Chapter 6

Patient Protection and Affordability Care Act (ACA)

Introduction

The Public Health and Safety Act (PHSA) was amended by the ACA by adding a new Section 2716 which introduced new discrimination rules for certain health care plans. These rules became effective for plan anniversaries on or after September 23, 2010 but are to be applicable only to non-grandfathered plans. This new PHSA Section references IRC Section 105(h) which prior thereto was applicable only to self-funded health care plans.

Text of ACA Section 2716

SEC. 2716. PROHIBITION OF DISCRIMINATION BASED ON SALARY. (a) In General – A group health plan (other than a self-insured plan) shall satisfy the requirements of Section 105(h) of the Internal Revenue Code of 1986 (relating to prohibition on discrimination in favor the highly compensated individuals).; (b) Rules and Definitions – For purposes of this Section -- (1) CERTAIN RULES TO APPLY Rules similar to the rules contained in paragraphs (3), (4) and (8) of Section 105(h) of the Code shall apply; also, (2) HIGHLY COMPENSATED INDIVIDUAL – The term “Highly Compensated Individual” has the same meaning given such term in Section 105(h) of the Code.

Text of PHSA Section 2716

SEC. 2716. PROHIBITION OF DISCRIMINATION BASED ON SALARY. In general, a plan sponsor of a health care plan (other than a self-insured plan) may not establish rules relating to the health insurance eligibility (including continued eligibility) of any full-time employee under the terms of the plan that are based on the total hourly or annual salary of the employee or otherwise establish eligibility rules that have the effect of discriminating in favor of the higher wage employees. But this Section shall not be construed to prohibit a plan sponsor from establishing contribution requirements for enrollment in the plan or coverage that provide for the payment by employees with lower hourly or annual compensation of a lower dollar or percentage contribution than the payment required of similarly situation employees with a higher hourly or annual compensation.

The Legislative Maze

Prior to ACA, IRC Section 105(h) applied only to self-funded health care plans. PPACA added Section 2716 to ACA which required that fully insured plans must not discriminated in favor ot he Highly Compensated Individual.

PPACA Section 2716 provides that rules similar to the rules contained in paragraphs set forth in IRC Sections 105(h) (3), (4) and (8) plus the specific definition of *Highly Compensated Individual* in IRC Section 105(h) (5) are to be used for determining if an insured group health plan satisfies the IRC Section 105(h)(2) rules. Also, ERISA Section 715 and IRC Section 9815 which incorporated many of the new provisions of the PHSA Act including Section 2716 into these two acts

The result is that insured group health plans that were established or amended after March 23, 2010 must satisfy the IRC Section 105(h)(2) requirements. Under these rules a plan may not discriminate in favor of the *Highly Compensated Individual* as to eligibility to participate and the benefits provided by the plan.

Non-IRC Discrimination in ACA

In General

Numerous provisions in the new Health Reform Act (ACA) will have an impact on discrimination issues. These may occur (a) directly (as the denial of IRC Section 105(h) to fully insured plans) or (b) indirectly (by action of the newly-invoked Unfair Trade Practices laws, in new defined classes of individuals, or other reasons. Only time and the courts will give us answers to the many questions arising therefrom.

New ACA-created classes that are potentially subject to discrimination testing include: (a) consumers; (b) insurers and (c) health care providers.

Consumers

Annual Review of Health Insurance Premiums

HHS, with the states, shall annually review (beginning in 2010) unreasonable increases in health insurance coverage premiums. Health insurance issuers must justify to HHS and the relevant state any unreasonable premium increase prior to implementation. State insurance commissioners shall provide HHS with information regarding premium trends and make recommendations about excluding providers from the Exchange for premium increases. Beginning in 2014, HHS and the states shall monitor premium increases in and out of the Exchange.

