Third Quarter Health Reform Highlights

Essential Health Benefits

The Department of Health and Human Services (HHS) requested the Institute of Medicine (IOM) to develop a process that would assist HHS in further defining the types of benefits that should be included in an "essential health benefits" (EHB) package, and to propose a set of criteria and methods that should be used in deciding what benefits are most important for coverage. The IOM issued a 297-page report (Essential Health Benefits: Balancing Coverage and Costs) on Oct. 7. The IOM report specifically states that when determining the EHB package, there are four considerations for HHS to incorporate:

- Setting a balance between comprehensiveness and affordability
- Defining what "typical" should mean in a typical employer plan
- Determining how specific EHB guidance should be and when variation from state-to-state might be allowable; and
- Developing criteria and methods that address calls for the best evidence, patient protection, opportunities for innovation, and fair processes

Individual Mandate Litigation

On Sept. 23, the D.C. Circuit Court of Appeals heard the appeal of the D.C. District Court's decision upholding the individual mandate provision of the Affordable Care Act (the Act). During the argument, the court, similar to the Fourth Circuit appellate court, questioned the plaintiffs about their ability to bring the suit due to the Anti-Injunction Act, which basically requires that people must pay a tax before challenging it in court. On Sept. 28, the litigants in the Eleventh Circuit case (the one striking down the mandate), filed a petition with the Supreme Court seeking a review of the Eleventh Circuit's decision, which struck down the mandate but upheld the remainder of the law. Thus it is likely the Supreme Court will hear the case in its term that begins in October and ends in June 2012. On Sept. 12, a district court in Pennsylvania, hearing a case challenging

the mandate, struck it down in addition to finding the guarantee issue and pre-existing conditions provisions of the Act are non-severable from the mandate (thus striking down these provisions as well).

"Play or Pay" Employer Penalty Rules – Notice 2011-73

The Internal Revenue Service (IRS) published Notice 2011-73 on Sept. 13, requesting comments on the "Play or Pay" penalties set forth in the Act, and outlining initial clarifying guidance. The "Play or Pay" rules require certain employers to offer their full-time employees minimum essential coverage. Pursuant to the rules, and beginning in 2014, large employers (those employing 50 or more full-time equivalent employees) will be subject to a penalty if one or more full-time employees receives a tax credit or cost-sharing reduction to purchase insurance in the Exchanges (a "Subsidy") because (a) the employer doesn't offer coverage, or (b) the coverage offered by the employer either does not provide "minimum value" or is unaffordable to the employee.

Rate Review, Association Business – Amended Final Rule

The Act directs the Secretary of HHS, in conjunction with the states, to establish a process for the annual review of "unreasonable increases in premiums for health insurance coverage," excluding grandfathered health insurance coverage and self-funded plans. On May 23, HHS published a final rule, in which HHS specifically solicited comments on amending the definitions of "individual market" and "small group market" in the Act (§154.102) to include coverage sold to individuals and small groups through associations. After consideration of the comments, HHS is now amending the final rule to provide that individual and small employer policies sold through associations will be included in the rate review process, even if a state otherwise excludes such coverage from its definitions of individual and small group market coverage.

Exemption of HRAs from Annual Limit Waiver Filings – Supplemental Guidance – CCIIO 2011-1E

The Center for Consumer Information & Insurance Oversight (CCIIO) issued sub-regulatory guidance on Aug. 19 that exempts health reimbursement accounts (HRAs) that are subject to the restricted annual limits as a class from having to apply individually for an annual limit waiver. An HRA in effect prior to Sept. 23, 2010, is exempt from applying for an annual limit waiver for plan years beginning on or after Sept. 23, 2010, but before Jan 1, 2014. These HRAs still must comply with the record retention and Annual Notice requirements to participants and subscribers set forth in the supplemental guidance issued on June 17. CCIIO has also tailored the model notice to the unique circumstances of HRAs.

Summary of Benefits and Coverage, and Summary of Material Modifications – Proposed Rules

On Aug. 17, HHS and the departments of Labor and Treasury (the Agencies) issued new proposed rules relating to the uniform coverage document requirements set forth pursuant to Section 2715 of the Act, copies of the uniform template documents and instructions, and guidance regarding the timing for issuance of summaries of material plan modifications. When originally passed, the Act required the Agencies to, not later than 12 months after the date of enactment of the law (by March 23, 2011), develop standards for use by a group health plan and a health insurance issuer (group or individual) to provide "applicants, enrollees, and policyholders or certificate holders" a uniform summary of benefits and a coverage explanation describing the benefits and coverage under each policy or plan. The Agencies worked over the past 17 months to develop these standards in consultation with the National Association of Insurance Commissioners, a working group composed of representatives of health insurance-related consumer advocacy organizations, health insurance issuers, health care professionals, patient advocates, and other qualified individuals. The proposed rule sets forth requirements establishing the necessary content to be included in a summary of benefits and coverage (SBC) document, the timing for issuance of the document, and notification requirements relating to any changes of coverage noted in the SBC.

Exchanges – Proposed Rules (set two)

HHS and Treasury released three more proposed rules on Aug. 12 that are associated with the Exchanges. The three areas covered by this latest set of rule-making include:

- Exchange Eligibility and Employer Standards: This HHS-sponsored rule details the standards and process for enrolling in qualified health plans (QHPs) and insurance affordability programs. The rule also outlines basic standards for employer participation in the SHOP.
- Health Insurance Premium Tax Credit: The rule issued by Treasury outlines how individuals and families may receive premium tax credits to subsidize costs for certain qualified individuals.
- Medicaid Eligibility: The second HHS rule in this package discusses the expansion of Medicaid eligibility and coordination with CHIP and the new Exchanges.

