PPACA Overview:
Impact on the Small Group Market

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Overview

- Summary of part of the Patient Protection and Affordable Care Act (PPACA).
- Legislation is starting point; majority of details will come from regulations (most still to be promulgated).
- Impact of federal reform will be different from state to state (e.g. some PPACA provisions are similar to existing Minnesota law).
- Discussion will cover: insurance market reforms, coverage requirements and assistance and the Health Insurance Exchange.

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Insurance Market: 2010

- **High Risk Pool:**
  - Federal pool for uninsured individuals. Federal Government is administering program in Minnesota.
- **Early Retiree Reinsurance Program (ERRP):**
  - Program encourages provision of retiree health benefits by reimbursing portion of those claims.

- **Insurance Changes Effective for Plan Years on or After September 23, 2010:** (Provisions apply to fully-insured and self-insured plans)
  - No lifetime benefit limits and "restricted" annual benefit limits on the "dollar value of essential benefits"
  - Dependent coverage to age 26
  - Coverage of preventive services and immunizations as recommended by the U.S. Preventive Services Taskforce, CDC, and HRSA without cost-sharing
  - No pre-existing condition exclusions for kids under age 19
  - No rescissions, except in cases of fraud or intentional misrepresentation

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Insurance Market: 2010

- **Grandfathered Plans:**
  - Individuals and employers may keep the plan they currently have.
  - However, new rules on lifetime limits, rescissions, and dependent coverage apply to all plans.
  - All employer plans must also comply with the pre-ex for kids and “restricted” annual limits provisions.
  - Grandfathered plans may make routine plan changes (e.g. inflation modifiers, adding new benefits, or voluntarily adopting new consumer protections) without losing grandfathering status.
  - Plans will lose grandfathered status if they make significant changes that reduce benefits or increase costs to consumers.
  - Grandfathered plans must disclose to consumers that the plan is not subject to various rules and consumer protections under PPACA.

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Insurance Market: 2011

- **Medical Loss Ratio:**

  –In January 2011, 80% MLR for individual and small group, 85% MLR for large group. Rebates for failing to meet MLR.

  –National Association of Insurance Commissioners (NAIC) charged with creating definition and rebating formula with HHS certification. NAIC has approved reporting form.

- **Premium Rate Review:**

  –In January, annual process to start for premium rate review by states.

  –Relationship to state rate review unclear; how are “unreasonable” rates defined and what are the potential sanctions.

  –NAIC still working on recommendations.

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Insurance Market: 2013

- Create the Consumer Operated and Oriented Plan (CO-OP) program (i.e. non-profit, member-run health insurance companies in all 50 states and the District of Columbia). There is a $6 billion appropriation to finance the program and award loans and grants to establish CO-OPs by July 1, 2013)
- Administrative simplification process starts (i.e. the first set of rules, eligibility verification and claims status, is effective January 1, 2013). Other rules dealing with electronic funds transfers and health care payment and remittance, and health claims or equivalent encounter information, enrollment and disenrollment in a health plan, health plan premium payments, and referral certification and authorization have different phase in dates.

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Insurance Market: 2014

- **Insurance Changes Effective January 1, 2014:**
  - Small group definition set at 1 to 100 employees. No federal definition yet of what counts as an employee. State can go back to 50 on or before January 2016.
  - Premium variation based on health status prohibited for individual and small group.
  - Rating variation for individual and small group limited to tobacco use (1.5:1), age (3:1), geography, and family composition. State to define geographic rating areas.
  - Wellness discounts allowed under HIPAA for group plans increased from 20% to 30% (HHS may increase to 50%). 10-state demonstration to apply wellness discounts to individual market.
  - Guarantee issue (and renewal) required for individual and small group plans during an open enrollment period.
  - Pre-existing condition exclusions prohibited for fully-insured and self-funded plans.
  - Annual limits prohibited for all fully-insured and self-insured plans.

