Discussion of Key Health Care Reform Provisions Affecting Commercial Health Plans

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Scope of Presentation

- Provisions affecting commercial health plans
  - Individual, small and large group, including self-insured
- Does not directly address:
  - Medicare, Medicaid, or CHIP
  - Impact on employers
  - Pharmaceuticals, device makers, or clinical
  - Tax impact
  - Long term care

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Scope of Presentation (cont.)

- Some uncertainty involved
  - Some provisions are not clear, or are subject to interpretation
  - As regulations are issued, some provisions may change
  - We continue to study the issues
- Caveats
  - Intended to provide an overview -- limited to key provisions affecting the commercial health plan market
  - Not exhaustive and not a substitute for the language in the bills
  - Does not constitute legal advice

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Structure of the Health Care Reform Legislation

The Patient Protection and Affordable Care Act (H.R. 3590)

- The original Senate bill, passed in the Senate on December 24, 2009, and later by the House
- This Act has 10 titles
- Title X, known as the “Manager’s Amendment”, amends provisions in Titles I through IX

The Health Care and Education Affordability Reconciliation Act of 2010 (H.R. 4872)

- Includes a separate “Manager’s Amendment”,
- Makes changes to certain provisions of the PPACA

This discussion addresses the integrated impact of these bills

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Structure of The Patient Protection and Affordable Care Act

Title

I. Quality, Affordable Health Care for All Americans

II. Role of Public Programs

III. Improving the Quality and Efficiency of Health Care

IV. Prevention of Chronic Disease and Improving Public Health

V. Health Care Workforce

VI. Transparency and Program Integrity

VII. Improving Access to Innovative Medical Therapies

VIII. Community Living Assistance Services and Supports Act

IX. Revenue Provisions

X. Strengthening Quality, Affordable Health Care for All Americans

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Major Elements of Health Care Reform Affecting Health Care Plan Coverages, Rating, and Underwriting

1) Individual mandate, subsidies and penalties
2) Employer requirements, subsidies and penalties
3) Health care Exchanges and health plan qualification requirements
4) Essential Health Benefits Package and other coverage requirements
5) Rating and underwriting reform, including reinsurance and risk adjustment, as well as other health plan requirements

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Overview of Health Care Market Impact -- Individual and Small Group

- State-based (or multi-state) Exchanges established by 1/1/2014 to sell small group (100 or less) and individual insurance (State may limit small group to 50 prior to 2016)
- Essential Health Benefits Package prescribed for all plans sold in the Exchanges, and to be offered by all insurers offering individual or small group coverage
- Plans sold outside the Exchanges must have the same price as in the Exchanges
- All enrollees, in and out of Exchange (except grandfathered plans), must be considered members of a single risk pool (separately for individual and small group)

Overview of Health Care Market Impact -- Individual and Small Group (cont.)

- Rating and underwriting rules (some immediate, some effective 1/1/2014) apply in and out of Exchanges
- Appears that insurers can choose to sell only outside the Exchanges
- Structural mechanisms affecting these markets:
  - 80% Minimum Loss Ratio / Rebates (2011+)
  - Individual High-Risk Reinsurance Pool ("Transitional Reinsurance" – 2014-2016)
  - Risk Corridors (2014-2016)
  - Risk Adjustment
- Existing plans are grandfathered with respect to some provisions

Overview of Health Care Market Impact -- Large Group

- States may choose to add large groups to Exchanges in 2017
- Rating limitations do not apply, but would if added to Exchanges
- Underwriting rules apply
- Essential Health Benefits Package requirement does not apply
- Cost-sharing limitations (deductible(?) and out-of-pocket limit) do apply
- Requirements for 85% Minimum Loss Ratio / Rebates (2011+)
- Existing plans are grandfathered with respect to some provisions

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Topic: Qualified Health Plans

- Qualified Health Plans Must:
  - Meet certification criteria established by the Secretary
    - Certification performed by the Exchange
    - Required to consider the reasonableness of rate increases
  - Provide the Essential Health Benefits Package
  - Be offered by a licensed health insurance issuer that:
    - Offers at least one “silver level” and one “gold level” plan in the Exchange
    - Agrees to charge same premium rates in and out of Exchange
    - Offers a child-only plan at the same level in the Exchange
    - Complies with other regulations
- All plans offered through Exchanges must be qualified

