

Rating and Underwriting Under the New Healthcare Reform Law

Provisions Affecting the Operations of Health Insurers in the Individual, Small Group, and Large Group Markets



Phyllis A. Doran, FSA, MAAA

The healthcare reforms passed recently by Congress and signed into law by President Obama will have a far-reaching impact on virtually all aspects of the operations of health insurance companies. The law consists of the Patient Protection and Affordable Care Act (PPACA) and the Health Care and Education Affordability Reconciliation Act of 2010 (Reconciliation Act), with the latter amending certain provisions of the former.¹

While most of the regulations implementing the new law have yet to be issued, it is clear that the industry will face a new layer of regulatory complexity. Health plans will be more heavily scrutinized at both the state and federal levels.

Some changes will become effective within six months, while many others will not occur until 2014 or later. The law's reach is extensive, and it can be expected to spawn volumes of regulations spelling out the implementation and, with respect to a number of provisions,

filling in the details on what will actually be required. Until then, we cannot fully ascertain the implications of many of the law's provisions, because of the lack of details and, in some cases, confusing or ambiguous wording.

There are reform provisions dealing with the commercial markets (both individual and group) and public programs (Medicaid and Medicare), as well as new individual and employer requirements. Other requirements affect healthcare providers and vendors, and many new responsibilities are assigned to states. These and other aspects of the new law, including premium and cost-sharing subsidies for low- and moderate-income individuals and families, have significant implications for health insurers. The following discussion will first outline the scope of the changes that health insurers face in the commercial individual, small group, and large group markets, and then present a description of the major features that will most directly affect rating and underwriting operations in these markets. These features include the new exchanges and benefit coverage requirements, rating and underwriting reforms, provisions requiring rebates if applicable minimum standards are not met, new reinsurance and risk adjustment programs, the excise tax on high-cost plans, and various operational requirements applicable to health insurers.

UNCERTAINTY REGARDING IMPACT ON HEALTH INSURERS

Taken as a whole, the provisions of the new healthcare reform law are extremely complex. The ultimate impact on health insurers, which is likely to be monumental, will not be known for years. Because of the substantial discretion that has been extended to federal agencies in many of the provisions, the impact of the voluminous regulations to be issued in the coming months and years cannot be fully anticipated by studying the law as it was passed. Further, the potential for legislative modifications, in the form of technical corrections or more substantial changes, holds even more uncertainty.

Health insurers will need to dedicate substantial resources in the coming years to activities related to the new law, such as: (1) analysis and evaluation of the many provisions affecting the company's operations, (2) participation in requests for information and comment by regulators, (3) identification of strategic considerations and adaptation of strategic initiatives, (4) development of systems and procedures for responding to the new market characteristics and for satisfying compliance requirements, and (5) processes for implementation, monitoring, and evaluation of required actions.

MAJOR FEATURES OF THE PPACA RELATING TO RATING AND UNDERWRITING

| | |
|---|----|
| A. Health Benefit Exchanges and Qualified Health Plans | 3 |
| B. Grandfathered Plans | 6 |
| C. Benefit Coverage Requirements | 6 |
| D. Rating Requirements | 7 |
| E. Underwriting Requirements | 8 |
| F. Prohibitions on Discriminatory Practices | 8 |
| G. Medical Loss Ratio Reporting and Rebates | 9 |
| H. Reinsurance and Risk Adjustment | 10 |
| I. Excise Tax on High-cost Plans | 12 |
| J. Operational Requirements, Fees, and Other Provisions | 12 |
| Appendix: Healthcare Reform Law Implementation Timeline | 14 |

¹ As used in this paper, the terms "PPACA" and "Act" will refer to the final legislation, as amended by the Reconciliation Act.

THE NEW HEALTH INSURANCE LANDSCAPE

While the most significant changes for health insurers will occur in 2014, when new rating and underwriting rules become effective and health benefit exchanges are established by the states, there are also a number of market reforms and requirements that will take effect this year and next, including two new reinsurance programs.

Insurers will face increased restrictions on rating and underwriting practices, new minimum benefit standards, administrative and reporting requirements, and fundamental structural changes in the individual and small group markets (and perhaps ultimately the large group market, at the discretion of individual states).

Although the commercial individual and small group markets will be the most greatly affected, many of the new requirements will affect the large group market as well. Insurers will face increased restrictions on rating and underwriting practices, new minimum benefit standards, administrative and reporting requirements, and fundamental structural changes in the individual and small group markets (and perhaps ultimately the large group market, at the discretion of individual states).

Beginning in 2014, insurers will be required to guarantee availability and renewability of insurance coverage, by accepting every employer or individual that applies for coverage and continuing coverage at the option of the individual or plan sponsor. Such enrollment may be restricted to open or special enrollment periods, however, subject to regulations to be issued by the Secretary, and waiting periods of up to 90 days may be applied for group plans.

In addition, states will be required to establish exchanges to facilitate the purchase of qualified health plans by individuals and small employer groups. Beginning in 2017, states may also choose to allow large group plans to be offered through an exchange. The law permits regional exchanges, as well as multiple exchanges (referred to as subsidiary exchanges) within a state, and provides for the establishment of qualified nonprofit entities (Consumer Operated and Oriented Plans, or CO-OPs) to issue insurance.

The law requires that all individuals must maintain minimum essential coverage (see sidebar) beginning in 2014, and failure to do so will result in a penalty. There are exemptions, including for hardship and lack of affordable coverage, as well as premium tax credits and cost-sharing assistance for those whose household income is at or below 400% of the federal poverty level (FPL). To receive these subsidies, eligible individuals must purchase coverage through an exchange.

It appears that insurers can choose whether or not to sell health plans through the exchanges, but all insurers in the individual and small group markets will be required to offer the *essential*

MINIMUM ESSENTIAL COVERAGE

Under the new healthcare reform law, all individuals are required to maintain minimum essential coverage beginning January 1, 2014, and failure to do so will result in a financial penalty, subject to certain exemptions.

The term *minimum essential coverage* means any of the following:

- (a) Government-sponsored programs (including Medicare, Medicaid, SCHIP, TRICARE for Life, veterans' programs, and coverage for Peace Corps volunteers)
- (b) Eligible employer-sponsored plans
- (c) Health plans offered in the individual market in a state
- (d) Grandfathered health plans
- (e) Other coverage recognized by the Secretary, such as coverage offered by state high-risk pools

Eligible employer-sponsored plans include group health coverage offered by employers that are either governmental plans or any other plan offered in the small or large group market in a state, including grandfathered plans.

This appears to be relatively straightforward, and would seem to confirm that the essential health benefits package requirement is intended to apply to all plans in the individual and small group markets (other than grandfathered plans), thus providing a minimum level of coverage associated with *minimum essential coverage*.

health benefits package, which is defined to require (among other things) one of four levels of coverage measured in terms of the *actuarial value*. This provision may imply that, with the exception of grandfathered plans, insurers will be allowed to offer only plans meeting the essential health benefits package criteria in these two markets, although the wording is not clear on this point. If so, this would imply that only products meeting one of the four actuarial value levels could be offered outside the exchange, as well as in the exchange, in the individual and small group markets. For large groups, maximum cost-sharing levels will be imposed.

