



PPACA Implementation: Consumer Recommendations for Regulators and Lawmakers May, 2010

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Acknowledgements and Disclaimer

These materials were prepared to assist regulators, lawmakers, and the National Association of Insurance Commissioners during the initial phase of the Patient Protection and Affordable Care Act of 2010, (PPACA). Their purpose is to convey the perspectives of policyholder/consumer advocates on appropriate standards and guidelines for implementing PPACA.

The enclosed issue briefs were drafted and/or reviewed by teams of professionals who are currently serving as funded and unfunded consumer representatives at the National Association of Insurance Consumers. The specific recommendations contained in the materials were not presented to the organizations with which the drafters are affiliated for formal endorsement. Therefore, organizational affiliations are listed for identification purposes only. The authors thank and acknowledge NAIC members and staff, as well as the following individuals for their assistance and contributions to the enclosed materials:

Eliza Bangit, Senior Researcher, Georgetown University

Birny Birnbaum, Center for Economic Justice

Claire Borelli, American Diabetes Association

Sally Duran, The American Heart Association

Harvey S. Frey, MD PhD Esq., Health Administration Responsibility Project

Katie Horton, George Washington University

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Andy Kurz, former CFO of Blue Cross of Wisconsin

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Sally McCarty, Former Indiana Insurance Commissioner

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Erin Reidy, American Cancer Society Cancer Action Network

Steven Taffet, Taffet Law, P.C.

Dr. Nancy Turnbull, Harvard School of Public Health

Randall S. Udelman, DeFusco & Udelman, P.L.C.

The authors thank and acknowledge Stefanay Allen, Dragoon Studios, and United Policyholders for design/graphics/report production. www.dragoonstudios.com

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Rate Review Process

Section 1003 of the Patient Protection and Affordable Care Act (PPACA) amends §2794 of the Public Health Service Act. Section 1003 requires the Secretary of the Department of Health and Human Services (HHS), in conjunction with the States, to establish an annual premium review process. It requires health insurance issuers to disclose and justify an unreasonable premium increase prior to implementation of the increase. It requires issuers to post justification for the increase on the issuer's website. The Secretary must ensure public disclosure of information on such increases and justifications for all health insurance issuers. Section 1003 of the PPACA makes \$250,000,000 in grants available to States. The grants are for States to review premium increases during fiscal years 2010 through 2014. The Secretary is required to establish a formula for allocating the grants. No state that qualifies for a grant will receive less than \$1,000,000 or more than \$5,000,000 for a grant year.

Background

Section 1003 of the PPACA amends § 2794 the Public Health Service Act (42 U.S.C. 300gg - 91 et seq.). Section 1003 became effective on the date of enactment of the PPACA.

Section 1003 of PPACA is entitled “Ensuring That Consumers Get Value for their Dollars.” It establishes an initial and a continuing premium review process. It requires the Secretary of HHS, in conjunction with the States, to establish a process for the annual review of unreasonable increases in premiums for health insurance coverage beginning with the 2010 plan year.

Health insurance issuers must submit to the Secretary and the relevant State a justification for an unreasonable premium increase prior to the implementation of the increase. Health insurance issuers must disclose and justify an unreasonable premium increase prior to implementation of the increase. Health insurance issuers must post justification for the increase on the issuer's website. The Secretary must ensure public disclosure of information on such increases and justifications for all health insurance issuers.

Section 1003 of the PPACA makes \$250,000,000 in grants available to States. The grants are for States to review premium increases during fiscal years 2010 through 2014. To qualify for a grant, a State, through its Insurance Commissioner, must provide the Secretary with “trends in premium increases in health insurance coverage in premium rating areas in the State.” The State must also “make recommendations, as appropriate, to the State Exchange about whether particular health insurance issuers should be excluded from the Exchange based on a pattern or practice of excessive or unjustified premium increases.” The Secretary is required to establish a formula for allocating the grants. No state that qualifies for a grant will receive less than \$1,000,000 or more than \$5,000,000 for a grant year.

In plan years beginning in 2014, the Secretary, in conjunction with the States, must monitor premium increases of health insurance coverage offered through an Exchange and outside of an Exchange.

In determining whether to offer qualified health plans in the large group market through an Exchange, the State must take into consideration any excess of premium growth outside of the Exchange as compared to the rate of growth inside the exchange.

Principles That Should be Used to Create Standards

Individual consumers are the ultimate payers of all health care - and health coverage - costs. Even workers in large businesses, whose employer contributes 100% of the insurance premium for the employee, understand that their wages are reduced to reflect the cost of health coverage offered through their employer. Moreover, state courts readily recognize many insurance contracts as contracts of adhesion. In essence, courts recognize the imbalance of economic power between an individual insured and an insurance company. To address this imbalance of power and to create fairness, accountability, and affordability in the setting of insurance rates, consumers, whether individual policyholders or certificate holders in group plans, are entitled to the following:

- A regulatory review process for rate filings that places the interest of policyholders and certificate holders first and foremost;
- A fair and thorough regulatory review process that is conducted before a rate filing can be implemented;
- A regulatory review process that is accessible to the public, provides opportunities for affected policyholders and certificate-holders to participate, and includes public comment periods during which policyholders and certificate-holders can attend on an after-business hours or weekend basis in various geographic locations where large numbers of policyholders and certificate-holders live;
- Sufficient advance notice of a rate filing to enable policyholders and certificate holders to meaningfully prepare for and participate in rate review process;
- Access to all of the information filed by the health insurance issuer in a rate filing including all accompanying documentation;
- A standard of review that determines not only whether a rate filing is “reasonable” but also “necessary;”
- A regulatory process in which the regulator has the authority to require health insurance issuers to refund or return premiums in excess of medical loss ratios set;
- A regulatory process in which the regulator can consider factors such as profitability and surplus/reserves across lines of business in making a determination as to whether a rate filing is “unreasonable;” and
- A regulatory process in which the regulatory agency has the resources necessary to competently and aggressively review and evaluate the assumptions and justifications for the filing.

Recommendations

In order to ensure fairness, affordability, and accountability, we believe that the NAIC should create and adopt a national standard of rate review that at a bare minimum, include:

- 1) authority of insurance departments to review proposed rate filings and authority to approve or disapprove them before they go into effect;
- 2) a definition of “rate filing” that includes new and renewed premium rates, any proposed rating formula, classification of risks, or modification of any formula or classification of risks;
- 3) a standard of review that places the burden of proof on the health insurance issuer to demonstrate that the proposed rate filing is not unreasonable, unnecessary, inadequate, or unfairly discriminatory;
- 4) a standard of review that establishes specific criteria that the health insurance issuer must meet before approval can be granted;
- 5) a standard of review that establishes additional factors that the commissioner should consider when making a determination as to whether filed rates are “reasonable;”
- 6) a process that requires the health insurance issuer which fails to meet an established medical loss ratio to refund excess premium collected to policyholders and certificate-holders;

- 7) transparency in the rate filing process that make all filings and all accompanying documentation public record, thereby removing the trade secret and other exceptions to disclosure;
- 8) sufficient advance notice to policyholders and certificate-holders to enable them to participate in or comment on rate filing processes; insurance departments should provide a well-publicized and meaningful process for consumers to participate in and provide input into rate reviews and hearings; insurance departments conducting rate reviews should offer consumers after business hours or weekend hearings for public comment sessions;
- 9) a process that requires the health insurance issuer to post their rate filing to their website;
- 10) a process that requires the department of insurance to post to its public website information about the rate filing and justification in easy to understand language for the public;
- 11) a process that allows the commissioner, the state Attorney General, or an affected policyholder or certificate holder to request a hearing be conducted in the rate filing; and,
- 12) increased capacity within insurance departments to meaningfully and adequately review rate filings employing competent actuaries, economists, and consultants.

Individual and small group market rate review standards

Policy	Purpose	Proposed Model Act Language
Notice to Policyholders and Certificate-holders	Provides policyholders and certificate holders with advance notice of a rate request in order to have adequate time to budget for increase, gather information about alternative benefit options, provide information to insurance department regarding rate request, participate in rate hearing or approval process, or change insurer.	Every insurer offering individual and small group health plans as defined in section XXXX must provide written notice by first class mail of a rate filing to all affected policyholders and certificate holders at least 90 days but no earlier than 120 days before the effective date of any proposed increase in premium rates or any proposed rating formula, classification of risks, modification of any formula or classification of risks. The notice must also inform policyholders and certificate holders of their right to request a hearing pursuant to section XXXX and any scheduled public hearing dates or public comment opportunities. The notice must state the proposed rate, proposed effective date, and state that the rate is subject to regulatory approval. The superintendent [commissioner] may not take action on a rate filing until 30 days after the notice is mailed and may not take final action until 60 days after the notice is mailed by an insurer. An increase in premium rates may not be implemented until 90 days after the notice is provided or until the effective date under section XXXX, whichever is later.

Policy	Purpose	Proposed Model Act Language
Rate Filing Requirements	Defines what the insurer must file, in what format, when, and with whom. Provides for the superintendent [commissioner] to suspend the filing period for compliance reasons.	Every insurer shall file for approval with the superintendent [commissioner] every rate, rating formula, classification of risks and every modification of any formula or classification that it proposes to use in connection with individual health insurance and small group policies [and certain group policies specified in section XXXX]. If the filing applies to individual or small group health plans as defined in section XXXX, the insurer shall simultaneously file a copy with the Attorney General. Every such filing must state the proposed effective date of the filing. Every such filing must be made not less than 90 days in advance of the proposed effective date, unless the 90-day requirement is waived by the superintendent, and the effective date may be suspended by the superintendent for a period of time not to exceed 30 days. In the case of a filing that meets the criteria in subsection XX, the superintendent may suspend the effective date for a longer period not to exceed 30 days from the date the organization satisfactorily responds to any reasonable discovery requests. A filing required under this section must be made electronically in a format required by the superintendent unless exempted by rule adopted by the superintendent. Rules adopted pursuant to this subsection are routine technical rules as defined in [State APA Statute].
Rate Filings Are Public Records	Provides transparency and disclosure to policyholders and the public.	A filing and all supporting information, except for protected health information required to be kept confidential by state or federal statute are public records notwithstanding Title XXX, Chapter XXX, subsection XXX [specific provision(s) in the state Freedom of Information Act, e.g., trade secret or information not subject to court discovery] and become part of the official record of any hearing held pursuant to section XXXX. When a filing is not accompanied by the information upon which the insurer supports such filing, or the superintendent does not have sufficient information to determine whether such filing meets the requirements that rates not be unreasonable, unnecessary, inadequate, or unfairly discriminatory, the superintendent shall require the insurer to furnish the information upon which it supports the filing. The insurance department shall publish the rate filing on its website and include an explanation of the rate filing, the basis for the rate filing, and terms used in the rate filing in easy to understand language that will provide the public with information that they need in order to comment on or participate in the rate review process.
Standard of Review	Defines legal standard that insurer must meet in order to receive regulatory approval of its rate filing.	In any filing or in any hearing conducted under this [chapter of the insurance code], the insurer has the burden of proving that rates are not unreasonable, unnecessary, inadequate, or unfairly discriminatory.

Policy	Purpose	Proposed Model Act Language
Right to Hearing; Superintendent/ Commissioner Order	Provides affected policyholders, affected certificate-holders, superintendent, or Attorney General with right to request a hearing.	If at any time the superintendent has reason to believe that a filing does not meet the requirements that rates not be unreasonable, unnecessary, inadequate, unfairly discriminatory or that the filing violates any of the provisions of this [chapter of the insurance code], the superintendent shall cause a hearing to be held. If a filing proposes an increase in rates in an individual or small group health plan as defined in section XXXX, the superintendent shall cause a hearing to be held at the request of the Attorney General. If the superintendent does not cause a hearing to be held at his or her request or if the Attorney General does not request a hearing, any affected policyholder or certificate-holder. Where an affected policyholder or certificate-holder requests a hearing be held, the superintendent shall hold such hearing. Hearings held under this section must conform to the procedural requirements set forth in Title XXX, chapter XXX, subchapter XXX [adjudicatory provision of the state's Administrative Procedures Act]. In any hearing conducted under this section, the insurer has the burden of proving rates are not unreasonable, unnecessary, inadequate, or unfairly discriminatory and in compliance the provisions of this chapter [of the insurance code]. The superintendent shall issue an order or decision within 30 days after the close of the hearing or of any rehearing or reargument or within such other period as the superintendent for good cause may require, but not to exceed an additional 90 days. In the order or decision, the superintendent shall either approve or disapprove the rate filing. If the superintendent disapproves the rate filing, the superintendent shall establish the date on which the filing is no longer effective, specify the filing the superintendent would approve and authorize the insurer to submit a new filing in accordance with the terms of the order or decision.

Policy	Purpose	Proposed Model Act Language
80% MLR Requirement; Policyholder and Certificate-Holder Refund	Establishes an 80% MLR for the coverage period; excludes quality improvement, wellness programs, and cost containment measures from inclusion in the loss ratio calculation;	<p>Rates subject to this subsection must be filed for approval by the superintendent. The superintendent shall disapprove any premium rates filed by any insurer, whether initial or revised, for an individual health plan [and certain group policies specified in section XXX] or small group health plan unless it is anticipated that the aggregate benefits estimated to be paid under each of the individual health plans or each of the small group health plans maintained in force by the insurer for the period for which coverage is to be provided will return to policyholders and certificate-holders at least 80% of the aggregate premiums collected for those policies or such higher amount as may be set under state law, as determined in accordance with accepted actuarial principles and practices and on the basis of incurred claims experience and earned premiums. Medical loss ratios shall be calculated separately for each small group and for each individual health plan. For the purposes of this calculation, expenses of or related to wellness programs or cost containment must not be included in the calculation. If incurred claims were less than 80% of aggregate earned premiums during the period for which coverage is to be provided, the insurer shall refund a percentage of the premium to the current in-force policyholders. The excess premium is the amount of premium above that amount necessary to achieve an 80% loss ratio for each of the insurer's individual health plans during the period of coverage. The refund must be distributed to policyholders and certificate-holders in an amount reasonably calculated to correspond to the aggregate experience of all policyholders and certificate-holders holding policies or certificates having similar benefits. The total of all refunds must equal the excess premiums.</p> <p>The superintendent may require further support for the unpaid claims estimate and may require refunds to be recalculated if the estimate is found to be unreasonably large or not in compliance with the calculation requirements of this [section].</p> <p>The superintendent may adopt rules setting forth appropriate methodologies regarding medical loss ratio factors, reports, refunds and credibility standards pursuant to this subsection. Rules adopted pursuant to this subsection are routine technical rules as defined in Title XXX, chapter XXX, subchapter XXX [the state's APA].</p>

Policy	Purpose	Proposed Model Act Language
Standards Before Approval Can Be Granted; Additional Factors For Consideration	Sets standards that must be met before the superintendent can grant approval. Allows superintendent to take into consideration various additional factors in approving or disapproving a rate filing.	<p>Standard for approval. The following standards apply to the making and use of rates pursuant to this section.</p> <p>A. Rates are determined not to be reasonable and necessary if the rates are likely to produce a profit from business in this State that is unreasonably high in relation to the benefits provided, the surplus requirements and the surplus available, or if expenses are unreasonably high in relation to the benefits provided.</p> <p>B. Rates are determined not to be reasonable and necessary if the rate structure established by a stock insurance company provides for replenishment of surpluses from premiums when replenishment is attributable to investment losses.</p> <p>C. Rates are determined to be inadequate if the rates are clearly insufficient, together with investment income attributable to the rates, to sustain projected losses and expenses for the benefits provided.</p> <p>D. Rates are determined to be unfairly discriminatory if price differentials fail to equitably reflect the differences in expected losses and expenses or the rates fail to clearly and equitably reflect consideration of the policyholder’s participation in a wellness program or clinically accepted course of preventive care.</p> <p>Factors to be considered. In determining whether the standards in subsection XXX [Standard for approval] have been met, the factors considered by the superintendent may include but are not limited to:</p> <p>A. The past and prospective net underwriting gains of the insurer from the line of insurance for which the insurer seeks rate approval and from all of its lines of insurance;</p> <p>B. The past, current and reasonably expected surplus levels of the carrier anticipated in the filing;</p> <p>C. Investment income reasonably expected by the carrier from premiums anticipated in the filing, plus any other expected income from currently invested assets representing the amount expected on unearned premium reserves and loss reserves;</p> <p>D. The degree of competition in the market for which the rate approval is sought and in the overall health insurance market;</p> <p>E. The degree to which testimony offered by the carrier in support of the components of its requested rates is supported by written evidence such as analyses, reports or studies; and</p> <p>F. The profit and risk charge included in the previous year’s rate filing and the profit actually achieved.</p> <p>G. Historical and projected administrative costs, and the reasonableness of administrative expenses;</p> <p>H. Reasonableness of executive compensation;</p> <p>I. Anticipated change in the number of enrollees by rate class if the proposed premium is approved;</p>

Policy	Purpose	Proposed Model Act Language
		<p>J. Affordability and equity of the premium structure, given community needs and the insurer's mission;</p> <p>K. Profitability, surplus, reserves, and investment earnings of the issuer over time; rates should be set at the minimum level necessary to ensure solvency, contribute to affordability, maintain rate stability, and deliver quality care.</p> <p>L. Changes in covered benefits and plan design;</p> <p>M. The insurer's health care cost containment and quality improvement efforts, and their results.</p>
Blocks of Business	Prohibits health insurance issuers from closing blocks of business to meet rating or other requirements	<p>1) No block of business shall be closed by a health plan unless (1) the plan permits an enrollee to receive health care services from any block of business that is not closed and which provides comparable benefits, services, and terms, with no additional underwriting requirement, or (2) the plan pools the experience of the closed block of business with all appropriate blocks of business that are not closed for the purpose of determining the premium rate of any plan contract within the closed block, with no rate penalty or surcharge beyond that which reflects the experience of the combined pool.</p> <p>(2) A block of business shall be presumed closed if either of the following is applicable:</p> <p>(a) There has been an overall reduction in that block of 12 percent in the number of in force plan contracts for a period of 12 months.</p> <p>(b) That block has less than 1,000 enrollees in this state. This presumption shall not apply to a block of business initiated within the previous 24 months, but notification of that block shall be provided to the director pursuant to subdivision (c).</p>
Insurance Department Capacity	Funds available to cover the costs of actuaries, financial analysts, economists, or other experts to assist superintendent/commissioner to review and determine whether rates meet state standards or to act as expert witnesses in rate hearings.	
Consumer Participation in rate hearings	To ensure balanced rate review proceedings	<p>Consumer Participation. (a) Any person who intervenes in any proceeding permitted or established pursuant to this chapter, may challenge any action of the commissioner under this [section or provision], and enforce any provision of this article.</p> <p>(b) The commissioner or a court shall award reasonable advocacy and witness fees and expenses to any person who demonstrates that (1) the person represents the interests of consumers, and, (2) that he or she has made a substantial contribution to the adoption of any order, regulation or decision by the commissioner or a court. Where such advocacy occurs in response to a rate application, the award shall be paid by the applicant.</p>



Consumer Ombudsman Program

Grants for Ombudsman Programs

Section 2793 of the Public Health Act, as amended by Section 1003 of the Patient Protection and Affordable Care Act (PPACA) calls for HHS to provide grants to states to establish and operate independent offices of health insurance consumer assistance or health insurance ombudsman programs. Consumer advocacy groups whole heartedly support this program and want to ensure the offices have the independence, resources and authority and are organized to best serve the interests of consumers.

