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America's Health Insurance Plans

The New Health Reform Law and Private Insurance

Pennsylvania House of Representatives Insurance Committee

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America's Health Insurance Plans
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Health Plans and Implementation

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- Implementation Efforts Underway
- Near Term Market Reforms
- Long Term Market Reforms

Implementation: Plan Efforts Underway

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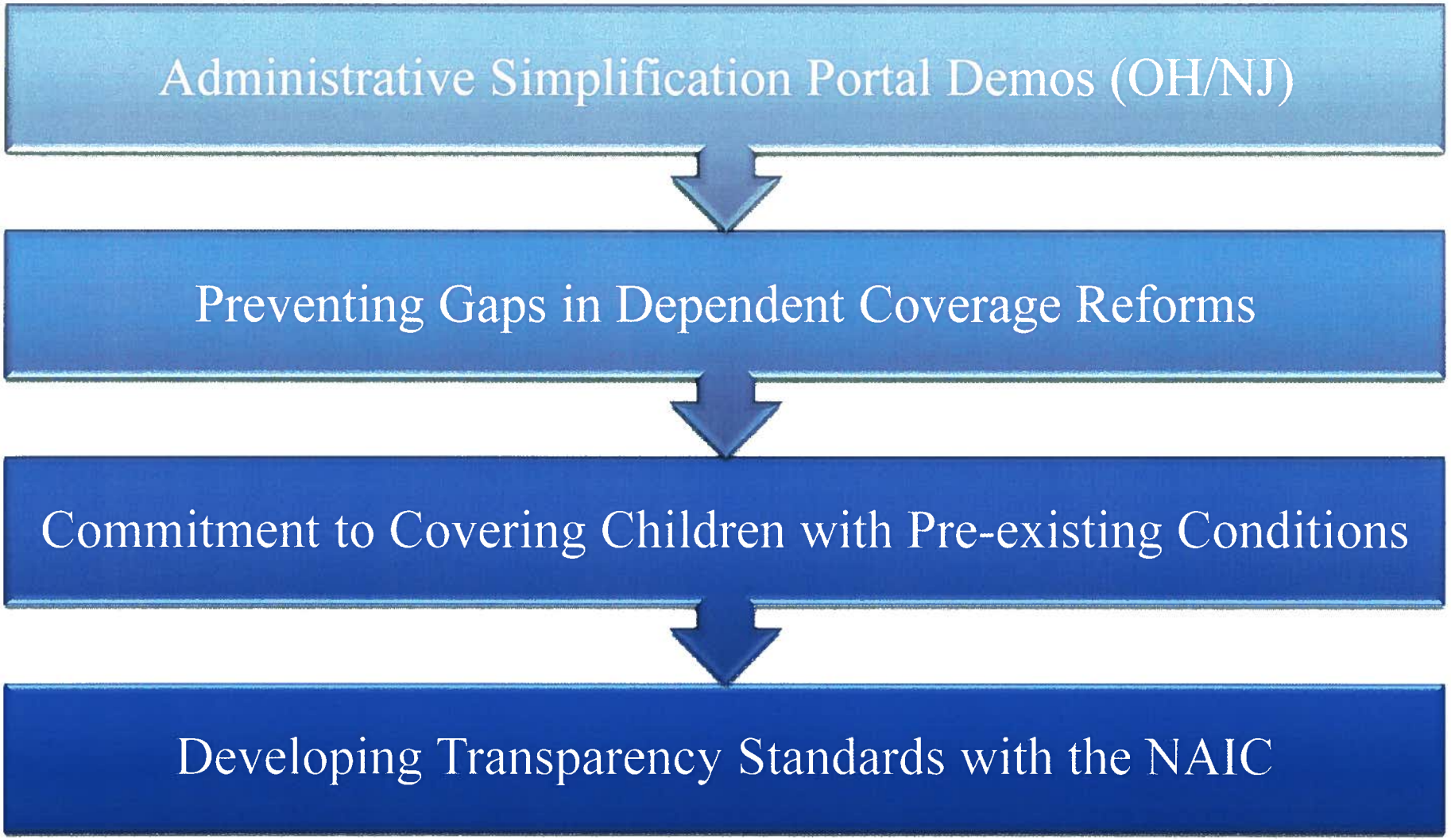

Near Term Reforms Impacting Plans

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Regulatory
- MLR
- Premium Rate Review
- Rescission/External Review

Access
- High Risk Pool
- Dependent Coverage
- Coverage for Children with Preexisting Conditions
- Small Business Tax Credits

Benefits
- First Dollar Preventive Coverage
- Annual Limits ("Restricted")
- Prohibition on Lifetime Limits

Impact on Costs and Premiums; Provider Capacity?

Note: All near term reforms implemented by Jan 1, 2011

Long Term Reforms Impacting Plans

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Note: All long term reforms implemented by Jan 1, 2014