Health Insurance Ombudsman

HHS shall award grants to states to establish or expand offices of health insurance consumer assistance or a health insurance ombudsman program. A state office of health insurance consumer assistance or health insurance ombudsman shall (a) assist with the filing of complaints and appeals; (b) collect, track and quantify problems encountered by consumers; (c) educate consumers on their rights and responsibilities regarding health care coverage; (d) assist consumers with enrollment; and resolve problems with premium tax credits.

Information Regarding Coverage Options

HHS, in consultation with the states, will establish a mechanism, including an Internet website, through which an individual may identify affordable health insurance coverage options. Information shall be in a standard format, including information eligibility, availability, premium rates and cost sharing.

Appeal and Grievance Procedures

A health plan must have an effective appeals process for appeals of coverage determinations and claims. Participants must have the ability to receive continued coverage during the review process. A health plan must have an effective internal appeals process, including notice to enrollees of available appeals processes, along with an opportunity to review their file and present evidence.

Uniform Summary of Benefits

All health plans shall use HHS standards for the provision of summary of benefits and coverage explanations. HHS will consult with NAIC to develop standards. Standards shall ensure that outline of coverage: (a) is presented in a uniform format that does not exceed four pages in length and does not include print smaller than 12 point font; (b) is presented in a manner determined to be understandable by the average health plan enrollee; (c) includes uniform definitions of standard insurance terms as well as a description of the coverage, including dollar amount for benefits as identified by HHS; (d) includes the exceptions, reductions and limitations on coverage; (e) includes the cost-sharing provisions; (f) includes the renewability and continuation of coverage provisions; (g) includes examples of common benefit scenarios; (h) includes a statement as to whether the plan provides minimum essential benefits; (i) includes a statement as to whether the plan meets 60% of actuarial value; (j) includes a statement that the outline is a summary; and (k) includes a contact number for the consumer and a web link where a copy of the actual individual coverage policy or group certificate of coverage can be reviewed and obtained. (l) Requirements apply to grandfathered plans as well. Electronic delivery is acceptable 60 day advance notice of modification in a plan is required. These standards preempt any related state standards that require an outline of coverage. An entity that willfully fails to provide the information required under this section shall be subject to a fine of not more than

$1,000 for each such failure. Such failure with respect to each enrollee shall constitute a separate offense. (New PHSA).

Minimum Benefits

Annual and lifetime limits. No lifetime or annual maximums subject to an annual maximum phase-in.

Preexisting. No preexisting conditions subject to a phase-in.

Guaranteed Issue. There must be guaranteed issue and/or guaranteed renewal subject to a phase-in.

Preventive Care. Must be covered without a copay .

Dependent Coverage. Dependent children must be covered to age 26 regardless of student or marital status.

Essential Benefits. Must be at the bronze, gold, platinum or silver levels as determined by actuarially-determined. Benefit value computations.

Nondiscriminatory Benefits. Insured group health plans are prohibited from discriminating in favor of highly compensated Individuals. Parity in mental health and substance use disorder benefits) applies to qualified health benefit plans. A health plan may not establish rules for eligibility (including continued eligibility) of any individual to enroll under the rerms of the plan or coverage based on any of the following health status-related factors in relation to the individual or a dependent of the individual:

(a) health status;
(b) medical condition (including both physical and mental illnesses);
(c) claims experience;
(d) receipt of health care;
(e) medical history;
(f) genetic information;
(g) evidence of insurability (including conditions arising out of acts of domestic violence);
(h) disability; or
(i) any other health status-related factor determined appropriate by the HHS. Wellness programs may condition a premium discount of rebate on an individual satisfying a standard that is related to a health status factor if the plan meets certain requirements. Codifies current HIPAA wellness rules, but increases the wellness incentive limit from 20% to 30%.

Labor, HHS and Treasury may promulgate regulations to effectuate this section and have discretion to increase limit to 50%.

Insurers

Loss Ratio and Cost Accounting

A health shall publicly report (in a manner to be established by the laws) the percentage of total premium revenue that such coverage expends:

- On reimbursement for clinical services provided to enrollees under such plan or coverage;
- For activities that improve health care quality; and
- On all other non-claims costs, including costs associated with compliance with the PPACA, with an explanation of the nature of such costs.

