver and one gold plan
- Exchanges will be prohibited from setting premiums for plans. However, they can ask insurers to justify rate hikes, and if they are dissatisfied with the answer, can use price as a reason to drop a particular plan from their list of qualified offerings
- The Exchanges will offer four levels of QHPs, each including mandated essential benefits (which are not yet fully defined)

The next issue of *Healthcare Re-Forum* will discuss in detail the plans that will be sold on the Exchanges.

By 2014, many new federal standards will apply to all insurers offering new coverage in the individual and small group markets, regardless of whether the coverage is purchased through an Exchange. Insurers who offer coverage through an Exchange will also be subject to additional requirements, such as adequacy of provider networks, reporting requirements, grievance procedures and marketing practices, which could make some insurers less willing to sell through an Exchange.

On the other hand, Exchanges may be attractive to insurers due to the large pool of prospective customers. Billions of dollars in premium tax credit subsidies and cost-sharing subsidies will be available to individuals within a defined income range. For example, individuals whose income levels fall between 133 percent and 400 percent of the federal poverty level will be eligible for subsidies on a sliding scale basis, but can only apply the subsidies to plans purchased on an Exchange. Of the roughly 35 million individuals that the Congressional Budget Office projects will be enrolled in individual coverage in 2009 (including grandfathered coverage), 24 million are expected to have purchased that coverage through an Exchange. Of that 24 million, it is anticipated that 20 million will receive premium credits or cost-sharing subsidies.

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Healthcare Re-forum No. 30

Types of Plans Sold on the Exchanges

***Healthcare Re-Forum: Issue 29 — An Overview of the American Health Benefit Exchanges* — provided an overview of the guidelines established for the formation of the state-based American Health Benefit Exchanges (the Exchanges), effective January 1, 2014. The Exchanges will be overseen during both implementation and operation by the Department of Health and Human Services (HHS) Office of Consumer Information and Insurance Oversight (OCIIO). This HHS subsidiary, also created by the reform legislation, will implement all private insurance reforms enacted by the Patient Protection and Affordable Care Act (PPACA) and the Health Care and Education Reconciliation Act (HCERA).**

Beginning January 1, 2014, all citizens and legal residents of the United States will be required to have qualifying health coverage. Those without appropriate coverage at this time will be assessed a tax penalty, which, by 2016, will be the greater of $695 per year for an individual (or up to three times that amount, $2,085, per family), or 2.5 percent of household income. Health plans in effect on March 23, 2010, are grandfathered under the law and will fulfill the mandate for "qualified coverage."

When the state-based Exchanges are operating, it will be important to note:

- The PPACA does not require insurers to participate in an Exchange, but does stipulate requirements for plans sold on the Exchange.
- Qualified health plans sold on an Exchange must agree to charge the same premium whether the plan is sold through the Exchange or outside of the Exchange; this "same price" requirement applies only to insurers that choose to sell products both within and outside of an Exchange.
- The Exchanges must be self-sustaining by 2015 and may therefore charge assessments or user fees to participating issuers who sell plans on the Exchanges.
- Tax credits and cost-sharing subsidies are only available to individuals who purchase their healthcare coverage through an Exchange.
- The PPACA restricts employees of small businesses to a choice of options at one tier as selected by the employer.

Individuals and families with income between 133 percent and 400 percent of the federal poverty level will be eligible for premium tax credits and cost-sharing subsidies if they purchase plans on the Exchanges.

Qualified Health Plans

A qualified health plan (QHP) is a health insurance policy sold through an Exchange. The PPACA requires Exchanges to certify that QHPs meet minimum standards contained in the law, such as the requirements for an essential benefits package. Rules applicable to QHPs include:

- Defined categories of essential benefits must be included in a QHP; the essential benefits requirements are yet to be fully clarified by HHS
- Grandfathered and self-insured plans do not need to comply with the essential benefits requirement
- Essential benefits currently include: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance abuse disorder services (including behavioral health treatments), prescription drugs, rehabilitative and habilitative services and devices, lab services, preventive and wellness services, chronic disease management, and pediatric services, including oral and vision care
- Out-of-pocket cost-sharing limits are $5,950 per individual and $11,900 per family; deductible limits are $2,000 per person or $4,000 per family
- QHPs must meet one of four benefit categories created by PPACA; insurers participating in an Exchange must offer at least one plan at the Silver level and one plan at the Gold level (see descriptions below)

- Exchanges must provide for the certification, recertification and decertification of QHPs, consistent with guidelines developed by HHS
- Plan issuers must offer any QHP as a "child-only" plan to individuals under the age of 21
- Exchanges may not sell plans that are not QHPs, other than stand-alone dental plans if they offer pediatric dental benefits meeting the requirements of the PPACA (stand-alone dental plans are considered to be an "excepted benefit" and are not subject to the rules for QHPs)
- Insurers offering individual or small group plans can only base premium rates on four factors: whether the plan or coverage is offered to an individual or family, age (3:1 ratio), tobacco use (1.5:1 ratio) and geographic area based on rating areas as defined by state insurance commissioners

Please note: plans offered outside of an Exchange must also comply with the essential benefits requirements.