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Topic: Essential Health Benefits Package

1) Covers essential health benefits:

- To be defined by Secretary, to equal scope of a typical employer plan (survey to be conducted)
- Must include at least the following categories:
  - Ambulatory Services
  - Emergency Services
  - Hospitalization
  - Maternity/Newborn
  - MH/SA
  - Prescription Drugs
  - Rehab Services/Devices
  - Lab
  - Preventive/Wellness/Disease Mgt
  - Pediatric Services incl. Oral/Vision
  - Requirements for coverage of emergency services:
    - No prior authorization requirements
    - No restrictions on access or cost-sharing for out-of-network services

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Topic: Essential Health Benefits Package (cont.)

2) Incorporates limitations on cost sharing:

- Cost-sharing not to exceed HSA current law limits in 2014 ($5,950 / $11,900 currently)
- For small groups, deductible may not exceed $2,000 / $4,000, unless offset by FSA contributions
  - Limits increased annually by average change in premiums
  - No cost-sharing on preventive benefits

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Topic: Essential Health Benefits Package (cont.)

3) Provides one of four levels of coverage:

- Four levels defined
  - Bronze: 60% Actuarial value
  - Silver: 70% Actuarial value
  - Gold: 80% Actuarial value
  - Platinum: 90% Actuarial value
- Actuarial value based on essential health benefits provided to a standard population
- Secretary to issue regulations addressing the consideration of HSA contributions in determining the level of coverage
- De minimus variation allowed for "differences in actuarial

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Topic: Essential Health Benefits Package (cont.)

4) Alternatively, provides a Catastrophic Plan:

- Available to individuals under 30 or those exempt from mandate due to affordability or hardship
- Individual market only
- Cost-sharing based on HSA current law limits (not applicable to preventive services)
- Must include coverage for at least three primary care visits

Topic: Other Coverage Provisions Applicable to All Plans*

- Effective for plan years beginning 6 months after enactment:
  - No limits on the dollar value of essential health benefits:
    - No lifetime limits on dollar value
    - Restricted annual limits allowed until January 1, 2014; none thereafter
  - 100% coverage of preventive services (as defined)
  - Dependent coverage to age 26
  - Requirements for coverage of emergency services
  - Choice of primary care provider or pediatrician, no pre-authorization or referral requirements for OB/GYN care

* Except as noted below for grandfathered plans

Topic: Other Coverage Provisions Applicable to All Plans*

- Effective for plan years beginning 1/1/2014:
  - Child-only plan required for any plan that is one of the four levels of coverage
  - For groups, cost-sharing not to exceed HSA current law limits in 2014 ($5,950 / $11,900 in 2010)
  - For (small?) groups, deductible may not exceed $2,000 / $4,000, unless offset by FSA contributions
  - Coverage of routine patient costs in a clinical trial cannot be denied

* Except as noted below for grandfathered plans

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Topic: Underwriting Reform Provisions

- Applicable to individual and small and large group markets
- Effective for plan years beginning 6 months after enactment:
  - Prohibition on rescissions
  - Prohibition on pre-existing condition exclusions for children under age 19 (likely to require guaranteed availability, also)
- Effective for plan years beginning on or after 1/1/2014:
  - Prohibition on pre-existing condition exclusions
  - Guaranteed availability (may restrict to open enrollment periods)
  - Guaranteed renewability
  - No eligibility rules based on health status (special rules for wellness programs)
  - Waiting periods limited to 90 days (group only)

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Topic: Rating Reform Provisions

- Applicable to individual and small group markets only
- Effective for plan years beginning on or after 1/1/2014
- Rates can vary only by:
  - Plan design
  - Family structure
  - Rating area (established by State)
  - Age, limited to 3:1 for adults (permissible age bands to be defined)
  - Tobacco use, limited to 1.5:1
- No health status, case size, industry, etc.
  - If State permits Exchanges to apply to large groups, these rating provisions will apply as well

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Topic: Grandfathered Plans

- Exempts plans existing on date of enactment from certain requirements
- Allows new employees and new family members to enroll in such plans
- Silent on whether any changes may be made to such plans (although the law requires some changes)
- Some of the grandfathered exemptions were removed in the Reconciliation Act

Topic: Grandfathered Plans (cont.)

