Immediate Health Insurance Reforms

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Important Note: The rules under which many of these reforms apply are dependent on whether or not the health insurance plan involved is considered to be grandfathered or not, (refer to information in *italics* at the end of each category of reform requirements).

Generally effective for plan or policy years on and after 9/23/10:

- **No lifetime limits**: Plans may not establish lifetime limits on the dollar value of essential benefits. Details about essential benefits are still to be determined by HHS, but we do know generally that they include the following:

  Ambulance
  Emergency services
  Hospitalization
  Maternity and newborn care
  Mental health and substance abuse disorder services
  Prescription drugs
  Rehabilitative services and habilitative services and devices
  Lab services
  Preventive and wellness services and chronic disease management
  Pediatric services, including oral and vision care

  HHS released interim final rules addressing lifetime limits on 6/21. Anyone who previously lost coverage because of having reached lifetime limit must be given a special enrollment period. *All plans*

- **Restricted Annual limits**: Annual limits are limited as they apply to essential benefits, and the limits vary depending on the plan year, ranging from $750,000 in 2010 to $2 million in 2012. *All plans except individual grandfathered plans*

- **Restrictions on Rescissions** – coverage may only be rescinded for fraud or intentional misrepresentation of a material fact. Prior notification of cancellation must be provided to the policyholder. HHS released interim final rules addressing this on 6/21. *All plans*

- **First Dollar Coverage of Preventative Health Services** – a number of preventative care services and immunizations must be provided without cost sharing, (no deductibles, coinsurance, etc.), except that cost sharing may be applied when these services are provided by out-of-network providers for network plans. HHS released interim final rules addressing this on 7/9. *All non-grandfathered plans*

- **Extended Dependent Coverage** - for adult children to age 26. Very liberal requirements – no dependency criteria at all, other than in terms of the relationship between the child and the plan participant. For example, conditions like financial dependency, student status, or residency with the participant can not be used. In the case of a child whose coverage previously ended, the insurers must provide that child with at least a 30 day period to enroll. This requirement became effective 9/23, and it essentially applies to plans or policies on the beginning of their first plan or policy year following that date, but many carriers voluntarily implemented this extended coverage earlier. HHS released interim final rules on 5/13. *All plans*

- **Internal/External appeals** of adverse coverage decisions – interim final rules addressing internal and external reviews were released on 7/22. We are still reviewing these rules, but it does appear that the processes in place in Virginia will be significantly impacted,

particularly as they relate to external appeals. We do have a grace period until 7/1/11, though, under which existing state requirements for external appeals are applicable. *All nongrandfathered plans*

- **No preexisting conditions for Children:** no exclusions (including denial of coverage) can be imposed on individuals under age 19. HHS released interim final rules on 6/21. *All plans except grandfathered individual market plans*
- **Disclosure of Justifications for Premium Increases**: Effective this year, insurers will be required to report to HHS and to the states justifications for "unreasonable" rate increases prior to implementing the increase. The states are working collaboratively on providing to HHS, for consideration, a format for reporting these increases. The term "unreasonable", though, has not yet been defined.

MLRs and Rebates:

Medical loss ratios and rebates – No later than 1/1/2011, carriers will be required to report to HHS a medical loss ratio relating to their fully insured plans. The components of the MLR are still being discussed, but they must account for clinical services, activities that improve health care quality and non-claim expenses, including federal and state taxes, licensing and regulatory fees. If the percentage of premium expended for clinical services and activities that improve health care quality is less than 85% in the large group market and 80% in the small group and individual market, a rebate to consumers will be required. *All fully insured plans including grandfathered plans.*

The medical loss ratio calculation contemplated by the federal act is very different from the loss ratio requirement currently required with individual health products in Virginia. This is perhaps the most debated and discussed provision in the federal act so far. The debate focuses primarily on the components of the loss ratio calculation – what is considered to improve quality of care, what is considered to be cost containment measures, and what is considered to be administrative costs, for example. All the states, Virginia included, are working collaboratively through the NAIC to develop recommendations for HHS' consideration relating to the components of the medical loss ratio. This issue is not yet finalized at this point.

In 2014:

Exchanges

By 1/1/2014, a health insurance exchange must be operational in each state to facilitate the purchase of qualified health insurance plans and assist small employers in enrollment of their employees in qualified health insurance plans. Essentially, by 2013, each must have made a definitive decision as to whether or not the state will operate its own exchange. In the event the state chooses not to operate an exchange the federal HHS secretary will contract with an entity to operate the exchange.

There are a number of alternatives available to states, such as merging the individual and small employer exchanges and offering regional exchanges among states. At this point, it is obviously too early to provide many specifics about where Virginia may go with this initiative.

2014 Market Reforms:

- **Guaranteed issue**: insurers will be required to accept every employer and every individual that applies for coverage except that they will be permitted to restrict enrollment to special enrollment periods. *Non grandfathered fully insured plans*

- **No pre-ex Condition Exclusions for adults**. Insurers will not be permitted to apply any pre-existing condition exclusions (right now that requirement applies to individuals under age 19, but the prohibition will extend to everyone in 2014) *All plans except grandfathered*
- **Rating Rules**: Premium variation will only be permitted based on age, tobacco usage, geographic rating areas and whether or not the coverage is for an individual or for a family. *Non grandfathered fully insured small group and individual plans and fully insured large group plans sold through the exchange.*
- **Essential Benefit plans**: In order to be certified as a "qualified health plan" for the exchange, the plan will have to provide the essential benefit package, among other things. Details about essential benefits are still to be determined by HHS, but we do know generally that they include the following:

  Ambulance
  Emergency services
  Hospitalization
  Maternity and newborn care
  Mental health and substance abuse disorder services
  Prescription drugs
  Rehabilitative services and habilitative services and devices
  Lab services
  Preventive and wellness services and chronic disease management
  Pediatric services, including oral and vision care

There will also be restrictions on cost sharing and deductibles. There will be 4 levels of coverage through the exchange, which are defined in terms of the benefits provided: bronze, silver, gold and platinum.

- **No annual limits for Essential Benefits**: The annual restricted limits that currently apply to essential benefits under the "immediate reforms" will be removed.

What has the Bureau done so far?

- We have enhanced our website to include a special link to health care reform issues. http://www.scc.virginia.gov/division/boi/
- We have provided information to HHS to facilitate the development of a web portal for individuals to find available health insurance plans in Virginia: http://www.healthcare.gov/
- We have convened an internal working group to review processes and procedures and, most importantly, to identify potential conflicts with state law. This project is ongoing.
- We are developing outreach materials to insert into some of our publications to alert people to the changes that are upcoming.
- We are sitting on numerous working groups within the NAIC to provide input in the development of uniform language for policies and policy summaries, to review the rating requirements, and to generally follow the reform activities.
- We have submitted an application for a $1 million grant to enhance and strengthen our rate review processes.