The requirement that health plans must comply with one of the alternative actuarial value levels raises questions regarding how the compliance would be handled on a year-to-year basis, as changes in cost levels and utilization patterns lead to changes in actuarial values. If there were a strict requirement that a health plan maintain an actuarial value of, say, 70% in every year, the cost-sharing provisions may need to be modified each year in order to remain in compliance.

Insurers will be required to charge the same premium rates for each qualified health plan, whether sold in or out of an exchange, and whether sold directly or through an agent. Additionally, all enrollees in all health plans sold in and out of an exchange, other than grandfathered plans, are required to be considered members of a single pool. While this pooling requirement applies separately to the individual and small group markets, a state may require that these two markets be merged.

The Act includes a number of reforms and requirements related to rating, underwriting, and minimum coverage levels, some of which become effective for plan years beginning on or after September 23, 2010. These provisions, which apply to health plans in and out of the exchanges, are outlined in the sections that follow.

The rating requirements, which apply only in the individual and small group insurance markets, will be effective for plan years beginning on or after January 1, 2014. They provide that permitted rating variations are restricted to: (a) benefit coverage, (b) family structure, (c) rating area, (d) age, limited to a ratio of 3 to 1 for adults, and (e) tobacco use, limited to a ratio of 1.5 to 1. Significantly, if a state chooses to include large groups in its exchange, which is permitted beginning in 2017, these rating restrictions will then apply to large groups as well, meaning that no experience rating would be allowed for insured large groups.

Minimum loss-ratio standards of 80% for the individual and small group markets and 85% for the large group market take effect on January 1, 2011. (At this point it is unclear whether the standard will be applied to plan years beginning only after that date, or to plan years beginning in 2010 as well.) Rebates will be payable to enrollees if the minimum standard is not met. The new law does not provide detail regarding the financial components or the level of aggregation to be used to determine the loss ratios for this purpose.

There are a number of provisions in the PPACA relating to reinsurance and risk adjustment. Within 90 days of enactment, a temporary high-risk health insurance pool program and a temporary reinsurance program for early retirees are to be established. By January 1, 2014, each state is required to establish a three-year transitional reinsurance program in the individual market, and the Secretary of the Department of Health and Human Services (the Secretary) is to establish a program of risk corridors in the individual and small group markets for calendar years 2014, 2015, and 2016. Finally, each state is required to carry out a risk-adjustment process for plans in the individual and small group markets.

The new law provides that existing plans are grandfathered with respect to a number of these requirements. For example, the new rating requirements applicable to coverage in the individual and small group markets do not apply to grandfathered plans, and some of the new coverage requirements and underwriting restrictions also do not apply. The grandfathered status of such a plan is attached to a plan of coverage maintained by an individual or an employer group. There is no indication, however, as to what conditions are required in order to maintain this grandfathered status to qualify for the exemptions

granted by this provision. The treatment of grandfathered plans is addressed in the more detailed discussion below.

The law does not directly address the treatment, upon implementation of the rating and underwriting reforms in 2014, of plans that are not grandfathered. Health insurers can continue to issue new coverage under current rating and underwriting rules and regulations up until plan years beginning in 2014. When the new regulations become effective, many of these plans may not be in compliance and would presumably need to be discontinued because they are not grandfathered. This may lead to significant discontinuities of coverage and rates.

Health insurers will also face many new operational and administrative requirements related to issues such as standardized explanation of coverage documents, review of premium increases, quality reporting, appeals processes, and disclosures related to claim payment and rating practices.

The many changes to be imposed by this new healthcare reform law will greatly alter the health insurance landscape, particularly the individual and small group markets. ...Many insurers will be challenged to pursue more focused care-management and cost-containment objectives, and to achieve greater administrative efficiency.

The many changes to be imposed by this new healthcare reform law will greatly alter the health insurance landscape, particularly the individual and small group markets. They are likely to lead ultimately to greater homogeneity of products and rates, at least in the individual and small group markets. In the short term, until the conditions that will be required in order for a health plan to maintain grandfathered status have been clarified, group plan sponsors may be hesitant to change their health plan coverage and/or health insurer.

Many insurers will be challenged to pursue more focused care-management and cost-containment objectives, and to achieve greater administrative efficiency. At the same time, they will face significant new regulatory oversight and administrative compliance requirements, along with a high level of uncertainty regarding the regulatory requirements and their effect on the company's health insurance operations.

DISCUSSION OF MAJOR FEATURES OF THE PPACA

A. HEALTH BENEFIT EXCHANGES AND QUALIFIED HEALTH PLANS

One of the most significant changes that will occur under the healthcare reform law is the requirement that states establish health benefit exchanges by January 1, 2014. Each state is to establish an American Health Benefit Exchange that will: (1) facilitate the

purchase of qualified health plans and (2) provide for establishment of a Small Business Options Program, or SHOP Exchange, that is designed to assist small employers in facilitating the enrollment of their employees in qualified health plans offered in the small group market. A state may choose to provide only one exchange that provides both types of services if the exchange has adequate resources to assist both qualified individuals and qualified small employers.

Small employers are defined ... as those with one to 100 employees, but for plan years beginning prior to 2016 a state may limit the definition to a maximum size of 50 employees. Beginning in 2017, states may also choose to allow large group plans to be offered through an exchange.

Small employers are defined for this purpose as those with one to 100 employees, but for plan years beginning prior to 2016 a state may limit the definition to a maximum size of 50 employees. Beginning in 2017, states may also choose to allow large group plans to be offered through an exchange.

Not later than one year after enactment, the Secretary is to award grants to states, to be used for the purpose of establishing exchanges. These grants may be renewed if the state is making progress and meeting benchmarks, but no grants will be awarded after January 1, 2015, and the exchange must be self-sustaining by that date. The exchange will be allowed to charge assessments or user fees to participating insurers.

Low- and moderate-income individuals and families who qualify for premium tax credits and cost-sharing reductions must purchase individual coverage through the exchange to receive these subsidies. It appears that health insurers will not be required to offer plans through the exchange, and may continue to offer plans outside the exchange, subject to the various requirements of the new law.

A variety of responsibilities are assigned to exchanges, some of which include: (1) implementation of procedures for certification of health plans, (2) maintenance of an Internet website with comparative plan information, (3) assignment of plan ratings based on quality and price criteria to be established by the Secretary, and (4) granting of certifications of exemption from the individual mandate or penalty.

Exchanges may operate statewide, or states may establish *subsidiary exchanges* serving geographically distinct areas. Beginning in 2016, subject to regulations to be issued by July 1, 2013, and approval of the Secretary, states can enter into *healthcare choice compacts*. Under such compacts, one or more qualified health plans could be offered in the individual markets in all participating states, but would only be subject to the laws and regulations of the state in which the plan was written or issued, with certain exceptions.

The exceptions include, among others, the need for the qualified health plan to comply with market conduct, unfair trade practices, network adequacy, and consumer protection standards (including rating standards) of the state in which the purchaser resides, and to be licensed in, or submit to the jurisdiction of, each such state. Individuals enrolling in an exchange may choose any qualified health plan for which they are eligible. These may include qualified health plans offered by health insurance issuers, CO-OP plans, and multi-state plans.