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Coverage Requirements & Assistance

- **Individual Coverage Requirement:**
  - Starting 2014, individual mandate starts. Enforced via tax fines administered by IRS.
- **Benefit Requirements:**
  - By 2014, HHS is to establish a minimum benefit set (“Bronze” plan) for individuals and small employers. States may require additional benefits, but must cover the costs of these additional benefits for individuals eligible for Exchange subsidies.
- **Individual Coverage Assistance**:
  - Premium and cost-sharing subsidies for those not eligible for “affordable” employer coverage between 133% and 400% FPL buying in “Exchange” starting in 2014.

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Coverage Requirements

- **Employer Requirements:**
  - Starting in 2014, if an employee of a larger employer (i.e. 50+ “full-time” employees) gets a subsidy in the Exchange, that employer pays a penalty.
    - Full-time employees defined as 30 or more hours per week. Both full-time and part-time employees are included in the calculation of determining if an employer is a “large employer”; however, part-time employees are not included in the penalty calculation.
  - Employers must also provide “Free Choice Vouchers” for certain employees for whom the premium for an employer plan exceeds 8% of income.
  - Employers with 200+ employees must do auto enrollment with opt out.
  - Waiting periods exceeding 90 days prohibited.

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Coverage Assistance

- 2010: Establishes a Small Business Health Care Tax Credit.
- 2011: Access to “simple” cafeteria plans expanded to the 100 or fewer employer marketplace. Certain eligibility, participation, and contribution requirements apply.
- 2014: the maximum tax credit will increase from 35 to 50 percent. For more detailed guidance on tax credit, please go to this link. http://www.irs.gov/pub/irs-drop/n-10-44.pdf

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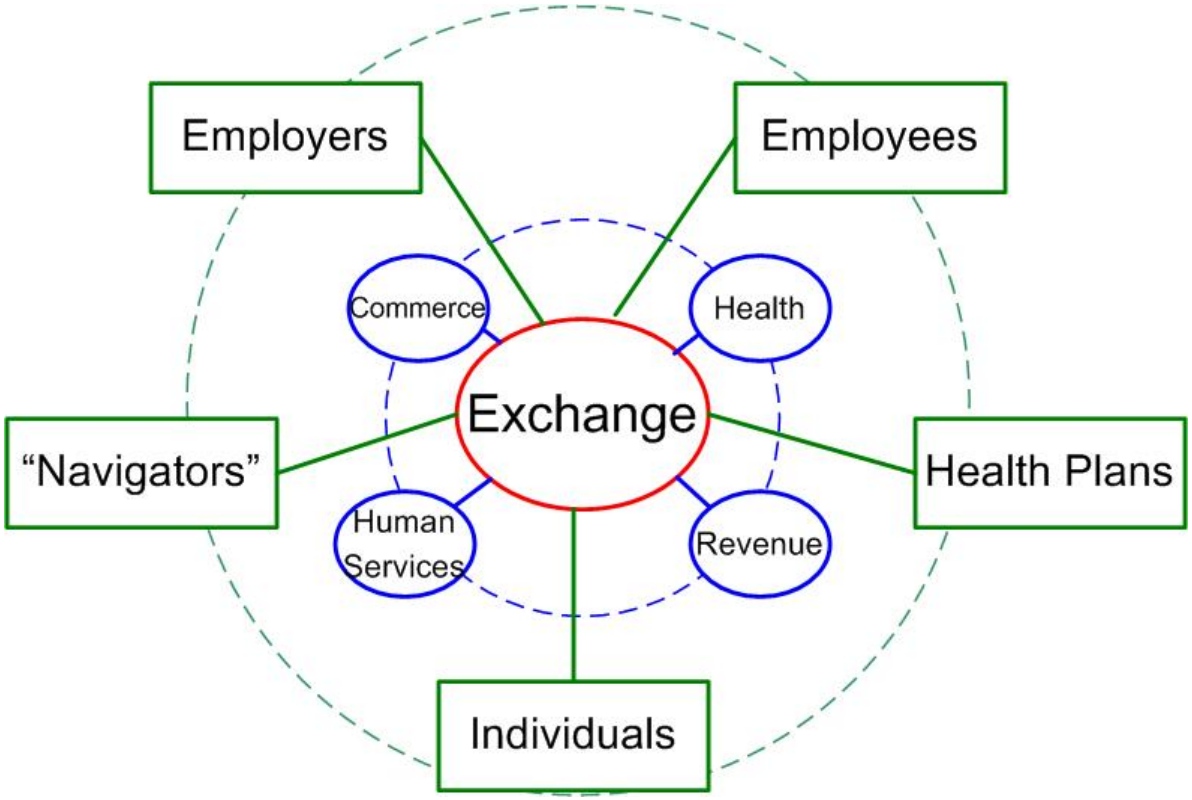
What is an Exchange?