Background

The PPACA makes \$30 million in the first fiscal year for health insurance consumer assistance or health insurance ombudsman programs, with additional funding for later years. These programs, which we refer to as ombudsman programs for the purposes of this brief, are to:

- Assist with the filing of complaints and appeals;
- Collect, track, and quantify problems and inquiries;
- Educate consumers on their rights and responsibilities;
- Assist consumers with enrollment in plans; and
- Resolve problems with obtaining subsidies.

As a condition of receiving a grant, a state must collect and report to HHS data on the types of problems and inquiries encountered by consumers. The data shall be used to identify areas where enforcement action is necessary and shall be shared with state insurance regulators, the Secretary of Labor and the Secretary of Treasury.

Principles For Allocating Grant Funds

Grant dollars should be allocated to fund high-quality programs and reach consumers with the greatest need.

Characteristics of a “good” ombudsman/consumer assistance program include:

- Projects completed or in process that document their skill at policy advocacy, intervention on behalf of consumers, or successful outreach or educational efforts.
- Prepared to assist consumers who have limited English proficiency, low health literacy, and/or limitations that make it difficult for them to make informed health care choices.
- Demonstrates their independence as a consumer assistance organization by submission of documentation regarding their mission as primarily serving consumers. The bill requires that the ombudsman operate an *independent* office. Ombudsman programs must be independent so they can assist consumers in filing appeals and focus on the consumer’s side of the case.

- Protects the consumers' confidentiality, yet includes mechanisms to access the data needed to resolve the consumers' problems.¹ To that end, the program should have or establish good working relationships, with relevant state agencies including the health insurance regulatory agencies. Ombudsman programs should also secure provider/insurer cooperation working within the patient privacy protections afforded by HIPAA.² Finally, it is critically important that ombudsman programs coordinate with insurance departments to address violations of state insurance laws.³
- Regularly reports to legislators and the public, so policymakers benefit from the valuable and timely information about problems consumers face in the health care system. Data collection and reporting is key to systemic change. Quarterly aggregated consumer data should specify plan names and patient gender, age, location and condition. This data should inform consumers and purchasers of health care regarding the number, content, and resolution of inquiry and complaints. This data should be readily accessible to the public.
- Ensures that consumers get information about the Ombudsman program at the points they most need such assistance. For example, plans should notify consumers of the availability of these programs on coverage determination notices.
- Is adequately staffed and has the resources to competently and efficiently assist consumers with a wide range of grievances and other substantive tasks. Staff training must include detailed knowledge of state and federal laws regarding health insurance and group health plans. Staff knowledge must also include capacity to help resolve consumer problems with obtaining subsidies.

Problems That Consumers Might Encounter

The new grant funds won't help consumers unless they are aware of these resources. Unfortunately, many consumers don't know about the assistance resources available to them today. For example, no participant in a 2006 Consumers Union focus group was aware of the state health insurance resources available to them.⁴

Consumers should not have to struggle to determine regulatory jurisdiction if they have a complaint. States should avoid having the consumer be batted back and forth between the ombudsman office and insurance department. Ideally, the state will establish a "no wrong door" policy and insurance department staff and the consumer assistance department will work seamlessly and cooperatively to ensure the consumer receives the correct services.

Consumers need a coherent system of for tracking complaints and letting them influence policy. Today's multiplicity of agencies involved in oversight of health insurance plans makes it difficult to develop a comprehensive picture of how well insurance plans are performing on consumer complaints.⁵ Many other federal, state and private agencies are also involved in oversight of health insurance plans or complaints management. There is no system or universal model of health insurance complaints management across these states and federal agencies.⁶

Recommendations

Grants to the states must be conditioned on meeting specified standards that ensure the goals of the program are realized, maximum benefit for consumers is obtained, and maximum value for tax payer dollars achieved. To that end, we recommend that priority be given to grant applicants that:

Demonstrate a Broad Ability to Help Consumers

- Grant applicants should be empowered to direct people to coverage, take and respond to complaints, and advocate with regulators, health plan internal appeals panels, and external reviewers on consumers' behalf.
- Have access to relevant data collected at relevant state agencies (e.g., complaints lodged with state attorneys general or the insurance department). In addition, ombudsmen need strong working relationships with staff in the other relevant agencies.
- Grant applicants should explain their plans for tracking complaints, which can be complex, including whether it seeks to aggregate complaints data from other agencies. Some complaints may be filed directly with the state regulatory agency, others may go to the insurance company directly and be resolved/not resolved there, others may go to a private attorney in the case of an individual who wants to sue.
- Grant applicants should demonstrate an intention and capacity to analyze and publicly report consumer complaint data they receive (in addition to forwarding it to HHS), in an effort to proactively assist consumers. For example,

a pattern of similar complaints might indicate that the office should contact the insurer being cited or issue a consumer advisory. Grant applicants should demonstrate a willingness to use their casework to aid in state and local policy development.⁷

- In their consumer education efforts, grant applicants should indicate they will proactively identify the type of information that is most useful to consumers. These consumer materials should be appealing, use plain language, be written in the languages of state residents, and be understandable by those with lower literacy levels.⁸ Applicants should use a variety of methods to “push” this information out to consumers so it is available when they need it (for example, at the point where they are purchasing an insurance policy or at the doctor’s office). Educational efforts that rely on consumers to visit the website on their own initiative are insufficient.
- Grant applicants should document the independence of the ombudsman program they propose to fund. Independence can be enhanced through legislative authority and dedicated funding.⁹ If the applicant part of a state agency, documentation should specify all relevant reporting lines. If a free-standing non-profit, this documentation should also include governance structure, organizational funding, and board composition (which should be free from conflicts of interest involving plans, providers and pharmaceutical and device manufacturers). The ombudsman office should have no other programmatic responsibility than to assist consumers with complaints and educate them as to their insurance coverage options as set forth in the Patient Protection and Affordable Care Act.¹⁰

Demonstrate Easy Consumer Access

- Grant applicants should demonstrate the myriad ways in which they will make consumers aware of their office and services. For example: including a toll-free number staffed during hours that go beyond 9-5 weekdays; perhaps social media such as Facebook; coalitions with state organizations and agencies who educate and assist health care consumers, and a welcoming physical and online presence (institutional look/government look can be off putting; some people who need help may deeply distrust the government).
- A state law should require health plans to provide, in all consumer-facing materials, contact information for the office.
- Grant applicants should designate a central entry point for health insurance consumer complaints with referrals to other agencies as relevant. If state responsibility for insurance products is split across several agencies, this should be invisible to the consumer.¹¹ They should state their intent to establish a cooperative relationship with other relevant agencies and consumer groups and provide transfers to the correct agency/consumer help organization if the consumer problem is beyond their mandate.

Demonstrate Ability and Willingness to Contribute to a National Knowledge Bank of Consumer Experiences

- Applicants should demonstrate they will track and analyze complaints by health status, age, race, ethnicity, language, geographic location and gender¹² in order to identify any problems that particular populations are facing, and make timely and regular reports of this information to the public.
- HHS should work with programs to establish a simple, standardized reporting format and common definitions of terms (such as what constitutes a complaint).¹³ HHS, after public comment, should determine what common data elements should be reported the first year, and then further enhance data reporting in future years as grants continue. They should also use the standard insurance/medical terms required as part of PHSA Section 2717. Report to the federal government on how they are spending the grant dollars, and make this report publicly available.

It makes sense that ombudsman program duties be construed as broadly as possible, allowing flexibility for varying needs among the states. At minimum, ombudsman offices should serve as a portal for consumers to complain about plan behavior in enrollment and appeal handling, and consumer access to subsidies; and as an information source to help consumers understand public and private insurance options, supplementing what the State Exchanges may provide.¹⁴ Prior to soliciting grant applications, HHS should clarify the following with respect to the scope of their duties:

- Are the ombudsman programs expected to help with complaints filed with insurers or also with complaints filed with the insurance department (e.g., in a case where the consumer didn’t get a satisfactory response from the company or what about a complaint about the insurance department itself)?
- Will insurance departments refer consumers with complaints to the ombudsman offices and/or vice versa?
- Are ombudsman programs responsible for helping consumers enrolled in ERISA plans?

- Are ombudsman programs responsible for helping eligible small employers obtain tax credits as well as helping individuals to get subsidies? If not, who is?

As a condition of getting a grant, PPACA requires that states collect and report data on the types of problems encountered by consumers, as well as other types of inquiries. We recommend that HHS take their own steps to maximize the utility of the information being reported by grantees:

- HHS should standardize the reporting format and establish common definitions of terms (such as what constitutes a complaint). For example, HHS may want to distinguish between: complaints where the insurance company is not at fault compared to those where it is at fault. HHS may also want to track at what stage the issue was resolved (e.g, whether it required a formal internal appeal or was resolved through the external appeals process with a third party) and the number of days to resolution. Further, HHS should work with programs to determine what categories of complaints are useful to track. For example, in addition to tracking complaints and appeals regarding denials by diagnoses (a common data element in many states), HHS may want to track complaints about pre-existing condition exclusions, rate-ups, benefit limitations, etc. The use of standardized reporting format and common definitions of terms will allow the agency, states, and consumer advocates to effectively assess trends and respond to issues across states and regions. These standard terms should also be consistent with the standard insurance/medical terms required as part of PHSA Section 2717.
- HHS should develop a strategy for incorporating consumer complaint data from non-grantee states and the other federal and private agencies that receive complaints about health insurance (such as the SHIP offices for seniors or DOL for ERISA plans). HHS must move toward a coherent system for analyzing health insurance complaints management across the states and federal agencies so we have a truly comprehensive picture of how well insurance plans are performing from the perspective of the consumer.
- HHS should use the information provided by states to help guide the necessary standards and rules for the reforms scheduled to take effect in 2014. The information also should be available to researchers under the HIPAA constraints for health services research.

Finally, we recommend that HHS provide resources to help ensure the success of the grantees and the wise use of tax payer dollars:

- States that do not currently have this capability may be reluctant to apply. HHS should encourage them to do so, and help arrange for mentoring by states or non-profit organizations that already have strong, centralized consumer health insurance assistance programs.
- Provide an easy-to-use summary of best practices (commission one if necessary), and a list of experts to provide just-in-time assistance, as necessary.
- Require grantees to document their successes and failures, in such a way that helps future grantees and contributes to an accessible, usable store of knowledge.
- HHS should require and fund annual face to face training events and develop materials by consultation with grantees. HHS could use the services of an outside entity [nonprofit organization] that has experience with consumer assistance to provide this type of back-up support.

We encourage you to look at programs such as Connecticut's Office of the Healthcare Advocate and the consumer assistance programs run by Health Care for All in Massachusetts (the HelpLine), The Health Consumer Alliance in California, and the Community Service Society of New York as proven models of providing consumers with assistance on health insurance issues.

END NOTES

- ¹ Protecting the consumers confidentiality, while still bringing the maximum resources to bear to help the consumer, is tricky proposition. Insurers will try to get out of talking to anyone except the insured or the commissioner's office. Also, the ombudsman may need access to records that the insurance company has and may not want to share.
- ² To clarify, HIPAA applies to providers and health plans, not to state agencies except insofar as they are business partners. Usually, programs have HIPAA-compliant authorization forms that let them talk to insurers. States have to enter into business partner arrangements if they do this with a nonprofit so that they can share info (regarding Medicaid eligibility, for example) easily and in a HIPAA-compliant way.
- ³ Insurance departments have traditionally seen themselves as responsible for closely related tasks such as assisting with filing complaints (in the technical sense, not substantive appeals write-ups), collecting, tracking and quantifying problems and inquiries, and educating consumers on their rights and responsibilities. In many cases, insurance departments administer an external appeals system for state-licensed plans.
- ⁴ Michael Wroblewski. "Uniform Health Insurance Information Can Help Consumers Make Informed Purchase Decisions," *Journal of Insurance Regulation*, 2007;26(2):21-37.
- ⁵ These include the U.S. Department of Labor, the federal Centers for Medicare and Medicaid Services (CMS), state Medicaid agencies, the federally funded SHIP program providing counseling and assistance to seniors on health insurance and many private assistance programs targeting condition-specific populations.
- ⁶ <http://aspe.hhs.gov/health/Reports/consumer/phi/conclusion.htm>
- ⁷ The Sacramento-based Center for Health Care Rights, part of the Health Consumer Alliance in California, is a strong example of using casework to drive policy advocacy. For example, the Center for Health Care Rights is particularly active in using information derived from its consumer hotline to undertake what it calls "evidence-based advocacy". Hence the Center publishes policy reports with concrete recommendations directed at health plans, providers, policymakers and regulators on reforms necessary to improve the health system. See: <http://aspe.hhs.gov/health/Reports/consumer/phi/conclusion.htm>
- ⁸ A criteria could be adapted from a recent CA law, (SB 853): "These materials should be written in any language shown to represent the language spoken at home by at least 5% of the state's population or corresponds to the specific required languages for communication with the highest percentages of consumers enrolled in public programs in the state (Medicaid, food stamps, general assistance, TANF etc.). All written communication should be in readable sans serif fonts that exceed the minimum font size standard reflected in academic research, currently 12-point font or larger. Interpretation services should be available for a consumer based on their request by utilizing multi-lingual staff, video medial interpretation technology, telephonic language assistance lines, or other language assistance technology that becomes available in the future. Educational efforts and consumer counseling should available not only in multiple languages corresponding to the languages spoken/read in the state, but also available via TTY lines for the hearing impaired or in Braille or by recording for the visually impaired."
- ⁹ For example, the Vermont Health Care Ombudsman has legislative protection "to speak on behalf of consumers...without being subject to any retaliatory action". The Vermont Health Care Ombudsman also has funding guaranteed under a contract, in contrast to the absence of funding in the authorizing legislation for the ombudsman program in Texas. See: <http://aspe.hhs.gov/health/Reports/consumer/phi/conclusion.htm>
- ¹⁰ The act allows for the Secretary to award grants to exchanges to establish, expand or provide support for an office of consumer assistance. Generally, we recommend against exchanges establishing their own ombudsman programs that are in addition to the independent office serving other consumers, although there maybe configurations where this could work smoothly if there are very clear lines of reporting.
- ¹¹ In 2000, in at least three states (California, Maryland and New York), responsibility for indemnity health insurance and HMOs is split across two government agencies.
<http://aspe.hhs.gov/health/Reports/consumer/phi/conclusion.htm>
- ¹² We recognize that collecting some of this information may be difficult, as it may be off-putting to the person requiring assistance. They may, for example, resist questions about their age and ethnicity, wondering what this has to do with their insurance complaint. If the ombudsman program can get address and zip code information (which most people don't resist supplying) then the program can at least say this person lives in an area whose population is predominantly low-income and African American.
- ¹³ Colorado can provide an example. Consistent reporting across states would also be valuable to insurance departments doing market conduct exams.
- ¹⁴ SHIPs now play this latter role with respect to Medicare and Medigap and may be a good model.