CO-OP plans: The law provides for establishment of a Consumer Operated and Oriented Plan (CO-OP) program, to *foster the creation of qualified nonprofit health insurance issuers to offer qualified health plans in the individual and small group markets*. The Secretary is to award loans and grants under the CO-OP program, not later than July 1, 2013.

The requirements of a *qualified nonprofit health insurance issuer* include that the organization must be organized under state law as a nonprofit, member corporation, and substantially all of its activities must consist of issuing qualified health plans in the individual and small group markets. The law prohibits any organization or related entity that was a health insurance issuer as of July 16, 2009, or any government or government-sponsored organization, from qualifying as a CO-OP.

Multi-state plans: In addition to state-based exchanges and healthcare choice compacts involving two or more states, the federal Office of Personnel Management (OPM), which oversees the health and other benefit programs for federal government workers, is required to contract with health insurers to offer at least two multi-state qualified health plans in each exchange. At least one of these multi-state plans must be nonprofit. To be eligible to offer a multi-state plan, a health insurance issuer must offer a health plan that is uniform in each state and that meets all requirements of a qualified health plan. The premiums must comply with the new rating requirements, except that a state with age-rating requirements that are lower than the 3:1 ratio may require that the multi-state plan comply with the more restrictive limits.

The issuer must be licensed in each state, and must offer the plan in all states and all geographic regions, except that in the first year the requirement is to offer the plan in at least 60% of the states, followed by at least 70% in the second year, and 85% in the third year.

The Act provides that health insurance plans may not be subject to certain state and federal laws unless CO-OP plans and multi-state plans are also subject to them. This requirement encompasses laws relating to guaranteed renewal, rating, preexisting conditions, and a number of other categories, including solvency and financial requirements.

Qualified health plans: Only qualified health plans may be offered through an exchange. A qualified health plan must be certified by the exchange and be offered by an insurer that is licensed and in good standing in the state and in compliance with applicable regulations. It must provide the essential health benefits package (see below), and

the issuer must agree to offer at least one silver level and one gold level plan in the exchange, and to charge the same premium rates for a qualified plan whether sold in or out of an exchange, or directly vs. through an agent.

The exchange must require qualified health plans to submit justification for any premium increases in advance of implementation and to post this information on their websites, and must also take into consideration any patterns of excessive or unjustified premium increases when determining whether to allow the health plan to be offered in the exchange. The law also states that the exchange must *take into account any excess of premium growth outside the exchange as compared to the rate of such growth inside the exchange*. The certification requirements for qualified health plans will address issues related to marketing, choice of providers, quality accreditation, and use of uniform enrollment forms and coverage documents. A rating system will be developed by the Secretary to rate qualified health plans offered through the exchange based on relative quality and price, and this information will be made available on the Internet.

A rating system will be developed by the Secretary to rate qualified health plans offered through the exchange based on relative quality and price, and this information will be made available on the Internet.

A qualified health plan may provide coverage through a *qualified direct primary care medical home plan*, subject to criteria to be established by the Secretary as well as meeting all other applicable requirements, so long as the medical home plan services are coordinated with the qualified health plan issuer.

Additionally, a standalone dental plan may be offered through an exchange if the plan provides pediatric dental benefits as required by the essential health benefits package.

Essential health benefits package: The requirements for the essential health benefits package that must be provided by all health plans in the exchange consist of: (1) the essential health benefits scope, (2) specified limits on cost sharing, and (3) four defined levels of coverage, referred to as bronze, silver, gold, and platinum. These requirements are outlined below.

- **Essential health benefits scope:** The scope of the essential health benefits is to be equal to the scope of benefits provided under a typical employer plan as determined by the Secretary, and must include: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative services and devices; laboratory services; preventive and wellness services and chronic

disease management; and pediatric services, including oral and vision care.

Health plans may offer additional benefits in excess of the essential health benefits. If a state should require that a qualified health plan offer additional benefits, the state must pay the additional cost.

Coverage for emergency services may not require prior authorization, must cover services by a nonparticipating provider, and must cover out-of-network services at the same cost-sharing levels as in-network services.

- **Cost-sharing and deductible limits:** The annual maximum out-of-pocket cost sharing for plan years beginning in 2014 is not to exceed the levels in effect for health savings accounts (HSAs) in that year (current limits in 2010 are \$5,950 for self-only coverage and \$11,900 for family coverage). For health plans offered in the small group market, the annual deductible may not exceed \$2,000 and \$4,000 for self-only and family coverage, respectively, except that these amounts may be increased by *the maximum amount of reimbursement that is reasonably available to a participant under a flexible spending arrangement*. There are no separate limits on deductible amounts for plans sold in the individual market. In subsequent years, these limits will be increased by a premium adjustment percentage reflecting national average per capita premium increases.

Specified preventive services must be covered at 100%, consistent with a new requirement that applies to health plans in general.

The law does not address the extent to which the applicable cost sharing may vary by type of service category. It does require, however, that the Secretary define the essential health benefits to ensure that they *... reflect an appropriate balance among the categories described ... so that benefits are not unduly weighted toward any category*. This would imply that regulations will address the relative levels of cost sharing by category. The provision goes on to state that, among other things, the benefit design may not discriminate against individuals because of their age, disability, or expected length of life.

- **Levels of coverage:** A plan to be offered in an exchange must comply with one of four levels of coverage. These levels, referred to as bronze, silver, gold, and platinum, are defined as being *actuarially equivalent to [X] percent of the full actuarial value of the benefits provided under the plan*, with applicable percentages for X of 60%, 70%, 80%, and 90%, respectively, for the four levels. De minimis variation (that which is considered insignificant under the law) in the actuarial valuations is permitted. The law also provides that the Secretary issue regulations *... under which employer contributions to a health savings account ... may be taken into account in determining the level of coverage for a plan of the employer*.

It appears that this provision, referred to as the *actuarial value*, is intended to reflect the percentage of allowed costs that are

payable under the plan. It is to be determined based on the essential health benefits as provided to a standard population, *without regard to the population the plan may actually provide benefits to*.

This raises a number of questions: Will the standard population be specified by the government, or will an insurer develop its own assumptions regarding a standard population? Given that a single plan of benefits can be expected to generate different actuarial values in different geographic areas, which are due to variations in healthcare cost levels and utilization patterns, how will such differences be addressed? How will the effects of network discounts be reflected, where plan enrollees pay a percentage coinsurance and therefore directly benefit from favorable discounts negotiated by the insurer? This seemingly simple measure will involve numerous actuarial assumptions and calculations, and could easily produce anomalous results if not appropriately defined. We have weighed in on some of these difficulties in prior research.²

- **Alternative catastrophic plan:** A plan meeting specified criteria may be classified as a catastrophic plan that is eligible to be a qualified plan, even though it does not provide one of the four levels of coverage. The plan must provide the essential health benefits, must have a deductible equal to the HSA annual limits (with no cost sharing for preventive services), and must cover at least three primary care visits. The plan may cover only individuals who are under age 30, or who are exempt from the individual mandate because of hardship or lack of affordable coverage, and may be offered only in the individual market.
- **Child-only plans:** A qualified health plan offered through an exchange must also be offered as a plan only for individuals under the age of 21.