Tiered QHPs

QHPs will provide different levels of coverage and will be tiered as follows, with the indicated cost-sharing requirements (up to the out-of-pocket limits noted above):

- **Bronze plans** will provide coverage that is actuarially equivalent[1] to 60 percent of the defined package of essential benefits, with a 40 percent cost share for the beneficiary
- **Silver plans** will provide coverage that is actuarially equivalent to 70 percent of the defined package of essential benefits, with a 30 percent cost share for the beneficiary
- **Gold plans** will provide coverage that is actuarially equivalent to 80 percent of the defined package of essential benefits, with a 20 percent cost share for the beneficiary
- **Platinum plans** will provide coverage that is actuarially equivalent to 90 percent of the defined package of essential benefits, with a 10 percent cost share for the beneficiary

Individuals who are under the age of 30, or who are exempt from the individual mandate because no affordable plan is available to them or they have a hardship exception, may purchase **Catastrophic Coverage**, which will provide the essential benefits package with a cost-share limit in 2014 of $5,950 for an individual or $11,900 for a family. The beneficiaries of this plan will qualify for first-dollar coverage of at least three primary care visits before the high deductible is met. Catastrophic coverage may only be offered in the individual market and will be available on the Exchanges.

The National Association of Insurance Commissioners (NAIC) published Frequently Asked Questions on its website on November 11, 2010. One of the questions addresses the ability to maintain a Health Savings Account and notes "… nothing in the legislation would infringe upon the ability of an individual to contribute to a Health Savings Account (HSA), or discourage an individual from doing so. The minimum level of coverage required to meet the individual mandate was specifically designed to allow for the purchase of a qualified high deductible [health] plan that would complement the HSA."

There is potential for significant variance in the states' regulation of QHPs on the Exchanges due to the political and philosophical differences that exist within the state governments who must establish and operate the Exchanges within their respective states.

[1]Actuarial value of a plan is the portion of the total cost of covered benefits that is paid by a health insurance plan.

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Healthcare Re-forum No. 31

Updates to Previously Issued Regulations

On November 15, 2010, HHS amended its position on grandfathered group plans and their ability to change insurers. Per HHS... "Under this amendment, all employers have the flexibility to keep their grandfathered plan but change insurance company or third-party administrator." Groups that choose to change insurers are still required to follow other regulations defining what changes are allowed to be made by a group that wants to maintain its grandfathered status. The HHS website provides additional information about this amendment: http://www.hhs.gov/ociio/regulations/grandfather/factsheet.html.

CO-OPs and Multi-State Plans on the Exchanges

This issue of *Healthcare Re-Forum* continues our discussion of the provisions pertaining to the state-based American Health Benefit Exchanges (the Exchanges) as designed by the Patient Protection and Affordable Care Act (PPACA). The Exchanges, which will begin in 2014, will offer healthcare consumers different options for obtaining certified coverage through new Consumer Operated and Oriented Plans and Multi-State Plans.

Consumer Operated and Oriented Plans

Consumer Operated and Oriented Plans (CO-OPs) will be member-run, non-profit health insurance issuers that sell qualified health plans (QHPs) in the individual and small group marketplaces on the Exchanges. By July 1, 2013, the Department of Health and Human Services (HHS) will begin distributing $6 billion in loans and grants for CO-OPs, which must ultimately repay the monies borrowed. The Secretary of HHS will give loan and grant priority to issuers offering statewide provider networks; to those using an integrated care model, such as an accountable care organization; and to those with significant private support. The Secretary will also ensure there is sufficient funding to establish at least one qualified non-profit health insurance issuer in each state and the District of Columbia.

According to the PPACA, any issuer participating in a loan agreement must not use such funds "for carrying on propaganda, or otherwise attempting to influence legislation; or for marketing." In addition, a health insurance issuer who receives a grant or loan through the CO-OP program may qualify for a federal income tax exemption, but only during the period in which the organization is compliant with CO-OP program requirements and with the terms of any CO-OP grant or loan agreement.