Driving Value in Delivery Reform

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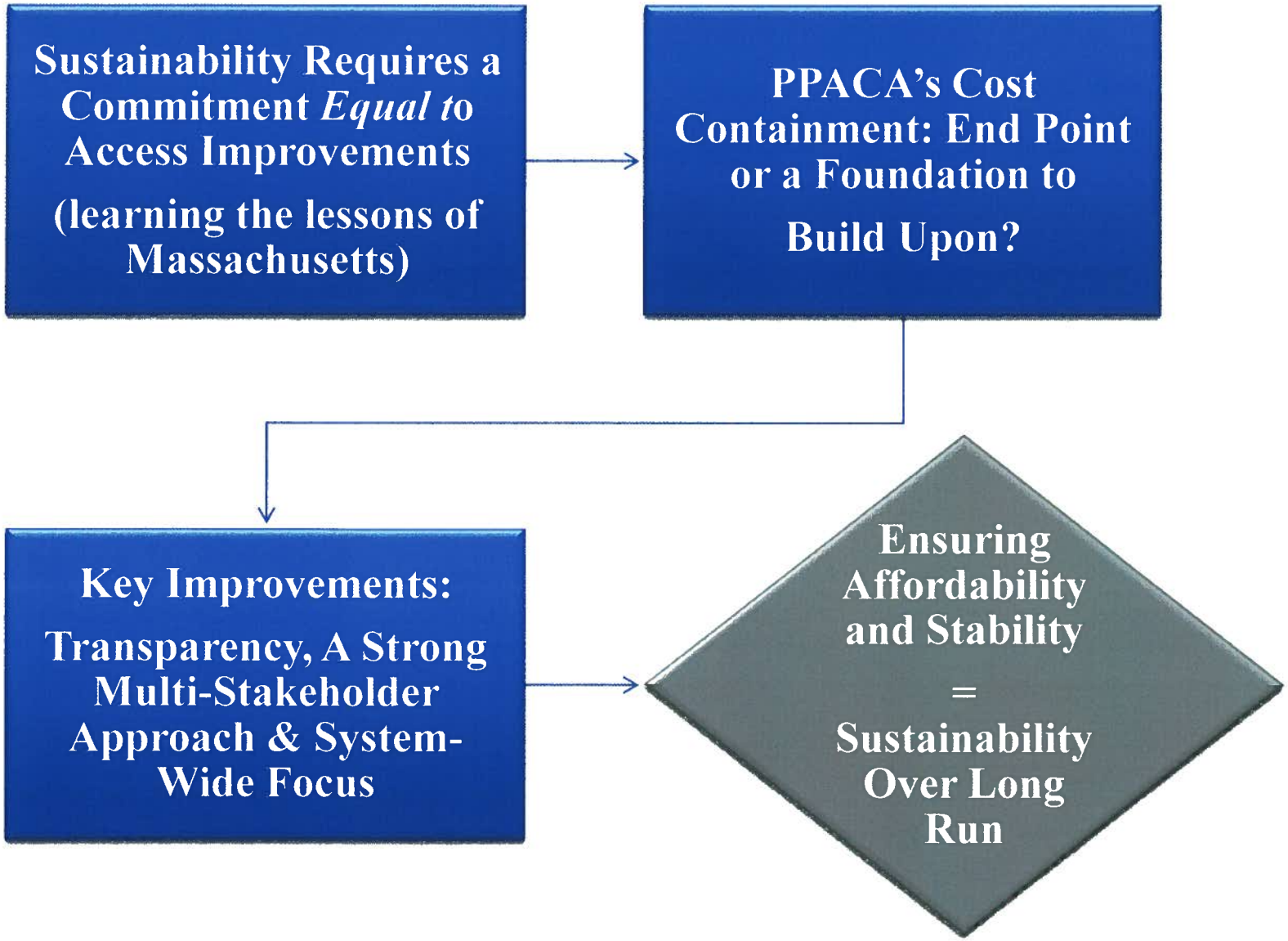

Executive Summary of "The Patient Protection and Affordable Care Act" and the "Health Care and Education Reconciliation Act of 2010"

[as signed into law by President Obama]

Overview

On March 23, 2010, President Obama signed into law H.R. 3590, the "Patient Protection and Affordable Care Act." One week later, on March 30, the President signed into law H.R. 4872, the "Health Care and Education Reconciliation Act of 2010." These two new laws alter how consumers access health insurance coverage by creating exchanges to facilitate enrollment in health plans, changing insurance market rules, reforming Medicare and Medicaid, and imposing taxes on various health care stakeholders. The Congressional Budget Office score of the reconciliation measure estimates that the measure, in conjunction with the Senate bill, devotes $938 billion to coverage expansion, while proposing budget offsets that reduce the deficit by $143 billion over ten years.

The information below highlights the major provisions of the Patient Protection and Affordable Care Act as amended by the Health Care and Education Reconciliation Act of 2010. For additional details on the provisions of this law, please see AHIP's Summary of the Senate "Patient Protection and Affordable Care Act" and the "Health Care and Education Reconciliation Act of 2010." For a summary of specific provisions in the Health Care and Education Reconciliation Act of 2010, please see AHIP's "Executive Summary of Key Provisions of the Senate Health Reform Legislation Impacted by the House Reconciliation Legislation."

Changes to Administrative Processes

Administrative Simplification: The law directs the HHS Secretary to adopt standards and operating rules to improve the administrative efficiency of health plans and providers. Such rules and standards include eligibility verification, claims status, claims remittance/payment, and electronic funds transfers. The Secretary must also, no later than January 1, 2012 and at least every three years thereafter, solicit input from the National Committee on Vital and Health Statistics, the Health Information Technology Policy and Standards Committees, and standards setting organizations and stakeholders (as defined by the Secretary) on (1) whether greater financial and administrative uniformity in activities and items might be achieved, and (2) whether such activities should be considered. Such activities and items include:

- whether the application process might be standardized and made electronic;
- whether standards and operating rules should be expanded to apply to automobile insurance, worker's compensation, and other programs;
- whether standardized forms could be applied to financial audits required by health plans, federal and state agencies (such as the Centers for Medicare and Medicaid Services and the HHS Office of the Inspector General), and other agencies;

- whether health plan processes to establish claim edits could be made more transparent and consistent; and
- whether health plans should be required to publish timeliness of payment rules.

The Secretary must task the ICD-9-CM Coordination and Maintenance Committee, no later than January 1, 2011, to receive input from relevant stakeholders (including health plans, providers, and clinicians) regarding the crosswalk to ICD-10, and to make recommendations on appropriate revisions.

Health Insurance Markets Rules

Medical Loss Ratio: Beginning in 2011, plans are subject to a medical loss ratio (MLR) requirement of 80 percent in the individual and small group markets and 85 percent in the large group market. Plans are required to pay rebates to enrollees if they fail to meet this requirement. States will have discretion to increase these thresholds. Also, with respect to the individual market, the HHS Secretary is permitted to adjust the MLR threshold for a state if the Secretary determines that the application of the requirement could destabilize the individual market in that state. This provision applies to grandfathered plans. It excludes federal and state taxes and fees from the calculation of non-claims costs. This provision is permanent and does not sunset. The NAIC has primary responsibility for developing uniform definitions for the new federal MLR reporting categories and standardized methodologies for calculating measures of such activities by December 31, 2010. Such methodologies must be designed to take into account the special circumstances of smaller plans, different types of plans, and newer plans.

Federal Rate Review and Medical Reimbursement Data Centers: Health insurance reform provisions grant the HHS Secretary the authority to review health plan rate filings in an annual review process that will be conducted with the states. States are eligible to receive grants to establish Medical Reimbursement Data Centers to support the law's federal premium review process. The functions of such centers include developing tools that fairly and accurately reflect market rates for medical services and the geographic differences in those rates. These centers will also make health care cost information readily available to the public through an Internet website that allows consumers to understand the amounts that health care providers in their area charge for particular medical services.

Rescissions: Rescissions will be allowed only when fraud occurs or if the individual makes an intentional misrepresentation of material fact as prohibited by the policy.

External Review: Health plans in states with existing external review laws – that meet the minimum consumer protection standards of the National Association of Insurance Commissioners (NAIC) Uniform External Review Model Act (NAIC Model Act) – will be required to comply with those state laws. The health reform law makes determinations by an external review entity binding on plans. For states without external review laws and self-funded plans (that are not subject to state laws), the Secretary must develop an effective external review process that is similar to the NAIC Model Act. The Secretary may deem the external review process of a group health plan or health insurance issuer that is in operation on the date of enactment to be in compliance with the requirements of this section.