Grandfathering Principles

Grandfathered Plans

Patient Protection and Affordable Care Act (PPACA) “grandfathers” health plans in existence on the date of enactment, exempting them from many insurance market reforms. The Consumer Representatives to NAIC strongly support the market reforms and consumer protections required under PPACA. We recommend setting reasonable, well defined limits on a health plan’s ability to maintain grandfathered status through federal regulation to ensure that the law fulfills its promise for the maximum number of patients and consumers. Our recommendations include:

- Ensuring that any change to coverage in a grandfathered health plan results in the loss of grandfathered status;
- Granting an exception that allows a plan to make changes while maintaining grandfathered only for plan changes that benefit all enrollees;
- Applying limits to grandfathering equally to all fully insured and self-insured plans; to active employee and retiree plans; and both before and after full reform take effect in 2014; and
- Requiring that plan sponsors annually notify enrollees of a plan’s grandfathered status and explain reform provisions that do not apply.

Background and Discussion

Section 1251 of the Patient Protection and Affordable Care Act (PPACA) “grandfathers” health plans in existence as of the date of enactment, March 23, 2010. Grandfathered plans are exempt from many insurance market reforms and benefits, with the exception of a few specific reforms enumerated in PPACA and the Health Care Education Reconciliation Act of 2010 (HCERA). Current enrollees may renew grandfathered coverage, new employees may enroll, and dependents can be added without a plan losing grandfathered status. Otherwise, PPACA is silent on whether grandfathered plans can make changes without having to come into compliance with all reform provisions, creating a need for regulatory guidance on the scope of exceptions for grandfathered plans.

Allowing grandfathered plans to avoid compliance with many reforms that apply to new plans creates several issues for consumers.

- Grandfathering is a loophole in the promise of health reform that could prevent many consumers from fully benefiting from increased consumer protections and standards. The table on page 2 lists key provisions of the health reform law that do and do not apply to grandfathered plans.
- Most consumers are covered through an employer, and regardless of their wishes, are not free to choose whether that employer coverage will remain in a grandfathered plan or move to a plan that contains improvements made through health reform.

Apply to Grandfathered Plans	Do NOT Apply to Grandfathered Plans
<ul style="list-style-type: none"> • Prohibition on dollar-value lifetime limits [1001: 2711; 10101(a); 2301 of HCERA] • Restriction of annual limits (in group coverage) [1001: 2711; 10101(a); 2301 of HCERA] • Prohibition on rescissions [1001: 2712; 2301 of HCERA] • Dependent coverage for children until age 26 (before 2014, only if child lacks access to employer-sponsored coverage) [1001:2714; 2301 of HCERA] • Uniform explanation of coverage documents [1001:2715; 10101(b); 10103(d)] • Medical loss ratio reporting and rebates [1001: 2718; 10101(f); 10103(d)] • 90-day limit on waiting periods [1201: 2708; 10103(b); 2301 of HCERA] • No denials for pre-existing conditions for children in 2010 (in group coverage) [1201:2704; 10103(e); 2301 of HCERA] • No denials for pre-existing conditions for everyone in 2014 [1201:2704; 10103(e); 2301 of HCERA] 	<ul style="list-style-type: none"> • Restriction of annual limits (in individual coverage) [1001: 2711; 10101(a); 2301 of HCERA] • Preventive health benefits available with no cost sharing [1001: 2713; 1302 (b)] • Plain language disclosure of data on health plans [1001:2715A as added by 10101(c)] • Prohibition on coverage discrimination based on salary [1001:2716; 10101(d)] • Annual reports on health care quality and care coordination [1001:2717; 10101(e)] • Strengthened internal and external appeals processes [1001:2719; 10101(g)] • Choice of participating PCPs including pediatricians; direct access to OBGYNs [1001:2719A as added by 10101(h)] • No prior approval and higher out-of-network cost sharing for emergency services [1001:2719A as added by 10101(h)] • Review of unjustified premium increases [1003:2794; 10101(i)] • Modified community rating [1201: 2701; 1301; 1312(c); 10103(a); 10104(a)] • Guaranteed issue and renewability [1201: 2702-3] • No denials of pre-existing conditions for children (in individual coverage) [1201:2704; 10103(e); 2301 of HCERA] • Prohibition on health status discrimination [1201:2705] • Prohibition of health plan discrimination of providers, individuals, and employers [1201: 2706] • Essential benefits package [1201:2707; 1301; 1302; 10104(a) and (b)] • Limits on annual cost-sharing exposure [1201:2707(b); 1302(c)] • Transitional reinsurance in individual market, transitional risk corridors, and risk adjustment [1341-3; 10104(r)] • Coverage for approved clinical trials [10103]

- Insurers and health plan sponsors may look for ways to use the two different sets of rules created by grandfathering to their advantage, to the detriment of consumers. For example, insurers may attempt to segment “good” and “bad” risks between grandfathered and new plans, resulting in higher costs for older and less healthy enrollees. Incentives for health plans to game the system may be especially pronounced in retiree health plans, a major concern for early retirees who are not yet eligible for Medicare.
- Grandfathering will create confusion for consumers. Because some health reform provisions apply to grandfathered plans while others do not, it will be difficult for consumers to determine whether their policy has or should have new rights and benefits. This complexity may make it harder for consumers to get accurate assistance when needed from employers, brokers, and regulators.
- Grandfathering requires federal and state regulators to operate a dual regulatory system with different rules for grandfathered and new plans, resulting in the need for more aggressive oversight to protect consumers.

Consumer Principles Related to Grandfathered Plans

- Federal and state regulators should protect consumers by setting reasonable, well defined limits on a health plan's ability to maintain grandfathered status.
- These state and federal rules should anticipate and mitigate opportunities for health plans to exploit differing rules that apply to grandfathered and new plans, to the detriment of consumers.
- Consumers should be able to easily identify whether their coverage is grandfathered or not and clearly understand the benefits and protections not included in grandfathered coverage.

Recommendations

- Federal regulators should ensure that any change to coverage in a grandfathered health plan, other than changes explicitly required by PPACA and HCERA, results in the loss of grandfathered status. For example, benefit changes not required by law, cost sharing increases, and wellness program modifications should terminate a plan's grandfathered status.
- An exception that allows a plan to make changes while maintaining grandfathered status should be made only for plan changes that benefit all enrollees. Federal regulators must create a clear and rigorous standard of what changes constitute a benefit to all enrollees that is not open to manipulation. It must:
 - Count as improvements only changes that leave no individual enrollee worse off,
 - Not rely on changes in plan actuarial value to determine a plan improvement (such changes can mask cost-sharing changes that benefit certain types of enrollees but leave others worse off), and
 - Not use a concept of “net benefit improvement”, i.e. allowing some benefit improvements to offset other reductions.
- Limits on grandfathering should apply equally to all fully insured and self-insured plans; to active employee and retiree plans; and both before and after full reform take effect in 2014.
- U.S. Department of Health and Human Services regulations should clarify that it is not the intent of the law that new individuals can enroll after March 23, 2010 in grandfathered plans—except for the clear exceptions specified in the Act (e.g., only for family members of individuals in grandfathered plans (sec. 1251(b)) and new employees in group plans and their dependents (sec. 1251(c)). Fully insured health plans approved by state regulators and marketed before enactment that are sold as of March 24, 2010 to new enrollees (not renewals) to anyone but the individuals excepted above, should be considered a new plan, one which does not have grandfathered status.
- Federal and state regulators should require plan sponsors of grandfathered plans to annually disclose the plan's grandfathered status to enrollees with an explanation of what health reform benefits do not apply because of the plan's grandfathered status.
- States regulators should close any remaining loopholes by reforming state laws applicable to grandfathered plans so that they meet federal standards for new plans. The NAIC should adopt model laws that assist states with this effort.

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High Risk Pool

Immediate Consumer Disclosure Standards

The Patient Protection and Affordable Care Act (PPACA) calls on HHS, with help from the NAIC, to develop a uniform insurance disclosure form. The goal of this form is to help consumers understand and compare health insurance policies including cost-sharing and covered benefits. These new requirements are a tremendous gain for consumers, who typically struggle to understand the provisions of their policies.¹ In this draft, we provide recommendations designed to ensure that these new insurance disclosures are appealing, readily understandable, meaningful and helpful to consumers.

Background

There are three related provisions in PPACA that must be kept in mind when designing disclosures: Section 1103, Section 2715, and Section 2715A. Each of these provisions has a different deadline, the first being May 22, 2010.

Section 1103 of PPACA calls for HHS to create a “mechanism” (including a website) to display current insurance options available in a state, not later than 60 days after enactment (or May 22, 2010). The Act calls for the Secretary to develop a standard format to be used in presenting information relating to coverage options, which shall include:

- The percentage of total premiums spent on non-clinical costs;
- Eligibility (for public coverage programs);
- Plan availability;
- Premium rates; and
- Cost sharing.

The Act requires this information to be consistent with the uniform explanation of coverage as provided for in Section 2715.

Section 2715 of the Public Health Act, as amended by PPACA, calls for HHS to develop a uniform explanation of coverage 12 months from the date of enactment (or by March 23, 2011). These standards will apply to all health plans.² This 4-page disclosure form will feature (among other things):

- Standardized medical/insurance terms; and
- A coverage facts label, displaying cost-sharing associated with common benefit scenarios.

Section 2715A further calls for all plans to submit to the Secretary and State insurance commissioner, and make available to the public, the following information in plain language:

- Claims payment policies and practices;
- Periodic financial disclosures;
- Data on enrollment;

- Data on disenrollment;
- Data on the number of claims that are denied;
- Data on rating practices;
- Information on cost-sharing/payments with respect to out-of-network coverage;
- Other information as determined appropriate by the Secretary.

This requirement starts six months after enactment, or September 23, 2010.

These three provisions are closely related and should be considered together. Collectively, we will refer to them as insurance disclosures. The first task, which we will call the web portal, will be extremely challenging. It must be implemented on an exceedingly tight timeframe. Furthermore, the HHS standards used to display insurance information would ideally be the same as the uniform disclosure standards to be developed in the months *following* the May 22 deadline.

Principles That Should be Used to Create Standards

All insurance disclosures must be readily understandable, meaningful and helpful to consumers, as determined by focus group testing and usability studies. These disclosures must also be visually appealing, increasing the likelihood they will actually be used by consumers.

Briefly, the features that make hard copy documents more appealing and useful include:³

- plain-language headings⁴;
- a typeface and type size that are easy to read (the law calls for 12-point type);
- wide margins and ample line spacing;
- boldface or italics for key words; and
- a distinctive type style and graphic devices, such as shading.

When such documentation moves to the Web, myriad other features can greatly increase appeal and usability of the information (over and above the formatting considerations above). For example:

- Ability to customize their view of the material (“I’m a young adult” or “Hablo Espanol”), including building custom plan comparisons;
- Provide definitions via text “roll-overs”;
- The ability to “drill down” when additional information is desired via hyperlinks to new pages; and
- Ability to increase text size for easier reading.

To make the disclosures meaningful, the first page of information should include the information most desired by consumers. The limited research in this area indicates that consumers most want to know 1) whether or not a given provider participates in the plan; 2) potential out-of-pocket costs under common medical scenarios; and 3) their premium cost.⁵ Consumers also want a summary measure, developed by a trusted source, that quickly tells them whether or not this is a “good” plan. Because research in this area is limited, and focus group testing minimal, we strongly urge more consumer research and usability testing.

Disclosures must be linguistically appropriate and culturally sensitive.

Finally, and most importantly, disclosures must provide real protection for consumers. Disclosures should help avoid these situations:

- A 2008 Consumer Reports article described a health insurance policy in which hospitalization coverage excluded the first day of hospitalization (in the fine print) – usually the most expensive day when lab and surgical suite costs are incurred.⁶
- Similarly, a detailed comparative study of health plans in Massachusetts and California found that plans with seemingly similar provisions would have left policyholders with out-of-pocket obligations that differed by thousands of dollars.⁷ For example, a typical course of breast cancer treatment would end up costing nearly \$4,000 in one plan but \$38,000 in the other plan—despite the fact the plans contained similar deductibles, co-pays and out-of-pocket limits.

Problems That Consumers Might Encounter

HHS must take very seriously the goal of ensuring that the new disclosures actually help consumers. Numerous studies have documented the failure of mandated disclosures in many consumer areas, such as consumer credit. These mandated disclosure rules often fail to effectively inform consumers, to improve their decisions, or to change the behavior of the relevant institutions. They fail because ordinary people don't read them, cannot understand them, do not know what to do with the information, and face way too many such disclosures in their every day lives.

In fact, too much mandatory disclosure may even be harmful by desensitizing consumers to warnings that may be helpful.

Designing a disclosure document that is both useful and protects consumers will be very challenging in today's environment. Prior to the 2014 reforms, consumers will continue to encounter extensive variation in health plan designs.⁸ A simple, usable form simply cannot capture all the important policy detail. Consumers may be reduced to "reading the fine print" — reducing the chances that they will understand the policy to near zero. HHS must look for tools and techniques that help consumers meaningfully compare these disparate plan designs.

We are also concerned about managing consumers' expectations with respect to the web portals scheduled to come online May 22. Due to this rapid deployment, and the fact that the mandated information is not yet standardized, initial versions are likely to be somewhat limited. Consumers' expectations must be carefully managed so that they are not permanently turned off from using the web portal, just because they initially find limited information there. We expect, given enough time, HHS will be able to put significant improvements in place, leveraging the best ideas from the many excellent examples around the country of "one-stop-shopping" for coverage.⁹

Recommendations

Disclosure form design and side-by-side comparisons are key areas where consumer and patient groups can work closely with NAIC and HHS to ensure that the new standards meet the needs of consumers. To that end, we recommend the following immediate actions.

Analyze consumer needs and preferences. HHS should immediately convene focus groups, and a review of current health insurance disclosures to determine what pieces of information and layout styles consumers find most helpful. This testing needs to be unbiased and account for the needs of a wide variety of consumers, including those with low literacy or low English language proficiency, as required by the law. We also recommend HHS consult with enrollment counselors and patient/consumer advocacy groups in the development phase, as well as for a review of the final prototypes. These groups have a background of working with patients and consumers, and may be able to jump start the search for effective standards.¹⁰ HHS should make the results of this focus group/usability testing publicly available.

Design a summary measure that quickly tells consumers whether or not this is a "good" plan. We recognize the complexity and subjectivity inherent in this task. We encourage HHS to persevere, perhaps using an iterative process, such as starting with summary measures for sub-set of measures. The quality "stars" adopted for Medicare Advantage plans are an example of a summary measure that looks at one component of a plan's overall performance. This iterative process should feature a strong feedback loop so consumers can report how well they are served by the measures. Early work in the area will help inform the 2014 exchanges, who are tasked with rating health plans. HHS/NAIC may want to identify a "trusted source" to make this determination, increasing the likelihood that consumers will trust the result.

Assess whether or not a variety of disclosure forms might be needed, reflecting the wide variety of consumer needs. This approach might help overcome language/cultural differences, differences in the preferences of younger/older consumers¹¹ and other areas where preferences vary.

Commit to an ongoing evaluation of the usability of these forms. Identify ways to include a variety of feedback mechanisms so that the usefulness of the forms can be assessed and improved over time. HHS may want to consider leveraging approaches like those used by Yelp or Amazon, where consumers share their own feedback among themselves, to see how well consumers are being served and which types of information are of greatest interest to consumers. This should not serve as the sole feedback mechanism but may provide a useful complement to other methods and be appreciated by consumers.

Consider the “media” of the disclosures for example, as a) paper products, b) online, c) as part of an enrollment counselor’s “tool set.” Anticipate that different media may call for different disclosure designs, but incorporate as much uniformity as possible. Uniformity will help consumers “learn” to use the disclosures and embed them more deeply into their shopping practices.¹²

Consider how these disclosures will dovetail with other “consumer-facing” reporting requirements in the Act. Again, widespread uniformity at every point will help consumers “learn” to use the disclosures. To that end:

- Develop and test the standalone insurance disclosure (as called for in Section 2715) first, using an aggressive timetable and well in advance of the March 23, 2011 deadline.
- Use this tested standard to build out the comparative “side-by-side” insurance information (as called for in Section 1103 and eventually through the exchanges—Section 1311).
- In building the standalone insurance disclosure, consider how it will interact with other reporting requirements in the law such as:
 - The new quality reporting requirement (section 2717 of PHSA);
 - The new MLR reporting requirement (section 2718(a) of PHSA);
 - Any information on rate justification that will be publicly available; and
 - The other additional information that must be provided (Section 2715A; for example transparency with respect to claims payment policies and practices; Data on enrollment and disenrollment; etc).

