# Insurance Market Reforms

Cancer Action Network℠ American Cancer Society®

The Patient Protection and Affordable Care Act (PPACA) includes a range of health insurance reforms designed to set a new federal standard for consumer protection. While most of the bill's market reforms are effective January 1, 2014, a number of important provisions to improve the availability and adequacy of coverage will go into effect starting September 23, 2010.

## Background and Discussion

### Application to "Grandfathered" Health Plans

PPACA's new standards for health insurance generally apply to new health plans in the individual and group insurance markets, as well as, in some cases, to self-insured group health benefit plans.[1] However, policymakers felt it was also important to ensure that if people like the insurance they have, they should be able to keep it.[2] To allow that, the law provides for the "grandfathering" of certain plans that were in existence as of the date the law was enacted (March 23, 2010).[3] These plans, which could be sold to individuals or groups, are exempt from most, but not all, of the new insurance market reforms. Individuals who are in those plans can renew them indefinitely, and can add dependents, without the plan losing grandfather status. Similarly, employers can add new employees to the plan indefinitely and the plan will remain grandfathered.

[1] "Self-insured group benefit plans" are sponsored by employers that have elected to pay claims under the plan out of the employer's own funds. Under a federal law called "ERISA", only the federal government has jurisdiction to regulate employer-sponsored health plans.

[2] Remarks by President Obama, Town Hall meeting in Portsmouth, N.H., Aug. 11, 2009, available at http://www.whitehouse.gov/the_press_office/Remarks-by-the-President-at-Town-Hall-on-Health-Insurance-Reform-in-Portsmouth-New-Hampshire/.

[3] PPACA § 1251.

## Table 1. Application of Insurance Reforms to Grandfathered Plans

| Apply to Grandfathered Plans | Do NOT Apply to Grandfathered Plans |
|---|---|
| • Prohibition on dollar-value lifetime limits<br>• Restriction of annual limits (in group coverage)<br>• Prohibition on rescissions<br>• Dependent coverage for children until age 26 (before 2014, only if child lacks access to employer-sponsored coverage)<br>• Uniform explanation of coverage documents<br>• Medical loss ratio reporting and rebates<br>• 90-day limit on waiting periods<br>• No denials for pre-existing conditions for children in 2010 (in group coverage)<br>• No denials for pre-existing conditions for everyone in 2014 | • Restrictions of annual limits (in individual coverage)<br>• Preventive health benefits available with no cost-sharing<br>• Plain language disclosure of data on health plans<br>• Prohibition on coverage discrimination based on salary<br>• Annual reports on health care quality and care coordination<br>• Strengthened internal and external appeals processes<br>• Choice of participating primary care providers, including pediatricians; direct access to OB/GYNs<br>• No prior approval and higher out-of-network cost sharing for emergency services<br>• Review of unreasonable premium increases<br>• Modified community rating<br>• Guaranteed issue and renewability<br>• No denials of pre-existing condition exclusions for children in 2010 (in individual coverage)<br>• Prohibition on health status discrimination<br>• Prohibition of health plan discrimination of providers, individuals, and employers<br>• Essential benefits package<br>• Limits on annual cost-sharing exposure<br>• Transitional reinsurance in individual market, transitional risk corridors, and risk adjustment<br>• Coverage for approved clinical trials |

While "grandfathering" plans that people currently have allows those who like the insurance they have to keep it, it creates an uneven playing field in which some plans are subject to rules that others are not. Keeping the rules the same for all health plans is critical to discouraging them from using those differences to game the system and divide the sick from the healthy.

To guard against employers and health plans from using "grandfather" status to cherry pick the healthy and forever be exempt from critical consumer protections, PPACA requires the Department of Health and Human Services (HHS) to issue rules that define at what point changes made to a grandfathered plan would be significant enough to result in the loss of grandfathered status. These rules were published in June 2010.[4]

[4] 75 Fed. Reg. 34538 (Jun. 17, 2010).

To maintain grandfathered status, the plan can not:

- Enter into a merger, acquisition or restructuring for the primary purpose of adding enrollees without losing grandfathered status;
- Eliminate all or substantially all benefits to diagnose or treat a particular condition;
- Increase the cost-sharing requirements for enrollees by more than a certain percentage;
- Reduce the employer contribution rate; or
- Change annual or lifetime limits on the dollar value of covered benefits.

In addition, grandfathered plans must provide a statement to all enrollees that the plan is a grandfathered one, and detail the benefits provided.[5]

While it's difficult to predict how health plans and employers will respond to the new market reforms, HHS estimates that by 2013, about 51% of all employer plans will lose grandfather status. In the individual market, because most people keep their policies for very short periods of time, HHS estimates that more than 67% plans could lose grandfather status within the first year.[6]

While these new rules will be helpful in preventing grandfathered plans from taking advantage, it will be important to monitor these plans, who is enrolled in them, and whether they are making benefit design or other changes that would result in losing grandfather status.

