# Health reform right out of the chute: Immediate insurance reforms

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Large chunks of any new health reform law are not designed to go into effect until 2013 or later – but both the House and the Senate bills provide some immediate help for those who currently lack healthcare coverage. Here is a summary of what is in the bills passed by the House and Senate as they head to conference committee.

## High risk pool for the uninsured –

Both bills create a temporary High Risk Pool Program to make insurance available to uninsured people with pre-existing conditions. Both bills would make health insurance available to people who are currently uninsured and have pre-existing conditions, and both contain sanctions to discourage employers and existing insurance carriers from forcing or persuading enrollees from dropping their current coverage. Both prohibit pre-existing condition exclusions in the coverage offered by the high-risk pools and both would establish an appeal mechanism for people who are denied coverage.

Otherwise, the details vary considerably between the two bills.

**Administration**
Under the House bill, it can be organized directly by the Secretary of Health and Human Services or through agreements, contracts, and grants to States that establish State high-risk pools.

The Senate version would organize the pools through contracts with the States or private nonprofit entities.

**Eligibility**
The House bill would make risk-pool insurance available to those not eligible for Medicare, Medicaid, or employment-based group insurance (not counting COBRA extension benefits). There are four different ways a person can qualify for eligibility to obtain coverage from the high-risk pool under the House bill –

- He must be either eligible for COBRA coverage or "medically eligible" – which means either that he has a condition listed by the HHS Secretary in regulations or that within the past 6 months he applied for an individual policy and was turned down due to pre-existing condition, or only offered a policy that excluded the pre-existing condition, or the premium of what was offered was more expensive than the premium charged by the high-risk pool.

- The spouse and dependents of any person who qualifies under the above mechanism would also be eligible for risk-pool insurance.

- She hasn't had health insurance coverage or coverage under an employment-based health plan for at least the 6-month period immediately preceding the date of the her application for high-risk pool coverage.

- On or after October 29, 2009, he had employment-based retiree health coverage and the annual increase in premiums for a new coverage period exceeds an "excessive percentage" to be specified by the Secretary of Health and Human Services.

Under the Senate bill, a person will qualify to obtain health insurance through the high-risk pool if (1) she has had no employer-based health insurance for at least 6 months and (2) she has a pre-existing condition and (3) she is a citizen of the United States or is lawfully present within the United States.

**Premiums**
Under the House bill, premium rates can be no higher than 125% of prevailing standard rate for individual coverage in relevant geographic market. Age adjustments limited to highest premium being no more than twice the cost of the lowest premium.

The Senate bill states that premium rates must be established at a standard rate for a standard population. They may not vary on the basis of age by a factor of greater than 4 to 1 and they may not vary on the basis of any other factor than age, tobacco use, and geographic location.

**Deductibles and cost-sharing limits**
The House version states that the deductible must be less than or equal to $1500 for individual coverage and that the HHS Secretary may set a higher deductible for family coverage. The Senate bill does not address the amount of deductibles.

Both versions would limit enrollees' maximum annual cost-sharing to $5,000 for an individual, $10,000 for a family.

**Other provisions**
The Senate version requires the insurance offered by the pool to provide benefits that pay at least 65% of the cost of the covered services.

The House bill specifically states that the number of people who may be able to get coverage through the pool will be limited by if the amount of money appropriated to pay for them requires such limitation.

## Immediate reforms that are generally applicable –

In addition, there are a number of provisions that will help people who already have (or have access to) health insurance.

**Provisions under both bills –**

- Limitation on rescissions. Insurance companies will be prohibited from rescinding policies unless there is clear evidence that the covered person has committed fraud.

- Elimination of lifetime limits. No lifetime benefits limits for plan years beginning during the first year after enactment. (In the House version, this protection is effective for group plan years starting on or after January 1, 2010 and for individual insurance "offered, sold, issued, renewed, in effect, or operated" on or after the same date. The Senate bill is effective for plan years beginning six months after the date of enactment.)

- Coverage of adult children. Plans that provide dependent coverage must cover adult children up to 26 years old in the Senate bill, under 27 in the House bill.

- Possible limitation on premium price increases. A procedure will be put into place to monitor and require justification for premium price increases.

- Pre-existing conditions. The House bill only would immediately substantially reduce pre-existing condition restrictions in group coverage. The Senate bill's flat prohibition of pre-existing condition exclusions does not become effective until January 1, 2013. In the House bill, a similar permanent prohibition kicks in on various later dates for each particular group plan.

**Provisions under House bill only –**

- Domestic violence. The House bill only would prohibit group and individual plans from imposing a pre-existing condition requirement because of domestic violence, effective for group plan years starting on or after January 1, 2010 and for individual insurance "offered, sold, issued, renewed, in effect, or operated" on or after the same date. (The Senate bill would prohibit health plans from establishing rules of eligibility based on conditions arising out of domestic violence, but only as of January 1, 2013.)

- COBRA. Under the House bill only, people who have COBRA continuation coverage in effect as of the date of enactment will see the 18-month duration limitation lifted, although the COBRA coverage could terminate for other reasons, such as nonpayment of premiums. The COBRA coverage ends when the covered person becomes eligible for "acceptable coverage" or for health insurance coverage through a Health Insurance Exchange.

- Disabled children. In the House bill only, group and individual plans that offer surgical benefits must provide coverage for outpatient and inpatient diagnosis and treatment of congenital or developmental deformity, disease, or injury for children under 21, effective for group plan years starting on or after January 1, 2010 and for individual insurance "offered, sold, issued, renewed, in effect, or operated" on or after the same date. "Treatment" is defined to include reconstructive surgical procedures to improve function, but can also include procedures performed to approximate a normal appearance that are performed on abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease (including procedures that do not materially affect the function of the body part being treated, and procedures for secondary conditions and follow-up treatment). Cosmetic surgery is not included unless it is performed to reshape normal structures of the body to improve appearance or self-esteem.

**Provisions under Senate bill only –**

***Requirement that insurers spend a high percentage of premiums on subscribers' health care.***

The Senate bill requires health insurers to file annual reports showing the percentage of total premium revenue spent on –

(a) direct healthcare services for subscribers,

(b) activities to improve healthcare quality, and

(c) all other costs, except state taxes and licensing and regulatory fees.

These reports will be displayed on the Internet.

Expenses detailed in (c) above cannot exceed 15% of premium revenue for large-group insurance, unless a lower limit is set by state law. For small-group and individual insurance, the expenses detailed in (c) above cannot exceed 20% of premium revenue, unless a lower limit is set by state law "except that such percentage shall be adjusted to the extent the Secretary determines that the application of such percentage with a State may destabilize the existing individual market in such State."

If the percentage of premium revenue spent on "other costs" exceeds the relevant limit, the insurance company must provide an annual rebate to each enrollee, on a pro rata basis, in an amount that is equal to the amount by which premium revenue on such activities exceeds the cap.

These requirements effective for plan years beginning on or after the date that is 6

months after the date of enactment. After January 1, 2014, the calculations will be based on a 3-year rolling average..

***Coverage of preventive health services***

Group and individual health plans must cover, and may not impose cost-sharing requirements on, certain preventive health services, including –

- Items and services that have been given evidence-based "A" or "B" rankings by the U.S. Preventive Services Task Force.
- Vaccinations as recommended for the individual involved by the CDC's Advisory Committee on Immunization Practices.

This provision is effective for plan years beginning 6 months or more after date of enactment.