For example, the standalone 4-page disclosure may want to include a reference to the other health plan information that is available to consumers (such as the data called for by Section 2715A), and indicate where it can be found; ideally, all in one place.

- Require the standardized medical and insurance definitions and terms be used in all consumer-facing documents (not just insurance disclosures), and all insurer communications to state agencies and HHS. For example, when state agencies or insurers report complaint data to HHS, they should adopt the same consistent terms and definitions.

Finally, we ask that the consumers testing explore — in a realistic manner — how and why consumers understand and make use of the document, and whether it meets the goals of being appealing, understandable, meaningful and helpful. Such a process should include focus groups, preference testing, pretesting, and diagnostic usability testing, to iteratively develop and refine the prototype. The testing design must avoid these potential pitfalls:

- **Most conventional focus groups actually measure the wrong thing.** They do not measure what people think when making a purchase. They measure what people think when participating in a focus group.
- Since there are often major differences between what people say and what they do, it is better to **watch users as they attempt to perform tasks** with the disclosure forms or the side-by-side comparison tools, such as the web portal. Direct observation of this nature always needs to be done to supplement focus groups.¹³
- People have little, if any, reliable access to the cognitive reasoning that underlies their decision-making. In most instances, people are unaware of the factors that influence their responses.¹⁴ Again, this points to the need for usability testing to compliment focus group activity.

END NOTES

¹ Consumers Union, *Simplifying Health Insurance Choices*, June 2009.

² Including grandfathered plans (Sec. 10103).

³ HHS may want to leverage the recent interagency work done to redesign model privacy notices, specifically the very detailed requirements about the appearance of the form (font size, leading, printing, color, etc.) (See pages 30-35 of: http://www.ftc.gov/privacy/privacyinitiatives/PrivacyModelForm_FR.pdf). Consumer groups would also be happy to provide additional feedback on desirable features.

⁴ The average U.S adult reads comfortably—especially about subjects they do not understand well—at an 7th grade level. To reach an even broader audience, a 6th grade reading level is often recommended. Yet the typical health plan document is written at a first-year college reading level. Furthermore, health literacy is a broader concept that goes beyond reading literacy. For example, it includes the ability to process numbers and a basic understanding of how our nation’s health care system works. Unfortunately, just 12 percent of adults are characterized as fully “proficient” in health literacy. The standards that HHS will develop must take into account these myriad comprehension issues.

⁵ Consumers Union, *Simplifying Health Insurance Choices*, June 2009.

⁶ “Hazardous Health Plans,” *Consumer Reports*, May 2009.

⁷ Karen Pollitz, Eliza Bangit, Jennifer Libster, Stephanie Lewis, and Nicole Johnston. *Coverage When It Counts, How much protection does health insurance offer and how can consumers know?*, Center for American Progress Action Fund, May 8, 2009.

⁸ Putting the disparate health plans available to federal employees on a side-by-side basis is an example of the challenge facing HHS. The Consumers’ Checkbook Guide to Health Plans for Federal Employees reports that “hundreds of thousands of employees and annuitants are still enrolled in plans that are much more expensive than average, and that give them no needed extra benefits.”

⁹ We would be happy to supply a set of references to current, successful “one-stop-shopping” venues.

¹⁰ For example, when preparing consumer education materials for the Round 1 Rebid of the Medicare Competitive Bidding Program, CMS reached out to several consumer advocacy groups to review the materials and discuss dissemination plans. As patient advocates who regularly hear from their constituents, these groups were able to provide useful feedback on the readability and understandability of their prepared materials. Additionally, the patient advocacy groups provided valuable feedback on CMS’s dissemination plans. CMS staff remarked on the value of using a collaborative process.

¹¹ For example, this study found striking differences between the Medicare and a younger sample in ability to use disclosure information accurately. <http://content.healthaffairs.org/cgi/content/full/20/3/1199>

¹² These authors argue that transparency policies are only effective when the information they produce becomes embedded in the everyday decision making process. David Weil, Archon Fung, Mary Graham, Elena Fagotto. “The Effectiveness of Regulatory Disclosure Policies.” *Journal of Policy Analysis and Management*, Vol. 25, No. 1. (2006), pp. 155-181.

¹³ <http://www.useit.com/papers/focusgroups.html>

¹⁴ <http://www.userfocus.co.uk/articles/focuspocus.html>



Medical Loss Ratio

The Patient Protection and Affordable Care Act (PPACA) requires health insurance issuers offering individual or group coverage to submit annual reports to the Secretary of Health and Human Services that show the percentages of premiums that the coverage spends on reimbursement for clinical services and activities that improve health care quality, and to provide rebates to enrollees if this spending does not meet minimum standards for a given plan year. The consumer representatives to the NAIC applaud lawmakers both for their understanding of the importance of setting minimum standards for medical loss ratios and also for the strong emphasis in PPACA on improving quality of care.

PPACA directs the NAIC to establish uniform definitions of activities being reported to the Secretary and standardized methodologies for calculating measures of these activities no later than December 31, 2010. The NAIC consumer representatives believe it is critically important that the regulations prohibit insurers from classifying or reclassifying certain administrative expenses as medical expenses, and from taking other actions unrelated to quality improvement that would automatically increase their medical loss ratios. We believe that allowing insurers to boost their medical loss ratios (MLRs) in such artificial ways would violate Congressional intent.

We also believe that because the development of definitions and measurements of insurers' MLR requirements is of such critical importance to consumers, the process of developing the definitions and standards must be transparent and include consumer group participation and input.

Background and Discussion

Section 2718(C) provides that, beginning not later than January 1, 2011, health insurance issuers offering group or individual health insurance coverage must with respect to each plan year provide an annual rebate to each enrollee under such coverage if the ratio: (1) the amount of premium revenue the issuer spends on reimbursement for clinical services provided to enrollees and activities that improve health care quality to (2) the total amount of premium revenue for the plan year (excluding federal and state taxes and licensing or regulatory fees and after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance under sections 1341, 1342, and 1343 of PPACA) is less than the following percentages, referred to as "the applicable minimum standards":

- 85 percent for coverage offered in the large group market (or a higher percentage that a given state may have determined by regulation); or
- 80 percent for coverage offered in the small group market or in the individual market (or a higher percentage that a given state may have determined by regulation), except that the Secretary may adjust this percentage for a state if the Secretary determines that the application of the 80 percent minimum standard may destabilize the individual market in that state.)

Section 2718(b)(1)(B)(ii) requires that beginning on January 1, 2014, the determination of whether the percentage that the coverage spent on clinical services and quality improvement exceeds the applicable minimum standard (under Section 2718(b)(1)(A)) for the year involved shall be based on the average of the premiums expended on these costs and total premium revenue

for each of the previous three years for the plan. PPACA also directs the NAIC to develop uniform definitions and methodologies for calculating these percentages (subject to certification by the Secretary).

In anticipation of the law's requirement that health insurers meet minimum MLR standards, at least one insurer began taking actions that would make it much easier for the company to comply with the law simply by reclassifying certain administrative expenses as medical expenses. As reported widely by the media, WellPoint executives told investors in March they already had begun reclassifying several categories of expenses that would result in a substantial increase in its 2010 MLR. The company said its reclassifications involved expenses related to its "nurse hotline" and health and wellness activities, including disease management and medical management programs, and expenses pertaining to "clinical health policy." By reclassifying these expenses, WellPoint projected that its 2010 medical loss ratio would increase by 170 basis points, or 1.7%. The Office of Oversight and Investigations for the U.S. Senate Commerce Committee noted in an April 14, 2010, report that because WellPoint expects to collect more than \$30 billion in premiums from its commercial health customers in 2010, "this 'accounting reclassification' means that the company has converted more than a half a billion dollars of this year's administrative expenses into medical expenses."

Other insurers are expected to follow WellPoint's lead. Insurers have proposed such reclassifications in the past when states have considered adopting minimum MLR requirements. When California was considering minimum MLRs in 2007, one insurer proposed that any services to improve health outcomes or reduce health care costs should be included in the medical portion of the ratio, such as: disease management programs; wellness programs, care management programs, nurse hotlines, quality assurance oversight activities, health information technology expenses; transparency initiatives; and provider credentialing.

It is important to note that until lawmakers began focusing on MLRs, insurers thought that expenses related to those costs were categorized appropriately as administrative costs—not medical costs. Significantly, when the California legislature did not enact a minimum MLR provision, the company took no action to reclassify the expenses.

While NAIC accounting rules pertaining to MLRs define "medical loss" as the value of medical claims an insurer actually paid ("incurred claims"), plus the amount of money the insurer sets aside to pay future claims ("contract reserves"), the Patient Protection and Affordable Care Act will potentially allow insurers to classify a broader set of expenditures as medical. But, as the U.S. Senate Commerce Committee report noted, "Boosting medical loss ratios through creative accounting will not fulfill the new law's goal of helping consumers realize the full value of their health insurance payments."

Further, because the new law will in 2014 prohibit insurers from denying coverage or refusing to pay claims for anyone with preexisting conditions, insurers after that date should no longer need to spend as much as they do today on underwriting activities. Similarly, since Congress has passed a healthcare reform package, funds spent on lobbying should be greatly reduced. When underwriting and lobbying-related expenses are reduced, insurers' MLRs should rise as a direct consequence, which will make it considerably easier for them to comply with the minimum ratios set forth in PPACA. MLRs will rise even further if the amount of money paid in commissions to brokers declines once the exchanges are in operation.

Recommendations

As HHS and the NAIC approach the task of deciding how to classify health insurance costs, they must not allow whole categories of administrative work to be re-defined as medical costs, especially if the category or department has only a partial medical care role. While the inclusion of evidence-based quality improvement initiatives in an insurer's MLR would appear to be what lawmakers intended by including "activities that improve health care quality" in the section of the new law pertaining to MLRs, the new regulations should not allow insurers to classify expenses for which there is little or no evidence that the related activities "improve quality." For example, most consumers would not consider "utilization review" nurses and other administrators whose job it is to review and often deny physician-recommended treatments to be providing medical care or, in many if not most cases, "improving quality" of their health. Likewise, quality assurance programs and provider credentialing activities are administrative functions that insurers have not considered direct medical expenses in the past and should not be allowed to be reclassified as such now.

Information technology spending is another area too broad to allow wholesale reclassifications. Some investments in IT have contributed to greater adherence to clinical guidelines and, as a result, might have improved quality of care. Further, plans can and should help physician practices make the investments they need to meet the "meaningful use" requirements recently promulgated by the Centers for Medicare and Medicaid Services. Information technology spending can lead to more streamlined operations, fewer mistakes and

duplications and, consequently, better patient outcomes and lower medical costs. But many other areas of IT spending have nothing to do with improving quality. Insurers have invested in information technology to enhance underwriting capabilities, reduce expenses pertaining to paying claims and even to identify unprofitable accounts. It is also important to note that insurers have not in the past included IT expenditures as direct medical costs. Insurers have invested in IT to give them competitive advantages and for research and development purposes. Regulations pertaining to IT spending must include a methodology to ascertain and allocate an appropriate portion of technology infrastructure costs directly tied to quality initiatives—with rigorous oversight.

In addition, “medical management” is such an all-encompassing term that it can include purely administrative functions as well as the salaries of employees whose work does not in any way improve quality. Many “medical management” expenses, including expenses related to “nurse hotlines” and proprietary disease and care management programs, are related more to cost control or expense management than to improving quality. While nurse hotlines can be a useful tool for consumers, there is the potential for them to be used by insurers to reduce utilization without regard to medical necessity.

Health plans frequently cite their disease management programs as evidence of a focus on improving the health of people with chronic conditions. One insurer said recently it has 34 different disease management programs in place. Yet as of 2010, the National Committee for Quality Assurance (NCQA) has accreditation programs for only five disease management programs: asthma, diabetes, chronic obstructive pulmonary disease, heart failure and ischemic vascular disease. (The NCQA has separate preventive health measures for tobacco use, influenza vaccination and pneumococcal vaccination). Many disease management programs operated by health plans lack verifiable evidence demonstrating that they improve patient outcomes.

Health plans should not be discouraged from offering evidence-based disease and care management programs, but ***no program should be included for which there is insufficient empirical evidence that it improves the health of enrollees.*** In order to advance and support the overall quality agenda within PPACA, we believe the NAIC could consider as allowable quality improvement expenses the following: expenses related to implementing and maintaining the QI program required by Medicare, Medicaid, the Child Health Insurance Program and other government programs; expenses relating to establishing and updating the data collection and reporting required to comply with the Secretary of HHS’s national strategy to improve the delivery of health care services, patient health outcomes and population health; and expenses related to government QI demonstration projects. ***Plans should be required to be much more transparent in this area and should be required to provide cost and outcome results of such programs.*** Before regulators consider allowing these programs to be classified as medical expenses, they should ask the following questions: “Does the program result in reduced claims for the insurer? If yes, does the program also have a documented and demonstrable impact on improved quality? If no, then it should not be construed as a medical expense. If yes, would the insurer offer the program if it did not have an impact on reduced claims? If no, then it should not be construed as a medical expense.”

Consumer-focused services that health plans should be allowed to classify as medical care are professional interpretation and translation services in health care settings for enrollees who are limited English proficient (LEP). For these plan participants, language access resources are an integral part of the clinical encounter. Moreover, health plans should not be discouraged from providing these services to LEP enrollees when communicating with them about covered benefits and other plan information. Unless it is for marketing purposes, plans should also be permitted to consider as “quality improvement” interpretation and translation services used when directly communicating with LEP enrollees.

Other considerations:

- Insurers should be prohibited from grouping their plans together to mask the low MLRs of some of their plans. The new law may incentivize insurers to combine into the largest groups possible to have their most profitable plans offset by their least profitable ones.
- If insurers operate under several legal entities in a state, they should not be allowed to combine results. Insurers separated entities for a reason: to limit liabilities. They should not now be able to combine their entities’ MLRs.
- Medicare Part D and specialized and supplemental products, such as vision only, dental only and Medicare supplement plans should be exempted from inclusion in the loss ratio requirement, so that the requirement is limited to health insurance.
- Insurers should not have the flexibility to pool their experience across different product lines/markets at their discretion. Additionally, an insurer should not have the flexibility to average its premium equivalents under administrative services only (ASO) contracts. Insurers should also not be allowed to pool their experience across different states.

- The MLR should be based simply on paid claims. Insured claims, as noted earlier, are the sum of claims paid and changes in reserves (not paid claims plus all reserves). Since the review is historical, use of actual claims paid is reasonable and avoids the possibility of insurers gaming the system by manipulating reserves.
- Some insurers would like to have a special consideration or accommodation for their low cost products, e.g., limited-benefit and high-deductible plans and possibly even so-called “mini-med” plans, because, in their view, a high medical loss ratio requirement would discourage insurers from offering such products. Products with lower premiums (made possible by reducing benefits and/or requiring enrollees to pay more out of their own pockets than they would under higher premium products) have a higher percentage of revenue attributable to administrative costs. Because these products shift more of the cost of care from insurers and employers to consumers, they also typically have high profit margins. Insurers should not be given any special consideration in computing the MLRs for such products. Many of these products contribute to the growing number of people who are underinsured.
- The cost of settling claims—considered a loss adjustment expense—must not be included in the MLR numerator used for determining rebates. Expenses related to settling claims are not payments for health services. Including them in the MLR numerator would provide a perverse incentive for insurers to spend more money on denying claims. Although section 2718(a) requires insurers to report their loss adjustment expenses together with incurred claims, it separately requires insurers to report expenditures for reimbursements for clinical services and for activities that improve health care quality. Under 2718(b), only the latter two categories of expenses are considered in determining rebates. “Reimbursement for clinical services” clearly does not include loss adjustment expenses.
- Regulators must insist that health plans be transparent in what they include in the MLR numerator. If the NAIC and HHS allow any expenses related to “quality improvement” activities to be reclassified as medical expenses, consumers must be able to see exactly how much plans are paying on claims. Therefore, ***plans must be required to report on the amount they spend on the payment of claims, separate from the total amount they report for the numerator in the MLR ratio.***
- Finally, it should be noted that insurers gain an important advantage under PPACA, which will boost some MLRs. Small groups currently are defined as groups with 50 or fewer employees. The new law raises that definition to 100 employees. Since small groups have more generous MLR minimums, this definitional change will move groups of 51-100 from large to small groups with a 5% greater MLR allowance, providing additional insurer margins.

An additional—and important—recommendation

If carriers are permitted to shift or reclassify any expenses, they should be required to restate their MLRs over the previous five years using the new standards and definitions so that the public — as well as lawmakers, regulators and shareholders — can see the effects of the new definitions on the reporting of MLRs. There are precedents for requiring such restatements by carriers. It is not at all uncommon for the SEC to require publicly traded companies, including insurers, to restate earnings retrospectively following the discovery or disclosure of information considered material to earnings. Similarly, carriers have restated membership totals after discovering that their previous methods of calculating membership totals were flawed. If the HHS, NAIC and SEC are truly dedicated to transparency, they will insist that carriers restate their MLRs retrospectively for a specified period of time.