## Restricted Annual and Lifetime Limits

Beginning September 23, 2010, PPACA prohibits all health plans from imposing lifetime dollar limits on essential benefits. In addition, the statute prohibits annual limits on the dollar value of benefits, but allows "restricted annual limits" before January 1, 2014.[7] This restriction applies to all new plans and grandfathered group plans, but not to grandfathered individual plans.[8] HHS has defined "restricted annual limits" so that they are phased in over three years. Starting in September 2010, plans cannot impose an annual limit less than $750,000. In 2011, the limit can't be less than $1.25 million, and in 2012 and 2013, it can't be less than $2 million. In 2014, plans can't impose any annual limit at all. However, HHS may waive the annual limits restrictions if a plan or employer can show that they would result in a significant increase in premiums.[9]

While the law bans monetary lifetime limits and restricts annual limits, health plans can still impose non-monetary limits, such as limits on physician visits, days in the hospital, and prescription drug refills. For people with cancer, heart disease and other chronic conditions these restrictions could continue to limit access to treatment.

[5] Ibid.

[6] Ibid.

[7] § 1001, adding new Public Health Service Act § 2711.

[8] 75 Fed. Reg. 37188 (Jun. 28, 2010).

[9] Ibid.

The lifetime and annual limit requirements are tied to the benefits covered in the minimum essential benefits package, which will be defined in future regulations.[10] If an item or service is not included in the essential benefits package, then the prohibition on lifetime and annual limits does not apply. However, some plans, such as self-insured employer plans and grandfathered plans, do not need to provide the essential benefits package. HHS has said that plans and employers must make “good faith” efforts to define essential benefits, consistent with the categories provided for in the law.[11]

***Example:***

***Mark**, at 7 years old, was diagnosed in 2006 with acute myeloid leukemia (AML). He needed aggressive chemotherapy and a bone marrow transplant. He also suffered complications from his treatment, resulting in kidney problems and a compromised immune system. Within three years of his diagnosis, Mark hit his plan’s lifetime cap of $1 million on coverage, and was dropped from his family’s policy.*

**Post — PPACA**

***Mark** is diagnosed in 2011. His treatments are covered as long as he needs them — his plan is prohibited from imposing a lifetime limit, and he doesn’t hit the annual cap of $1.25 million in 2011.*

## Rescissions

PPACA prohibits all health plans, including grandfathered plans, from rescinding a health insurance policy once an enrollee is covered, unless the enrollee has committed fraud or made an “intentional misrepresentation of material fact” in his or her application.[12] Before PPACA was enacted, health plans could — and often did — rescind policies when an enrollee became sick, if he or she — or her employer — made an unintentional mistake in filling out the paperwork.

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[10] The essential benefits package must, at a minimum, include the following categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance abuse disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness and chronic disease management services; and pediatric services, including oral and vision care. § 1302(b).

[11] 75 Fed. Reg. 31788.

[12] §1001, adding new PHSA § 2712.

***Example pre PPACA:***

***Patsy**, 56, was dropped by her health plan after her physician submitted a claim for breast cancer treatment. While she was not diagnosed until after she enrolled, the plan claimed that her cancer had existed before she bought coverage. She faced more than $129,000 in medical bills and was forced to stop chemotherapy for several months. Girion, Lisa "Health Net Ordered to Pay $9 million after Canceling Cancer Patient's Policy," Los Angeles Times (2008), available at: http://www.latimes.com/business/la-fi-insure23feb23,1,5039339.story.*

**Post — PPACA**

***Patsy** gets treatment for her breast cancer and her health plan pays the claims. They cannot rescind her coverage because she filled out her application forms in good faith and did not know she had cancer.*

PPACA also requires plans, if they do rescind a policy, to provide a minimum 30 days notice to the enrollee.[13]

## Guaranteed Coverage for Kids

PPACA prohibits health plans, except for grandfathered individual plans, from excluding children under 19 from being covered because they have a pre-existing condition.[14] This prohibition includes both benefit limits (i.e., an insurance company can't refuse to pay for chemotherapy for a child with cancer because the child had the cancer before obtaining insurance) and outright coverage denials (i.e., when an insurance company refuses to issue a policy to the child because of the child's cancer). This new consumer protection applies for children under 19 starting September 23, 2010; beginning January 1, 2014, it will be available to individuals of all ages.

***Example pre-PPACA:***

***Bobby** was born in Texas with a heart defect that required surgery. His mom's insurance company denied coverage because they considered it a "pre-existing condition." After extensive media coverage, the plan backed down and agreed to cover the baby's surgery. See Jarvis, Jan, "Under Fire, Blue Cross Blue Shield of Texas Offers to Cover Medical Expenses for Crowley Baby," Houston Star-Telegram, (March 31, 2010)*

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[13] Ibid., and 75 Fed. Reg. 31788.
[14] § 1201, adding new PHSA § 2704.