Preventive Services Guidance – Amended IFR

On Aug. 1, HHS released a pre-publication of an amendment to the preventive services interim final rule. The new guidelines were developed by IOM and require health insurance plans to cover women's preventive services such as well-woman visits, domestic violence screening, and contraception without charging a copayment, coinsurance or a deductible. Under the Act, women's preventive health care – such as mammograms, screenings for cervical cancer, prenatal care, and other services – are covered with no cost-sharing for new health plans. The following additional preventive services will also be impacted by the new guidelines:

- well-woman visits
- screening for gestational diabetes
- human papillomavirus (HPV) DNA testing for women 30 years and older
- sexually transmitted infection counseling
- human immunodeficiency virus (HIV) screening and counseling
- FDA-approved contraception methods and contraceptive counseling
- breastfeeding support, supplies, and counseling; and
- domestic violence screening and counseling

CO-OP – Proposed Rules

HHS published a Notice of Proposed Rulemaking (NPRM) on July 18 establishing additional standards governing the creation of Consumer Operated and Oriented Plans (CO-OP). A CO-OP is a consumer-governed, private, non-profit health insurance issuer created pursuant to Section 1322 of the Act. The Proposed Rule establishes basic eligibility standards for participation as a CO-OP, outlines the requirements for distribution and repayment of loans, and sets forth the basic standards a CO-OP must meet in order to participate.

Exchanges – Proposed Rules (set one)

On July 11, HHS published two NPRMs impacting Exchanges. The first NPRM outlines general operating guidelines for the state-based health benefit exchanges ("Exchange Rule"), and the second addresses standards related to reinsurance, risk corridors, and risk adjustment for qualified plans in these markets ("Premium Stabilization Rule"). The NPRMs do not address all of the Exchange provisions contained within the Act. Additional guidance will be provided in forthcoming proposed rules (e.g., the issuance of guidance on the definition of "Essential Health Benefits").

The main topics contained with the Exchange Rule include:

- The structural requirements that states must meet if they elect to establish and operate an Exchange, including enrollment standards and tools (e.g., website content) that must be established
- Minimum requirements that health insurers must meet to be eligible to offer qualified health plans within an Exchange
- Basic standards that employers must meet to participate in the Small Business Health Options Program (SHOP); and
- Approval timing

The second NPRM implements standards for states relating to reinsurance, risk adjustment and risk corridors. The intent of these programs is to stabilize the insurance market as the Exchanges begin to take effect, and equitably spread the financial risk across plans for high-cost enrollees. The Premium Stabilization Rule offers states options in designing and administering these programs. States can also tailor the risk adjustment program, for example, using their own methodology if approved by HHS, and determine when and how payments to plans will be made.

Claim and Appeals – Corrected Amendment to IFR

The Agencies released a "pre-publication" copy of a correction to the recently published Amendment to the June Interim Final Rule relating to Internal Claims and Appeals and External Review Processes. The correction addresses an omission in the IFR Amendment, which inadvertently failed to include a reference to insurance coverage sold in the individual market. The correction makes clear that the changes to the IFR Amendment with respect to internal claims and appeals also apply to the individual insurance market. More specifically, the amendments regarding expedited notification of benefit determinations involving urgent care claims (within 72 hours), notice requirements for internal claims and appeals (CPT/Diagnosis codes and meanings), and deemed exhaustion of internal claims and appeals processes. The correction also addresses several other minor errors in the Amendment.

MLR IFR Questions and Answers – CCIIO Technical Guidance (2011-004)

CCIIO issued Technical Guidance (2011-004) in the form of two detailed questions and answers. This guidance supplements the medical loss ratio (MLR) interim final rule published Dec. 1, 2010. This new guidance also supplements the CCIIO's Technical Guidance 2011-002 issued May 13, 2011. Technical Guidance 2011-004 provides some further clarity around the following two MLR topics: (1) Counting Employees for Determining Market Size, and (2) Third Party Vendor Payments.

List of Effective State Rate Review Programs

On May 19, HHS released a Final Rule establishing a process for reviewing "unreasonable" health insurance rate increases in the individual and small group markets, as required by the health care reform legislation. The guidance clarifies that the CCIIO will maintain a list of those states with an "effective rate review program" that includes certain disclosure and transparency requirements. If a state is deemed not to have an effective program, the federal government will review rate increases in excess of the threshold.

On July 6, the CCIIO released the list of states that have "effective" rate review programs. The list will be updated and maintained on the following website: http://cciio.cms.gov/resources/factsheets/rate_review_fact_sheet.html

Wellness – Workplace Health Protection and Promotion Program – Request for Proposal

On July 5, the Centers for Disease Control and Prevention (CDC), a division of HHS, published a request for proposal for any entity interested in participating in the CDC's workplace health protection and promotion program. The CDC is making available $10 million from the Act's Prevention and Public Health Fund to establish and evaluate comprehensive workplace health promotion programs. The funds will be awarded through a competitive contract to an organization with the expertise and capacity to work with groups of employers to develop and expand workplace health programs. The entity chosen to assist in implementing the program will work with participating companies to help educate employees about good health practices, and assist these organizations in establishing work environments that promote physical activity and proper nutrition.

Administrative Simplification (eligibility and claim status) – Interim Final Rule

On June 30, HHS released a pre-publication of an interim final rule that is the initial set of regulations required by the administrative simplification provisions contained within the health care reform legislation. Under this provision, the HHS Secretary is required to adopt "operating rules" for the existing standards that health insurance plans use to communicate electronically with providers. The use of these standards for electronic transactions is mandated by HIPAA. The regulation designates the Council for Affordable and Quality Healthcare's Committee on Operating Rules for Information Exchange (CAQH CORE) as the operating rules authorizing entity for the first two required transactions.

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