Internal Appeals Process: A health insurance insurer offering individual or group health insurance must implement an internal claims appeals process. The plan must provide notice to enrollees of available internal and external appeals processes, and the availability of any applicable office of health insurance consumer assistance or ombudsman. Enrollees must be able to review their files, to present evidence

and testimony as part of the appeals process, and to receive continued coverage pending the outcome of the appeals process.

Dependent Coverage: Health plans that provide dependent coverage of children must extend coverage to children up until age 26. Within six months of enactment, plans will be prohibited from excluding coverage of pre-existing conditions for enrollees under age 19. Children with pre-existing conditions may not be denied access to their parents' health plans.[1]

Lifetime and Annual Dollar Limits: Group health plans and health insurance issuers offering group or individual health insurance coverage are prohibited from establishing lifetime or annual dollar limits on essential health benefits, with the exception that, prior to January 2014, plans may establish restricted annual limits on essential health benefits, as determined by the Secretary. Health plans may place limits on benefits that are not essential health benefits.

Any Willing Provider and Prior Authorization: Health plans must allow enrollees to select their primary care provider (or pediatrician). Prior authorization or increased cost-sharing for emergency services, whether provided in-network or out-of-network are prohibited. Health plans may not require authorization or referral for enrollee access to OB-GYN services.

High Risk Pool and Other Immediate Reforms: A national high-risk pool, established within 90 days of enactment, will provide coverage until the establishment of the Exchange in 2014 to individuals who have preexisting conditions, as determined by the Secretary, and have not had creditable coverage for the six months prior to applying for coverage with the high risk pool. The law appropriates $5 billion to subsidize the pool coverage. Within 90 days of enactment, the Secretary must develop a voluntary reinsurance program for employers of early retirees that ends on January 1, 2014. The Secretary, in consultation with the states, must also develop an internet portal by July 1, 2010, that identifies affordable health insurance coverage options in a state.

Guarantee Issue and Rating Requirements: Effective January 1, 2014, health insurance plans must guarantee issue coverage to all individuals seeking coverage during open or special enrollment periods, and are prohibited from applying preexisting condition exclusions. Adjusted community rating standards apply to the individual and small group markets (if a state permits large groups to access coverage through the Exchange, the rating provisions would apply to the large group market as well). Rate variation is allowed for age (limited ratio of 3:1), geography, family size, and tobacco use (1.5:1). Enrollees in employer wellness programs will be eligible for a premium discount or rebate. Small groups are defined as an employer having between 1-100 workers. A state is allowed, for plan years beginning before January 1, 2016, to define small group as between 1-50 workers.

The new law exempts "grandfathered" individual and group health insurance coverage (plans where a person was enrolled coverage on or before enactment) from the insurance market reform provisions, with these plans continuing to be exempted from these requirements even if renewed. Grandfathered plans are required to comply with certain insurance reform provisions including, by six months after enactment, a prohibition on lifetime benefit limits, a prohibition on rescissions, and extending dependent coverage to age 26. For grandfathered group plans within six months of enactment, the law prohibits

[1] The provision regarding *coverage for children with pre-existing conditions* is expected to be clarified by a Department of Health and Human Services regulation in the weeks following enactment.

pre-existing condition exclusions for dependents who are under 19 and allows only "restricted" annual benefit limits for essential benefits; for grandfathered group plan renewals beginning in 2014, the law prohibits all pre-existing condition exclusions and excessive waiting periods (longer than 90 days). Health plans could continue to offer coverage of grandfathered health plan benefits, but only to current enrollees, dependents, or (in the case of an employer) new employees and their dependents. Individuals enrolled in grandfathered plans will be ineligible for premium tax credits. All grandfathered plans will be subject to the minimum medical loss ratio requirements in 2011.

All products in the individual market (excluding grandfathered health plans) will be subject to a new risk adjustment mechanism. Reinsurance entities will administer a transitional state-based reinsurance program for the individual market from 2014-2016 that will be funded through contributions from health plans totaling $25 billion. The Secretary must establish risk corridors over that same period for plans in the individual and small group markets. States have the option to merge the pooling and rating requirements for the individual and small group markets. A health insurance issuer is required to create a single individual market risk pool for all enrollees in an individual plan (other than grandfathered health plans), including individuals who purchase coverage outside of the Exchange, and a single group market risk pool for all enrollees in a small group health plan (other than grandfathered health plans), including groups who purchase coverage outside of the Exchange. Starting on January 1, 2014, all plans offered in the individual and small group markets, whether through the Exchange or outside of the Exchange, will have to comply with the rating reforms and benefit options detailed under this law.

Clinical Trials: Health plans are prohibited, starting in 2014, from canceling health care coverage when an individual participates in a clinical trial (that treats cancer or other life-threatening diseases) or from denying coverage for routine care that would otherwise be covered absent an individual's participation in a clinical trial.

Essential Health Benefits Package

Health plans will be required to cover various categories of services, including among others prescription drugs and mental and behavioral health treatments. The Secretary must define and update no less than annually these categories of covered treatments as well as the items and services within benefit classes through a transparent and public process that allows for public input. The benefit package will be defined so as not to be more extensive than the "typical" employer plan (not defined). The Secretary must update or modify the benefit package to account for changes in medical evidence or scientific advancement or to address any gaps in access or changes in the evidence base.

Beginning in 2014, health plans need to conform to new product designs and one of five benefit levels: bronze, silver, gold, platinum, and young adult. The bronze coverage provides coverage that is actuarially equivalent to 60 percent of the full actuarial value of the essential health benefit package. Silver coverage has a 70 percent actuarial value, gold coverage 80 percent, and platinum coverage 90 percent. Health plans may also offer a young adult policy for those under age 30 that would be a catastrophic-only policy in which the catastrophic coverage level would be set at the level for HSA-high deductible health plans (with prevention benefits and three primary care visits exempt from the deductible). The out-of-pocket maximum for all plans is limited to the level allowed for an HSA-high deductible health plan ($5,950 for individuals and $11,900 for families in 2010).

The new law provides that if a state requires benefits that go beyond the federal essential benefit package, the state must make payments to defray the cost of the additional benefits for individuals enrolled in qualified health plans offered in the state and receiving tax credit subsidies.

Exchange

Federal funding will be provided to assist states in establishing an American Health Benefit Exchange (Exchange) in each state by January 1, 2014. The Exchange facilitates the purchase of qualified health plans for individuals and establishes a Small Business Health Options Program (SHOP Exchange) for small businesses. The law requires the Secretary (directly or through agreement with a not-for-profit entity) to establish an Exchange should a state fail to establish its own Exchange. An Exchange is permitted to operate in more than one state, as approved by the Secretary, and one or more subsidiary Exchanges may be created to serve a geographically distinct area. A state may enter into agreements to carry out Exchange responsibilities to the extent the agreements are with a person who is subject to state laws, has demonstrated experience with individual and small group health insurance markets, and is specifically not a health insurance issuer or a state Medicaid agency.