“Near Term-Consumer Protections”

Issues Regarding the Application of Annual And Lifetime Limits

Under the Patient Protection and Affordable Care Act (PPACA), all health plans are prohibited from imposing lifetime dollar limits on essential benefits, beginning with plan years starting six months after enactment. Also effective six months after enactment, new individual plans and all group plans are prohibited from imposing “unreasonable” annual limits on the dollar value of benefits, as defined by the Secretary of Health and Human Services. In 2014, annual dollar limits on essential benefits will be prohibited in all plans.

These provisions represent important new protections for consumers. In this brief, we describe how to make these provisions as strong as possible.

Concerns Regarding Annual and Lifetime Limit Provisions

- PPACA is not explicit about the minimum acceptable level of adequate levels of annual limits in place between Sept. 23, 2010 and January 1, 2014. It is critical that such limits are sufficient for patients facing chronic diseases and high medical costs. However, restrictions on annual limits will also have an impact on premiums, which must be considered so that they don't inadvertently increase the number of low and moderate families who cannot afford coverage.
- Between the period of 2010 and 2014, there may be an incentive for plans that prior to September 23, 2010 did not have annual limits to adopt annual limits as a means of replacing the loss of lifetime limits.
- The restriction on annual and lifetime limits for essential benefits begins in new plan years after September 23, 2010, however HHS is not required to define the essential benefits package by such time.
- Self-insured plans are not subject to the market conduct reviews that individual and commercial plans are; rather, they are subject to US Department of Labor oversight which does not have the enforcement staff to effectively conduct such reviews. Consequently, it will be difficult to confirm that self-insured plans are properly implementing the annual and lifetime limit provisions, with respect to the essential benefits that are covered in these plans.
- The law bans lifetime limits on benefits covered by the essential benefits package. But because self-insured plans never have to conform to the essential benefits package, it is unclear how the ban on lifetime limits will apply to them.
- While the law bans monetary lifetime and restrictive annual limits, health plans may still apply non-monetary limits, such as numerical limits on physician visits or hospital days. These non-monetary limits are damaging to the adequacy of coverage for consumers, particularly those with chronic diseases such as cancer, heart disease, and diabetes who have high utilization of health care.

Recommendations

We recommend that HHS rules clarify the following:

- Permitted annual limits on essential benefits must be sufficient to cover medically necessary and evidence-based care of patients with chronic diseases such as cancer, heart disease, and diabetes. The most common plans in the FEHBP could be considered as models.
- Plans that must raise their annual limits to comply with HHS regulations should be allowed to retain their grandfathered status. However, the addition of new annual limits should constitute loss of grandfathered status (eg, the creation of annual limits in plans which did not previously have such a limit or the lowering of annual limits).
- Because the restrictions on annual and lifetime limits begin prior to the implementation of the essential benefits package, it will be necessary for the HHS Secretary to clearly define what constitutes a covered benefit. This definition should include the full range of services typically needed by patients, particularly those with conditions such as cancer, heart disease or diabetes.
- There must be a strong regulatory process to monitor and enforce the restrictions of annual and lifetime limits on essential benefits in self-insured plans, by HHS and US DoL.
- Recommendations for lifetime and annual limits on essential benefits should be developed in a transparent manner. These recommendations must remain consistent with the evidence-based guidelines developed by experts such as voluntary health organizations and professional medical societies; and consumers and consumer advocates.
- A description of the annual limits should provide details needed by consumers, such as how frequently a service can be obtained and still be a covered under the annual limits (i.e., once a year or once every three years).
- Because health plans may still apply non-monetary benefit limits, HHS and the US DoL should ensure that consumers understand what benefit limits can be applied and how they are in effect in their plans.
- It is possible that health plans may increase the use of non-monetary benefit limits to adjust for the bans in lifetime and annual limits. HHS and DoL should track trends in non-monetary benefit limits across all markets and make this information public.

The Patient Protection and Affordable Care Act (PPACA) contains several provisions related to the coverage of clinical preventive services. The Consumer Representatives to NAIC strongly support the expansion of preventive benefits required under PPACA and have a number of recommendations that should be addressed through regulation to ensure that the law fulfills its promise for patients and consumers, including:

- The need for an open and consultative process to translate broad recommendations into a uniform set of clinical preventive benefits applied consistently across all plans;
- Clarity that recommendations from the United States Preventive Services Task Force (USPSTF), Health Resource and Services Administration (HRSA) and Advisory Committee on Immunization Practices (ACIP) serve as a floor and not a ceiling, for covered preventive services;
- The need for specific guidance as to the appropriate interval for plan updates of preventive benefits;
- The need for transparency and clarity around the use of value-based design in the coverage of preventive benefits to ensure that quality is the primary driver of such policies;
- Assure that insurers and health plans provide information regarding all covered preventive services to enrollees. This should include a definition of the service, and any specific age, frequency, or health pre-conditions. This information should be accessible through a variety of communication channels and sources; and
- A process for ensuring adequate consumer and patient group input into coverage decisions made by USPSTF, ACIP, and HRSA.

Background and Discussion

Section 2713 requires a health plan to provide coverage for certain preventive benefits without imposing cost sharing requirements. These benefits include: evidence-based items or services that have a rating of ‘A’ or ‘B’ in the current recommendations of the USPSTF; immunizations that have a recommendation from the ACIP; and, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by HRSA for infants, children, and adolescents, and for women. Nothing in the new law prohibits a plan from providing coverage for services in addition to those recommended by the USPSTF or for denying coverage for services that are not recommended. The law also specifies that the Secretary shall establish a minimum interval of at least a year between the date on which a recommendation is adopted and when a plan is required to incorporate the preventive service into its coverage. And finally, this section allows the Secretary to develop guidelines to permit a health plan to utilize value-based insurance designs.

The coverage of preventive services provision is effective six months after the date of enactment; however, the law exempts from these requirements any individual and group health insurance coverage in effect on or before the law’s date of enactment.

There are four sets of issues that should be addressed with regard to this provision.

First, the recommendations that have been developed by the USPSTF and the ACIP are not always specific, particularly when the benefits include counseling and other interventions. (Smoking cessation benefits –which include both pharmaceutical and counseling components –are a case in point.) The lack of clarity could reflect a lack of evidence or the need for some discretion on the part of the clinician based on the patient’s risk factors, but if the goal is a uniform set of preventive benefits across health plans it is critical that the recommendations are clear regarding covered benefits. Likewise, as HRSA develops recommendations for preventive services going forward, such as guidelines for specific populations such as children and women, there needs to be clarity about the specific benefits to be covered. The Agency for Healthcare Research and Quality is likely the most appropriate entity for developing these specific recommendations; however, the processes for developing these specific benefits should be designed to incorporate input from groups that develop guidelines in the relevant areas.

Second, it is critical that the regulations clearly state that plans are not prohibited in any way from covering preventive benefits for which coverage may not be required by the new law. This is particularly important for those preventive services currently

offered by plans that are not recommended with an A or B rating by the USPSTF or meet other criteria now in the law. The Department of Health and Human Services (HHS) should do everything it can to support and encourage insurers and health plans to broaden their coverage of preventive benefits, consistent with evidence-based guidelines.

Third, the regulation should specifically prohibit the use of preventive benefits as a back-door methodology for underwriting riskier patients. Some insurers and health plans have continued to identify consumers who take advantage of preventive benefits (even at no cost) as likely to cost them more in claims and medical costs. Examples of this include smoking cessation and weight loss programs. When consumers utilize those services, they may be inadvertently identifying themselves as higher risk, higher cost subscribers and enrollees. Insurers and plans must be prohibited from imposing unfair costs or other discriminatory practices against these consumers based on their election of preventive services.

Fourth, it may be useful to recommend that the interval between the adoption of a recommendation and its implementation in plan benefits not exceed one year and one day. The law currently states that it may not be less than one year but does not set a specific deadline.

And finally, it is critical that some caveats be placed around the use of value-based benefit design to ensure that quality is a higher priority than efficiency.

Section 2715 requires plans to issue a uniform summary of benefits and coverage and standardized definitions. HHS will need to translate this requirement into coverage specifications that ensure patients understand which benefits are covered.

Standard definitions must be implemented in 12 months; and the uniform explanation of coverage documents must be implemented within 24 months. This provision does not exempt grandfathered plans.

Since this requirement goes into effect within 12 months, it is critical that HHS develop the preventive services definitions and standardized coverage language so that all plans will be able to incorporate the language into all of their plan documents, in their marketing materials, on their websites, and in all of their other communication materials by the effective dates. The Department will need to translate these requirements into coverage specifications that ensure enrollees have the access to appropriate, evidence-based preventive items and services, and that both enrollees and employers understand the coverage they have. These documents will be of great value to consumers and employers, but may rely on more specificity and uniformity in the provision of preventive benefits than exists currently.

Section 4003 outlines the roles and responsibility of the USPSTF with regard to coverage decisions. Although the final health care reform measure does not require increased membership on the Task Force, nor does it create an advisory body to secure additional input from patient and consumer groups, the language appears to be broad enough to accommodate such changes made through regulation.

As a result of the new responsibilities assumed by the USPSTF, ACIP, and HRSA with regard to the coverage of preventive benefits, the regulations must address issues related to the transparency of this new decision-making process. In the case of the USPSTF, it is critical that the membership be expanded beyond the traditional base of primary care clinicians to include recognized and appropriately credentialed experts on the specific disease states that the services are intended to prevent or detect. An alternative to expanded membership is the creation of an advisory body – similar to that created in the House health care reform bill.

In addition, there are some issues that impact implementation of the preventive services provision that are also relevant to many of the other insurance market reforms, such as defining when a plan is grandfathered (and therefore exempt from the preventive services coverage requirement) and when a consumer can appeal. The Consumer Representatives to the NAIC have developed separate white papers on those issues.

Recommendations

- A process must be developed to clearly define and describe the specific preventive services covered under the law with no cost-sharing requirements using a transparent process that is based on the latest evidence and allows for public comment. The process must be sufficiently flexible to allow changes without requiring legislative or regulatory action when evidence of effectiveness of clinical preventives services indicates that the standard of care or the frequency, age parameters or type of service required has changed and that allow deviations from the standard level of care based on The processes for developing these specific benefits should be designed to incorporate input from groups that develop guidelines in the relevant areas increased risk.) (It is critical that this definition be in place to guide States in providing an appropriate level of tobacco cessation benefits to pregnant women.)
- The regulations should state that the interval between the adoption of a recommendation and its implementation in plan benefits not be less than one year (as the law states) or greater than one year and one day.
- The guidelines the Secretary develops with regard to value-based insurance design pursuant to section 2713(c) should incorporate public comment; require the use of evidence-based quality measures; and preserve high value care – making quality a priority over efficiency.
- The regulations should clarify that the USPSTF, HRSA and ACIP guidelines are a floor, not a ceiling for preventive services.
- A mechanism must be developed to ensure that what constitutes a covered preventive service is clearly defined and available to the public for all plans. This mechanism should provide details needed by consumers, such as how frequently a service can be obtained and still be free of charge (i.e., once a year or once every three years). Limitations on free preventive coverage based on patient characteristics (such as minimum age) should also be clear to consumers and contained in the health plan coverage documents. Insurers and health plans should be required to communicate clear and specific information on preventive benefits in plain language through a variety of mechanisms, such as plan materials, policy coverage documents, on websites, and in response to consumer inquiries at customer assistance centers. In addition, this information should be available in multiple languages for low English proficient consumers and other formats for visually and hearing impaired consumers.
- Recommendations from the USPSTF, the ACIP, and HRSA should be developed in a transparent manner that incorporates input from consumer and patient groups through the creation of a clinical prevention stakeholder's board to make recommendations for clinical preventive services that would be reviewed by the Task Force. The recommendations from the USPSTF must remain consistent with the evidence-based guidelines developed by experts such as voluntary health organizations and professional medical societies; incorporate findings from comparative effectiveness research; and reflect innovations in the efficient delivery of services.
- There must be a strong regulatory process to monitor and enforce the requirements for preventive benefits in self-insured plans, possibly through the new Ombudsman program in HHS.
- The separate recommendations of the Consumer Representatives with respect to the definition of grandfathered plans and applicability of appeals and grievances should also be taken into account when implementing the preventive services provision.

Pre-Existing Condition Exclusions

The Patient Protection and Affordable Care Act (PPACA) contains a provision prohibiting health insurers from excluding children under 19 with pre-existing conditions from being covered under their parents' insurance plan. The Consumer Representatives to NAIC strongly support prohibiting pre-existing condition exclusions required under PPACA and have a number of recommendations that should be addressed through regulation to ensure that the law fulfills its promise for families with children with pre-existing conditions, including:

- The need for a clear definition of pre-existing condition exclusions that includes all forms of discrimination based on health status;
- The requirement that annual rate submissions include documentation about any rate increases applied to policies that cover children subject to the new protections;
- The need for clear regulation that prohibits insurers from charging children unreasonable premiums based on health status; and
- The requirement that rate filings and market conduct examinations include standardized reporting about changes in underwriting actions and policies.

Background and Discussion

Effective six months after enactment (or September 2010), PPACA prohibits individual and group health plan issuers from imposing pre-existing condition exclusions for children under 19.¹ This policy is critical to helping families purchase adequate coverage for children with pre-existing conditions without any discrimination based on a child's health status.

However, families with children with pre-existing conditions may still face barriers to coverage based on health status, particularly in regards to affordability of health insurance coverage. While insurers will be required to issue coverage to all children under the age of 19 without the application of pre-existing condition exclusion periods, currently there are not any express restrictions on what families can be charged for such coverage. PPACA is silent on what rates may be charged for children being covered under this provision. Effective in plan years starting January 1, 2014, PPACA requires the use of adjusted community rating, thereby prohibiting insurers from basing premium rates on health status. However, prior to 2014, there are no restrictions on ratings based on health status associated with the prohibition on pre-existing condition exclusions for children.

In a letter to AHIP², Secretary Sebelius stated that the Congressional intent is to prohibit the denial of coverage to children based on preexisting condition exclusion periods. In this statement the Secretary did not clearly express that §2704 is also intended to prohibit rating based on health status. However, the Secretary may still address the affordability issue when issuing regulations.

Additionally, PPACA §1003 adding §2794 to the PHSA, requires the Secretary to establish a procedure through which to review ratings for unreasonable premium increases. However, this provision does not prohibit the application of unreasonable premiums.

While current federal nondiscrimination provisions⁴ prohibit group health plans from charging an individual higher premiums based on health status (the group may be charged more as a whole if a member of the group has an existing health condition), this protection does not extend to the individual market.³ Without any clear restriction on rating for children, individual health insurers are free to make an offer of coverage to children with existing medical conditions at a rate that is simply unaffordable for many parents.

Recommendations

- Pre-existing condition exclusions should be defined to include all the forms of discrimination that a child may face because of their health status, including denial of coverage, the exclusion of their specific condition and treatment for their condition from coverage, and excessive waiting periods. An excessive waiting period should be defined as no longer than 90 days, in line with provision that goes into effect in 2014.
- Regulations on annual rate submissions should require the inclusion of documentation about rate increases (if any) that are applied to policies that cover children subject to the new protections.
- Regulations should clarify that insurers may not charge children unreasonable premiums based on health status. In addition to establishing a procedure through which to review ratings for unreasonable premium increases, the Secretary should also be given the authority to prohibit the application of unreasonable premiums, at least until 2014 when PPACA requires the use of adjusted community rating.
- Regulations should require that rate filings and market conduct examinations include standardized reporting about changes in underwriting actions and policies, and the number of children under 19 that were added to the subscriber's coverage as a result of the new law.

END NOTES

¹ Patient Protection and Affordable Care Act of 2009 (PPACA) §§ 1201, 10103(e), PHSA § 2704.

² "Sebelius Letter to America's Health Insurance Plans on Coverage for Children with Pre-Existing Conditions," March 29, 2010, available at http://www.healthreform.gov/newsroom/children_preexisting.html.

³ §2705 of the PHSA as amended March 23, 2010.

⁴ A few states currently have community rating laws in the individual market, which does prohibit the use of health status in rating. However, the vast majority of states permit rating based on health status in the individual market. See <http://www.statehealthfacts.org/comparetable.jsp?ind=354&cat=7>.

Extension of Dependent Coverage

Effective six months after enactment (or September 23, 2010), PPACA requires plans that provide dependent coverage to extend coverage to adult children up to age 26.¹ Insurers are not required to cover the children or spouses of covered adult dependents, although adult dependents can receive coverage under their parent's plan regardless of marital status. Coverage for adult dependents will terminate on the 26th birthday of the covered dependent. Prior to 2014, for grandfathered group plans (plan years beginning before the date of enactment or March 23, 2010), insurers will be required to cover adult dependents only if the adult child is not otherwise eligible for employer-sponsored coverage.² The Consumer Representatives to NAIC strongly support this protection under PPACA and have a number of recommendations that should be addressed through regulation to ensure that the law fulfills its promise to provide adult dependents with access to affordable, adequate coverage during a transitional period in their lives.