- Remaining exemptions (Provisions that do not apply to grandfathered plans):
  - Limits on cost sharing and deductible levels
  - Rating and underwriting restrictions (except as noted below)
  - Prohibition of annual limits, for the individual market (but applies for group market)
  - Prohibition on pre-ex, for individual market but applies for group market) -- under age 19 in 2010-2013 and complete prohibition beginning in 2014
  - 100% coverage of preventive services
  - Requirements related to emergency services, and pediatrician and OB/GYN access
  - HHS review of premium increases
  - Coverage of certain clinical trial costs
  - Other miscellaneous, including prohibitions on discrimination, appeals process

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Topic: Grandfathered Plans (cont.)

- Provisions that do apply to grandfathered plans:
  - Loss ratio reporting and rebates
  - Prohibition of rescissions
  - Prohibition on pre-ex, for the group market only -- under age 19 in 2010-2013 and complete prohibition beginning in 2014
  - Prohibition of lifetime limits (for essential benefits)
  - Restrictions on annual limits, for the group market only -- restricted in 2010-2013 and prohibited beginning in 2014
  - Extension of dependent coverage to age 26 (applies to all plans, except that for grandfathered group plans prior to 1/1/2014, applies only if not eligible for other employer-sponsored health plan)
  - 90 day limit on waiting periods (applies to group market only)
  - Other miscellaneous, including uniform benefit reporting standards

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Topic: Grandfathered Plans (cont.)

- Requirements to retain grandfathered health plan status (per regulations issued June 14, 2010)

– No reductions in benefits:

- Cannot significantly cut or reduce benefits
- Cannot raise coinsurance charges – no increase in the percentage paid by enrollees
- Cannot significantly raise copayment charges – no greater than $5 (indexed) or medical inflation plus 15 (cumulative) percentage points
- Cannot significantly raise deductibles – no greater than medical inflation plus 15 (cumulative) percentage points

– Other restrictions:

- Cannot significantly lower employer contributions – no decrease greater than 5 percentage points
- Cannot add or tighten an annual limit (unless replacing a lifetime limit with an annual limit)
- Cannot change insurance companies (self-insured plans can change administrators)

Topic: Individual and Employer Responsibilities -- In Brief

- Individual mandate
  - Must maintain minimum essential coverage
  - Penalty for adults grades from $95 in 2014 to $695 in 2016 (or 1.0% of income, grading to 2.5%, whichever is greater)
  - Cost-of-living adjustments after 2016
  - Capped at national average bronze plan premium
  - Exemptions for financial hardship and other factors
- Employer penalties
  - Employer size 50+ full-time employees (lower threshold for construction industry)
  - Penalties for not offering minimum essential coverage, or if any employees receive subsidies

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Topic: Individual and Employer Responsibilities -- In Brief (cont.)

- Free choice vouchers
  - Requires employers offering minimum essential coverage to provide vouchers to certain eligible low-income employees not enrolled
  - Only required if employee contribution is between 8.0-9.8% (indexed) of income
  - Voucher to be used to buy individual coverage on Exchange

Topic: Subsidies – In Brief

- Premium and Cost Sharing Subsidies

– Provides premium and/or cost sharing subsidies based on sliding income scale, up to 400% of FPL

– Cannot be covered by an employer-sponsored plan

– Cannot be eligible for an employer-sponsored plan unless it pays less than 60% (AV) or employee contribution exceeds an applicable threshold

– Applies to individual coverage purchased through an Exchange

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Topic: Subsidies – In Brief (cont.)

- Small Business Tax Credit

– Eligible employers have no more than 25 full time equivalent employees and average annual wages do not exceed $50,000
  – Employer must contribute at least 50% of premium cost
  – Begins in 2010; for 2014 and later, available for two years only
  – Beginning in 2014, employer must sponsor a qualified plan through an Exchange
  – Employer tax credit based on percentage of employer's premium contributions

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Topic: Exchanges

- Become effective 1/1/2014
  - Government agency or nonprofit entity
  - Established by States with federal grant assistance
  - Must be self-sustaining by 1/1/2015

- To facilitate the purchase of qualified health plans
  - Separate Exchanges for individual (“American Health Benefit Exchange”) and small group (“SHOP Exchange”)
  - State may elect to merge them
  - All plans sold in Exchanges must be certified to be qualified health plans
  - Health plans must submit justification for premium increases

Topic: Exchanges (cont.)