The Secretary must, among other things, establish certification criteria for qualified health plans, ensure network adequacy, develop a rating system for qualified health plans, develop a model template for an Exchange Internet portal, and determine initial and annual open enrollment periods.

Eligibility: Individuals and small employers are eligible to participate in the Exchange beginning in 2014. Beginning in 2017, states may make a determination as to whether large groups may participate in the Exchange.

Benefit Categories: An Exchange is required to make a qualified health plan available that contains essential health benefits (described above). States are permitted to require additional benefits; however, a state must assume costs for any additional premium increase for such benefits for individuals receiving a tax credit subsidy.

Standards for Health Insurance Plans: Qualified health plans within the Exchange are required to be certified as meeting specified marketing and network adequacy requirements, to use uniform enrollment forms, and implement quality improvement strategies. Also, health plans must achieve accreditation of, among other things, clinical quality measures, utilization management, consumer access, provider credentialing, and appeals processes. An Exchange must consider the account data from the federal rate review process when making a determination about whether to certify a plan as a qualified health benefit plan.

Outreach and Enrollment: Exchanges must maintain an Internet website to provide standardized comparative information on qualified health plans. Exchanges are to award grants to "Navigators" to educate the public about qualified health plans, distribute information on enrollment and tax credits, facilitate enrollment, and provide referrals to questions and grievances.

Disclosure Requirements: The new law establishes disclosure requirements (for coverage issued in and out of the Exchange) including: disclosure of claims payment policies and practices, periodic financial disclosures, data on enrollment and disenrollment, data on the number of claims that are denied, data on rating practices, information on cost-sharing and payments with respect to out-of-network coverage, information on enrollee/participant rights, and other information identified by the HHS Secretary. Such information must be provided in "plain language." Plans that offer coverage through the Exchange are

required, upon request, to educate consumers about cost-sharing amounts that the individual would be responsible for paying with respect to a specific item/service by a participating provider. This information must be provided through the Internet and other means.

Multi-State Plans

The new health reform law directs the Director of the Office of Personnel Management (OPM) to contract (on a competitive bidding basis) with health insurance issuers to offer at least two multi-state qualified health plans within each state Exchange. At least one of the contracting entities must be a non-profit entity. OPM must oversee the program in a manner similar to the Federal Employees Health Benefit Program (FEHBP), including negotiating with each multi-state plan on medical loss ratio, profit margin, premiums, and "other terms and conditions of coverage as are in the interest of enrollees of such plans." Multi-state plans must provide individual coverage and small group coverage to small employers, offer a benefits package uniform in each state and consistent with the essential benefits package, meet all requirements with respect to a "qualified health plan" (including the requirements related to the gold, silver, and bronze levels of coverage, as well as catastrophic coverage), offer the plan in all geographic regions and in all states that have adopted adjusted community rating before the date of enactment, and provide for premium determinations based on specified rating requirements.

A state may require the multi-state plans to offer additional benefits (mandates). An individual enrolled in the multi-state plan is eligible for tax credits and cost sharing assistance, but a state's requirement to offer additional benefits does not increase the tax credit. States are required to defray the costs of the mandates. If the state has a rating requirement that is more restrictive than 3:1, the state may require that the plan comply with the more protective age rating requirements. A phase-in schedule is established for the requirement that the plan be offered in all states – 60 percent of states in year one, 70 percent in year two, 85 percent in year three, and all states in year four.

Health Insurance Cooperatives (CO-OP)

The Secretary must establish a Consumer Operated and Oriented Plan (CO-OP) program to foster the creation of qualified nonprofit health insurance issuers to offer qualified health plans in the individual and small group markets. The law appropriates $6 billion for the Secretary to provide loans for start-up costs and grants to meet solvency requirements under the CO-OP program. Health insurance issuers in existence on July 16, 2009 and governmental organizations are prohibited from participating in the program. CO-OP participants must meet all requirements of state law with respect to solvency, licensure, payments to providers, network adequacy, rate and form filing, and any applicable premium assessments and must meet all insurance market reforms outlined in the law. CO-OP program participants are allowed to form a private purchasing council to enter into collective purchasing agreements for items and services that increase efficiencies, including health IT and claims administration. A private purchasing council is prohibited from setting payment rates for providers and facilities. A tax exemption is provided for qualified nonprofit health insurance issuers receiving a loan or grant under the CO-OP program.

State Option for a *Basic Health Plan*

States may provide a basic health program option through negotiated contracts with one or more standard health plans (as defined) to provide at least an essential benefits package (as described above) to residents of a state whose household incomes are between 133 percent and 200 percent of FPL and who

are not eligible for employer coverage. States may negotiate a regional compact with other states to include coverage of eligible individuals in all such states in agreements with standard health plans. A state may coordinate this program's administrative functions with the state's Medicaid program. The implementation of care coordination, managed care techniques, and use of performance measures is allowed under this program.

Individual Responsibility

Mandate to Purchase Coverage: Beginning in 2014, all U.S. citizens and legal residents are required to purchase coverage and are subject to a penalty for the failure to maintain coverage. Undocumented aliens, incarcerated individuals, and those with religious objections are exempt from this requirement. In addition, individuals are exempt from the responsibility mandate if they are unable to find affordable coverage that costs less than 8 percent of household income, or if the individual's income does not meet the filing threshold. Individuals demonstrate compliance with this requirement through federal tax reporting.

Excise Tax: The penalty assessed for failing to maintain coverage is the greater of: (1) a flat fee of $695 per year, or (2) 2.5 percent of income. This is phased in over time in the following manner:

Year	Penalty
2014	The greater of $95 or 1 percent of income
2015	The greater of $325 or 2 percent of income
2016	The greater of $695 or 2.5 percent of income
2017 and after	The greater of $695 (plus a COLA) or 2.5 percent of income

Tax Credits for Health Insurance Premiums: The law creates refundable tax credits for individuals with incomes between 133 and 400 percent FPL, assessed in the following manner:

Income Level	Initial Premium Percentage	Final Premium Percentage
Up to 133 percent	2 percent	2 percent
133 – 150 percent	3 percent	4 percent
150 – 200 percent	4 percent	6.3 percent
200 – 250 percent	6.3 percent	8.05 percent
250 – 300 percent	8.05 percent	9.5 percent
300 – 400 percent	9.5 percent	9.5 percent

In addition, the law reduces the standard out-of-pocket maximum limits by two-thirds for those between 100-200 percent FPL; reduces by one-half for those between 200-300 percent FPL, and reduces by one-third for those between 300-400 percent FPL. The plan's share of total allowed costs of benefits is increased to 94 percent for those between 100-150 percent FPL and to 87 percent for those between 150-200 percent FPL. The plan's share of total allowed costs of benefits is increased to 73 percent for those between 200-300 percent FPL, and to 70 percent for those between 300-400 percent FPL. The cost-sharing assistance does not take into account benefits mandated by states.

