CHAPTER 5

QUALITY, AFFORDABILITY, AND ACCESSIBILITY

Congress recognized that while universal access to affordable, quality health care coverage could not be implemented immediately, preliminary measures could be adopted to begin the transition and improve access to coverage. The major reforms, such as prohibitions on pre-existing condition exclusions for adults,[1] guaranteed availability and renewability of individual insurance coverage, and the state Exchanges, do not begin until January 1, 2014. The period from the date of enactment of the 2010 Health Care Reform Act, March 23, 2010, through January 1, 2014, is sometimes referred to as the "transition period."

The changes that become effective during the transition period generally are interim measures intended to preserve or improve access to affordable coverage by demographic groups that currently represent significant portions of the underinsured—young adults, early retirees, and high-risk individuals. The 2010 Health Care Reform Act also imposes a number of immediate coverage and reporting requirements on existing group health plans and individual insurance coverage. Premiums charged by insurance issuers begin to be regulated and limited. Finally, new reporting requirements begin the process of providing more consumer information about available options and costs, premium transparency, and quality information. Each of these measures is described in detail in subsequent chapters. A quick list of the reforms that begin during the transition period follows.

§ 5.01 Immediate Steps to Expand and Preserve Coverage[2]

Effective as of March 23, 2010, HHS is directed to take steps immediately to establish the following programs and activities:

- A high-risk health insurance pool program to provide health insurance coverage for eligible individuals beginning no later than June 21, 2010 (90 days after enactment), and ending on January 1, 2014;[3]
- A temporary reinsurance program to provide reimbursement for employer-sponsored group health plans for a portion of the cost of providing health insurance coverage to early retirees (including their eligible spouses, surviving spouses, and dependents) for the period June 21, 2010, through January 1, 2014;[4]
- A small-employer tax credit to subsidize part of a small employer's cost of coverage for employees;[5]
- An Internet portal through which a resident of any state may identify affordable health insurance options in that state, including Medicaid coverage, any high-risk pool offered by a state, and the new federal high-risk pool described above (beginning July 1, 2010).[6]

§ 5.02 Transition Period Coverage Improvements Applicable to Group Health Plans[7]

Effective for plan years beginning on or after September 23, 2010 (six months after the date of enactment), the 2010 Health Care Reform Act amends the PHSA to prohibit certain practices and add

[1] Prohibitions on pre-existing condition exclusions for children under age 19 apply for the first plan year beginning on or after September 23, 2010. PPACA § 1255(2) (amending PHSA § 2704).

[2] These steps are found primarily in Subtitle B of Title I of the Act.

[3] PPACA § 1101.

[4] PPACA § 1102.

[5] PPACA § 1421.

[6] PPACA § 1103.

[7] The immediate changes applicable to health plans are found primarily in Subtitle A of Title I of the Act. Also, these requirements are subject to the discussion of grandfathered health plans and collectively bargained plans in **Chapter 4**.

new coverage requirements for group health plans and health insurance issuers offering group or individual health insurance coverage, including:

- A prohibition on lifetime or annual limits on the dollar value of benefits;[8]
- A prohibition on pre-existing condition exclusion provisions for children under age 19;[9]
- Minimum preventive health services coverage requirements without cost-sharing by the enrollee;[10]
- The extension of coverage for children until age 26;[11]
- Requirements for an appeals process of coverage determinations and claims which must include, at a minimum, an internal process and an external review process that is binding on the plan;[12]
- Restrictions on rescissions of plan coverage of an enrollee, other than for fraud or an intentional misrepresentation of material fact, and subject to notice of cancellation;[13]
- A required standardized summary of benefits and coverage to be provided to applicants, enrollees, and policy holders prior to enrollment and upon renewal of coverage;[14] and
- A prohibition on eligibility rules for insured group health plans that have the effect of discriminating in favor of higher-wage employees.[15]

§ 5.03 Coverage Improvements Applicable to Employment-Based Coverage Effective January 1, 2014[16]

Some coverage improvements are deferred until January 1, 2014, when the Exchanges begin and the insurance issuer market reforms become effective. These include:

- Prohibitions on pre-existing coverage exclusions for adults;[17]
- Underwriting of premiums for insured coverage is limited to certain ratios for age and tobacco use;[18]
- All insured plans must guarantee availability and renewability of coverage;[19]
- Prohibitions on discrimination in benefits against individual participants and beneficiaries based on health status;[20]
- Annual cost-sharing limits for comprehensive benefits;[21]
- Prohibitions on discrimination against health care provider participation;[22]

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[8] PPACA § 1001 (adding PHSA § 2711).
[9] PPACA §§ 1201 (adding PHSA § 2704), 1255(2).
[10] PPACA § 1001 (adding PHSA § 2713).
[11] PPACA § 1001 (adding PHSA § 2714).
[12] PPACA § 1001 (adding PHSA § 2719).
[13] PPACA § 1001 (adding PHSA § 2712).
[14] PPACA § 1001 (adding PHSA § 2715).
[15] PPACA § 1001 (adding PHSA § 2716).
[16] These provisions are found primarily in Subtitle C of Title I of the Act.
[17] PPACA § 1201 (adding PHSA § 2704).
[18] PPACA § 1201 (adding PHSA § 2701).
[19] PPACA § 1201 (adding PHSA §§ 2702, 2703).
[20] PPACA § 1201 (adding PHSA § 2705).
[21] PPACA § 1201 (adding PHSA § 2707(b)).
[22] PPACA § 1201 (adding PHSA § 2706).