Background and Discussion

Definition of dependent. The PPACA calls for the Department of Health and Human Services to define who will qualify for coverage as an adult dependent. States today use a wide variety of definitions with respect to young adults' eligibility for dependent coverage; some are narrower and others are quite broad. For example, New York provides coverage for unmarried adult children up to the age of 29, regardless of educational status or financial dependence.³ It is important that states with broader coverage expansions not be pre-empted by the new federal extension of dependent coverage.

Impact on recent college graduates. This provision does not go into effect until plan years beginning after September 23, 2010. For plans that run on a July to June cycle, for example, it will not go into effect until July 1, 2011. In the meantime, thousands of young adults will graduate from college and lose coverage under their parent's health insurance. The current language does not provide for a special enrollment period for these recent graduates, potentially forcing them to remain uninsured until the next open enrollment period in to the plan. This protection needs to be extended as soon as possible to these young adults and this can be achieved by including in the regulations a special enrollment period of 90 days for this year's crop of graduates or any other young adult who loses coverage before the provision goes into effect. On April 19, 2010, Health and Human Services Secretary Sebelius issued a statement noting HHS's efforts to work with insurers to voluntarily expedite extending coverage to adult dependents prior to the September 23, 2010 deadline.⁴ Consequently, over fifty-five insurers have agreed to begin extending dependent coverage on June 1, 2010. The Consumer Representative to NAIC applauds HHS and the health insurers for the agreement to ensure there are no gaps in coverage for adult dependents graduating this spring. Health plans should also provide advance notice to all plan enrollees of this special enrollment right to dependents in writing.

Issues of affordability. The PPACA does not include any provisions with respect to premium rating for adult dependents prior to the implementation of modified community rating in 2014. Unless regulations provide otherwise, an insurer might be free to charge a 25 year old adult dependent significantly more than a 6 year old or a 17 year old dependent. In addition, the dependent coverage provision in PPACA does not clearly specify that adult dependents are to be treated as any other dependent child with regards to premiums and employer contributions. Consequently employer plans may extend coverage to adult dependents but fail to make the same contributions as they would for minor dependent children. In addition, health insurers may seek to create a new category for coverage, for example instead of individual or family coverage, they may create a new classification for family groups with adult dependents, thus increasing premiums for the entire family. In line with the language of PPACA, regulations should further clarify that adult dependent children are to be treated in the same manner as minor children in terms of family composition to prevent this practice. Any attempt to separately underwrite an adult dependent from a minor child should be deemed non-compliant.

Recommendations

- Adult dependents should be defined to include biological, adopted or step- children who otherwise do not have access to a group health insurance plan. No additional restrictions should be placed on the definition of eligible adult dependents, i.e. he/she must reside in the parent’s home or must be enrolled in school.
- Regulations should clarify that adult dependent children are to be treated in the same manner as minor children in terms of family composition. Adult dependents should continue to be enrolled through the subscriber’s coverage and where appropriate at the same tier structure. For example, adult and child, adult and children or family coverage. This minimizes the administrative burden in implementing the law and also ensures that the dependent is covered at the most affordable premium.
- Regulations should clearly specify that states with more expansive laws extending coverage to adult dependents are not pre-empted.
- Regulations should designate that eligibility for this new option is to be considered a “qualifying enrollment” event so that adult dependents that have recently graduated or otherwise lost family coverage can quickly obtain coverage through their parents’ plans without waiting until the next open-enrollment period. The initial instance of this special enrollment period should be a minimum of 90 days to allow for public education and to provide families sufficient time to understand their options and make educated decisions.
- Regulations should require individual and group insurers to send written notice to beneficiaries about the new dependent coverage under PPACA prior to the start of the special enrollment period. In the case of group coverage, regulations should allow for maintenance of COBRA rights, so that when an adult dependent ages out of dependent coverage on his/her 26th birthday, COBRA continues to be an option, with timely written notice of COBRA eligibility provided to dependent adults in advance of their 26th birthday.
- Regulations should require insurers to document and report on the adult dependents they cover and whether consumer notices were sent as required.

END NOTES

¹ Patient Protection and Affordable Care Act of 2009 (PPACA) §§1001, 10103(e), PHSA § 2714

² HR 4872 §2301

³ New York State Insurance Law §4305(c)(1)

⁴ <http://www.hhs.gov/news/press/2010pres/04/20100419a.html>

Rescission and Other Post-Claims Underwriting Practices

The Patient Protection And Affordability Care Act (PPACA) provides health insurance enrollees protection against the abusive post claims underwriting practice of rescission. Effective for plan years starting 6 months after enactment, PPACA permits rescissions only for fraud or intentional misrepresentation of material fact and with prior notice to the enrollee. The Consumer Representatives to NAIC strongly support this protection under PPACA and have a number of recommendations that should be addressed through regulation to ensure that the law fulfills its promise to protect consumers from rescissions and other abusive post claims underwriting practices that have the same effect as rescission.

Background and Discussion

Problems of individuals who had health coverage cancelled in the wake of expensive claims for medical care were widely reported in the 1980s and 1990s. This was a clear threat to the health security that people expected from their insurance coverage. During the health care reform debate of 1993-1994, President Clinton's plan provided for guaranteed renewability of all health insurance, as did counter proposals put forth by many others. Calls for guaranteed renewability continued after that national health care reform debate concluded, and in 1996, the protection was included in the federal minimum requirements established for all health insurance by HIPAA.

However, the guaranteed renewability requirements under HIPAA failed to limit the use of rescission as a way for insurers to avoid paying claims for high cost enrollees. Representatives of the insurance industry have testified that rescission is rare and occurs in less than one percent of policies. Even if this estimate is accurate, it is not comforting. One percent of the population accounts for one-quarter of all medical bills. The sickest individuals may be small in number, but they are the most vulnerable and most in need of coverage.

In addition to rescission, health insurance enrollees may be subjected to other post-claims underwriting actions that have a similar effect as rescission, such as cancellation, retroactive or prospective increases in premiums, and policy reformation, among other actions.

The Patient Protection And Affordability Care Act (PPACA) provides health insurance enrollees protections against abusive rescission. Effective for plan years starting 6 months after enactment, PPACA permits rescission only for fraud or intentional misrepresentation of material fact and with prior notice to the enrollee. This protection applies to both individual and group plans in all markets, including grandfathered plans. (PPACA § 1001; PHSA § 2712)

'SEC. 2712. PROHIBITION ON RESCISSIONS. "A group health plan and a health insurance issuer offering group or individual health insurance coverage shall not rescind such plan or coverage with respect to an enrollee once the enrollee is covered under such plan or coverage involved, except that this section shall not apply to a covered individual who has performed an act or practice that constitutes fraud or makes an intentional misrepresentation of material fact as prohibited by the terms of the plan or coverage. Such plan or coverage may not be cancelled except with prior notice to the enrollee, and only as permitted under section 2702(c) or 2742(b).

The intent of the "Prohibition On Rescission" under PPACA is to protect health insurance enrollees from abusive post claims underwriting practices that ultimately lead to rescission. Practices would include, by any reasonable analysis, any other post claims underwriting action that has the same effect as rescission, such as cancellation, retroactive or prospective increases in premiums, policy reformation, among other actions. In implementing PPACA, it is crucial that the federal government and the states adopt a regulatory framework that addresses all aspects of underwriting/post claims underwriting processes that lead to rescission and any other post claims underwriting action that have a similar effect as rescission.

Although rescission should be less of a problem once health status becomes irrelevant to underwriting, post claims underwriting investigations may continue after 2014 as insurers try to avoid cost claims for reasons such as misrepresentation about age, tobacco use, participation in wellness programs and other factors. Standards adopted to protect individuals from abusive post claims underwriting practices in the near term of PPACA implementation will continue to be applicable after 2014.

Recommendations

- Establish standard information and health history questions to be used by health plans for health care policy application forms.
- Review and approve all health care policy application forms prior to use of these forms by a health care plan.
- Require health care plans to meet certain requirements with regard to medical underwriting, including requirements that health care plans
 - Review each application for accuracy and completeness,
 - Review specified claims information,
 - Make prescription drug database inquiries,
 - Identify, consult with the applicant, and resolve any omissions, ambiguities, or inconsistencies.
- Require all health care plans to complete medical underwriting prior to issuing a health care policy.
- Allow a health plan to investigate potential omissions or misrepresentations only if it can prove to the State that it has reasonable grounds to suspect that an enrollee intentionally omitted or misrepresented material information during the application process.
- Require health care plans to provide specified notices to subscribers and enrollees of the initiation of a post-claims underwriting investigation.
 - If the health plan initiates such an investigation, the plan shall provide a prompt written notice to the enrollee or subscriber informing them that they are initiating an investigation that could lead to the rescission or cancellation of the health care service plan contract.
 - Such written notice shall include full disclosure of the allegedly intentional material omission or misrepresentation and offer the applicant an invitation to provide any relevant evidence or information within a reasonable timeframe
- Require health plans to allow enrollees being investigated the opportunity to offer relevant evidence to the insurer within a reasonable timeframe.
- Prohibit a plan or insurer from rescinding or imposing any other post claims underwriting action that has a similar effect of rescission unless specified conditions (see next bullet) are met with regard to whether an applicant “performed an act or practice that constitutes fraud or made an intentional misrepresentation of material facts in the application for the health insurance application.”
- A rescission or any other post-claims action that has a similar effect as rescission, except as otherwise permitted under federal law, can only be effectuated if all the following conditions (a) through (d) exist:
 - a. A showing by clear and convincing evidence of **intentional, material fraud** (actual intent to deceive) **and** a causal relationship between the condition allegedly misrepresented and the condition resulting in the claim. Innocent, minor, or unrelated misrepresentations (e.g. teenage acne or bunions) cannot form a basis for a rescission, and;
 - b. Less than **12 months** have elapsed from the application date. After a policy has been in force for a period of **one year** it shall become incontestable as to statements contained in the application, and;
 - c. The insurer seeking to rescind or cancel completed all required underwriting procedures and exercised due diligence in underwriting the policy. Where an insurer could have reviewed records and information, ordered medical records, an attending physician statement or taken other underwriting steps prior to issuing a policy, but failed to do so and issued a health insurance policy, it is estopped from rescinding, and;
 - d. The request to rescind, or any other post-claims underwriting action that has the same effect as rescission, has been reviewed by an independent review organization, through a review process administered by a government agency, with a determination that conditions a-c has been met.

- Require the health plan to provide full notice to the enrollee or subscriber regarding their rights to file an appeal or grievance of their decision and that their decision is subject to an independent review by a third party.
- Require that the date of cancellation or rescission, if any, shall be no earlier than the date that the enrollee or subscriber receives notification that the independent review organization has made a determination upholding the health care service plan's decision to rescind or cancel their coverage.
- Require that during a post-claims underwriting investigation and subsequent independent, third party review process, the health insurance policy will remain in full effect, including payment of all claims, and that the health plan will not perform any action that will deter the continuation of ongoing treatment.
- The health plan is required to cover all claims or covered charges under the enrollee's or subscriber's health care service plan contract until the effective date of rescission or any other post claims action that has the same effect as rescission.
- Require quarterly reports to the state regulatory agency of all post claims underwriting actions that resulted in rescission or any other post-claims action that has the same effect as rescission, such as cancellation, retroactive or prospective premium increases, benefit limitations, among other similar actions, during the preceding quarter. The results of these reports should be publicly available on a timely basis on the state agency's website.
- Impose administrative sanctions or civil/criminal penalties upon health insurance plans engaging in any pattern of conduct that has the effect of prolonging independent review processes, conducting unauthorized underwriting practices, failing to implement independent review process decisions, or otherwise demonstrating a pattern of anti-consumer practices of unlawful rescissions or other post-claims action that has the same effect as rescission.

Grievances and Appeals

The Patient Protection and Affordability Care Act (PPACA) provides health insurance enrollees with the consumer protections that enable them to ask for a review of an unfavorable decision rendered by an insurer or a health plan. These protections establish a standardized first level internal appeals procedure administered by the plan and then a second level, external, appeals procedure administered by an independent third party. Each step of the appeals procedure guarantees specific protections to the consumer such as:

- accessibility to the appeal procedure at no cost to the consumer,
- the continuation of services and treatment throughout the duration of the appeals process,
- a broad definition of what decisions can be appealed,
- a broad time frame for request of the appeal,
- guaranteed assistance by a knowledgeable consumer advocate in exercising their appeal rights,
- the selection of the external reviewing entity who has no material conflict of interest (professional, familial, or financial) with the insurer or the claimant and is able to conduct the external review de novo,
- full disclosure of the basis for the decision that must be rendered in a timely fashion, and
- collection and publication of appeals data to assist the purchaser and the consumer in their choice of insurer/health plan.

The Consumer Representatives to NAIC strongly support these protections under PPACA and have a number of recommendations that should be addressed through regulation to ensure that the law fulfills its promise to protect consumers by offering a broad-based, standardized, responsive, and effective appeal level review process.

Background and Discussion

The Patient Protection and Affordable Care Act (PPACA) outlines a number of provisions to standardize and enhance the consumer appeals processes in existence at plans and in the states.

The specific provisions of the law are defined as follows:

Sec. 2719- Appeals Process “(a) INTERNAL CLAIMS APPEALS.—

“(1) IN GENERAL.—A group health plan and a health insurance issuer offering group or individual health insurance coverage shall implement an effective appeals process for appeals of coverage determinations and claims, under which the plan or issuer shall, at a minimum— “(A) have in effect an internal claims appeal process; “(B) provide notice to enrollees, in a culturally and linguistically appropriate manner, of available internal and external appeals processes, and the availability of any applicable office of health insurance consumer assistance or ombudsman established under section 2793 to assist such enrollees with the appeals processes; and “(C) allow an enrollee to review their file, to present evidence and testimony as part of the appeals process, and to receive continued coverage pending the outcome of the appeals process. “(b) EXTERNAL REVIEW.—A group health plan and a health insurance issuer offering group or individual health insurance coverage— “(1) shall comply with the applicable State external review process for such plans and issuers that, at a minimum, includes the consumer protections set forth in the Uniform External Review Model Act promulgated by the National Association of Insurance Commissioners and is binding on such plans; or “(2) shall implement an effective external review process that meets minimum standards established by the Secretary through guidance and that is similar to the process described under paragraph (1)— “(A) if the applicable State has not established an external review process that meets the requirements of paragraph (1); or “(B) if the plan is a self-insured plan that is not subject to State insurance regulation (including a State law that establishes an external review process described in paragraph (1)).

This language should be translated into strong consumer protections to fully realize the promise of health care reform. Although several states currently have regulations in place that mandate model appeals procedures, this is by no means universal. For many insurers and health plans in many states, the consumer appeal rights are limited, use not generally available or clear, or have other problems such as:

- Appeal rights are excessively time- and scope-limited, or non-existent,
- The appeal processes do not function as a real review of the original decision, nor do they include a true external review by an independent reviewer with the relevant expertise.
- Consumers are unaware of their appeal rights, have no assistance in navigating the complex quasi-legal steps in the appeal, or are discouraged from exercising their rights due to the lengthy processing time to render a decision or the difficulty of deciphering the decision when actually rendered.
- Industry further discourages the exercise of appeal rights by consumers by refusing to maintain coverage during the resolution of the appeal and/or by discharging patients in the cases of hospitalization.
- The internal appeals process for some insurers, where it exists, serves merely as a rubber-stamp review of the plan's original decision.
- The state regulator provides some impetus to resolve individual complaints, but makes no effort to track complaints by insurer as a measure of their performance.
- The state regulator does not actively evaluate the performance of the insurer or health plan and make data publicly available to enable a purchaser or consumer to make informed choices.
- The state regulator does not exercise oversight of the industry or apply appropriate administrative fines, restrictions on sales, and civil/criminal penalties for patterns of infractions and systemic violations.