Employer-Based Coverage

The law requires employers with more than 50 full-time workers that do not offer coverage and have at least one worker who receives the premium assistance tax credit to pay a fee of $2,000 for each full-time employee (the first 30 employees are exempt from the payment calculation for firms that do not offer coverage). Employers with more than 50 employees that offer coverage and have at least one full-time employee receiving the premium assistance tax credit will pay an amount equal to the product of the number of full-time employees for that month and 1/12 of $3,000. Large employers must report to the Secretary on the coverage they make available to employees. Employers may count part-time workers' time as "full-time equivalents," calculated by dividing the aggregate number of hours of service of these employees for the month by 120.

Employers must provide written notice to their employees at the time of hire (or, for current employees, no later than March 1, 2013) of the existence of an Exchange. If the employer plan's share of the total allowed costs of benefits provided under the plan is less than 60 percent of such costs, the employee may be eligible for a premium assistance tax credit and cost sharing reduction. If the employee purchases a qualified health plan through the Exchange, the employee will lose the employer contribution to the plan offered by the employer, and all or a portion of such contribution may be excludable from income for federal income tax purposes.

Free Choice Vouchers: Employers that offer qualified employer-sponsored coverage are required to provide "free choice vouchers" to certain employees to allow them to purchase coverage through a Health Insurance Exchange. Employees whose income does not exceed 400 percent of the federal poverty level and whose employer contributes between 8 percent and 9.8 percent of the employee's income to coverage would be eligible for a voucher. The voucher is equal to the amount of the employer's contribution to employer-sponsored coverage. Free choice vouchers are excluded from taxation and voucher recipients are not eligible for tax credits.

Small Employer Tax Credit: Effective January 1, 2010, small employers (those employing less than 25 employees and average annual wages of less than $50,000, indexed per CPI after 2013) who purchase health insurance for their employees may receive a sliding scale tax credit. The credit phases out gradually for firms with average wages between $25,000 and $50,000, and for firms with the equivalent of between 10 and 25 full-time workers. To qualify for a tax credit, an employer must contribute at least 50 percent of the total premium cost of a benchmark premium. From 2010-2013, eligible employers may receive a credit for up to 35 percent of their contribution toward the employee's health insurance premium. Tax-exempt small businesses are eligible for a reduced credit of up to 25 percent of their contribution. Beginning in 2014, eligible employers who purchase coverage through the Exchange may receive a tax credit for two years of up to 50 percent of their contribution. Tax-exempt small businesses will be eligible for a reduced credit of up to 35 percent of their contribution.

Auto-Enrollment: The law requires employers, starting January 1, 2015, with 200 or more workers to automatically enroll employees into health insurance plans offered by the employer. Workers may opt-out of this enrollment.

Long-term Care Public Plan: The CLASS Program

The Secretary will establish a national voluntary insurance program, the CLASS Independence Benefit Plan, to provide community living assistance services and supports. The Secretary will also set criteria for participation in the program that does not restrict eligibility based on underwriting, establish criteria for eligibility for benefits and benefit levels, and establish mechanisms for collecting and distributing payments and assisting beneficiaries in the use of benefits. The Secretary must promulgate rules as necessary and take actions, including adjusting benefits or premiums, to maintain program solvency and ensure the program remains deficit neutral. The CLASS program begins enrollment in 2012.

Workforce Provisions

Workforce Evaluation and Assessment: A National Health Care Workforce Commission will be established to disseminate information related to workforce supply issues; coordinate with relevant departments and agencies on related activities; commission evaluations of activities; identify barriers to improved communication between local, state, and federal levels; and encourage innovation to address population needs. The Commission will report to Congress on the application of grants established in this Act, and submit recommendations to Congress and to the Departments of HHS and Labor on improving workplace safety. Additionally, the Secretary will establish the National Center for Health Workforce Analysis, which will collaborate with the Commission to evaluate the effectiveness of programs created by the law annually, and develop and publish performance benchmarks.

Grant and Loans Programs: The law establishes grant programs to encourage workforce development in a variety of areas, including family, general internal, and general pediatric medicine; physician assistantship; dentistry; geriatrics; behavioral and mental health education; nursing; and community health. It also provides grants to support health professionals serving in underserved communities and encourage training in cultural competency, disabilities, prevention, and public health.

Prevention and Wellness

Wellness Programs: The health reform law allows an employer that offers programs of health promotion or disease prevention to provide discounts or rebates based on an individual or employee satisfying a health factor-related standard. To adhere to HIPAA non-discrimination rules, the programs must cap the reward at 30 percent of the employee only coverage under the plan (allows the Secretaries of HHS, Labor and Treasury to increase to 50 percent), and provide protections for participants that cannot meet the standard due to medical conditions. Wellness programs must be reasonably designed to promote health or prevent disease (and must not be a subterfuge for discriminating based on a health status factor), provide individuals the opportunity to qualify for the reward under the program at least once a year, ensure the reward is available to all "similarly situated" individuals, provide a reasonable alternative standard for individuals with medical conditions or if it is medically inadvisable for them to try and achieve the reward, and disclose the availability of the alternative standard.

Pilot Program: The law directs the Secretaries of HHS and Treasury to establish a 10-state pilot program in 2014 to apply the above provisions to programs of health promotion and disease prevention offered in the individual market.

National Prevention, Health Promotion, and Public Health Council: The President will establish this Council, comprised of various federal agency representatives, to provide coordination and leadership on

prevention and wellness initiatives, advise the President and Congress on the most pressing health issues affecting Americans, and develop a strategy that incorporates the most effective and achievable means of improving the health status of Americans and reducing the incidence of preventable disease. No later than July 1, 2010, and annually thereafter until January 1, 2015, the Council will report to the President and Congress on the activities and efforts to develop a national strategy and the national progress in meeting specific goals.

Increasing Public Awareness: The law provides for a number of education and outreach initiatives, including a public-private prevention and health promotion outreach and education effort to raise public awareness of health improvement across the life-span, and a national science-based media campaign on health promotion and disease prevention.

CDC and Employer-Based Wellness Programs: The CDC Director will conduct national educational campaigns to inform employers on the benefits of workplace wellness programs and provide employers with assistance in evaluating these programs.