While health plans will no longer be allowed to deny coverage or benefits to children with pre-existing conditions, until 2014 they will be allowed to charge significantly higher premiums to their families because of the child's health status. Thus, while coverage can no longer be denied to these children, it could be effectively unavailable because the family cannot afford the new price.

## Preventive Coverage

Beginning September 23, 2010, the law requires all health plans, except for grandfathered plans, to cover and impose no cost-sharing for the following preventive items and services:

- Those that receive an "A" or a "B" recommendation from the United States Preventive Services Task Force (USPSTF).[15, 16] ,
- Immunizations recommended by the Center for Disease Control and Prevention's (CDC) Advisory Committee on Immunization Practices (ACIP);
- Preventive care and screening for infants, children and adolescents that are included in comprehensive guidelines issued by the Health Resources and Services Administration (HRSA); and
- Women's preventive care and screenings, to be issued in future HRSA guidelines.[17]

***Example pre PPACA:***

***Frank****, just turned 50 and his physician recommends a colonoscopy. He has a health plan with a $1000 deductible and charges a $25 copayment per physician visit. Frank has his colonoscopy, but must pay $1025 out of pocket because of his deductible and copayment.*

**Post — PPACA**

*As a screen for colorectal cancer, USPSTF gives colonoscopy an "A" recommendation. Frank has his colonoscopy and is not charged any co-payment or deductible.*

## Extension of dependent coverage

In most states, insurers can and do remove young adult children from their parents' policies when they turn 19, or if still a student, when they graduate from college.[18] PPACA changes

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[15] The USPSTF is convened by the Public Health Service to evaluate clinical research in order to assess the merits of preventive measures, including screening tests, counseling, immunizations, and preventive medications. An "A" recommendation signifies that the net benefit of the item or service is "substantial," and a "B" recommendation signifies a "moderate to substantial" net benefit.

[16] PPACA specifically rejects the USPSTF's recommendations on breast cancer screening, prevention, and mammography issued in November 2009 as the standard for coverage and cost sharing. Instead, the Task Force's pre-November 2009 recommendations set the standard. § 1001, adding 2713(a)(5).

[17] Ibid.

[18] See Kaiser Family Foundation, statehealthfacts.org, "Dependent Coverage" (updated Jan. 2010).

that by requiring plans that provide dependent coverage, including grandfathered plans, to extend coverage to adult dependents up to age 26.[19] Plans must implement this requirement by September 23, 2010, but many have publicly pledged to comply before then, so that new college graduates don't experience a gap in coverage. Many, but not all employers are also implementing this new requirement before the statutory start date in September.

These young adults can obtain coverage whether or not they live in their parents' home, and even if they're married and are no longer claimed as a dependent on their parents' tax return. But insurers do not need to cover their spouses, nor, if they have any, their children. And before January 1, 2014, grandfathered group plans will only be required to cover adult dependents if they are not otherwise eligible for employer-sponsored coverage.[20]

## Internal and External Appeals

PPACA provides health insurance enrollees, except for those in grandfathered plans, with a new national standard for appealing an unfavorable decision by a health plan.[21] The new standard establishes a mandatory first level internal appeals procedure, administered by the health plan, and then a second level, external appeals procedure administered by an independent third party.

At each step the consumer gets the following specific protections:

- An accessible appeals process at no cost to the consumer;
- Continuation of services and treatment throughout the appeals process;
- A broad definition of what can be appealed;
- A broad time frame for requesting the appeal;
- Guaranteed assistance from a knowledgeable consumer advocate;
- The selection of an external reviewing entity that has no conflict of interest;
- Full disclosure of the basis for the decision, rendered in a timely fashion; and
- The collection and publication of appeals data for each health plan, so that consumers can access information about a plan's record before deciding to enroll.

Most states do require some form of external review for the health plans they regulate, but the process and level of consumer protection varies widely. The PPACA provisions for the first time set a minimum federal standard that all new plans, including large, self-funded employer plans, must meet.

[19] § 1001, adding PHSA § 2714.
[20] Ibid.
[21] § 1001, adding PHSA § 2719.

## Conclusion

The insurance reforms required by PPACA, many of which go into effect this year, will provide critical protections to thousands of families who count on their insurance to be more than an empty promise. However, grandfathered health plans are largely exempt from the market reforms, leaving millions of Americans without the new protections. The exemption also sets up an uneven playing field in the marketplace, in which some plans have to play by the rules and other don't. This could lead to adverse selection, with grandfathered plans able to retain healthier people and new plans, which must abide by the new rules, attracting sicker ones.

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