

KEY MESSAGES

The “What” and “When” of Health Reform

April 2010

Background

With nearly 3,000 pages in the health reform legislation recently signed into law by President Obama, there are bound to be questions from associates, health care providers, brokers and other key partners about what the law does – and when.

To help you understand the ramification of the legislation and the timing of several key components, below is some initial information to help you begin to understand the “what” and “when” of a few of the key issues that will be addressed over the coming months and years.

A couple caveats

First, because of the far-reaching nature of the legislation, there have already been areas of uncertainty about what the law does and when. Therefore, Health Net and many others are awaiting clarifying regulations that will be announced by government regulators, including the U.S. Department of Health and Human Services. This means some of the interpretations and timeframes noted below may change.

And second, the below information does not address all of the provisions in the legislation. For an in-depth summary of the reform legislation provisions, please click on the *Reform Summary* link that is included with the email message for a summary prepared by Health Net’s Government Relations Team. Note that this summary does not constitute legal advice and is intended to serve only as a discussion guide, not as a definitive interpretation of the law.

In addition, the National Association of Insurance Commissioners has a site with a wealth of reform information: http://www.naic.org/index_health_reform_section.htm.

More Information as the Process Progresses

There is a great deal of work being done by Health Net’s reform implementation teams, and further information will be provided as the process progresses.

What the Law Does ... and When

- Effective Immediately
 - For the individual and group markets: Imposes **federal review** of health plans’ justifications for unreasonable premium rates for employers’ 2010 plan years
 - Gives states the option to cover childless adults with incomes up to 133 percent of federal poverty level in **Medicaid**
 - Gives grants to states for **State Insurance Ombudsman** programs
 - Provides \$250 rebate for all Part D enrollees who reach the **coverage gap**, sometimes called the “doughnut hole”
 - Begins process of developing a model form for insurers to use when referring **suspected fraud and abuse** to state insurance departments

- Effective June 23, 2010
 - Establishes temporary **high-risk pool**
 - Creates a **reinsurance program** until 2014 for employers offering early retiree health coverage
 - Create **Internet portal by July 1, 2010**, to facilitate consumers' and small employers' ability to shop for coverage
 - Requires carriers to submit **incurred loss information** to U.S. Department of Health and Human Services (DHHS) and to individual states' departments of insurance (awaiting guidelines from DHHS)

- Effective September 23, 2010 (for new and renewing plans, with several exceptions for grandfathered plans)
 - Extends coverage to include **dependent adult children** up to age 26 (for plans offering dependent coverage)
 - Requires **guarantee issue** (guidelines to be provided by U.S. Department of Health and Human Services) and eliminates **exclusions for pre-existing conditions** for children under 19 years of age
 - Prohibits **rescissions** except in case of fraud or intentional misrepresentation of material facts
 - Prohibits **lifetime limits** on specified essential health benefits
 - Restricts **annual dollar limits** on specified essential health benefits

**A "grandfathered" plan is a group or individual health plan or insurance coverage in which a person was enrolled on March 23, 2010. Grandfathered plans are subject to only some of the reforms. For instance, on renewal on and after September 23, 2010 (six months from the legislation's enactment), grandfathered plans will be required to comply with the prohibition on lifetime limits or annual dollar restrictions (group only) on essential health benefits, the prohibition on rescissions, the requirement to extend dependent coverage to children until age 26 (if not they are not eligible for other group coverage), and the prohibition on coverage exclusions for pre-existing health conditions for children under age 19 (group only). As noted above, the National Association of Insurance Commissioners maintains detailed information on health reform legislation at http://www.naic.org/index_health_reform_section.htm.*

- Prohibits cost sharing for specified **preventive care health services**
 - Requires coverage for **emergency services** at the in-network cost-sharing level
 - Allows access to **pediatricians** as PCPs and **OB/GYNs** without referral
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- 2011
 - By January 1, 2011, sets minimum **commercial MLRs** of 85 percent (for large group) and 80 percent (for small group and individual). Provides for adjustments to the MLR levels under certain circumstances
 - Provides for **rebates to members** if MLR levels are not met
 - **Reimbursement to Medicare Advantage** plans frozen at 2010 levels. And payment *reductions* to be implemented in subsequent years
 - **Annual fees** on pharmaceutical manufacturers begin
 - **Small employer tax credits** begin
 - **Standardized definitions**/uniform Evidence of Coverage terms developed by U.S. Department of Health and Human Services

- 2012
 - Requires **uniform coverage documents** to be implemented by March 23, 2012

- 2013
 - Increases **Medicaid payments** to providers for primary care services to 100 percent of Medicare (through 2014)
 - Imposes **excise tax** on medical devices
 - Repeals **deduction for employer subsidy** for Part D retirees

- 2014
 - Creates state-based and regional **Health Insurance Exchanges** through which individuals and small businesses may purchase coverage
 - Requires all individuals to have health insurance (**individual mandate**), with some exceptions
 - Requires **guarantee issue** – coverage provided to all applicants
 - Prohibits pre-existing condition exclusions for all enrollees
 - Limits **waiting periods**
 - Imposes **fees on certain employers** who do not provide employee coverage
 - **Premium assistance** and **cost-sharing subsidies** available to individuals and families with incomes up to 400 percent of the federal poverty level
 - Sets minimum **Medicare Advantage MLR** at 85 percent
 - Prohibits **annual limits** on policies
 - Imposes **health insurer fee**
 - Expands **Medicaid eligibility** to 133 percent of federal poverty level
 - Expands **federal Medicaid matching payments** to cover the costs of serving newly eligible individuals
 - States given option to **merge individual and small group** markets
 - Requires employers to offer “**free choice**” vouchers

- 2016
 - Requires **interstate compacts** before individual coverage is offered across state lines

- 2018
 - High-cost health plan **excise tax** begins