Medicare and Medicaid Programs: The law expands the preventive services covered under the Medicaid program and awards grants to states to provide incentives for Medicaid beneficiaries to participate in programs providing incentives for healthy lifestyles. The law also provides for coverage of an annual wellness visit and personalized prevention plan, free from cost-sharing, under the Medicare program, as well as waives beneficiary coinsurance for most preventive services. In addition, the CDC provides grants to states or large local health departments to conduct pilot programs to evaluate chronic disease risk factors, conduct evidence-based public health interventions, and ensure that individuals identified with chronic disease or at-risk for chronic disease receive clinical treatment to reduce risk in the 55-to-64 year old population. CMS will conduct a comprehensive assessment of community-based disease self-management programs that help control chronic diseases. The Secretary will then develop a plan for improving access to such services for Medicare beneficiaries.

Medicare[2]

Medicare Advantage (MA) Payments: The health reform law freezes 2011 MA payment rates at 2010 levels. Starting in 2012, MA plan county rates will phase down to benchmark targets based upon local fee-for-service (FFS) costs. County rates in areas in the highest quartile of FFS costs will be phased down to 95 percent of FFS; county rates in the second highest quartile will be phased down to 100 percent of FFS costs; county rates in the second lowest quartile will be phased down to 107.5 percent of FFS costs; and county rates in the lowest quartile will be phased down to 115 percent of FFS costs.

Organizations scoring four stars or more on the Centers for Medicare & Medicaid Services' (CMS) five-star rating scale will be eligible for a five percent county rate bonus phased in over three years. An additional five percent benchmark bonus will be available to four-star and above plans participating in specified areas. The phase-in period for the county rate changes will vary from two to six years, with plans that are estimated to experience larger reductions in their benchmarks subject to the longer phase-in period. The percentage of the savings that MA plans that bid below the benchmark may keep to provide additional benefits and reduce beneficiary cost-sharing will be reduced from 75 percent currently

[2] Information about the Independent Payment Advisory Board and the CMS Innovation Center is found under the **Cost Containment** heading.

to 50 percent to 70 percent, phased in over three years. Plans that perform higher on CMS's star rating scale will be permitted to keep a higher percentage of these savings.

The law extends federal authority for the MA coding intensity adjustment and establishes a minimum adjustment of 5.7 percent starting in 2019. Starting in 2014, organizations with a medical loss ratio below 85 percent will be subject to penalties. Other modifications to the MA program include extension of the federal authority for Special Needs Plans through 2013 and changes to the annual and open enrollment periods.

Improving Coverage in the Part D Coverage Gap: Part D enrollees receive a $250 bonus should they enter the Part D coverage gap in 2010. The law also gradually closes the Part D coverage gap from 2011-2020.

Additional Hospital Insurance Tax on High-income Taxpayers: The health reform law increases the Medicare hospital insurance payroll tax rate by 0.9 percentage points, beginning in 2013, on taxpayers above certain thresholds ($200,000, singles/$250,000, couples). It also retains this increase and adds a 3.8 percent tax on income from interest, dividends, annuities, royalties and rents for taxpayers who earn above certain thresholds ($200,000, singles/$250,000, couples).

Medicaid and CHIP

Medicaid: The law creates a new mandatory eligibility category of all non-elderly, non-pregnant individuals not otherwise eligible for Medicaid who are at or below 133 percent FPL effective January 1, 2014, and provides states the option of covering such populations beginning April 1, 2010. It provides an enhanced federal match rates for costs of services provided to the newly eligible. From 2014 through 2016, the federal government will pay 100 percent of the costs of covering the newly eligible.. Starting in 2017, the new law incrementally decreases the federal medical assistance percentage (FMAP) for covering the newly eligible resulting in a rate of 90 percent for 2020 and each year thereafter. For states that have previously made such coverage expansions, the state receives an enhanced match for services provided to nonpregnant childless adults that are currently eligible. The enhanced rate increases incrementally to a 90 percent FMAP rate in 2020.

A "maintenance of effort" is established under which states are required to maintain existing income eligibility levels for adults in Medicaid through September 30, 2013, and for all children in Medicaid and CHIP through September 30, 2019. Beginning in 2014, all states must use modified gross income for determining Medicaid eligibility. Income disregards and asset tests will no long apply in Medicaid except for long-term services and supports, and for certain populations, such as individuals eligible for Medicaid through another program.

States will be required to offer premium assistance and wrap-around benefits to Medicaid beneficiaries who are offered employer sponsored insurance if it is cost-effective as determined under current law requirements. In addition, the law facilitates enrollment coordination with state exchanges, and requires states to establish a state enrollment Web site to promote seamless enrollment in Medicaid, CHIP or the exchange should a Medicaid or CHIP-eligible individual apply for tax credits through a state exchange Web site or vice versa.

States must increase Medicaid payments to primary care physicians in 2013 and 2014 to levels that are no less than 100 percent of Medicare payment rates, and provides 100 percent federal match for the

incremental costs for meeting the mandate. Payments to primary care physicians under a capitated or partially-capitated arrangement must be consistent with the mandate.

The health reform law increases the brand-name drug and generic drug rebate amounts and extends the Medicaid drug rebate to include drugs dispensed to enrollees of Medicaid health plans. It includes several provisions that provide incentives for states to increase their coverage of home and community-based services and supports. The Secretary is directed to develop a set of quality measures for Medicaid-eligible adults similar to the quality measurement program for children enacted in the Children's Health Insurance Program Reauthorization Act of 2009. States are prohibited from making Medicaid payments for services related to a health care acquired condition. The scope of topics that the Medicaid and CHIP Program Advisory Commission (MACPAC) is to address is expanded to include federal Medicaid and CHIP regulations, and an assessment of adult services in Medicaid.

CHIP: The current CHIP structure is maintained under this law, requiring states to maintain income eligibility levels for currently eligible children in Medicaid (up to the CHIP eligibility level) and CHIP. CHIP is reauthorized through 2015. The new law allows states to expand their current income eligibility levels at any time. CHIP-eligible children who cannot enroll in CHIP due to federal allotment caps are eligible for tax credits in the state exchange. It provides additional federal allocations of $17.4 billion in FY 2013, $19.1 billion in FY 2014, and $21 billion in FY 2015. Beginning in 2014, the law provides a 23 percentage point increase in the CHIP match rate, subject to a cap of 100 percent, through federal FY 2019. Beginning in 2015, states that experience CHIP shortfalls may enroll targeted low-income children into qualified health plans that participate in exchanges. The qualified health plans must be certified by the Secretary as providing CHIP-comparable coverage.

