Immediate Insurance Reforms: Implementation Issues and Recommendations

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Issue: The Senate and House bills include several immediate insurance reforms (e.g., new benefit requirements, new rules on pre-existing exclusions, rate review and medical loss ratios requirements). Many of these reforms would be effective at enactment (House) or six months after enactment (Senate).

Recommendation: Ideally, these provisions should be effective for plan years beginning 12 months after final regulations have been promulgated to allow sufficient time to implement the processes and procedures necessary for compliance. At a minimum, the effective dates should be no sooner than plan years beginning 12 months after enactment of the legislation to provide sufficient time for group health plans and insurance issuers to make the necessary changes. Further, given the compressed timeframe, there should also be a safe harbor for plan sponsors and health plans that have acted in good faith to comply with the new law. A similar approach has been used with implementation of other major federal health legislation, including for example, HIPAA privacy and mental health parity requirements.

Background: Both the Senate and House bills would create numerous new requirements applicable in the first few years after enactment, many of which would be effective at enactment (House) or six months after enactment (Senate). The following charts lists these requirements,

Immediate Reforms	
• No lifetime limits on coverage (H/S)	• No pre-existing exclusions for children under 19 (S)
• Only HHS-defined annual limits on coverage (S)	• Reduction in group pre-existing exclusion periods from 12 to 3 months (H)
• Coverage for specific preventive services with no cost sharing (S)	• No pre-existing exclusion based on conditions resulting from domestic violence (H)
• Coverage for reconstructive surgery for children with congenital or developmental deformities (H)	• Extension of dependent coverage to age 26 (S) and 27 (H)
• Restrictions on rescissions (H/S)	• No discrimination in coverage or premium based on salary (S)
• Patient protections for emergency services and designation of primary care physicians (including OB/GYN and pediatrician) (S)	• Summary of coverage provided to applicants and enrollees, including uniform definitions of terms (S)
• Appeals process (S)	• Quality of care reporting by insurers (S)
• Rate review (H/S)	• Medical loss ratio reporting (H/S)

As outlined below, successful Implementation of these reforms will require a range of actions and collaboration by the federal government, the states, employer plan sponsors and insurers.

1. **Federal Government:** Regulations and/or informal agency guidance will be needed on several of these topics. In formulating guidance, federal regulators

will need to consult with the states, the National Association of Insurance Commissioners, and insurers to understand the interactions between the new requirements and existing state laws and current industry practices.

2. **States:** States must enact laws and promulgate regulations so they have clear enforcement authority to oversee compliance with these federal requirements (similar to the HIPAA model of state enforcement of the 1996 federal insurance reforms). Adequate time is needed so that state legislatures and insurance departments can act. In addition, state insurance departments will need to review updated contract and rate filings from insurers that arise out of the new federal requirements.

3. **Insurers:** Insurers will need time to fully analyze understand the new requirements before implementing them. This will require in-depth discussions among multiple departments within a company – including their medical affairs, actuarial, product development, marketing, public policy, and legal departments. Discussions with outside experts such as actuarial consultants and legal counsel also may be needed. Insurers likely will have interpretative questions on many issues requiring guidance from federal and state regulators. Several other steps will be required, as shown in this chart.

Additional Steps for Implementation

• Assess current benefit packages, data systems, and business practices	• Reprogram membership data systems (e.g., new rules on dependent eligibility age)
• Develop new contract language and rates	• Reprogram claims processing systems for benefit changes (e.g., no copayments on preventive services)
• Seek state insurance department approval for new contract language and rates	• Test data systems prior to final implementation
• Draft and distribute (mail, email, etc.) educational materials for current members about the changes	• Educate providers about the new changes
• Develop and distribute marketing materials for new members	• Update websites for new information

4. **Employers:** Employers will need to work with their insurers, third-party administrators, and benefit consultants to analyze these changes and identify and implement compliance strategies. Employers will play a key role in communicating benefit changes to their employees. Human resource departments will need to update benefit summaries and open enrollment materials, and other communications to inform employees and their dependents about the changes.

Attached are illustrations of the scope and timing of activities necessary to achieve compliance.