Recommendations

The NAIC Consumer Representatives make several recommendations to further define the consumer protections in the law. They are enumerated in the attached chart, catalogued by several guiding principles and referenced to specific consumer problems. They consist of specific recommendations in the following areas:

- Enhanced consumer education and a requirement for consumer assistance in navigating the appeals process
- Strong notice requirements including language, basis, and timeliness requirements
- Broad time frames for exercising appeals
- Continuation of coverage during the appeals process
- No cost to consumers associated with exercise of appeal rights
- Broad definitions of what decisions may be appealed
- Strengthening and, in some cases, establishment of a genuine external appeals process that has as its cornerstone a truly de novo independent review

Grievances and Appeals

ISSUE: STRENGTHENING CONSUMER PROTECTION IN THE INTERNAL APPEALS PROCESS

Guiding Principles	Consumer Problems	Recommended Solutions
Accessibility	<p>Consumers are not aware of their internal appeal rights. As a result, they do not exercise those rights despite having issues with insurers' decisions regarding: billing/payment, coverage, delays/denials of treatment including but not limited to pre-authorization and medical necessity determinations.</p> <p>Insurers often dismiss or ignore consumer complaints.</p>	<p>The internal appeals process must be clearly identified in all written material as a consumer right. It should be explained on the insurer's website, as part of the enrollment package, in the evidence of coverage, and as part of the requirements for consumer notices.</p> <p>Health plans must provide clear explanations in plain language (consistent with § 1311(e)(3)(B) of PPACA) regarding consumers' internal appeals rights including (but not limited to) how to use it, what forms to use (and permit equivalent language in lieu of a specified form,) where to send appeals, what kind of evidence to submit, and what the time frame is before a decision will be rendered. To ensure meaningful access for LEP individuals, plans should comply with the LEP Guidance issued by the U.S. Department of Health and Human Services' Office of Civil Rights.</p> <p>All consumer complaints, whether written or verbal, about any aspect of care or coverage shall be treated as grievance subject to the content requirements, deadlines, and restricts placed on the internal grievance and appeals process.</p>
No arbitration requirement.	Consumers experience delays in resolution of their complaint by going to through an extra step of arbitration.	Any additional step for consumers prior to the exercise of their internal appeal rights should be prohibited.
Security	Any threat of losing coverage would be a barrier to exercising a right to appeal.	Insurers should be required to maintain coverage until final resolution of all appeals, external review and litigation. If an appeal involves a hospitalized patient, hospital discharge should be not allowed until all appeals are concluded.
Affordability	Any cost to the consumer could serve as a barrier to exercising a right to appeal.	Insurers are prohibited from charging the consumer any fee or cost associated with a complaint or an appeal. Although ERISA regulations prohibit charging the consumer any fees or other costs, this protection should be extended to all policies sold inside and outside the exchange.
Broad eligibility	Consumers are restricted in the issues on which they can appeal to the insurer.	Consumers should be able to appeal any decision by the insurer to deny or limit coverage for a claim, including (but not limited to) determinations of eligibility, whether care is a covered benefit, determination of whether care is medically necessary or appropriate, coordination of benefits, out of network care for emergency, amount of cost-sharing, etc.
Broad time-frame for filing	It may be difficult for consumers who are seriously ill or dealing with multiple providers to file an internal appeal in a short time frame.	Consumers should have a broad timeframe for filing an appeal—6 months at a minimum.

Guiding Principles	Consumer Problems	Recommended Solutions
Assistance with appeal process	Consumers are not aware of the information insurers use to render decisions or what documentation consumers could submit that would support their position on appeal.	Insurers should provide clear instructions regarding documentation that consumers can submit to support their case. Any documentation that may help the consumer’s position should be allowed as evidence.
Full Disclosure of Basis of Decision	<p>Consumers are not aware of the information insurers use to render decisions or what documentation consumers could submit that would support their position on appeal.</p> <p>Consumers need to understand what affects the outcome of their appeal in order to understand the fairness of appeal process.</p>	Internal reviewers should disclose the scientific basis for their decisions. If a decision is based on policy language, they must identify language protocols or guidelines on which the decision is based and disclose all underlying treatment
Timeliness of decision making	ERISA permits plans to require two levels of internal review [29 CFR Part 2560.503-1(c)(2)]. This made sense for people who did not have access to state external review programs due to ERISA preemption. However, once health reform requires external review for all private coverage, the second level of internal review will just hassle claimants and delay payment of claims. Further, a study has shown that health plans tend to uphold their original decision. ¹	Insurers should have one level of internal appeal.
•Timeliness requires strict notification to consumer	Delay in notifying the consumer about outcomes of the appeals process can lead to delay in decisions and other medical treatment. Currently, the notification requirements for urgent claims is within 72 hours and for post-service claims is within 60 days after plan’s receipt of request for review [29 CFR Part 2560.503-1(h)(4)(i)]. As a result, it is common for weeks, even months, to go by in post-service claims without a decision being rendered.	<p>The time frames for notification of internal review of claims should be shortened.</p> <p>Urgent claims notice requirements should be shortened to 48 hours.</p> <p>Post-service denials notice requirements should be shortened to 30 days.</p> <p>Insurers should have a mechanism to identify urgent appeals. If an urgent appeal involves termination of a hospital stay, the patient should be allowed to stay in the hospital receiving care until the appeal is completed similar to the Medicare requirement.</p>
Data Collection for Performance Evaluation	Consumers and purchasers often have no access to performance data by insurer (e.g. percentage of claims approved on appeal, length of time before an appeal decision is rendered,) when they purchase a health policy. This is either because no substantive data is collected or it is considered “proprietary” and not public information.	<p>Insurers should be required to collect and make data publicly available regarding their performance in internal appeals on a quarterly basis.</p> <p>Insurers are already required to report the number of claims denied under §2715A of PPACA. That provision cross-references §1311(e), which allows the Secretary to require reporting of additional information. The data standards should reflect, at a minimum, the number of appeals filed, areas of dispute, the timeliness with which decisions are rendered, the disposition of the case with each level of appeal invoked. This information should be submitted to the regulatory agency and made available on that agency’s website.</p>
Standardization	Consumers are likely to have more than one type of insurance policy in their lives, and should be able to expect similar experiences in all plans.	<p>The internal appeals process should apply to all insurers and to plans sold inside or outside of the exchange.</p> <p>Federal law should establish a minimum standard for the internal appeals process.</p>

Guiding Principles	Consumer Problems	Recommended Solutions
Enforcement	Research finds that insurers tend to uphold their denials at all levels of internal appeal, making the process discouraging for consumers. We know there is a problem because nearly 50% of those consumers who move their appeal to the next level, an external review, win their appeals. ²	Regulations should provide strong oversight tools to the state regulator to ensure consumer protections. State commissioners should be required to review internal appeals data and external review data and issue warnings and/or penalties to insurers who consistently deny claims or have complaints brought against them.
Confidentiality	The appeals process necessarily involves the review of medical records and other sensitive personally identifiable data. The confidentiality of that information is an important concern of consumers.	Insurers and any of their contracted entities should ensure that there are safeguards in place to protect strict consumer confidentiality.

STRENGTHENING CONSUMER PROTECTION IN THE STATE-ADMINISTERED EXTERNAL APPEALS PROCESS

Guiding Principles	Consumer Problems	Recommended Solutions
Accessibility	Consumers are not aware of their external appeal rights. As a result, they do not exercise those rights despite having issues with insurers' decisions regarding: billing/payment, coverage, delays/denials of treatment (pre-authorization and medical necessity determinations). ³	<p>The external appeals process must be clearly identified in all written material as a consumer right. It should be explained on the insurer's website, as part of the enrollment package, in the evidence of coverage, and as part of the requirements for consumer notices.</p> <p>Insurers must provide clear explanations in plain language (consistent with § 1311(e)(3)(B) of PPACA) regarding an enrollee's external appeals rights including (but not limited to) how to use it, what forms to use (and permit equivalent language in lieu of a specified form,) where to send appeals, what kind of evidence to submit, and what the time frame is before a decision will be rendered. To ensure meaningful access for LEP individuals, plans should comply with the LEP Guidance issued by the U.S. HHS Office of Civil Rights.</p> <p>All consumer complaints, whether written or verbal, about any aspect of care or coverage shall be treated as grievance subject to the content requirements, deadlines, and restrictions placed on the external grievance and appeals process.</p>
Broad eligibility	Health plans determine eligibility for external review [NAIC Model Act Sec. 8(C)(1)]. This limits the issues on which consumers can appeal. This also could discourage some consumers from pursuing external review.	Consumers should be able to appeal any decision by the insurer to deny or limit coverage for a claim, including (but not limited to) determinations of eligibility, whether care is a covered benefit, determination of whether care is medically necessary or appropriate, coordination of benefits, out of network care for emergency, amount of cost-sharing, etc.
	Most states require consumers to exhaust all levels of internal review before they are deemed eligible for an external review [NAIC Model Act Sec. 7]. Many consumers have difficulty navigating this multilevel review process and fail to complete it.	Allow consumers to request an external review after receipt of an adverse determination (whether in the first or second level of internal review).
	Some states impose claims thresholds in order to be eligible for an external appeal. This limits access to external appeal rights for consumers.	Claims thresholds as an eligibility requirement for an external appeal should be eliminated

Guiding Principles	Consumer Problems	Recommended Solutions
Broad time frame for filing	There is a filing deadline of 4 months, after which persons are ineligible to apply for external review [NAIC Model Act Sec. 8(A)(1)]. Insurers have very limited time frames during which consumers can exercise their external appeal rights which further restricts the utilization of external review.	The filing deadline to request an external review should be increased to at least 12 months.
Affordability	In some states, consumers are required to pay a filing fee each time they exercise their external appeal rights.	There should be no filing fee required for exercising external appeal rights.
	Consumers may be forced to incur expensive out-of-pocket costs for health care while awaiting a lengthy external appeals decision.	Insurers should continue payment for the treatment that is denied or limited or modified in expedited appeal situations until the expedited decision is rendered.
Security	Fear of losing coverage would be a barrier to exercising right to appeal.	Coverage should be guaranteed during the external review process. If appeal involves a hospitalized patient, hospital discharge should not be allowed until all appeals are concluded.
Assistance	Consumers do not have any reliable source of customer assistance outside of the insurer to seek guidance on how to exercise their rights to coverage, challenge denials, or pursue appeals.	<p>Insurers should provide customer assistance during business hours to consumers to answer their questions regarding the denial or limitation of care, with access to after-hours consultation in emergencies. A medical director must be available 24/7 to answer urgent appeals.</p> <p>Insurers should be required to refer consumers to consumer assistance offices or ombudsman programs that are required to assist consumers throughout the external review process.</p>
Timeliness	Timelines for external review under the NAIC Model Act are too long. As a result, consumers are forced to incur expensive out-of-pocket costs for health care while awaiting a lengthy external appeals decision.	Regulations should specify the criteria which qualifies for expedited appeals such as thresholds based on cost and urgency of care. If the cost of care to a consumer would exceed the out-of-pocket maximum as prescribed under the policy, that should constitute an urgent claim on grounds of cost.
	Prudent layperson standard requires a level of knowledge not available to many consumers. A reasonable person standard recognizes that a reasonable person may not have clinical knowledge and that a reasonable person in severe pain or distress may act differently than the prudent layperson standard.	The insurer should recognize the “reasonable person rule” which dictates that they would continue payment for the treatment that is denied or limited or modified in expedited appeal situations until the expedited decision is rendered.
Transparency	Insurers do not have clear instructions in their policies, their consumer information literature (e.g. Evidence of Coverage), or on their websites regarding how to exercise appeal rights. When those instructions do exist, they are not generally understandable by consumers because they contain highly legalistic and opaque language.	<p>There are provisions about disclosure requirements under the NAIC Model Act, Sec. 17, but additional requirements should be implemented.</p> <p>Insurers should provide clear instructions in a variety of formats, locations, and languages, to explain their appeal procedures. The readability of the instructions should be in plain language and at a minimum designed for understandability in commonly accepted large <i>sans serif</i> typeface (the current standard from the research is 12-point font).</p>

Guiding Principles	Consumer Problems	Recommended Solutions
Strong consumer notice requirements	<p>Consumers who are unaware of appeal rights cannot be expected to exercise them.</p> <p>Consumers are unaware what documentation they could submit that would support their position on appeal.</p>	<p>Insurers must notify consumers in writing of adverse determinations on every level of appeal invoked.</p> <p>Insurers should clearly provide instructions regarding documentation that can be submitted by the consumer to support their case. Any documentation that may help the consumer's position should be allowed as evidence.</p>
Full disclosure of basis for decisions	<p>Consumers are not aware of the information insurers use to render decisions.</p> <p>Consumers need to be able to understand what affected the outcome of their appeal in order to understand the fairness of the appeal process.</p>	<p>External reviewers should disclose scientific basis for their decisions. If the decision is based on policy language, they must identify language protocols or guidelines on which decision is based, and disclose all underlying treatment. Insurers must include in that written notice the rationale for the denial, an explanation of the right to external review, the procedures on how to initiate the appeal, forms needed to initiate an external review, the cost associated, and the party responsible for the cost of appeal.</p>
Standardization across states and across plans	<p>Consumers often face completely different definitions of terms, forms, processes, deadlines, standards of proof, and/or consumer protections in different states or in different plans. It is not uncommon to live in one state, require care or have an emergency in one state, receive primary care and follow-up or specialty care in another state, and/or have the insurer be licensed in the laws of a different state.</p>	<p>Regulations on external review should specify standards and common definitions of terms, commonality of forms, deadlines, and procedures for the exercise of other consumer protections across state lines and for all plans, sold inside or outside of exchanges.</p>
Data Collection for Performance Evaluation	<p>Consumers and purchasers often have no access to performance data by insurer (e.g. percentage of claims approved on appeal, length of time before an appeal decision is rendered,) when they purchase a health policy. This is either because no substantive data is collected or it is considered "proprietary" and not public information.</p>	<p>Insurers should be required to collect and make data publicly available regarding their performance in external appeals on a quarterly basis.</p> <p>Insurers are already required to report the number of claims denied under 2715A. That provision cross-references 1311(e), which allows the Secretary to require reporting of additional information. The data standards should reflect, at a minimum, the number of appeals filed, areas of dispute, the timeliness with which decisions are rendered, the disposition of the case with each level of appeal invoked. This information should be submitted to the regulatory agency and made available on that agency's website.</p>
Confidentiality	<p>The appeals process necessarily involves the review of medical records and other sensitive personally identifiable data. The confidentiality of that information is an important concern of consumers.</p>	<p>Insurers and any of their contracted entities should ensure that there are safeguards in place to protect strict consumer confidentiality.</p>
Strong Oversight and Enforcement	<p>Consumers are forced to seek health care in a marketplace in which the state regulator has limited authority to enforce basic consumer protections because of the underlying statutory authority or understaffing.</p>	<p>Regulations should provide strong oversight tools to the state regulator to ensure consumer protections. These would not generally be invoked for individual infractions, but patterns of infractions and systemic violations. The remedies should include administrative fines, restrictions on sales, up to and including civil and criminal penalties.</p>
Additional Consumer Protections		

Guiding Principles	Consumer Problems	Recommended Solutions
<ul style="list-style-type: none"> Financial integrity 	<p>Consumers are entitled to benefit from a legally defined percentage of profit versus payment of medical benefits from their premium dollars.</p>	<p>Costs incurred during the external review process should be included in the non-medical costs when determining minimum loss ratios.</p>
<ul style="list-style-type: none"> Independence of Reviewer 	<p>Consumers should have a fair review without influence from the insurer or previous decisions concerning their claim.</p>	<p>The regulator, not the insurer should pick the independent reviewing organization. The insurer or health plan is responsible for notice requirements, such as informing the consumer about their further appeal rights. However, the regulator bears the responsibility for the transparency of the decisions and the disclosure to the public of the performance data tracking by insurer. This data should include: the name of plan; age, gender, geographic location of patient, service/treatment requested, for what illness/condition, time period from request to decision, names and types of physician reviewers and specific rationale for decision, including evidence or clinical guidelines relied upon. There should be no conflict of interest between the review organization, reviewer, or the consumer. A material conflict of interest is defined as a conflict based on professional, familial, or financial areas with the insurer or the claimant. Any external review is <i>de novo</i>.</p>
<ul style="list-style-type: none"> Integrity and Expertise of Reviewer 	<p>Consumers should be able to count on the use of appropriate expertise in decision making.</p>	<p>The reviewer should have relevant medical expertise. Reviewers should be given wide discretion in weighing evidence based on their own experience and expert medical judgment when determining what is medically necessary. Further, the reviewer should be given authority to evaluate the plan's medical necessity criteria that can then be overturned if they are determined to be inadequate or inappropriate.</p>
<ul style="list-style-type: none"> Binding, Publicly Available Decisions 	<p>External review is an important consumer protection, providing a mechanism for disputes between insurers and consumers to be resolved fairly, expeditiously, and inexpensively. These decisions should be publically available to consumers so they have access to precedents and to regulators for them to track performance by plan and key patient characteristics.</p>	
<ul style="list-style-type: none"> Maintain right to judicial remedies 	<p>Consumers should not have to give up their rights to other judicial remedies to get a fair external review.</p>	<p>External review decisions should be binding on insurers and not contestable in court. The regulator has the responsibility for the transparency of the decisions and the disclosure to the public of the performance data tracking by insurer. This data should include: the name of plan; age, gender, geographic location of patient, service/treatment requested, for what illness/condition, time period from request to decision, names and types of physician reviewers and specific rationale for decision, including evidence or clinical guidelines relied upon.</p>
		<p>All existing federal and state judicial remedies are preserved. Contracts must comply with existing state and federal law.</p>

END NOTES

¹ Karen Pollitz, Jeff Crowley, Kevin Lucia, and Eliza Bangit, (March 2002) "Assessing State External Review Programs and the Effects of Pending Federal Patients' Rights Legislation," Report for the Kaiser Family Foundation, Menlo Park, CA. Available at <http://www.kff.org/insurance/externalreviewpart2rev.pdf>

² Karen Pollitz, Jeff Crowley, Kevin Lucia, and Eliza Bangit, (March 2002) "Assessing State External Review Programs and the Effects of Pending Federal Patients' Rights Legislation," Report for the Kaiser Family Foundation, Menlo Park, CA. Available at <http://www.kff.org/insurance/externalreviewpart2rev.pdf>. The August 2005 update is available at <http://www.consumersunion.org/health/hmo-review/index.html>.