- Secretary to establish criteria for:
  - Certification of qualified health plans
  - Rating system based on relative quality and price
  - Open enrollment periods
  - Other operating requirements
- State options:
  - Regional or interstate Exchanges
  - Subsidiary Exchanges, if geographically distinct areas
  - Beginning in 2017, may add large groups
- OPM to contract with at least 2 multi-state plans in each Exchange (at least 1 to be non-profit)

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Topic: CO-OPs

- Consumer Operated and Oriented Plan (CO-OP) program
- To foster creation of qualified nonprofit health insurance issuers
  - To offer qualified health plans in individual and small group markets
  - Cannot be a health insurance issuer on July 16, 2009
  - Cannot be sponsored by a State or local government
- $6 billion available for loans (for start-up costs) and grants (for solvency requirements)
- Exempt from taxation

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Topic: Merging Small Group and Individual Markets

- States allowed to merge individual and small employer Exchanges or markets

- If markets were merged, presumably that would require merging them outside of Exchange as well (for Exchange carriers)

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Topic: Reinsurance & Risk Adjustment

Three provisions included:

1) Transitional reinsurance program for individual market -- 2014 to 2016
2) Risk corridors applicable to individual and small group markets -- 2014 to 2016
3) Risk adjustment

In addition, two temporary programs ending on January 1, 2014:

1) High risk pool
2) Reinsurance for early retirees

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Topic: Transitional Reinsurance

- Applies to all plan years beginning in 2014, 2015 or 2016
- Funded through contributions (% or per capita) from all insured and self-funded plans ($10 / $6 / $4 billion)
- Reinsurance Payments:
  - To individual market plans only
  - Based on high-risk conditions (or other comparable method)
  - Not limited to plans in Exchanges
  - Excludes grandfathered plans
- One or more reinsurance entities per state or group of states
- Replaces or coordinates with existing high-risk pools
- Established and maintained by States

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Topic: Risk Corridors

- Administered by the Secretary
- Applies to individual and small group markets in 2014 to 2016
- Qualified health plans only
- To be based on program for Medicare regional PPOs
- Corridors based on ratio of allowable costs to target amount:

– **Allowable costs** are "total costs (other than administrative costs) of the plan in providing benefits covered by the plan", reduced by any risk adjustment and reinsurance payments received

– **Target amount** is total premiums, including subsidies, "reduced by the administrative costs of the plan"

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Topic: Risk Corridors (cont.)

- Payment scheme:
  - Plus or minus 3%: No payments
  - Next 5%: 50% gain or loss sharing
  - Amounts beyond 8%: 80% gain or loss sharing

Example 1:

Ratio is 90%

Payment is 4.1%**:** 2.5% (i.e., 50% x .05) plus 1.6% (i.e., 80% x .02)

Plan pays 4.1% of the target amount to the Secretary

Example 2:

Ratio is 105%

Payment is 1% (i.e., 50% x .02)

Secretary pays 1% of the target amount to the plan

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Topic: Risk Adjustment

- Applies to individual and small group markets
  - Appears the intent is to exclude large group market
- Excludes grandfathered plans
- States to make assessments and payments:
  - Low actuarial risk plans to be assessed
  - Payments made to high actuarial risk plans
- Risk measured relative to average risk of all enrollees in all plans in a state, other than self-insured
- Secretary to prescribe criteria and methods
  - May use those utilized under Medicare Part C or D

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Topic: Temporary High Risk Pool

- Begins 90 days after enactment; terminates on 1/1/2014
- For individuals with pre-existing conditions, and without coverage for 6 months
- Coverage:
  - Minimum actuarial value of 65%
  - OOPL not to exceed HSA levels
  - Covers pre-existing conditions
- Premium rates
  - Based on standard population
  - Subject to new rating rules, but with 4:1 age rating
- $5 billion appropriated

Topic: Temporary Reinsurance for Early Retirees

- Begins 90 days after enactment; terminates on 1/1/2014
- Participating employment-based plans:
  - Provide benefits to retirees age 55+ (not yet Medicare-eligible)
  - Must implement programs to manage chronic conditions
  - Includes self-funded, government, multi-employer
- Pays 80% of costs between $15,000 and $90,000
- Payments must be used to reduce premiums, contributions, or out-of-pocket costs borne by plan participants
- $5 billion appropriated