CO-OPs have historically functioned effectively in the United States, but have never attracted significant membership. The substantial federal seed money offered by the PPACA could promote considerable growth of both CO-OP plans and their membership, encouraging greater health plan competition in some state and local markets.

To remain in compliance, a CO-OP must:

- Be organized under state law as a non-profit entity
- Be an entity whose primary purpose is to issue QHPs in the individual and small-group market
- Not be sponsored by a state, county or local government
- Have not existed as a health insurance issuer or related entity on July 16, 2009
- Have governing documents that incorporate ethics and conflict of interest standards protecting against involvement and interference in the insurance industry
- Have governance of the organization subject to a majority vote of its members
- Operate with a strong consumer focus
- Use profits to lower premium or improve benefits
- Comply with all appropriate state and federal laws

Multi-State Plans

The PPACA also requires new multi-state plans be created and overseen by the U.S. Office of Personnel Management (OPM), the agency that also administers the Federal Employees Health Benefits Program (FEHBP). To provide individual and small group coverage, the director of the OPM will contract with health insurance issuers to offer at least two multi-state qualified health plans (MSQHP) through every Exchange in each state. At least one of the carriers must be non-profit. To contract with the OPM, a health insurance issuer must offer the multi-state plan in at least 60 percent of states in the first year, at least 70 percent in the second year, at least 85 percent in the third year, and in all states in the fourth year.

Any individual eligible to purchase insurance through an Exchange may enroll in a MSQHP. Enrollment is voluntary, and individuals may be eligible for premium credits and cost-sharing assistance. Each MSQHP policy must be effective for at least one year and can be automatically renewed if neither the OPM nor the insurance issuer provides notice to terminate. MSQHPs must:

- Meet all QHP requirements, including those related to offering bronze, silver and gold levels of coverage, as well as catastrophic coverage in each state's Exchange (including the identified essential benefits)
- Meet the PPACA's rating requirements, plus any state's defined rating variations that may supersede federal requirements
- Offer plans in all geographic regions and in all states that adopted adjusted community rating prior to March 23, 2010, when the PPACA became law

Health insurance issuers offering MSQHPs must:

- Meet each state's Exchange requirements
- Be licensed in each state and subject to all requirements of each state's laws
- Comply with the minimum standards prescribed for carriers offering health benefit plans under the FEHBP

The director of the OPM will select and implement MSQHPs through negotiations based on issues such as:

- Medical loss ratios
- Profit margins
- Premiums to be charged
- Other terms and conditions of coverage that represent the best interests of those who will be covered

Both the CO-OPs and the multi-state plans are additional options for QHPs to be offered on the Exchanges. The goal of healthcare reform legislation is to not only create an "apples to apples" comparison of different plans offered on the Exchanges, but also to encourage as much competition as possible for increased consumer choice and decreased cost.

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Healthcare Re-forum No. 32

States' Construction of the American Health Benefit Exchanges

Qualified health plans (QHPs) for individual and small group coverage must be available through a system of American Health Benefit Exchanges (Exchanges), per section 1321 of the Patient Protection and Affordable Care Act (PPACA). *Issues 29, 30* and *31* of *Healthcare Re-forum* provide information about various aspects of the Exchanges and the types of plans to be offered as of January 1, 2014. This issue explores challenges facing each state as they establish the Exchanges.

There may be great variation in Exchange designs from state to state due to:

- The leeway granted to states by the PPACA
- The differences in political and philosophical make-up in the states' governments (for example, Ohio, Georgia, Indiana and South Carolina have Republican governors with Republican control of the state Houses and Senates; administrations dominated by Republicans have historically been less inclined to impose additional regulations on businesses)
- The number of insurers participating in each state (for example, Alaska's Insurance Director has suggested that an Exchange in Alaska may not be cost-effective due to the low number of insurers operating in the state)

Though the PPACA provides structural requirements of the Exchanges, the Department of Health and Human Services (HHS) and National Association of Insurance Commissioners (NAIC) are leaving much of the decision making in the hands of the states.

On September 30, 2010, California Governor Arnold Schwarzenegger signed a law creating the first state health insurance Exchange since the enactment of the PPACA, the California Health Benefit Exchange. Sandra Shewry, former director of and current adviser to the California Department of Health Care Services, was an active participant in the development of California's Exchange. Shewry stated, "There isn't a line in the ACA (Affordable Care Act) that defines what an Exchange should be, and I think it's quite purposeful that the ACA doesn't say the Exchange is 'X.' We have the ability to create what works best for us."