The PPACA also addresses rules related to the coverage of abortion services by qualified health plans offered through an exchange.

B. GRANDFATHERED PLANS

The new law incorporates a number of additional requirements for health plans that can be categorized as benefit coverage requirements, rating requirements, and underwriting requirements. Some of these provisions do not apply to grandfathered plans, and will be so noted in the following discussion of these features.

Grandfathered plans are described as a *group health plan or health insurance coverage in which an individual was enrolled on the date of enactment of this Act*. Therefore, such plans are defined in terms of a plan of coverage maintained by an individual or by an employer group.

The PPACA as originally written exempted grandfathered plans from certain sections of the Act, but a number of these exemptions were then reversed, first in amendments to the PPACA (in Title X of that Act) and then through provisions of the Reconciliation Act.

The new law does not indicate what a plan must do to maintain its grandfathered status and continue to qualify for the exemptions that remain. It states that additional family members will be permitted to enroll in the plan if such enrollment is permitted under the terms of the plan in effect on the date of enactment, and new employees and their families may enroll in group plans, without jeopardizing the grandfathered status. The law does not address, however, what if any changes in coverage or other provisions will be allowed after the date of enactment. Some changes will be necessary as a result of new requirements that extend to grandfathered plans, and presumably those will be allowed. Until the applicable regulations are issued, it is unknown to what degree plan modifications, including a change of insurer while maintaining the same benefit coverage, could be implemented without terminating the exemptions extended to grandfathered plans.

In the case of coverage subject to collective bargaining agreements that were ratified before the date of enactment, the grandfather provisions apply *until the date on which the last of the collective bargaining agreements relating to the coverage terminates*. Any amendments made to such agreements to conform to the new healthcare reform requirements will not be treated as a termination for this purpose.

C. BENEFIT COVERAGE REQUIREMENTS

In addition to the essential health benefits package requirements applicable to qualified health plans as outlined above, a number of benefit coverage requirements apply to all plans inside and outside of the exchanges, including large group plans (with some exceptions for grandfathered plans).

The major requirements relating to benefit coverage and the exemptions for grandfathered plans are outlined briefly below.

Effective for Plan Years

Beginning on or After September 23, 2010:

1. **Prohibition on lifetime limits:** No lifetime limits are allowed on the dollar value of benefits that are essential health benefits, which are to be defined by the Secretary consistent with the requirements of the new law. Benefits that are not essential health benefits may have lifetime limits, if otherwise permitted under applicable laws.
2. **Restricted annual limits (not applicable to grandfathered plans in the individual market):** For plan years beginning on or after January 1, 2014, annual limits on the dollar value of benefits that are essential health benefits are not permitted. For plan years prior to that time, only a *restricted annual limit*, where such term will be defined to *ensure that access to needed services is made available with a minimal impact on premiums*, may be established. Benefits that are not essential health benefits may have annual limits, if otherwise permitted under applicable laws.

² Snook, T., Dobson, R., & Harris, R. (June 2009). Understanding healthcare plan costs and complexities. Milliman Healthcare Reform Briefing Paper. Retrieved May 5, 2010, from <http://www.milliman.com/expertise/healthcare/publications/rr/pdfs/understanding-healthcare-plan-costs-rr06-15-09.pdf>.

3. 100% coverage of preventive health services (not applicable to grandfathered plans): Health plans must provide coverage, with no cost sharing, of specified types of preventive health services. These will include: (1) evidence-based services that have a rating of A or B from the United States Preventive Services Task Force, (2) immunizations recommended by the Centers for Disease Control and Prevention (CDC), (3) evidence-informed preventive care and screenings for infants, children, and adolescents, as well as additional preventive care and screening for women, as supported by the Health Resources and Services Administration.

4. Extension of dependent coverage to age 26: A health plan that provides coverage for dependent children must extend the coverage to adult children up to age 26. With respect to group plans that are grandfathered, for plan years beginning prior to January 1, 2014, this requirement applies only if the dependent is not eligible to enroll in an employer-sponsored plan.

Recently issued regulations clarify that the terms of coverage cannot vary based on the age of the child (except for children age 26 or older) and coverage may not be limited based on whether a child is married. However, health plans are not required to make coverage available to a spouse or a child of an eligible dependent child

5. Coverage for emergency services (not applicable to grandfathered plans): If a health plan includes coverage for a hospital emergency department, the coverage may not require prior authorization, must cover services by a nonparticipating provider, and must cover out-of-network services at the same cost-sharing levels as in-network services.

6. Choice of provider (not applicable to grandfathered plans): Plan participants must be permitted to choose, as their primary care provider, any participating primary care provider who is available to accept them. For a covered child, the choice of primary care provider must include a participating pediatric specialist if available. Also, a health plan may not require authorization or referrals for care provided by an in-network obstetrical-gynecological (OB-GYN) specialist.

Effective for Plan Years Beginning on or After January 1, 2014:

1. Prohibition on annual limits (not applicable to grandfathered plans in the individual market): For plan years beginning on or after January 1, 2014, annual limits on the dollar value of benefits that are essential health benefits are not permitted. Benefits that are not essential health benefits may have annual limits, if otherwise permitted under applicable laws.

2. Coverage for essential health benefits package (not applicable to grandfathered plans): The law states that a health insurer ... *that offers health insurance coverage in the individual or small group market shall ensure that such coverage includes the essential health benefits package.* This package is defined to require one of four levels of coverage, measured in terms of the

actuarial value. This provision may imply that, with the exception of grandfathered plans, insurers will be allowed to offer only plans meeting the essential health benefits package criteria in these two markets; however, the wording is not clear on this point. The requirement that health plans must comply with one of the alternative actuarial value levels raises questions regarding how the compliance would be handled on a year-to-year basis, as changes in cost levels and utilization patterns lead to changes in actuarial values.

3. Cost sharing under group health plans (not applicable to grandfathered plans): The limits on the annual out-of-pocket cost sharing that apply to the essential health benefits package, based on the levels in effect for HSA plans, will apply to all group plans other than grandfathered plans. In addition, the annual deductible for small groups may not exceed \$2,000 and \$4,000 for self-only and family coverage, respectively. These limits, applicable in 2014, are subject to an annual premium adjustment percentage. It is not clear whether the intent is to apply the deductible limits to large groups as well as small groups.

4. Child-only plans (not applicable to grandfathered plans): Any health plan that offers one of the four coverage levels (bronze, silver, gold, or platinum) must also be offered as a plan only for individuals under the age of 21.

5. Clinical trials (not applicable to grandfathered plans): Health insurers may not limit or deny coverage of routine patient costs in connection with a clinical trial for treatment of cancer or other life-threatening disease or conditions.

D. RATING REQUIREMENTS (NOT APPLICABLE TO GRANDFATHERED PLANS)

The new healthcare reform law incorporates a number of rating and underwriting requirements and prohibitions on discriminatory practices, each of which is addressed separately in the sections that follow.

The rating requirements outlined below apply to all health insurance coverage in the individual and small group markets, except for grandfathered plans. They will also apply to large group insurance coverage in states that allow large group coverage to be offered in their exchanges.