Cost Containment

Medicare Pilot and Demonstration Programs: The HHS Secretary is permitted to implement partial capitation under the Accountable Care Organization (ACO) program and to limit partial capitation to entities that are "capable of bearing risk." The Secretary has authority to give preference to ACOs "who are participating in similar arrangements with other payers." Other cost containment provisions include: payment bundling that covers ten medical conditions; the scope of pay-for-performance is expanded to include psychiatric, long-term care, and rehabilitation hospitals; value-based purchasing for hospitals is expanded to include ambulatory surgical centers; and the criteria for programs under the Center for Medicare and Medicaid Innovation includes activities that have effective linkage with other public sector or private sector payers.

Independent Payment Advisory Board: The law establishes a 15-member Independent Payment Advisory Board to make recommendations to Congress beginning January 15, 2014 to reduce Medicare spending and improve quality. The Board's recommendations become law in years that Medicare spending is determined to be unsustainable unless Congress enacts alternative measures to achieve similar savings. The Board is prohibited from making recommendations that increase beneficiary cost-sharing or eligibility standards or raise taxes. The Board is also prohibited from reducing payments to certain groups of providers including hospitals and certain physicians for the first five years (2014-2019).

CMS Innovation Center: The law directs the Secretary to establish, prior to January 1, 2011, an Innovation Center within CMS authorized to test, evaluate, and expand different payment structures and methodologies that aim to improve quality and slow the rate of Medicare, Medicaid, and CHIP cost

growth. The Center is funded by a transfer of $10 billion from the Part A and Part B Trust Funds over ten years.

Pathway for Biosimilars

Licensure of Biological Products as Biosimilar or Interchangeable: Any person may submit a biologic application, which must include information demonstrating that the biologic is biosimilar to the reference product; that the biologic and reference product utilize the same mechanism(s) of action for the condition(s) of use prescribed; that the conditions of use for the biologic have been previously-approved for the reference; that the route of administration, dosage form, and strength of the biologic are the same as those of the reference; and that the facility in which the biologic is manufactured meets standards designed to ensure safety, potency, and purity. Upon review of the application, the Secretary issues a license if the biologic meets interchangeability standards and the manufacturer consents to an inspection of its facility. The Secretary deems a biologic "interchangeable" if it is biosimilar to the reference product and can be expected to achieve the same clinical result as the reference and, if a biologic is administered more than once to an individual, the risk between use of the biologic and reference is no greater than the risk of using the reference without a switch. The new law imposes exclusivity periods on reference products (12 years) and first interchangeable biologics (the earlier of: 1) one year after the first commercial marketing as interchangeable for the reference; 2) 18 months after a final court decision with respect to all patent suits or dismissal of an action against the applicant; or 3) 42 months after approval if the applicant has been sued and such litigation is ongoing within such 42-month period **or** 18 months after approval of the first interchangeable biosimilar biologic if the applicant that submitted the application has not been sued).

Patents: The law establishes a process for the resolution of disputes relating to existing patents, including negotiation procedures and infringement actions.

Select Revenue-Raising Provisions

Excise Tax on High-Cost Insurance: The health reform law imposes an excise tax on insurers, equal to 40 percent of the aggregate value of employer-sponsored health coverage that exceeds the threshold amount of $10,200 for an individual policy and $27,500 for a family policy for 2018, indexed to CPI-U plus one percent. The law allows for threshold adjustments for retired persons over age 55 and employees engaged in "high risk professions," and grants further flexibility to adjust thresholds to account for instances in which firms have higher health costs due to the age or gender of the workforce. Certain products are exempt from this tax, including accident only, disability, long-term care, and employee-pay-all with after tax dollars for specified disease or illness, hospital or other fixed indemnity coverage, and dental and vision benefits.

Annual Fee on Health Insurance Providers: The new law imposes a national premium tax (or "fee"), in the aggregate amount of $70 billion over ten years, on the health insurance sector beginning in 2014, allocated by market share. The industry's total liability for the annual fee is as follows:

Calendar Year	Health Insurance Provider Fee Level
2014	$8 billion
2015	$11.3 billion
2016	$11.3 billion

2017	$13.9 billion
2018	$14.3 billion
2019 (and subsequent years)	The amount from the preceding year increased by the rate of premium growth

The law exempts from the fee certain non-profit insurers that receive more than 80 percent of income from government programs targeting certain populations and for voluntary employee benefit associations (VEBAs) that are not established by employers. In the case of certain tax-exempt entities, only 50 percent of premiums (over $50 million) are considered in calculating the tax. The law also exempts certain products from the fee including long-term care, disability, accident only, specified disease or illness, hospital or other fixed indemnity, and Medigap. The tax is non-deductible and applies only to fully-insured net premiums written.

Delay of Limitation on Health Flexible Spending Arrangements Under Cafeteria Plans: The law imposes a $2,500 cap on FSA contributions starting in 2013.

Annual Fee on Pharmaceutical Manufacturers and Importers: The law imposes a $28 billion fee over ten years, phased in between 2011 and 2019, with the applicable amount holding steady at $2.8 billion after 2019. This fee begins in 2011.

Conversion of Fee on Medical Device Manufacturers to an Excise Tax: The law establishes in 2013 an excise tax on medical device sales equal to 2.9 percent of the price of the device. Exemptions apply to certain devices.

