



Health Reform & the Individual Insurance Market

In March 2010, President Obama signed landmark new health reform legislation into law. This new law has two pieces—the Patient Protection and Affordable Care Act and the Health Care and Education Affordability Reconciliation Act of 2010 (“Health Reform Acts”). When joined together, these pieces will result in major changes across the U.S. health care system for virtually everyone, but especially health insurers and the customers who rely on our products to deliver both high-quality health care and financial security at an affordable cost.

Specifically, the Health Reform Acts will lead to **important changes in the individual insurance market** in the coming months and years. This document provides an overview of many of the biggest changes to the individual insurance market along with the effective date. However, it is important to remember that the specific details of how the changes will be implemented are subject to new regulations from the U.S. Department of Health & Human Services (HHS), National Association of Insurance Commissioners (NAIC), or other authorized entity.

Changes Effective in 2010		
Issue	Summary	Effective Date
Grandfather Plan Status	<ul style="list-style-type: none"> • Extends “grandfather status” to existing individual insurance plans in effect on the date of enactment • Specifies that nothing in the new law requires an individual to terminate their existing coverage 	Upon enactment (Mar 23, 2010)
Medical Loss Ratio (MLR) Reporting	<ul style="list-style-type: none"> • Requires health insurers to report MLRs to the HHS Secretary for each plan year that will be publicly posted on the Internet • Implementation subject to HHS regulations issued with the NAIC 	Effective upon date of enactment and applies to 2010 plan year
Premium Review Process	<ul style="list-style-type: none"> • Requires the HHS Secretary to establish a process for the annual review of changes in individual market premiums • Requires plan justification for any increase and disclosure on the plan’s public website 	Effective upon date of enactment and applies to 2010 plan year
Temporary High Risk Health Insurance Pool Program	<ul style="list-style-type: none"> • Requires the HHS Secretary to establish high risk health insurance pool program through Jan 1, 2014 <ul style="list-style-type: none"> ➤ Open to individuals with preexisting conditions who have been uninsured for at least 6 months ➤ Operates at a State level by State or nonprofit entities ➤ Establishes premiums based on standard population and limits variation to 4:1 age band ➤ Caps out-of-pocket expenses at health savings account limits (\$5,950 for individual or \$11,900 for family in 2010) 	Effective 90 days after enactment (Jun 22, 2010)

	➤ Provides \$5 billion in federal funding (capped)	
Federal Website for Consumers	<ul style="list-style-type: none"> Requires the HHS Secretary to establish an Internet website for resident of all States to identify affordable health insurance coverage options in their State 	By Jul 1, 2010
Children with Preexisting Conditions	<ul style="list-style-type: none"> Prohibits health insurers offering individual health insurance coverage from imposing any preexisting condition exclusion with respect to plan coverage for enrollees under age 19 Applies to a child's access to a plan and benefits after enrollment (HHS Secretary clarification) 	Effective plan years starting on or after 6 months after enactment (Sep 23, 2010)
Dependent Coverage to Age 26	<ul style="list-style-type: none"> Requires health insurers offering individual health insurance coverage that provides dependent coverage of children to cover an adult child until age 26 	Effective plan years starting on or after Sep 23, 2010
Annual or Lifetime Limits	<ul style="list-style-type: none"> Prohibits health insurers offering individual health insurance from establishing lifetime or annual limits on the dollar value of benefits Allows for annual limits on "essential health benefits" as defined by the HHS Secretary prior to 2014 	Effective plan years starting on or after Sep 23, 2010
Rescissions	<ul style="list-style-type: none"> Prohibits health insurers offering individual health insurance from rescinding the plan or coverage once an enrollee is covered except in instances of intentional misrepresentation of material fact 	Effective plan years starting on or after Sep 23, 2010
Appeals Process	<ul style="list-style-type: none"> Requires health insurers offering individual health insurance coverage to implement an effective appeals process for appeals of coverage determinations and claims Requires the process to include an internal claims appeal process, providing notice to enrollees in a culturally and linguistically appropriate manner and informing enrollee of any applicable consumer assistance, and allowing enrollee to review their file 	Effective plan years starting on or after Sep 23, 2010
Coverage of Preventive Health Services	<ul style="list-style-type: none"> Requires health insurers offering individual health insurance coverage to cover any preventive services rated A or B by the US Preventive Services Task Force, Advisory Committee on Immunization Practices (ACIP) recommended immunizations, preventive care for infants, children, and adolescents, and additional preventive care and screenings for women at \$0 co-pay 	Effective plan years starting on or after Sep 23, 2010
Grand-fathered Plan Rules	<ul style="list-style-type: none"> Requires dependent coverage to age 26 Prohibits rescissions Prohibits lifetime limits Eliminates waiting periods for coverage over 90 days 	Effective plan years starting on or after Sep 23, 2010

Changes Effective in 2011

Issue	Summary	Effective Date
Minimum MLR	<ul style="list-style-type: none"> Requires health insurers offering individual health insurance coverage to attain 80% MLR (or higher if required under State law) for each plan year Requires the plan to provide rebates to each enrollee on pro rated basis if the 80% target is not attained Authorizes the HHS Secretary to adjust percentage if the 80% MLR may destabilize the individual market in a State Directs the NAIC to establish uniform definitions and standardized methodologies to comply with requirements by Dec 31, 2010 	No later than Jan 1, 2011

	<ul style="list-style-type: none"> • Implementation subject to HHS and NAIC regulations 	
MSA Changes	<ul style="list-style-type: none"> • Prohibits distributions medical spending accounts (MSAs) for over-the-counter drugs and other non-prescription products unless prescribed by a physician 	Jan 1, 2011