Risk Pooling

Rating: States required to apply rating rules to the individual and small group market. Also applies to large group markets that offer coverage through the Exchange (where states permit such coverage).

Risk Adjustment: Each state shall assess a charge on plan in the individual and small group market (grandfathered plans excluded) if the actuarial risk of the enrollees is less than the average actuarial risk of enrollees in all plans in the state for that year (except self-insured plans). HHS, in consultation with the states, will establish criteria to carry out the risk adjustment.

Reinsurance: By 2014, each state shall establish a reinsurance program. HHS, in consultation with NAIC, shall set standards. Health insurance issuers and self-funded plans are required to contribute to a reinsurance program for individual policies that is administered by a non-profit reinsurance entity.

Risk Corridors: HHS shall establish a program of risk corridors in the individual and small group market, modeled after the program for regional participating provider organizations in Medicare Part D.

Premium Rating Rules. Premium rates in the individual or small group health market may vary only by:
(a) family structure;
(b) community rating area;
(c) actuarial value of the benefit;
(d) age (except it may not vary by more than 3 to 1); and
(e) tobacco use (except it may not vary by more than 1.5. to 1) If a state allows large groups to participate in the Exchange, these rules shall apply.

Insurer's Rebates

A health issuer offering large group coverage issuer shall provide an annual rebate to each enrollee if more than 15% of premium revenue is expended on non-claims costs (excluding taxes) or 20% (or lower by state regulation) for insurers offering coverage in the small group and individual market. States may adopt a higher percentage. Insurance issuers shall report to HHS the ration of incurred claims to earned premiums.

Qualified Benefit Plans

Group health plan must meet certain criteria. Qualified health plans are certified through an Exchange, provide essential health benefits, are offered by licensed issuers that offers at least one silver and one gold plan in each Exchange in which it participates, charge the same premium rate for the same plan whether offered in or out of the Exchange, and comply with applicable Exchange regulations. Self-funded plans and MEWAs are generally not included in the term "health plan.

Providers

Quality of Care Payment Structure

A health plan shall report on plan benefits and structures that provide incentives for:
(a) the implementation of case management, care coordination, chronic disease management, and medication and care compliance activities for treatment or services under the plan or coverage;
(b) the implementation of activities to prevent hospital readmissions;
(c) improving patient safety and reducing medical errors through best clinical practices, evidence based medicine, and health information technology; and (d) the implementation of wellness and health promotion activities. Plans shall report to the HHS annually. Reports shall be made available to enrollees at open enrollment. HHS may define exceptions to the above requirements for insurers that substantially meet the goals provided

Discrimination in Care and Services

A health plan shall not discriminate with respect to participation under the plan against any health care provider. (prohibition against retaliation) Individuals are protected against discrimination under the Civil Rights Act, the Education Amendments Act, the Age Discrimination in Employment Act, and the Rehabilitation Act from exclusion or participation in, or denial of benefits under any health program or activity.

Rx Plans

New disclosure requirements apply to Medicare Advantage plans, qualified health benefits plans offered through an Exchange and PDP sponsors.

Public List of Hospital Changes

Each hospital shall make public a list of the hospital's standard charges. See also Insurance Market Reforms, Annual Premium Review.

Choice of Providers

A health plan may not require a referral or preauthorization for and must provide the same level of cost-sharing out-of-network as is normally provided for emergency care in-network in a hospital where the plan offers coverage for some services. A health plan may not require a referral or preauthorization for female participants who seek coverage fro obstetrical or gynecological care provided by a participating health care professional who specializes in such care. Children may have pediatricians' primary care providers.

Clinical Trials

A health plan may not discriminate against an individual for participating in clinical trial. If plan covers qualified individual, it may not deny or impose additional conditions for participation in clinical trial.