Effective for Plan Years Beginning on or After January 1, 2014:

1. Permitted rating variations: Rates may vary only by: (a) benefit coverage, (b) family structure, (c) rating area, (d) age, limited to a ratio of 3 to 1 for adults, and (e) tobacco use, limited to a ratio of 1.5 to 1.

2. Rating areas: One or more rating areas are to be established by each state, and are to be reviewed and approved by the Secretary.

3. Permissible age bands: The permissible age bands are to be defined by the Secretary in consultation with the National Association of Insurance Commissioners (NAIC).

4. **Large groups:** If a state chooses to allow large group coverage to be offered through the exchange (permitted beginning in 2017), the above rating provisions will apply to all group coverage (other than self-insured plans) in the state, other than grandfathered plans.
5. **Rates in and out of the exchange:** A health insurer that offers a qualified health plan through an exchange must agree to charge the same premium rate whether it is sold in or out of the exchange, and whether sold directly or through an agent.
6. **Single risk pool:** A health insurer is required to consider all enrollees in all health plans offered in the individual market (other than grandfathered plans), including those sold outside exchanges, ... *to be members of a single risk pool*. The same requirement applies to the small group market. Further, a state may require that the individual and small group markets in the state be merged ... *if the state determines appropriate*. The law does not indicate whether the *single risk pools* would be defined at the state level or across states, or whether variations in utilization patterns that are due to differing demographic characteristics or benefit design could be reflected in the rates by product within such a pool.

E. UNDERWRITING REQUIREMENTS

The underwriting requirements outlined below apply to all health plans in the individual and group markets (large and small), whether offered inside or outside of an exchange, except as noted. Certain underwriting reforms become effective for plan years beginning on or after September 23, 2010, while others are effective for plan years beginning on or after January 1, 2014.

Applicability to grandfathered plans: Section 1251 of the PPACA (as amended by the Reconciliation Act) indicates that these provisions are not applicable to grandfathered plans, with the explicit exception of the prohibitions on rescissions and waiting periods and, for group plans, the prohibition on preexisting condition exclusions. Because many of the remaining provisions would have limited effect on existing plans, the significance of this grandfathered plans exclusion is limited.

Effective for Plan Years

Beginning on or After September 23, 2010:

1. **Prohibition on rescissions:** Coverage may not be rescinded once the enrollee is covered, except in the case of “a covered individual who has performed an act or practice that constitutes fraud or makes an intentional misrepresentation of material fact as prohibited by the terms of the plan or coverage.” Prior notice must be provided in the event of cancellation that is due to such fraud or intentional misrepresentation.
2. **Prohibition of preexisting condition exclusions for children under age 19 (not applicable to grandfathered plans in the individual market):** Health plans may not impose preexisting condition exclusions applicable to any enrollees who are under age 19. This provision applies more generally to all enrollees

for plan years beginning on or after January 1, 2014. Recent communications from the Secretary have indicated that the regulations implementing this provision will further require that no child under age 19 be denied access to coverage because of a preexisting condition—i.e., guaranteed availability for children under age 19. It is unclear whether this requirement will apply only to children under a parent’s coverage, or whether it will involve full guaranteed issue for all children.

Effective for Plan Years

Beginning on or After January 1, 2014:

1. **Prohibition of preexisting condition exclusions (not applicable to grandfathered plans in the individual market):** Health plans may not impose any preexisting condition exclusion.
2. **Guaranteed availability of coverage (not applicable to grandfathered plans):** Health insurers in the individual or group market in a given state are required to accept every employer or individual in the state that applies for coverage. Enrollment may be restricted to open or special enrollment periods, subject to regulations to be issued by the Secretary.
3. **Guaranteed renewability of coverage (not applicable to grandfathered plans):** Health insurers offering coverage in the individual or group market must continue the coverage at the option of the individual or plan sponsor.
4. **Prohibition of discrimination based on health status (not applicable to grandfathered plans):** Health plans in the individual and group markets may not base eligibility (including continued eligibility) rules on health status, medical condition, claim experience, medical history, or other related factors. Special rules are established for wellness programs (see sidebar).
5. **Prohibition on excessive waiting periods:** Waiting periods for health plans offering group coverage may not exceed 90 days.

F. PROHIBITIONS ON DISCRIMINATORY PRACTICES

The new law includes a number of prohibitions on discriminatory practices, as outlined below.

Effective for Plan Years

Beginning on or After September 23, 2010:

1. **Prohibition of discrimination based on salary (not applicable to grandfathered plans):** The sponsor of a group health plan (other than a self-insured plan) is prohibited from establishing rules related to eligibility (including continued eligibility) for coverage of any full-time employee that are based on the total hourly or annual salary of the employee.

Effective for Plan Years

Beginning on or After January 1, 2014:

- **Prohibition of discrimination against healthcare providers (not applicable to grandfathered plans):** Health plans may

NEW REQUIREMENTS FOR WELLNESS PROGRAMS

The healthcare reform law establishes new requirements for wellness programs, to be effective for plan years beginning January 1, 2014, and later. A wellness program is defined as *a program offered by an employer that is designed to promote health or prevent disease* and that meets the applicable requirements. These requirements, which do not apply to grandfathered plans, differ depending on whether or not the conditions for receiving a reward are related to a health status factor, as outlined below.

(a) **Conditions not based on health status factors:** If the conditions for obtaining a premium discount, rebate, or other reward are not based on an individual satisfying a standard related to health status, the program may be offered if participation is made available to all similarly situated individuals. Such programs include:

- Full or partial payment for membership in a fitness center
- Diagnostic testing programs
- Waiver of copayments or deductibles for services related to a health condition (such as prenatal care or well-baby visits)
- Smoking cessation programs
- Health education seminars

(b) **Conditions based on health status factors:** The following requirements apply to a wellness program if an individual is required to satisfy a health status factor in order to obtain a reward:

- The total reward may not exceed 30% of the total premium cost. The Secretary may increase this limit to 50%.
- The program must be reasonably designed to promote health or prevent disease.
- Eligible individuals must be allowed to qualify for the reward at least once each year.
- The full reward must be made available to all similarly situated individuals, with a reasonable alternative (or waiver of the standard) offered for any individual for whom meeting the standard is unreasonably difficult or medically inadvisable. The terms of this alternative must be disclosed in plan materials.

Existing wellness programs that were established prior to the date of enactment and were in compliance with all applicable regulations may continue to be carried out as long as such regulations remain in effect.

not discriminate *with respect to participation under the plan or coverage against any healthcare provider who is acting within the scope of that provider's license or certification under applicable state law*. The extent to which this differs from a requirement that plans contract with any willing provider is unclear, although the Act specifically states that it does not make such a requirement.

G. MEDICAL LOSS RATIO REPORTING AND REBATES

The new law requires that health insurers submit annual reports to the Secretary summarizing their medical loss ratio experience. Based on this information, insurers that do not meet applicable minimum standards are required to pay rebates. This requirement applies to insured coverage, including grandfathered plans.

The new law requires that health insurers submit annual reports to the Secretary summarizing their medical loss ratio experience. Based on this information, insurers that do not meet applicable minimum standards are required to pay rebates. This requirement applies to insured coverage, including grandfathered plans.