As the states move forward with construction of their Exchanges, they will need to address a number of specific questions:

Q1: Will a state's Exchange be administered by a government agency or a non-profit organization? If HHS determines before 2013 that a state will not have an operational Exchange by 2014, or will not be able to implement the required set of standards, HHS is required to establish and operate an Exchange within that state.

Q2: What will the composition of each state's Exchange Board look like and how much power will it be given? California gave its Exchange Board the ability to determine, without public scrutiny or review, which insurers will be permitted to participate in the Exchange, as well as the power to adopt major changes governing insurance coverage without public comment or legislative oversight.

Q3: Will a state's Exchange be exempt from the state's insurance producer or consultant licensing requirements, or must the Exchange or its employees obtain such a license? This question also applies to licensure of the "Navigators," which California decided was not required.

Insurer Participation in the Exchanges

States have three main ways to set up their Exchanges. They can act as a:

- **Market definer and organizer** – the state creates a controlled marketplace through which insurance may be bought on and off the Exchange; states may set up a "public plan" to compete with or replace other options in the market
- **Purchaser** – the Exchange selectively contracts with insurers
- **Clearinghouse** – the Exchange acts as a platform for all plans offered by all issuers in the state

When the California Exchange was designed, the state chose a model that selectively contracts with insurers (i.e., the Exchange acts as a purchaser). In a letter to California lawmakers in August, Natalie Cardenas, regional director of government relations for Anthem Blue Cross, complained that the Exchange has the power to pick winners and losers in the insurance market. Her point was that the plans should be presented and the free market should rule. Cardenas said, "… in California, the state bureaucrats will rule in selecting what plans can be offered on the Exchanges."

As states move forward with the development of regulations for plans sold on and off their Exchanges, they must perform a balancing act. The PPACA allows both individual and group health insurance markets to continue to exist outside the Exchanges. Timothy Jost, J.D., a healthcare law professor at the Washington and Lee University School of Law, has studied Exchanges and noted the PPACA has included protections intended to prevent adverse selection from occurring due to plans sold outside of the Exchanges. Healthy people will be able to find cheaper insurance outside vs. inside the Exchange. Jost explains, "A particular concern is the possibility that employer-sponsored groups can 'self-insure' (thus escaping state regulation) as long as their employees are healthy, only to turn to the Exchange once group members' health deteriorates. In this way, an Exchange can essentially turn into a high-risk pool, with its coverage becoming unaffordable and its enrollees becoming very unattractive to insurers."

The PPACA requires insurers to charge the same price for plans sold both inside and outside the Exchange. Nothing prevents health insurers from selling plans, such as those with low premiums and high deductibles, only outside the Exchange. Each state decides the regulations for its "off-Exchange" marketplace.

The NAIC released the "American Health Benefit Exchange Model Act" on November 22, 2010, to help establish the state-based Exchanges. The NAIC is not dictating rules for how the states should create their Exchanges, giving states the leeway to experiment with different options.

http://www.naic.org/documents/committees_b_exchanges_adopted_health_benefit_exchanges.pdf.

The HHS also released guidance to assist states in the development of their Exchanges. The Secretary plans to release regulations for public comment in 2011, but has provided this earlier guidance to assist states with their overall planning

http://www.hhs.gov/ociio/regulations/health_insurance_exchange_info_tech_sys.html

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Healthcare Re-forum No. 33

Updates to Grandfathering Legislation

During 2010, *Healthcare Re-Forum* has helped explain new healthcare rules initiated by the Patient Protection and Affordable Care Act (PPACA) and the Healthcare Education and Reconciliation Act (HCERA). Four issues provided information about grandfathering:

- *Grandfathered Plans* (No. 1)
- *Maintaining Grandfathered Plan Status* (No. 12)
- *Should My Plan Stay Grandfathered?* (No. 13)
- *How Do Collective Bargaining Agreements Affect Grandfathered Status?* (No. 27)

Legislation about grandfathering was clarified by Interim Final Regulations (IFR) issued by the Departments of Health and Human Services (HHS), Labor and the Treasury (the Departments) on June 14, 2010. The Departments also issued various Frequently Asked Questions (FAQs) on September 20, October 8 and October 29, 2010. Following are some key questions addressed in the FAQs.

FAQs Issued by the Departments

September 20, 2010

What happens if a carrier does not know the group's contribution rate?

Until the issuance of final regulations, if an insurer is unaware of a fully insured group's plan contribution rate change, it will not immediately impact the plan's grandfathered status, as long as the issuer:

1. Discloses in policies, certificates or contracts of insurance, "in a prominent and effective manner," that employers must notify the issuer if the contribution rate changes at any time during the plan year.
2. Requires the employer, upon renewal, to clearly indicate its contribution rate on March 23, 2010, as well as its contribution rate for the plan year covered by the renewal.