³ Consumers Union and the Kaiser Family Foundation did a report on external appeals in the states which provides more information on the importance of accessibility. It is available at <http://www.consumersunion.org/health/hmo-review/17-mistakes.html>.



Senior Issues-“CLASS”

Long Term Care Insurance: The CLASS Act and Coordination With Other Benefits

Title VIII of the Public Health Act, as amended by the Patient Protection and Affordable Care Act of 2009 (PPACA) establishes a national voluntary insurance program for long-term care, the Community Living Assistance Services and Supports, or the CLASS Act, the legislative legacy of Senator Edward Kennedy. Individuals who enroll in CLASS and become eligible for benefits will receive a daily cash benefit to purchase long term care services and supports intended to assist beneficiaries to remain independent at home or in the community. Many of the benefits of existing, and potentially future, long term care insurance policies sold individually, through groups, or through state and federal public employment entities cover many of the same services offered through CLASS. Medical rehabilitative benefits may also include some services covered by CLASS. Duplicate or overlapping benefits for the same or similar services raises questions about how these benefits will be coordinated with CLASS benefits, if at all.

Background and Discussion

Insurance is regulated by the individual states and most states base their regulatory framework for long-term care insurance in whole or in part on the National Association of Insurance Commissioners (NAIC) Long-Term Care Insurance Model Act and Regulation. The federal government bases federal tax deductibility of long-term care insurance premiums and benefits on selected standards and requirements of the Model Act and Regulation. The federal government also allows states to exempt certain assets protected by a “Partnership” long-term care insurance policy that the state Medicaid program would otherwise be required to take into account upon eligibility for state Medicaid benefits, and from estate recovery actions following the death of such an individual. The NAIC Model Act and Regulation therefore establishes a consistent minimum national standard for individual and group long-term care insurance policies, and for Partnership policies sold within the individual states.

The Problem

The availability of CLASS benefits will impact other benefits that pay for similar services and supports that are part of other insurance products, particularly long-term care insurance policies. Insurance products typically coordinate coverage with the same benefits available from other coverage to prevent collection of benefit amounts that exceed the cost of an insured loss. Section 3203 E of PPACA specifies that CLASS allows coordination with any supplemental benefits sold through an Exchange established under Section 1311 of PPACA, but is silent about how benefits sold through an Exchange, or on the open market, can coordinate with or against CLASS benefits.

CLASS does not prohibit the development of products outside an Exchange that is specifically designed to wrap around or supplement CLASS benefits, nor does it prohibit a product that would fill in one or more specific gaps in CLASS benefits.

The NAIC Model Act and Regulation does not address the issue of any products that might be designed to supplement or wrap around CLASS benefits, but the Regulation does allow limitations or exclusions for services or items paid under another long-term care insurance or health insurance policy. The Regulation does not however address how coordination such might occur, nor does it identify how primary coverage is to be determined when additional benefits are also available under any other

insurance product.¹ In addition, the NAIC Model Act only requires a long-term care insurance policy to meet the requirements of the Model Regulation when benefits are provided for 12 months or longer, leaving a loophole for supplemental or gap benefits with durations of less than 12 months.²

In states with Partnership programs, long-term care insurance policies that meet certain federal and state requirements provide one dollar of Medicaid asset protection for each dollar of benefits paid out by the policy. The state Medicaid program agrees to exempt those protected dollars if and when an individual applies for state Medicaid benefits, and to exempt them from estate recovery actions. It is unclear what effect CLASS benefits will have, if any, on assets that are protected by Partnership policies in the event an individual is covered by both;³ or how consumers will be informed of any conflict, or the lack of a conflict, between the two types of coverage.

Recommendations

The NAIC Model Act and Regulation should be amended to establish the rules under which coordination of benefits can occur and the standards that must apply to policies and riders specifically written to supplement items, services, and supports for people receiving long-term care. For instance:

- Identify the types of products that can be sold to supplement any long-term care benefits a person might be eligible to receive.
 - Establish minimum daily benefits, durations, and other rules for benefits that supplement, wrap around, or fill a gap for any other benefits a covered person might have
 - Require that eligibility standards could not be different than the benefits being supplemented
 - Establish disclosures, sales and marketing rules, and policy form standards that would apply to supplemental products
 - Specify how would benefit be coordinated between a supplemental product and any other benefits a person might have, and how those rules would apply if a person defers a benefit, or allows an existing benefit to accumulate for later withdrawal
 - Establish rating and loss ratio standards that would apply to supplemental policies that would presumably be taking far less risk
 - Develop marketing standards to take into account the presence of CLASS benefits and the relationship to long-term care insurance, as well as if or how protected assets are affected in long-term care insurance policies sold in conjunction with Partnership programs.
- Develop standards for coordination of benefits in existing long-term care policies and riders with CLASS Act benefits.
 - Determine what coordination standards should apply to benefits available through the CLASS program with any other benefits a person has for similar services, supplies, or supports
 - Determine whether the benefits of a long-term care insurance policy, or any other benefits, can be offset against benefits available through the CLASS program
 - Determine if existing long-term care insurance policy can be amended to take into account benefits available through the CLASS program, and if so what standards would apply
 - Determine what standards will apply to future coordination clauses in long-term care policies

In the absence of comprehensive nationally standardized rules and requirements insurance products will evolve in the private market and consumers will be disadvantaged or even sold worthless products while regulation and enforcement occurs piecemeal across the country.

While we understand that people cannot enroll for CLASS benefits before January 1, 2013, we encourage the NAIC to begin

the process of modernizing the Model Act and Regulation to address these issues as quickly as possible to make clear what can be sold to supplement or wrap around CLASS benefits, and how coordination of benefits must be written for policies and benefits sold now and in the future. Long-term care insurance is a product sold far in advance of need, and consumers need the certainty of how their benefits will be paid now and in the future.

END NOTES

¹ Section 6 B(6); Policy Practices and Provisions, the NAIC Long-Term Care Insurance Model Regulation

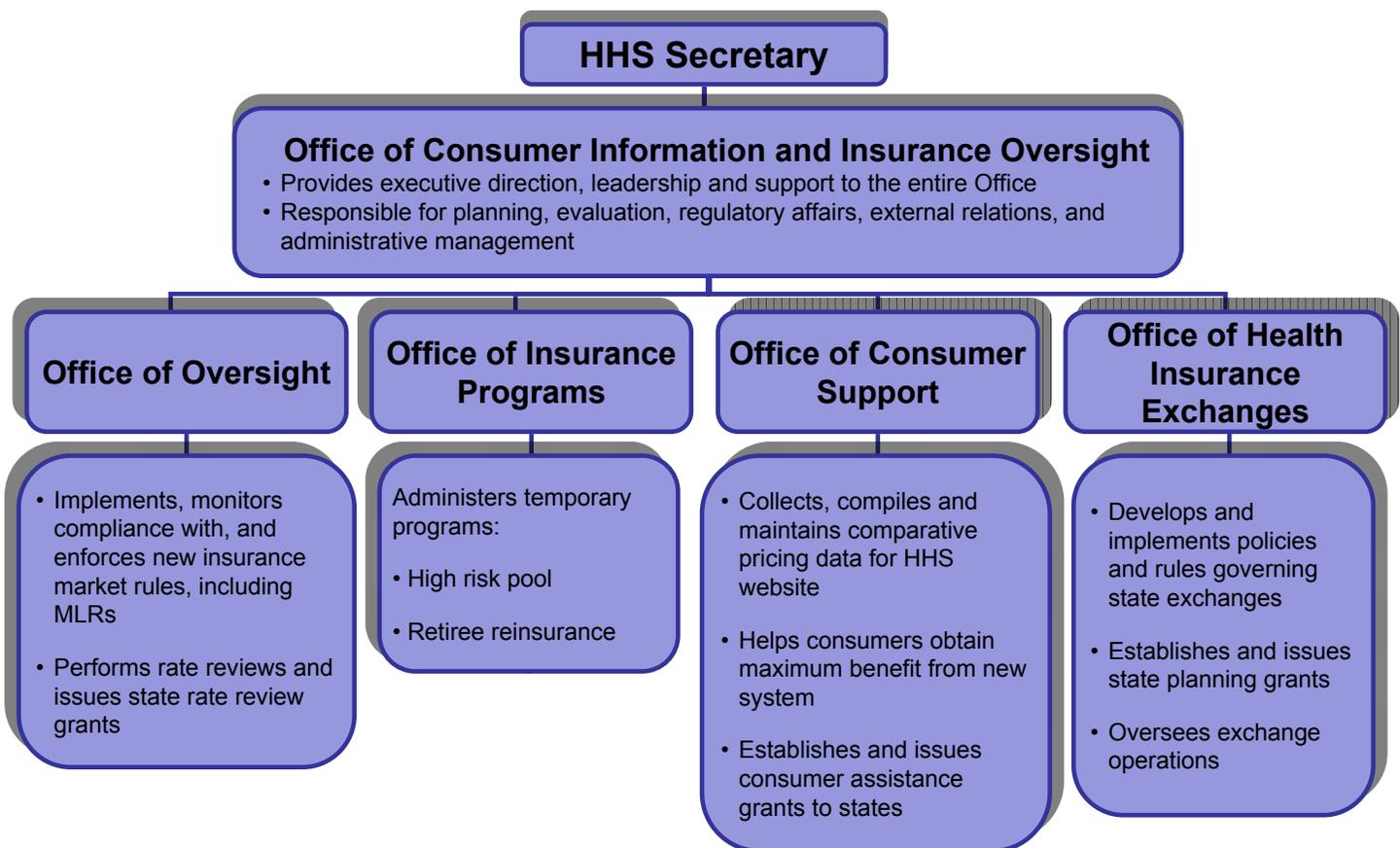
² Section 4 A, Definitions, the NAIC Long-Term Care Model Act

³ The Act is quite clear that CLASS benefits cannot be taken into account for an individual's eligibility for Medicaid or other public benefits.



Reference Materials

HHS Health Reform Organization Chart: New Office of Consumer Information and Insurance Oversight



Publication Expected in the Federal Register on April 19, 2010

Tax-Free Employer-Provided Health Coverage Now Available for Children under Age 27

IR-2010-53, April 27, 2010

WASHINGTON — As a result of changes made by the recently enacted Affordable Care Act, health coverage provided for an employee's children under 27 years of age is now generally tax-free to the employee, effective March 30, 2010.

The Internal Revenue Service announced today that these changes immediately allow employers with cafeteria plans — plans that allow employees to choose from a menu of tax-free benefit options and cash or taxable benefits — to permit employees to begin making pre-tax contributions to pay for this expanded benefit.

IRS Notice 2010-38 explains these changes and provides further guidance to employers, employees, health insurers and other interested taxpayers.

“These changes give employers a unique opportunity to offer a worthwhile benefit to their employees,” IRS Commissioner Doug Shulman said. “We want to make it as easy as possible for employers to quickly implement this change and extend health coverage on a tax-favored basis to older children of their employees.”

This expanded health care tax benefit applies to various workplace and retiree health plans. It also applies to self-employed individuals who qualify for the self-employed health insurance deduction on their federal income tax return.

Employees who have children who will not have reached age 27 by the end of the year are eligible for the new tax benefit from March 30, 2010, forward, if the children are already covered under the employer's plan or are added to the employer's plan at any time. For this purpose, a child includes a son, daughter, stepchild, adopted child or eligible foster child. This new age 27 standard replaces the lower age limits that applied under prior tax law, as well as the requirement that a child generally qualify as a dependent for tax purposes.

The notice says that employers with cafeteria plans may permit employees to immediately make pre-tax salary reduction contributions to provide coverage for children under age 27, even if the cafeteria plan has not yet been amended to cover these individuals. Plan sponsors then have until the end of 2010 to amend their cafeteria plan language to incorporate this change.

In addition to changing the tax rules as described above, the Affordable Care Act also requires plans that provide dependent coverage of children to continue to make the coverage available for an adult child until the child turns age 26. The extended coverage must be provided not later than plan years beginning on or after Sept. 23, 2010. The favorable tax treatment described in the notice applies to that extended coverage.

Information on other health care provisions can be found on this website, IRS.gov.

More Support for Young Adults

Posted by Nancy-Ann DeParle on April 27, 2010 at 12:24 PM EDT

When health insurance reform became the law of the land, we knew our work was just beginning. While passing the law was a tremendous accomplishment, the President and his Administration are now focused on the next challenge: making sure the law is implemented smoothly, quickly, and effectively. In fact, the day after the bill passed, the first thing the President asked of his senior staff was “Where are we on implementation?”

One of the most important provisions in health reform for young adults and their families is the new provision that allows young adults to stay on their parents' health care plan until age 26. This provision takes effect on September 23, 2010, and it could help more than 4.7 million uninsured young Americans.

But we knew that some young adults graduating from college this spring could risk losing their health insurance before the provision takes effect, only to be added back onto their parents' policy the next time their parents' plan comes up for renewal on or after September 23rd. That was bad news for families and bad news for insurance companies too. Removing an individual from a health insurance plan and then adding them back on a few months later takes time, and it costs money.

That's why on April 19, Health and Human Services Secretary Kathleen Sebelius called on leading insurance companies to begin covering young adults voluntarily before the September 23 implementation date required by the new health reform law. Early implementation would avoid gaps in coverage for new college graduates and other young adults and save on insurance company administrative costs of dis-enrolling and re-enrolling them between May 2010 and September 23, 2010. Early enrollment will also enable young, overwhelmingly healthy people who will not engender large insurance costs to stay in the insurance pool.

And we're pleased to report that the following insurance companies are doing just that:

Blue Cross and Blue Shield of Alabama	Blue Cross and Blue Shield of Vermont
Blue Cross Blue Shield of Delaware	Blue Cross & Blue Shield of Rhode Island
Blue Cross and Blue Shield of Arizona, Inc.	Premera Blue Cross
Blue Cross and Blue Shield of Florida	Blue Cross and Blue Shield of South Carolina
Arkansas Blue Cross and Blue Shield	Blue Cross and Blue Shield of Wyoming
Blue Cross and Blue Shield of Hawaii	Kaiser Permanente
Blue Shield of California	Cigna
Blue Cross of Idaho Health Service	Aetna
Regence Blue Shield of Idaho	United
Wellmark Blue Cross and Blue Shield of Iowa	WellPoint
Health Care Service Corporation	Humana
Blue Cross and Blue Shield of Kansas	Capital District Physicians' Health Plan (CDPHP), Albany, New York
Blue Cross Blue Shield Association	Capital Health Plan, Tallahassee, Florida
Blue Cross and Blue Shield of Louisiana	Care Oregon, Portland, Oregon
WellPoint, Inc.	Emblem Health, New York, New York
CareFirst BlueCross and BlueShield	Fallon Community Health Plan, Worcester, Massachusetts
Blue Cross and Blue Shield of Massachusetts	Geisinger Health Plan, Danville, Pennsylvania
Blue Cross and Blue Shield of Kansas City	Group Health, Seattle, Washington
Blue Cross and Blue Shield of Michigan	Group Health Cooperative Of South Central Wisconsin, Madison, Wisconsin
Blue Cross and Blue Shield of Montana	Health Partners, Minneapolis, Minnesota
Blue Cross and Blue Shield of Minnesota	Independent Health, Buffalo, New York
Blue Cross and Blue Shield of Nebraska	Kaiser Foundation Health Plan Oakland, California
Blue Cross & Blue Shield of Mississippi	Martin's Point Health Care, Portland, Maine
Horizon Blue Cross and Blue Shield of New Jersey, Inc.	New West Health Services, Helena, Mt
HealthNow New York, Inc.	The Permanente Federation, Oakland, California
The Regence Group	Priority Health, Grand Rapids, Michigan
Excellus Blue Cross and Blue Shield	Scott & White Health Plan, Temple, Texas
Capital BlueCross	Security Health Plan, Marshfield, Wisconsin
Blue Cross and Blue Shield of North Carolina	Tufts Health Plan, Waltham, Massachusetts
Independence Blue Cross	UCARE, Minneapolis, Minnesota
BlueCross BlueShield of North Dakota	UPMC Health Plan, Pittsburgh, Pennsylvania
Highmark, Inc.	
Blue Cross of Northeastern Pennsylvania	
BlueCross and BlueShield of Tennessee	

Today, we marked another step forward in our work to provide coverage to young adults with the release of new guidance from the Internal Revenue Service specifically stating that children can be covered tax-free now on their parents' health insurance policy. The new guidance also discusses incentives the Affordable Care Act provides for employers to immediately extend health insurance coverage to young adults.

This new guidance will help employers as they work to provide better benefits to their employees and cover more Americans. To learn more, check out the press release and fact sheet (pdf).

Nancy-Ann DeParle is Director of the White House Office of Health Reform