The major provisions relating to this requirement are outlined below.

- **Effective date:** The medical loss ratio reporting requirement is effective for plan years beginning six months after enactment, whereas the requirement to pay rebates begins not later than January 1, 2011. It is unclear whether the standard will be applied to plan years beginning only after January 1 or to plan years beginning in 2010 as well.
- **Medical loss ratio reporting:** The medical loss ratio is defined for this purpose as the ratio of: (1) expenditures on *reimbursement for clinical services and activities that improve healthcare quality* to (2) the total amount of premium revenue, excluding taxes and fees, and after payments or receipts for risk adjustment, risk corridors, and reinsurance. Beginning on January 1, 2014, this calculation will be based on the averages of the values for each of the previous three years.
- **Minimum standards:** The minimum loss ratios are 85% for the large group market and 80% for the individual and small group markets, or higher percentages established by the states. The Secretary may adjust the 80% standard if it is determined that it may destabilize the individual market, or may adjust all of the standards if determined appropriate on account of individual market volatility that is due to the establishment of state exchanges.
- **Rebates:** If the minimum standards are not met, rebates in the full amount of the shortfall are to be provided *to each enrollee under such coverage, on a pro rata basis*.

There are many questions regarding the application of these provisions, in particular relating to the level of aggregation at which the loss ratios will be tabulated, and how the terms *reimbursement for clinical services* and *activities that improve healthcare quality* will be defined. The law does not address the implementation details, and provides that the NAIC is to establish uniform definitions and standardized methodologies relating to the calculations.

H. REINSURANCE AND RISK ADJUSTMENT

There are several provisions in the new law relating to reinsurance and risk adjustment. Within 90 days of enactment, a temporary high-risk health insurance pool program and a temporary reinsurance program for early retirees are to be established. By January 1, 2014, each state is required to establish a transitional reinsurance program in the individual market, and the Secretary is to establish a program of risk corridors in the individual and small group markets for calendar years 2014, 2015, and 2016. Finally, each state is required to carry out a risk-adjustment process for plans in the individual and small group markets.

Programs Effective Within 90 Days of Enactment

The first two programs fall within a section of the PPACA titled *Immediate Actions to Preserve and Expand Coverage*. According to published materials,³ the temporary high-risk pool is intended to *provide affordable coverage to uninsured Americans with pre-existing conditions until new exchanges are operational in 2014*, while the program for early retirees will *protect coverage while reducing premiums for employers and retirees*.

The provisions of each of these programs are outlined below.

1. **Temporary high-risk pool:** A temporary high-risk health insurance program is to be carried out by the Secretary, directly or through contracts with eligible state or nonprofit entities, subject to the following conditions:
 - **Eligible entities:** An eligible entity must be a state or a nonprofit private entity. To be eligible, a state must agree not to reduce the expenditures for any existing state high-risk pools during the year prior to the contract.
 - **Health insurance coverage:** The coverage must provide benefits of at least 65% of total allowed costs, with an out-of-pocket limit no greater than the applicable HSA limits, and must cover preexisting conditions.
 - **Rating:** Premium rates are subject to the new rating requirements for the individual and small group markets, except that rate variation by age may be as great as 4 to 1. Rates must be *established at a standard rate for a standard population*.
 - **Individual eligibility:** Eligibility requirements for individual participants include having a preexisting condition, a lack of

insurance for six months, and U.S. citizenship or lawful presence in the United States.

- **Protection against dumping:** Sanctions will be imposed against an insurer or health plan found to have encouraged an individual to discontinue prior coverage based on health status.
 - **Funding:** The program is funded by an appropriation of \$5 billion, to be used to pay claims and administrative costs that exceed premium amounts collected.
 - **Termination:** The coverage under this program will terminate on January 1, 2014, subject to procedures allowing transition to coverage through an exchange.
2. **Reinsurance for early retirees:** The Secretary is to establish a temporary reinsurance program to provide reimbursement to employment-based plans for early retirees and their eligible dependents, as follows:
 - **Applicability:** This program applies to employment-based plans providing health benefits to early retirees, age 55 and over, who are not yet eligible for Medicare, including self-insured plans, plans sponsored by state and local governments, and multi-employer plans.
 - **Plan requirements:** To participate, an employment-based plan must implement *programs and procedures to generate cost-savings with respect to participants with chronic and high-cost conditions*, and provide documentation of actual medical claim cost amounts.
 - **Claims reimbursement:** The program will reimburse 80% of costs between \$15,000 and \$90,000 for an eligible retiree or dependent within a given plan year. The corridor limits will be adjusted in future years by the medical care component of the Consumer Price Index for All Urban Consumers (CPI-U). These payments are to be used to lower plan costs, through reductions in premium costs for the plan sponsor, or reductions in premium contributions or cost-sharing amounts payable by plan participants. They are excluded from the gross income of the plan sponsor.
 - **Funding:** The program is funded by an appropriation of \$5 billion.

Programs Effective in 2014 and Later

Three programs are identified for implementation in 2014 and later (although no dates are specified for the risk-adjustment program). With regard to the transitional reinsurance program, the new law states that the purpose is to *help stabilize premiums for coverage in the individual market in a state during the first three years of operation of an exchange for such markets within the state when*

³ Senate Democratic Policy Committee. The Patient Protection and Affordable Care Act: Immediate Benefits. Retrieved May 5, 2010, from <http://dpc.senate.gov/healthreformbill/healthbill64.pdf>.

the risk of adverse selection related to new rating rules and market changes is greatest.

Each of the three programs is described below.

1. Transitional reinsurance program for the individual market (not applicable to grandfathered plans):

Each state is to establish a reinsurance program for the individual market not later than January 1, 2014. The major provisions applicable to this program are summarized below.

- **Applicability:** The program will apply to plan years beginning in 2014, 2015, and 2016, and will cover high-risk individuals in the individual market, excluding grandfathered plans.
- **Reinsurance entities:** A state may have more than one entity, or may enter into agreements with one or more states to provide for an applicable entity to administer reinsurance in all such states. An applicable reinsurance entity must be a nonprofit entity, *the purpose of which is to help stabilize premiums for coverage in the individual market in a state during the first three years of operation of an Exchange.* Any existing state high-risk pool must be eliminated or modified to the extent necessary to carry out the new program.
- **Funding:** According to the law, the program will be funded through contributions from all health insurers and third-party administrators, allocated on a percentage or per-capita basis across all fully insured commercial business for all major medical products and all fees and coverage costs for self-insured business. Aggregate contribution amounts for all states, not including additional amounts to cover administration costs, are to be \$10 billion, \$6 billion, and \$4 billion for plan years beginning in 2014, 2015, and 2016, respectively. (Additional contributions of \$2 billion, \$2 billion, and \$1 billion, respectively, are to be collected and deposited to the general fund of the Treasury, not to be used for this program.)
- **Reinsurance payments:** Available funds will be allocated to insurers covering high-risk enrollees in the individual market (excluding grandfathered health plans), based on a schedule of payments for specific conditions, or based on *any other comparable method for determining payment amounts that is recommended by the American Academy of Actuaries and that encourages the use of care coordination and care management programs for high risk conditions.*

2. Risk corridors for plans in individual and small group markets (not applicable to grandfathered plans):

A program of risk corridors is to be established by the Secretary for calendar years 2014, 2015, and 2016, as outlined below.

