HEALTH REFORM IMPACT

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NEWS FOR THE CLIENTS AND FRIENDS OF BASS, BERRY & SIMS PLC

Less Flashy But Equally Newsworthy: Financial and Administrative Changes For Private Insurers

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While health reform's expansion of insurance coverage has captured much of the public attention so far this year, private insurers face a number of less-publicized premium requirements and limitations, notice and reporting obligations, and administrative changes under The Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (collectively, the "Act"), which was signed into law in final form on March 30, 2010.These less-publicized elements of the Act collectively present increased challenges to health insurers across all segments of their business.

While group health plans in existence as of March 23, 2010 are initially "grandfathered" out of some of these new requirements, insurers must be careful to understand the qualifications for grandfathered status and must be aware that most of the provisions regarding grandfathered plans simply delay, rather than eliminate, the Act's new financial and administrative requirements.[1] In addition, while mandated health insurance exchanges ("Exchanges") will not be in place until 2014, several provisions impact insurers this coming plan year. Below is a summary describing the significant changes to premium requirements, notice and reporting obligations, and administrative changes required under the Act.

Premium Requirements and Limitations

Caps on Medical-Loss Ratios and Rebates to Enrollees. For plan years beginning after September 23, 2010 (note that, for plans that run with calendar year, these changes will be mandatory on January 1, 2011), health plans offering coverage in the group or individual markets, including grandfathered plans (but excluding self-insured plans) must report to the Department of Health and Human Services ("HHS") the proportion of premium dollars spent on clinical services as compared to the percentage spent on administrative services. Each health plan must keep its annual non-medical costs lower than 15% of premium revenue for the group market and lower than 20% in the small group and individual market. Insurers that fail to meet the new medical-loss ratio are required to rebate to insureds the amount spent in excess of the threshold.

Review of Premium Increases and Required Justification For "Unreasonable" Increases. Beginning this next plan year, HHS must have a process for annual review of "unreasonable" increases in premiums. For any premium increase deemed "unreasonable," the health insurer will be required to provide justification for the increase to HHS and the state and to publicly post this justification and

[1] Please see our previous client alerts: "Grandfathered Health Plans – Significant Exemptions From Health Reform Legislation" (click here), "Existing Health Plans - Changes Requiring Attention this Year" (click here), "Coverage Provision Changes: Private Insurers Should Start Planning Now" (click here), and "Protecting Your Plan's Grandfathered Status Under Health Reform" (click here).

disclosure on its Web site prior to implementing the increase. Once the Exchanges are in place in 2014, HHS and the states will still monitor premium increases of all health plans, including those not offered on an Exchange.

Limitations on Premium Ratings. Beginning January 1, 2014, premiums in the individual and group markets (but not self-insured plans) may vary only according to family structure, geography, age (with no variance greater than 3 to 1) and tobacco use (with no variance greater than 1 ½ to 1).

Notice and Reporting Obligations

Web site Portal. On July 1, 2010, HHS (in consultation with the states) unveiled a Web site portal designed to allow any state resident or small business to find information in a standardized format on plan coverage options offered in the state. Available at www.healthcare.gov, the Internet site attempts to inform consumers on eligibility for existing government programs as well as availability, benefits and cost of private health insurance plans.

Uniformity in Explanation of Coverage Documents. No later than March 23, 2012, insurers must have their summary of benefits and coverage documents meet standards that are to be issued by HHS by March 23, 2011. These requirements will include a standard format for the summary documents, including a limit of four pages and a minimum of 12 point font, uniform definitions of standard insurance and medical terms, and the use of language that is easily understood by the average enrollee and is culturally and linguistically appropriate. Explanations of exceptions, reductions and limitations to coverage, as well as cost-sharing obligations and examples of common benefit scenarios, will also be included in the new standards.

Mandated Quality Reporting. By March 23, 2012, health plans must create a payment structure that rewards quality and that includes financial incentives for improving health outcomes, preventing hospital readmissions, improving patient safety and reducing medical errors, and implementing preventative and wellness activities. Implementation of these quality improvement activities must be reported to enrollees and HHS or else the insurers could face penalties from HHS.

Restrictions on Marketing Practices. To participate in the Exchanges in 2014, health plans must satisfy marketing requirements and not have benefit designs or use marketing practices that discourage enrollment by those with significant health needs.

Publicizing Claim, Payment and Enrollment Information. To participate in the Exchanges, health plans must publicly disclose claims payment policies, enrollment, denials, rating practices, out of network cost sharing, and enrollee rights.

Administrative Changes

Appeals Process. All health insurers must implement an effective internal appeals process for coverage and claims determinations, as well as comply with any external review procedures in the applicable state of operation.

If you have questions regarding the information in this issue, or with respect to other provisions of the health reform legislation as it relates to your insurance industry and operations, please contact any of the attorneys in our Insurance and Managed Care Practice Group listed below.

Also, please click here to visit our special Web page for Health Reform IMPACT.

Bass, Berry & Sims Insurance and Managed Care Attorneys

Elisa E. Harris
(615) 742-6553
eharris@bassberry.com

Angela Humphreys
(615) 742-7852
ahumphreys@bassberry.com

Robins H. Ledyard
(615) 742-6259
rledyard@bassberry.com

T. Scott Noonan
(615) 742-6273
snoonan@bassberry.com

T. Stephen C. Taylor
(615) 742-7758
staylor@bassberry.com

Bob F. Thompson
(615) 742-6262
bthompson@bassberry.com

Elizabeth S. Warren
(615) 742-7719
ewarren@bassberry.com

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