Changes Effective in 2012 and Later		
Issue	Summary	Effective Date
Information Standards	<ul style="list-style-type: none"> • Requires the HHS Secretary to develop standards with the NAIC on summary of benefits and coverage explanations • Requires plans to provide standardized information to applicants, enrollees, and policyholders in paper or electronic format • Preempts any related State standards 	Effective no later than 24 months after enactment (est. Mar 23, 2012)
Electronic Health Transactions	<ul style="list-style-type: none"> • Directs the HHS Secretary to adopt a single set of operating rules for electronic health transactions (e.g., eligibility verification, claims status) by July 1, 2011 • Requires health plans to certify to HHS that data and information systems are in compliance with standards and operating rules for electronic funds transfers, health plan eligibility, health claim status, and health care payment and remittance advice 	Dec 31, 2013
Health Exchanges	<ul style="list-style-type: none"> • Establishes State-based American Health Benefit Exchanges through which individuals can buy health insurance • Requires the Office of Personnel Management to contract with insurers to offer at least two multi-State plans in each Exchange with at least one plan offered by a non-profit entity • Creates four benefit-categories of plans—Bronze, Silver, Gold, Platinum—plus a Catastrophic Plan available to those under age 30 • Requires all plans (inside and outside the Exchange except grandfathered plans) to cover “essential health benefits” 	Jan 1, 2014
Health Benefit Standards	<ul style="list-style-type: none"> • Essential Health Benefits must include: ambulatory patient services, emergency room services, hospitalization, maternity and newborn care, mental health and substance abuse, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services • Caps out-of-pocket (OOP) costs equal to the limits under HSAs (\$5,950/individual and \$11,900 family in 2010) • Reduces OOP limits for those with incomes up to 400% of the federal poverty level (FPL) <ul style="list-style-type: none"> ➢ 100-200% FPL = \$1,983/individual and \$3,967/family limit ➢ 200-300% FPL = \$2,975/individual and \$5,950/family limit ➢ 300-400% FPL = \$3,987/individual and \$7,973/family limit 	Jan 1, 2014
Individual Subsidies to Buy Insurance	<ul style="list-style-type: none"> • Provides individuals with incomes between 133% to 400% FPL with sliding-scale, advanceable premium and cost sharing credits to buy insurance through the Exchanges 	Jan 1, 2014
Individual Cost Sharing Subsidies	<ul style="list-style-type: none"> • Provides individuals with incomes 133-400% FPL with sliding-scale, cost sharing subsidies to reduce the cost sharing amounts and annual cost sharing limits 	Jan 1, 2014
Individual	<ul style="list-style-type: none"> • Requires all U.S. citizens and legal residents to have qualifying 	Jan 1, 2014

Mandate	health coverage or pay a tax penalty starting at \$95 in 2014 or 1.0% of taxable income (penalty increases in future years)	
Insurance Market Rules	<ul style="list-style-type: none"> • Imposes many new insurance market rules in conjunction with start of the Exchanges: <ul style="list-style-type: none"> ➢ Guaranteed issue and renewability ➢ Rating variation based only on age (3:1), premium rating area, family composition, and tobacco use (1.5:1) ➢ No annual lifetime limits on dollar value of coverage ➢ No rescissions except in cases of fraud ➢ No exclusions for preexisting conditions 	Jan 1, 2014
Risk Pools	<ul style="list-style-type: none"> • Requires health insurers to consider all enrollees in all health plans offered in the individual market in a State (other than grandfathered health plans) to be a single risk pool • Authorizes States to require insurers to merge the individual and small group insurance markets within a State 	Jan 1, 2014
Health Insurer Premium Taxes	<ul style="list-style-type: none"> • Imposes a new \$8 billion tax on health insurers starting in 2014 that rises to \$14.3 billion in 2018 • Levies the tax based on plan net premiums as percentage of total US net premiums <ul style="list-style-type: none"> ➢ Excludes 50% of net premiums for non-profit plans ➢ Exempts non-profit plans that receive 80% or more of their revenue from Social Security Act programs that target low-income, elderly, or disabled individuals ➢ Exempts administrative-services only (ASO) fees for self-insured employers and self-insured employer plans ➢ Exempts long-term care insurance and Medigap plans ➢ Exempts voluntary employee benefit associations ➢ Exempts governmental entities 	Jan 1, 2014
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Risk Corridors	<ul style="list-style-type: none"> • Establishes a risk corridor program for qualified health plans in the individual market for 2014-2016 • Provides government payments to plans if total allowable costs exceed 103% of the target amount. Payments equal: <ul style="list-style-type: none"> ➢ 50% of costs above 103% but less than 108% of target ➢ 80% of costs above 108% of target • Requires plan payments to the government if total allowable costs are below 97% of the target amount. Payments equal: <ul style="list-style-type: none"> ➢ 50% of costs below 97% but above 92% of target ➢ 2.5% of target plus 80% of costs below 92% of target 	Jan 1, 2014
Independent Payment Advisory Board	<ul style="list-style-type: none"> • Creates the Independent Payment Advisory Board • Directs the Board to submit recommendations to Congress to slow growth in national health expenditures (and recommendations to reduce Medicare spending one year earlier) 	Submit proposal by Jan 15, 2015
Health Care Choice Compacts	<ul style="list-style-type: none"> • Permits States to form health care choice compacts and allow insurers to sell policies in any State participating in the compact 	Not before Jan 1, 2016