- **Applicability:** The risk corridor program will apply to qualified health plans offered in the individual or small group markets for calendar years 2014, 2015, and 2016. Presumably this would exclude grandfathered plans, which will generally not be

SAMPLE RISK CORRIDOR OPERATION

EXAMPLE 1:

- (1) **RATIO IS 90%**
- (2) **PAYMENT IS 4.1%: 2.5% (I.E., 50% X 0.05) PLUS 1.6% (I.E., 80% X 0.02)**
- (3) **PLAN PAYS 4.1% OF THE TARGET AMOUNT TO THE SECRETARY**

EXAMPLE 2:

- RATIO IS 105%**
- PAYMENT IS 1% (I.E., 50% X 0.02)**
- SECRETARY PAYS 1% OF THE TARGET AMOUNT TO THE PLAN**

qualified. It is to be based on the program for Medicare regional preferred provider organizations (PPOs).

- **Allowable cost ratio:** Corridors are to be established relative to the ratio of a plan's allowable costs to the target amount:
 - Allowable costs are defined as *the total costs (other than administrative costs) of the plan in providing benefits covered by the plan*, reduced by any risk-adjustment and reinsurance payments received.
 - Target amount is defined as total premiums, including any premium subsidies, *reduced by the administrative costs of the plan.*

These terms are not defined beyond these brief descriptions, leaving a number of questions. For example, do *administrative costs* refer to actual costs, or to the assumptions underlying the premium development?

- **Payment scheme:** If the allowable cost ratio is less than 97%, the plan must pay an amount to the Secretary, and if above 103%, the Secretary will pay an amount to the plan. Payment amounts are based on where the plan's allowable cost ratio falls relative to 100%, in accordance with the following corridors:
 - **Within three points:** No payments
 - **Variations between three and eight points:** 50% gain or loss sharing
 - **Variations in excess of eight points:** 80% gain or loss sharing

See the sidebar for an illustration of how risk corridors operate.

No reference is made to any source of funding to accommodate the payments required to be made to plans with costs above the target level, in the event that such payments exceed the payments received from plans with costs below the target level.

3. Risk adjustment in the individual and small group markets (not applicable to grandfathered plans): Each state is to make risk-adjustment payments and assessments to health plans and health insurers according to criteria to be established by the Secretary. The details of the program are not well defined, but include the following:

- **Applicability:** The risk adjustment is to apply to a health plan or health insurer *if such health plan or health insurance issuer provides coverage in the individual or small group market within the state*. It does not apply to grandfathered plans. No time period for implementation is specified.
- **Payments and assessments:** Plans with a lower-than-average actuarial risk will be assessed a charge, and plans with greater-than-average actuarial risk will receive a payment. Actuarial risk is to be measured relative to *the average actuarial risk of all enrollees in all plans or coverage in such state for such year that are not self-insured group health plans*.
- **Risk-adjustment methodology:** The risk-adjustment criteria and methodology are to be established by the Secretary, and may be similar to those utilized under Medicare Part C or D.

I. EXCISE TAX ON HIGH-COST PLANS

Effective in 2018, an excise tax of 40% will be levied on insurance companies and plan administrators. The tax will apply to the portion of the premium of an employer-sponsored health plan that exceeds a designated threshold.

- **Applicability:** The tax will apply to plans sold in the group market and to self-insured plans, but not to individual plans except coverage that is eligible for the deduction for self-employed individuals. It is to be paid by the health insurance issuer, plan administrator, or, in the case of employer contributions under a medical savings account (MSA) or HSA plan, by the employer. Standalone dental and vision plans are excluded. The tax applies to both the employer and employee premium shares, and applies to government-sponsored plans for civilian employees.
- **Thresholds:** The threshold in 2018 will be \$10,200 for single coverage and \$27,500 for family coverage. These amounts will be indexed at CPI-U plus one percentage point in 2019 and at CPI-U in subsequent years. If premium increases between 2010 and 2018 are greater than expected (i.e., greater than 55%), as measured by the change in the per-employee cost for the Blue Cross/Blue Shield standard benefit option plan in the Federal Employees Health Benefits Plan (FEHBP) from 2010 to 2018 (holding benefits constant at 2010 levels), the 2018 threshold

amounts will be increased. The increase adjustment will reflect the excess in the growth of the per-enrollee cost of that plan over 55%.

- **Adjustment for high-age/gender characteristics:** The thresholds are increased for employers with high-age/gender characteristics. The adjustment is calculated based on the Blue Cross/Blue Shield FEHBP standard option plan by comparing the premium cost of that plan, if priced for the employer plan age and gender characteristics, to the cost that would be produced by pricing for the national workforce characteristics.
- **Alternate thresholds for special groups:** For retired individuals who are age 55 and older and not eligible for Medicare, and for plans that cover employees engaged in certain high-risk professions, the threshold will be increased by \$1,650 for single coverage and \$3,450 for family coverage.
- **Multi-employer plans:** Multi-employer plans are subject only to the threshold for family coverage, regardless of whether the coverage is for self-only or family coverage.

J. OPERATIONAL REQUIREMENTS, FEES, AND OTHER PROVISIONS

A number of additional requirements are incorporated in the new law, including the following:

- **Various operational requirements (not applicable to grandfathered plans):** For plan years beginning on or after September 23, 2010, a range of operational and administrative requirements will apply to health insurers. These requirements include, but are not limited to, disclosure of claim payment practices; provision of data on enrollment, claim denials, rating practices and out-of-network cost sharing (i.e., transparency of coverage requirements); and requirements related to appeals processes.
- **Quality reporting (not applicable to grandfathered plans):** Quality reporting requirements are to be developed by the Secretary by March 23, 2012. Plans will be required to submit annual reports to the Secretary on whether the benefits under the plan satisfy specified quality criteria, and such reports are to be made available to enrollees during each open enrollment. These reports will also be available on the Internet.
- **Internet portal:** The Secretary is to establish, by July 1, 2010, an Internet portal to provide information that allows consumers, including small businesses, to identify affordable coverage options. The Department of Health and Human Services (HHS) has recently announced⁴ that the portal will launch in phases, with the first phase being introduced on July 1. This first phase will provide summary-level information on available coverage options by state and zip code in the private market and information about public programs with links to more detailed information. It will

⁴ U.S. Department of Health and Human Services, Fact sheet on Establishing the Web Portal Called For in The Affordable Care Act. Retrieved May 11, 2010 from <http://www.hhs.gov/ocio/gatheringinfo/factsheet.html>.

be followed by a second phase in October that will have more detailed pricing and benefit information.

- **Uniform reporting:** Health plans will be required to comply with uniform standards for provision of benefit summaries and explanation of coverage for applicants, policyholders, and enrollees. The Secretary is to develop standards within 12 months of enactment (i.e., not later than March 23, 2011) and health plans will be required to comply with these standards not later than March 23, 2012.
- **Administrative simplification:** New procedures related to health information transactions will be required of all health plans. The Secretary will adopt a single set of operating rules *with the goal of creating as much uniformity in the implementation of the electronic standards as possible.*

Beginning in 2014, the Secretary will monitor premium increases of coverage offered inside and outside of the exchanges.