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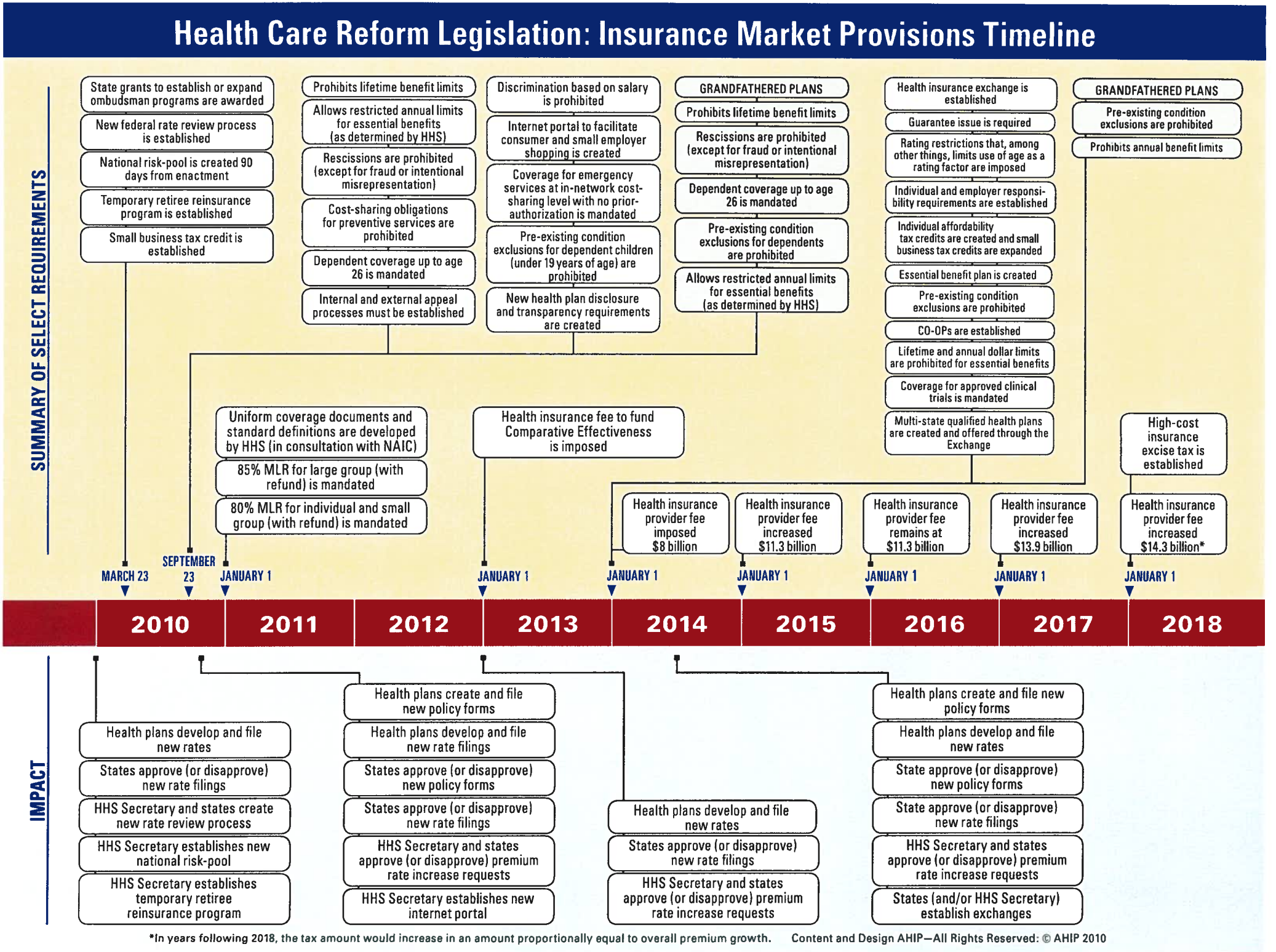
Health Care Reform Legislation: Insurance Market Provisions Timeline



*In years following 2018, the tax amount would increase in an amount proportionally equal to overall premium growth.

EXAMPLES OF NEW STATUTORY AND REGULATORY DIRECTIVES FOR HEALTH PLAN OPERATIONS

New Regulations on Operations

Caps on Medical Loss Ratios PHSA Sec. 2718	HHS Secretary Regulations* NAIC Guidance
Prohibition on Lifetime Limits PHSA Sec. 2711	None Specified
Regulated Annual Limits PHSA Sec. 2711	HHS Secretary Regulations
Guaranteed Issue PHSA Sec. 2702	HHS Secretary Regulations
Guaranteed Renewability PHSA Sec. 2703	None Specified
Premium Rate Review PHSA Sec. 2794	HHS Secretary
No Preexisting Condition Exclusion or Discrimination PHSA Secs. 2704 and 2705	HHS Secretary Guidance DOL Secretary Guidance Treasury Secretary Guidance
Regulation of Waiting Periods PHSA Sec. 2708	None Specified
New Federal Appeals Process PHSA Sec. 2719	NAIC Guidance HHS Secretary Guidance DOL Secretary Guidance
Regulation of Grandfathered Plans PPACA Sec. 1251	None Specified
No Health Status Rating PHSA Sec. 2701	HHS Secretary Guidance NAIC Guidance
Restrictions of Rescissions PHSA Sec. 2712	None Specified
Quality Reporting Requirements for Coverage and Provider Reimbursement PHSA Sec. 2717	HHS Secretary Regulations GAO Report
Standards for Health Data and Information Systems PPACA Sec. 1104	HHS Secretary Regulations National Committee on Vital and Health Statistics Guidance ICD-9-CM Coordination and Maintenance Committee Guidance

New Regulations on Product Design

Required Essential Health Benefit Package PPACA Sec. 1302	HHS Secretary Regulations DOL Secretary Guidance CMS Chief Actuary Guidance
Required Preventive Services PHSA Sec. 2713	HHS Secretary Guidance United States Preventive Services Task Force Guidance Committee on Immunization Practices of the Centers for Disease Control Health Resources and Services Administration Guidance
Required Uniform Summary of Benefit and Coverage Documents and Standard Definitions PHSA Sec. 2715	HHS Secretary Regulations NAIC Guidance
Required Emergency Room Services Coverage PPACA Sec. 1301	None Specified
Required Dependent Coverage PHSA Sec. 2714	HHS Secretary Regulations
Required Coverage for Approved Clinical Trials PHSA Sec. 2709	None Specified
New Federal Standards for 'Qualified' Health Plan PPACA Sec. 1301	None Specified

New Required Fees and Taxes

40% Excise Tax on High Cost Plans IRC Sec. 4980I	Treasury Secretary Regulations
Annual Fee on Health Insurance Providers PPACA Sec. 9010	Treasury Secretary Guidance
Pass-Through of Manufacturers' Fees PPACA Secs. 9008 and 9009	Treasury Secretary Guidance
Limitation on Deduction for Compensation for Health Insurance Executives PPACA Sec. 9014	Treasury Secretary Guidance, Rules, or Regulations
Risk Corridor Payment Adjustment System PPACA Sec. 1342	None Specified
Payment for Reinsurance Program for Individual Market PPACA Sec. 1341	HHS Secretary Regulations NAIC Guidance
Fees to Fund Comparative Effectiveness Research IRC Secs. 4375, 4376, and 4377	None Specified
Tax Treatment for Certain BCBS Plans PPACA Sec. 9016	None Specified
Federal Risk Adjustment Mechanism PHSA Sec. 1343	HHS Secretary Guidance

* Requests for comments for these consumer protection provisions were issued in the April 14, 2010 Federal Register.

Note: There are many provisions within the PPACA which, although not explicitly granting the Secretary of a federal agency regulatory authority, will require the federal agencies to issue regulations pursuant to their general regulatory authority. We are also aware that conforming regulations will likely be issued across several federal agencies.

Note: PPACA is the Patient Protection and Affordable Care Act as amended by the Health and Education Reconciliation Act of 2010; PHSA is the Public Health Services Act as amended by the PPACA; and the IRC is the Internal Revenue Code as amended by the PPACA.