Topic: Minimum Loss Ratios / Rebates

- Effective not later than January 1, 2011
- Minimum loss ratios applicable (States may require higher values):
  - Group: 85%
  - Small group and individual: 80%
- Measurement:
  - Numerator includes “reimbursement for clinical services” and expenditures “for activities that improve health care quality”
  - Denominator is premium, excluding taxes and licensing or regulatory fees (after accounting for risk adjustment, corridors and reinsurance payments or receipts)
  - NAIC to establish definitions and methodologies for calculations, subject to certification by Secretary

Topic: Minimum Loss Ratios / Rebates (cont.)

- Rebates payable to each enrollee, on a pro rata basis
- Applies to grandfathered plans
- Starting in 2014, loss ratio to be a 3-year average (2011 to 2013 for 2014)

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Topic: HSAs

- Effective in 2011, penalty for non-medical spending raised from 10% to 20%
- Only prescribed drugs and insulin qualify as medicine for distributions (OTC allowable if prescribed)
- Requires Secretary to issue regulations addressing the consideration of HSA contributions in determining the level of coverage for the essential health benefits package

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Topic: Excise Tax on High Cost Plans

- Effective in 2018, 40% excise tax on excess value above annual thresholds:
  - $10,200 (single) / $27,500 (family) in 2018
  - $11,850 (single) / $30,950 (family) for 55+ non-Medicare retirees and high risk professions in 2018
  - For subsequent years, thresholds increased by CPI-U (CPI-U +1% in 2019)
  - 2018 thresholds automatically increase if premiums rise faster than expected
  - For multi-employer plans, only family threshold applies
  - Threshold increased for employers with high age/gender characteristics
  - Calculation based on BCBS FEHBP standard option plan
  - Reflects variation from national workforce characteristics
  - Tax paid by issuer of insurance policy (plan administrator for self-insured plans)

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Topic: Excise Tax on High Cost Plans (cont.)

- Applies to government plans
- Does not apply to individual except if coverage is deductible for self-employed
- Plan Value
  - Includes both employer and member premium contributions
  - Includes reimbursements from FSA/HRA and employer contributions to HSA
  - Excludes stand-alone dental and vision

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Topic: Health Insurer Annual Fees

- Total fees:
  - 2014: $8.0B, 2015-2016: $11.3B, 2017: $13.9B, 2018: $14.3B
  - For 2019 and beyond, prior year amount is increased by premium growth rate
- Insurer Share
  - Based on net premiums from prior calendar year, excluding all of the first $25 million and half of the next $25 million
  - Resulting net premium amount is reduced 50% for certain tax-exempt entities
  - Excludes TPA fees, accident-only, LTC, disability, and Medicare Supplement

Topic: Health Insurer Annual Fees (cont.)

- Exemptions
  - Non-profits with >80% of income from government programs for low income, elderly, or disabled populations
  - VEBAs not established by an employer

- Special Deduction for Blue Cross / Blue Shield Organizations
  - Beginning in 2010, a nonprofit BC/BS organization must have a medical loss ratio of 85% or higher to receive the special tax benefits under IRC section 833

Topic: Process for Reviewing Unreasonable Increases in Rates

- Directs the Secretary and States to establish a process
  - Annual review of unreasonable increases
  - Require submission of justification to Secretary and to State prior to implementation, and post on website
- Secretary to monitor increases in and out of Exchanges
- Plan years beginning in 2010 -- effective on enactment
- State must make recommendation to Exchange for exclusion if increases are unreasonable
- Does not address approval of premium increases except as permitted under State law

Topic: Other Provisions and Requirements

- Uniform formats for description of benefits and coverage
- Internet portal to report coverage, loss ratios, rates, eligibility, cost sharing, etc.
- Standards for administrative simplification
- Effective internal and external appeals processes
- Prohibition of discrimination in favor of highly compensated individuals
- Numerous additional issues to be addressed in regulations

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References

- Link to text of the Act:
  - http://rules.house.gov/bills_details.aspx?NewsID=4606
    - Senate Bill as passed: H.R. 3590
    - Text of the Amendment (Reconciliation Act of 2010)
    - Text of the Amendment to the Amendment

Questions and Discussion

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