- No waiting periods in excess of 90 days;[23] and
- Coverage of medical services in clinical trials.[24]

§ 5.04 New Reporting Obligations

Insurers and group health plans will be subject to new reporting obligations to HHS:

- To facilitate the introduction of the Web portal for consumers beginning on July 1, 2010 (described above), insurers must submit plan background information to HHS for posting starting with basic summary information as early as May 21, 2010, and continuing with more specific pricing and benefit information later in the year.[25]
- Insurers will be required to report on the percentage of total premium revenue that is expended on clinical service, health care quality improvement, and non-claims costs.[26] Insurers will be required to provide an annual rebate to each enrollee, on a pro rata basis, if the non-claims costs exceed 20 percent of the premium for the group market and 25 percent of the premium for the individual market.[27]
- Group health plans and insurance coverage will be required to report on their benefits and reimbursement provisions that improve health outcomes, prevent medical errors and improve patient safety, and implement wellness and health promotion activities.[28]
- Group health plans and health insurance issuers must submit certain information regarding plan design to HHS.[29]
- Each hospital must publish annually a list of its standard charges for items and services it provides.[30]

§ 5.05 Additional Electronic Transaction Standards

To advance the financial transactions that will be necessary to implement and operate the exchanges, HHS also is charged with the adoption of additional uniform standards and business operating rules under HIPAA for the electronic exchange of information by health plans with respect to eligibility, electronic funds transfers, enrollment and disenrollment, health care premium payments, and claims-related transactions.[31]

[23] PPACA § 1201 (adding PHSA § 2708).
[24] PPACA § 1201 (adding PHSA § 2709).
[25] 45 C.F.R. 159.120. See **Appendix C**.
[26] PPACA § 1001 (adding PHSA § 2718(a)).
[27] PPACA § 1001 (adding PHSA § 2718(b)).
[28] PPACA § 1001 (adding PHSA § 2717).
[29] PPACA § 1001 (adding PHSA § 2715A).
[30] PPACA § 1001 (adding PHSA § 2718(c)).
[31] PPAC § 1104.

A. 2010 Health Care Reform Act Provisions Applicable to Grandfathered Health Plans

- A "grandfathered plan" is defined as a group health plan (insured or self-insured) in which individuals were enrolled for coverage as of March 23, 2010.

  —New employees and their families may be enrolled in a grandfathered plan after 3/23/2010.

  —Family members of new employees and existing enrollees may be added after 3/23/2010.

  —A grandfathered plan may be renewed indefinitely.

SUBJECT	SECTION(S) OF PHSA (UNLESS NOTED)	EFFECTIVE DATE	APPLY TO GRANDFATHERED PLAN?
Extension of dependent coverage to age 26	2714	1st plan year after 9/23/2010	Yes
Pre-existing exclusions prohibited for children under age 19	2704	1st plan year after 9/23/2010	Yes
Prohibition on lifetime dollar maximum on benefits	2711	1st plan year after 9/23/2010	Yes
Prohibition on annual dollar limits on restricted benefits	2711	1st plan year after 9/23/2010	Yes
Rescissions of coverage for reasons other than fraud or non-payment	2712	1st plan year after 9/23/2010	Yes
Required preventive health services without cost-sharing	2713	1st plan year after 9/23/2010	No
Mandated appeals process with binding external review	2719	1st plan year after 9/23/2010	No
Nondiscrimination against health care providers	2706	1st plan year after 1/1/2014	No
Summary communication requirements for enrollees	2715	24 months after date of enactment	Yes
No discrimination based on salary permitted	2716	1st plan year after 9/23/2010	No
Insured plans must rebate prorated share of premiums if medical claims ratios too low	2718	1st plan year after 9/23/2010	Yes (insured plans only)
HHS reporting requirements (quality outcomes, etc.)	2717	24 months after date of enactment	No
Reinsurance for retirees	PPACA 1102	June 23, 2010	Yes
Adm. Simplification—amends HIPAA to add new transaction standards	PPACA 1104	1/1/2013–1/1/2014	Yes (electronic funds transfer standards)
All insured plans must guarantee eligibility and renewability	2702, 2703	1st plan year on or after 1/1/2014	No
All insured plans are subject to premium underwriting restrictions	2701, 1252	1st plan year on or after 1/1/2014	No
Prohibitions on health status discrimination	2704, 2705	1st plan year on or after 1/1/2014	No
Comprehensive health insurance—annual cost-sharing limits	2707	1st plan year on or after 1/1/2014	No
Nondiscrimination in health care coverage (provider)	2706	1st plan year on or after 1/1/2014	No

SUBJECT	SECTION(S) OF PHSA (UNLESS NOTED)	EFFECTIVE DATE	APPLY TO GRANDFATHERED PLAN?
No waiting period in excess of 90 days	2708	1st plan year on or after 1/1/2014	Yes
Coverage for clinical trials	2709 (Can be found in Title X)	1st plan year on or after 1/1/2014	No
Reinsurance for early retirees	PPACA 1101	6/23/2010 to 1/1/2014	Yes
Automatic enrollment for large employers	FLSA, 1511	1/1/2011	Yes, employer responsibility
Employee notice re: coverage options (FLSA amendment)	FLSA, 1512	3/1/2013	Yes, employer responsibility
Health insurance fee	PPACA 9010	Calendar year 2014	Yes, except it does not apply to self-insured or government plans