Changes Affecting Private Insurance Plans and Issuers

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President Obama signed into law the Patient Protection and Affordable Care Act on March 23, 2010 and the Health Care and Education Affordability Reconciliation Act on March 30, 2010 (collectively, the "Act"). The Act will result in extensive changes to the U.S. healthcare system. This Advisory focuses on the Act's impact on private insurance plans and issuers.

Benefit and Market Reforms

No Lifetime or Annual Limits. Effective six months after enactment, the Act prohibits group health plans and health insurance issuers from establishing lifetime limits on the dollar value of benefits for any participant or beneficiary. The Act also prohibits annual limits beginning January 1, 2014. Prior to that date, the Act permits only "restricted annual limits," a term that will need to be defined by the Secretary of Health and Human Services (the "Secretary"). The restrictions and prohibitions on lifetime and annual limits apply only to services classified as "essential health benefits," as defined below.

Coverage for Essential Health Benefits. Effective January 1, 2014, health insurance issuers that offer health insurance coverage in the individual or small group market must ensure that such coverage includes the "essential health benefits" package. These "essential health benefits" will be determined by the Secretary and will include ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services including oral and vision care.

Coverage of Preventive Health Services. Effective six months after enactment, the Act requires group health plans and health insurance issuers to provide, at a minimum, coverage for certain specified healthcare services. Group health plans and health insurance issuers cannot impose any cost-sharing requirements for these healthcare services. The covered health care services are: (1) evidence-based items or services recommended by the United States Preventive Services Task Force; (2) immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; (3) with respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and (4) with respect to women, such additional preventive care and screenings not described in (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

Coverage for Preexisting Conditions. Effective six months after enactment, the Act prohibits excluding children from coverage on the basis of a preexisting medical condition in all group plans and plans in the individual market. This prohibition will be extended to adults beginning 2014. Additionally, the Act calls for a creation of a temporary high-risk pool within 90 days after enactment to provide health coverage to persons with preexisting conditions. The pool will be effective until January 1, 2014.

Guaranteed Availability of Coverage. Effective January 1, 2014, each health insurance issuer that offers health insurance coverage in the individual or group market in a given state must accept every employer and individual in that state that applies for such coverage.

Guaranteed Renewability of Coverage. Effective January 1, 2014, health insurance issuers that offer health insurance coverage in the individual or group market must renew or continue in force such coverage at the option of the plan sponsor or the individual, as applicable.

Extension of Dependent Coverage. Effective six months after enactment, the Act requires group health plans and health insurance issuers to provide dependent coverage for unmarried children of participants until the age of 26. The Act directs the Secretary to promulgate regulations defining dependents eligible for such coverage.

Antidiscrimination Provisions. Effective six months after enactment, the Act prohibits plan sponsors of group health plans from discriminating against full-time employees based on hourly or annual wages, or favoring of higher-wage employees. Effective January 1, 2014, the Act prohibits discrimination based on health status, medical condition (including mental illnesses), claims experience, receipt of healthcare, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence), disability, and any other health status-related factor determined by the Secretary. In addition, premium variations in individual and small group markets will

be restricted. Premiums can vary with respect to a particular plan or coverage only according to: (1) whether the plan or coverage covers an individual or family; (2) rating area, as established in accordance with the Act; (3) age; and (4) tobacco use. The Act directs the Secretary to define the permissible age bands for rating purposes in consultation with the National Association of Insurance Commissioners (NAIC).

Prohibition on Rescissions. Subject to certain exceptions for fraud and intentional misrepresentations by an enrollee, a group health plan and a health insurance issuer cannot rescind a plan or coverage with respect to an enrollee once the enrollee is covered under such plan or coverage. This prohibition goes into effect six months after enactment of the Act.

Prohibition on Excessive Waiting Periods. Effective January 1, 2014, group health plans and health insurance issuers offering group or individual health insurance coverage are prohibited from imposing coverage waiting periods that exceed 90 days.

With respect to the benefit and market reforms described above, the Act grandfathers requirements for certain existing individual and group health plans, generally for a period of six months.

Rate Review Reforms

Review of Increases in Premiums. The Act directs the Secretary to establish a process for the annual review of unreasonable increases in premiums for health insurance coverage, beginning with the 2010 plan year.

Documentation and Reporting Reforms

Development and Utilization of Uniform Explanation of Coverage Documents and Standardized Definitions. Within 12 months after enactment, the Secretary must develop standards for group health plans and health insurance issuers to use in providing consumers with information regarding their benefits and coverage. In developing the standards, the Act directs the Secretary to consult with the NAIC, a working group composed of representatives of health insurance-related consumer advocacy organizations, health insurance issuers, healthcare professionals, patient advocates including those representing individuals with limited English proficiency, and other qualified individuals. The standards for the summary of benefits and coverage must include, among other things, (1) uniform definitions of standard insurance terms and medical terms so that consumers may compare health insurance coverage and understand the terms of coverage (or exception to such coverage); (2) a description of the coverage, the exceptions, reductions, and limitations on coverage; (3) the cost-sharing provisions, including deductible, coinsurance, and co-payment obligations; (4) the renewability and continuation of coverage provisions; (5) a coverage facts label that includes examples to illustrate common benefits scenarios, including pregnancy and serious or chronic medical conditions; (6) a contact number for the consumer to call with additional questions and an internet web address where a copy of the actual individual coverage policy or group certificate of coverage can be reviewed and obtained. Group health plans and health insurance issuers must comply with the new standards with 24 months after enactment.

Quality Reporting Requirements. Within two years after enactment, the Secretary must develop reporting requirements for use by group health plans and health insurance issuers with respect to plan or coverage benefits and healthcare provider reimbursement structures that (1) improve health outcomes through implementation of activities such as quality reporting and care compliance initiatives, (2) implement activities to prevent hospital readmissions; (3) implement activities to improve patient safety and reduce medical errors; and (4) implement wellness and health promotion activities. For purposes of the reporting requirements, wellness and prevention programs may include personalized wellness and prevention services (e.g. smoking cessation and weight management), which are coordinated by a healthcare provider, a wellness and prevention plan manager, or a health, wellness or prevention services organization.

Reporting of Medical Loss Ratio. Beginning with the 2010 plan year, health plans will be required to report to the Secretary the percentage of premiums they spend on reimbursement for clinical services, known as the medical loss ratio ("MLR"). Effective January 1, 2011, if the MLR does not fall within the parameters specified by the Act, the Act requires payment of rebates to enrollees.

In addition to the reforms outlined above, the Act includes certain reinsurance provisions, including the creation of a reinsurance program for early retirees and a reinsurance program to protect against anti-selection. See our Healthcare Reform Update entitled *The Role of Reinsurance in Establishing the New Regime* for details.

For Further Information

If you have any questions, please contact the Edwards Angell Palmer & Dodge lawyer responsible for your affairs, or the authors of this Update, Eric D. Fader (212-912-2724) or Mohana Terry (212-912-2844).