- **Review of premium increases (not applicable to grandfathered plans):** The Secretary will establish a process for annual review of *unreasonable increases* in health insurance premiums, beginning with the 2010 plan year. Insurers will be required to submit a justification for an unreasonable premium increase prior to implementation, and post it on their websites. A state, through its insurance commissioner, is required to provide the Secretary with information about trends in premium increases, and to recommend to the exchange whether to exclude particular health insurance issuers based on a pattern of excessive or unjustified premium increases.

Beginning in 2014, the Secretary will monitor premium increases of coverage offered inside and outside of the exchanges.

- **Health insurance provider annual fees:** Health insurers will be required to pay annual fees, beginning in 2014. Total fees will be \$8 billion in 2014, \$11.3 billion in 2015 and 2016, \$13.9 billion in 2017, and \$14.3 billion in 2018. The fees will increase annually thereafter by a premium growth rate. The fees will be allocated among insurers using a formula based on net premiums, where the formula excludes the first \$25 million of annual premium, and excludes 50% of the second \$25 million. The net premium allocation is reduced by 50% for certain tax-exempt entities.

Fees for third-party administration agreements are excluded in the determination of fee allocations among insurers. Certain nonprofit insurers that receive more than 80% of their incomes from government programs for low-income, elderly, or disabled populations are exempted from the fees, as are voluntary employee benefit associations.

- **Special deduction for Blue Cross/Blue Shield organizations:** Beginning in 2010, a nonprofit Blue Cross/Blue Shield organization must have a medical loss ratio of 85% or higher in order to receive the special tax benefits provided under Internal Revenue Code section 833.

As stated at the outset of this paper, the changes that will occur as a result of this legislation are monumental, and will have a far-reaching impact on virtually all aspects of the operations of health insurance companies. Insurers will be required to dedicate substantial resources to understanding and addressing the many provisions affecting their business, and to adapt their management practices and priorities in response to the changing healthcare landscape.

Phyllis Doran is a principal and consulting actuary with the Philadelphia office of Milliman. Contact Phyllis at 610.975.8080 or at phyllis.doran@milliman.com.

APPENDIX: HEALTHCARE REFORM LAW IMPLEMENTATION TIMELINE

2010

- New requirement related to special deduction for nonprofit Blue Cross/Blue Shield organizations
- Process for annual review of unreasonable increases in health insurance premiums

June 2010

- Temporary high-risk health insurance pool program established
- Temporary reinsurance program for early retirees established

July 2010

- Internet portal established by the Secretary

Plan Years Beginning on or After September 23, 2010

- Prohibition of lifetime benefit limits for essential health benefits
- Only restricted annual limits (to be defined by HHS) allowed for essential health benefits
- 100% coverage of specified preventive services required
- Dependent coverage extended to age 26
- Requirements associated with coverage for emergency services
- Requirements related to participant choice of provider
- Rescissions prohibited (except for fraud or intentional misrepresentation)
- Prohibition of preexisting condition exclusions for children under age 19
- Prohibition of discrimination based on salary
- Medical loss ratio reporting requirement
- Grandfathered plans
 - Prohibition of lifetime benefit limits for essential health benefits
 - Dependent coverage extended to age 26
 - Rescissions prohibited (except for fraud or intentional misrepresentation)
- Group grandfathered plans
 - Only restricted annual limits allowed for essential health benefits
 - Prohibition of preexisting condition exclusions for children under age 19

2011

- Minimum loss ratio standards of 80% for individual and small group and of 85% for large group markets take effect; rebates payable to enrollees if standards not met
- Uniform coverage documents and standard definitions developed by HHS (in consultation with NAIC)

2012

- Health plans required to comply with uniform coverage documents and standard definitions

2013

- Consumer Operated and Oriented Plan (CO-OP) program established (any organization or related entity operating as a health insurance issuer as of July 16, 2009, or any government organization, is prohibited from qualifying as a CO-OP)
- Single set of rules for eligibility verification and claim status adopted

2014

- All individuals required to maintain minimum essential coverage or pay a penalty (subject to certain exemptions)
- Premium tax credits and cost-sharing assistance through the exchanges for those whose household income is at or below 400% of the federal poverty level
- Health insurance exchanges established
 - Essential health benefits package required
 - Identical rates required for plans sold in and out of an exchange
 - All enrollees in all health plans required to be considered members of a single pool (separately for individual and small group markets)
 - Child-only plans (up to age 21) must be offered
 - Small groups defined as one to 100; states may choose to lower limit to 50 for 2014 and 2015
- States required to establish transitional reinsurance programs in the individual market for plan years beginning in 2014, 2015, and 2016
- HHS to establish a program of risk corridors in the individual and small group markets for calendar years 2014, 2015, and 2016

- States required to carry out a risk-adjustment process for plans in their individual and small group markets (effective date not specified)

- Health insurance provider fees of \$8 billion imposed

Plan Years Beginning

on or After January 1, 2014 (plans in and out of exchanges)

- Prohibition of annual benefit limits for essential health benefits
- Coverage for clinical trials cannot be denied
- Preexisting condition exclusions prohibited
- Guaranteed availability of coverage required
- Guaranteed renewability of coverage required
- Prohibition of excessive waiting periods for groups
- Prohibition of discrimination based on health status
- Prohibition of discrimination against healthcare providers
- Comprehensive coverage requirements
 - All insurers in individual and small group markets required to offer essential health benefits package
 - Annual cost sharing under group plans limited to HSA levels
 - Annual deductible for small group plans limited to \$2,000/\$4,000
 - Child-only plans (up to age 21) must be offered for plans with essential health benefits package

- Rating variations restricted to:

- Benefit coverage
- Family structure
- Rating area
- Age, limited to a ratio of 3 to 1 for adults
- Tobacco use, limited to a ratio of 1.5 to 1

- Group grandfathered plans

- Preexisting condition exclusions prohibited
- Annual benefit limits for essential health benefits prohibited
- Excessive waiting periods for groups prohibited

2015

- Health insurance provider fees increased (\$11.3 billion)

2016

- States may enter into healthcare choice compacts under which qualified health plans could be offered in all participating states (subject to regulations to be issued by July 1, 2013)
- All small groups are defined as having one to 100 employees

2017

- States may choose to include coverage for the large group market in exchanges (restrictions on rating variations would apply)

- Health insurance provider fee increased (\$13.9 billion)

2018

- Health insurance provider fee increased (\$14.3 billion); in years following 2018, tax amount increases by a premium growth rate
- Excise tax on high-cost plans becomes effective

The materials in this document represent the opinion of the authors and are not representative of the views of Milliman, Inc. Milliman does not certify the information, nor does it guarantee the accuracy and completeness of such information. Use of such information is voluntary and should not be relied upon unless an independent review of its accuracy and completeness has been performed. Materials may not be reproduced without the express consent of Milliman.

Copyright © 2010 Milliman, Inc.