This relief will no longer apply as of the first date on which the issuer knows there has been a reduction in contribution rates of more than 5 percent, or the first date on which the plan no longer qualifies for grandfathered status for any other reason, whichever occurs first. Nothing in PPACA or the IFR prevents a policy, certificate or contract of insurance from requiring an employer to notify an issuer in advance of a contribution rate change.

Please refer to: http://www.dol.gov/ebsa/faqs/faq-aca.html

October 8, 2010

Does any change cause a plan to lose grandfather status?

The FAQs issued on October 8 clarified only the following six changes (measured from March 23, 2010) will cause a plan to lose its grandfathered status (any one of these changes alone is sufficient to cause loss of grandfathered status):

1. Eliminating all or substantially all benefits to diagnose or treat a particular condition
2. Raising coinsurance requirements
3. Increasing a deductible or out-of-pocket maximum by an amount that exceeds medical inflation plus 15 percent
4. Increasing copayments by an amount that exceeds medical inflation plus 15 percent (or $5 plus medical inflation, if greater)
5. Decreasing the employer's contribution rate by more than 5 percent
6. Imposing annual limits on the dollar value of all benefits below specified amounts

Does a change to one plan option cause all plans offered by the group to lose grandfathered status?

Determining grandfathered status applies to each benefit package individually. If a plan offers a PPO, a POS and an HMO, and makes changes to one option causing it to lose its grandfathered status, the remaining unchanged options are still grandfathered plans.

Will changing coverage tiers cause a loss of grandfathered status?

The IFR standards for employer contributions apply on a tier-by-tier basis. If an employer modifies or eliminates any coverage tiers it had on March 23, 2010, the contribution rate for any new tier would be compared to the contribution rate for the corresponding tier on March 23, 2010. If the contribution rate for the new tiers is within 5 percent of the rate for the prior structure, the plan will retain grandfathered status. However, if a plan adds one or more new tiers without eliminating or modifying any previous tiers and those new tiers cover classes of individuals not previously covered under the plan, the contribution rate for the new tier would not cause the plan to lose grandfathered status. For example, if the plan previously offered only single coverage and added family coverage, it would not lose grandfathered status.

What if a plan only changes the coinsurance for one type of service?

Plans that raise the coinsurance level in one category of services (i.e., specialty care) by an amount exceeding IFR standards while keeping coinsurance levels the same in another (i.e., primary care) will lose grandfathered status.

Please refer to: http://www.dol.gov/ebsa/faqs/faq-aca2.html

October 29, 2010

Where should a plan include the grandfathered notice?

Insurers and grandfathered health plans that include a disclosure in each summary plan description indicating the plan is grandfathered will be in compliance with the grandfathering disclosure requirement. It is not necessary to include the disclosure statement with every type of communication to participants and beneficiaries.

Can an individual lower his premium by increasing cost-sharing and still be grandfathered?

If an individual health insurance policy in place on March 23, 2010, gave a policyholder the option to pay a lower premium in exchange for higher cost-sharing amounts, the policyholder could select this choice after March 23 without losing grandfathered status, even if the increase in cost sharing for the individual exceeds the limits under the grandfathered rule on increases in cost sharing.

What if an employer offers a special supplemental plan that covers services for disabled children and that plan has a lifetime limit?

The PPACA's regulations prohibit lifetime dollar limits on "essential health benefits." However, some employers offer supplemental plans separate from the primary medical plan to provide special treatment and therapy for children with physical, mental or developmental disabilities. These plans often impose lifetime dollar limits on the supplemental benefits. According to the Departments' FAQ, until "essential health benefits" are defined by final regulations, plans may impose per-child lifetime dollar limits on benefits provided under such supplemental plans. The Departments will treat such limits as a "reasonable good faith interpretation" of the law and will not take enforcement action.

Please refer to: http://www.dol.gov/ebsa/faqs/faq-aca4.html

Guidance on Grandfathered Status of Groups Changing Carriers

Has the government updated its position on groups changing carriers?

On November 15, 2010, HHS amended its position on grandfathered group plans and their ability to change insurers. Per HHS, employers are able to change insurance companies or third-party administrators and still maintain grandfathered status. Groups that choose to switch insurers must still follow other regulations defining what changes a group may make while maintaining grandfathered status.

Please refer to:
http://www.hhs.gov/ociio/regulations/grandfather/factsheet.html

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