What is an Exchange?: An organized competitive marketplace (one stop shop) to facilitate the comparison, choice, and purchase of health insurance coverage for individual consumers.



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Exchanges: 2010

- **Web Portal:**
  - http://www.healthcare.gov was launched on July 1, 2010
  - Information to consumers on individual and group plans, Medicare, Medicaid, CHIP, and high risk pools.
  - Coming soon will be information on medical loss ratios (MLR), eligibility, availability, premium rates, and cost-sharing.
  - Eventually supposed to provide consumers with recommendations for preventive care and comparison information on provider quality.
  - May be precursor to federal exchange portal.

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Exchange Components: 2014

- **Functions:** Customer service, “Navigator” program, plan certification, plan comparisons, eligibility determination, enrollment, and electronic interchange with state and fed agencies
- **Health Plan Participation:** HHS to establish minimum standards for certification including marketing, network adequacy, accreditation, plan information, and enrollment forms
- **Eligibility:** Individuals not eligible for “affordable” employer coverage and small groups (50 or 100). May allow large groups starting 2017. Will determine eligibility for Medicaid, subsidies, and potentially a “Basic Health Plan.”

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Exchange Components: (cont.)

- **Market Rules and Risk Sharing:** Benefit rules, rating rules, and risk sharing (reinsurance, risk corridors, risk adjustment, risk pooling) apply inside and outside Exchange. States may merge individual and small group markets.
- **Structure and Governance:** State may create separate or combined Exchange for individuals and small groups. Regional (i.e. more than one state) and subsidiary Exchanges for distinct state geographies also allowed. Operated by governmental or non-profit entity (not health insurers), or run by federal government on behalf of state.
- **Financing:** Within 1 year of enactment, HHS to award funding to states (CBO has estimated $2 billion, but actual amount unknown) for Exchange start-up, but federal funding can not be used for ongoing operations.

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Current Efforts

- **National level:**
  - HHS (and other agencies) continuing to issue new rules and guidance – many more still to come.
  - NAIC working on both regulations and recommendations.
  - Other national organizations working on implementation efforts (e.g. National Governor's Association (NGA), National Association of State Medicaid Directors (NASMD), and National Academy for State Health Policy (NASHP)).
- **State level:**
  - Legislative Commission on Health Care Access
  - Small Business Working Group
  - Health Care Reform Task Force
  - Interagency work group

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Summary

2010:

- Health insurance premium tax credits.
- Patient Bill of Rights Provisions (e.g. age 26, No lifetime limits , preventive services, guaranteed issue for children up to 19 and limits on rescissions).

2011:

- Medical Loss Ratio.

2014:

- Health insurance exchanges.
- Guaranteed issue for all.
- Individual mandates start.
- Employer penalties and obligations ramp up.

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Resources

HHS Internet Portal: http://www.healthcare.gov

HHS Office of Consumer Information and Insurance Oversight: http://www.hhs.gov/ociio/

National Governor's Association: www.nga.org - "Health Reform Implementation" section: http://tiny.cc/yvrho

National Association of Insurance Commissioners (NAIC): http://naic.org/index_health_reform_section.htm

Minnesota Specific: www.insurance.mn.gov/healthreform

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