The Affordable Care Act's Impact on Insurance Regulation in South Carolina

Presentation to the
Senate Banking & Insurance Committee

March 23, 2011

The Affordable Care Act's Enactment

Made up of two laws:

1. The Patient Protection and Affordable Care Act
   Public Law No. 111-148
   Enacted March 23, 2010

As amended by:

2. The Health Care and Education Reconciliation Act
   Public Law No. 111-152
   Enacted March 30, 2010

Today's Focus

1. Temporary High Risk Pools
2. Key Insurance Market Reforms
3. Changes to Premium Rate Regulation
4. Health Insurance Exchanges

Temporary High Risk Pools

ACA Requirements

- Effective 2010 – 2013
- Must be established by HHS Secretary
  - Authorized to contract out operations to states or other eligible entities
- Premiums subsidized by federal government
- No pre-existing condition exclusions

- Funding:
  - $5 Billion Total
  - SC Allocation = $74 Million (est.)

- Eligibility Requirements:
  - ***Uninsured for 6 months***
  - Have a pre-existing condition or be denied coverage due to a health condition
  - U.S. citizen/ national, or lawful resident

Pre-Existing Condition Insurance Plan

- Governor Sanford declined to contract with HHS to operate program in SC
- HHS contracted with Government Employees Health Association, Inc. for operation of the program in SC and 22 other states and DC (program is called PCIP in these states)
- 242 SC Enrollees @ Feb. 15, 2011

- Separate from State's existing high-risk pool
  - SC Health Insurance Pool (SCHIP)
  - 1,926 enrollees in 3 major medical plans as of February 2011

PCIP Contact Information

www.pcip.gov

1 (866) 717-5826

Key Insurance Market Reforms

Immediate Market Reforms

*Effective September 23, 2010**

- Restricted Annual Dollar Limits
- No Pre-existing Condition Exclusions for Children (Up to Age 19)
- No Lifetime Limits
- No Rescissions of Coverage/ Appeals Process
- Extension of Dependent Coverage to Age 26
- First Dollar Coverage of Preventive Services
- Access to ER Services

*6 months following PPACA's enactment date of March 23, 2010

Additional Market Reforms

*Effective January 1, 2014**

- No Annual Dollar Limits
- No Pre-existing Condition Exclusions for All
- Guaranteed Issue for All
- Guaranteed Renewability
- Coverage for Individuals Participating in Approved Cancer Clinical Trials
- Coverage of Essential Health Benefits (as defined by HHS Secretary)

*Health Insurance Exchanges also go into effect at this time (more details on Exchanges in later slides).

Changes to Premium Rate Regulation

Medical Loss Ratios (MLRs)

- 2011 and thereafter

- Individual & Small Group: 80%
- Large Group: 85%

Small Group = 2-50 employees
Large Group = 51+ employees

Example:
An insurer offering individual insurance must spend 80¢ out of every $1 in premium revenues on claims/ health care quality improvements.

- State Flexibility:
  - Can Request Individual Market Waiver (Subject to HHS Approval)
  - Can Require Higher Minimum MLRs

- Rebates required if carriers fail to meet minimum MLR @ end of plan year.

Changes to Premium Rate Regulation

Premium Rate Review

- HHS Secretary to develop process for annual review of "unreasonable" premium increases in consultation with states
  - Effective for rate increases filed on/ after July 1, 2011
  - Rate filings with a 10% or more increase will be subject to review
- Carriers are required to submit to state/ HHS Secretary justification for unreasonable premium increase and post it online

Premium Rate Review Grants

- $250 Million for FFY 2010 – 2014
- First Phase
  - $46 Million awarded for a one-year period
  - 45 states and DC received $1 Million each (including South Carolina)

Limits on Rate Variations

Effective 2014

- Rates for a particular plan/ policy may only vary based on:
  - Plan/ Policy Type (Individual or Family)
  - Rating Area (As Established by States)
  - Age (Age Bands Permissible)
  - Tobacco Use

Health Insurance Exchanges

- Two Exchanges:
  - Individual Market: American Health Benefit Exchange
  - Small Group Market: Small Business Health Options Program Exchange/ SHOP (1-100 employees)

- Each state must establish Exchange(s).
  - States may combine individual and small group Exchanges into one.
  - States may define small group as 1-50 employees until 2016.
  - Other options include establishing multi-state or regional Exchanges.

- If a state does not establish an Exchange, the HHS Secretary is required to do so in that state.

Exchange Timeline

2010 - 2014: Grant Assistance to States

The HHS Secretary must award grants to the states within a year of enactment to assist in the planning and establishment of an Exchange.

January 1, 2013: HHS Secretary's Determination

The HHS Secretary must certify that a state will be able to operate an Exchange that meets the minimum requirements of federal law. Otherwise, HHS must proceed with implementation of a federal plan.

January 1, 2014: Exchanges Fully Operational

Exchanges must be fully operational before January 1, 2014 so that coverage can be effective on this date.

January 1, 2015: Exchanges Must Be Self Sustaining

Federal grant funds may no longer be used. Exchanges must be financially self-sustaining.

Exchange Planning Grants

- Initial Planning Grants
  - Announced July 29, 2010/ Awarded September 30, 2010
  - $49 Million initially awarded for a one-year period
  - 48 states and DC received $1 Million each (including South Carolina)

- Early Innovator Grants
  - Announced October 29, 2010/ Awarded February 16, 2011
  - $241 Million awarded for a two-year period
  - 7 awards (Kansas, Maryland, New York, Oklahoma, Oregon, Wisconsin, and a Multi-State Consortium led by University of Massachusetts Medical School)

- Establishment Grants
  - Announced January 20, 2011
  - Ongoing funding opportunity (available on a quarterly basis)

Exchange Basics

- Must be operated by a governmental agency (state or federal) or nonprofit entity.
- Can only offer qualified plans to individuals or employers. (Exception: dental plans OK)
- Must provide for enrollment periods (initial, annual, special).

Exchange Plans

- Qualified Health Plans (QHPs) Must:
  - Be offered by a carrier licensed and in good standing in the state
  - Provide Essential Benefits Package (as determined by HHS)*
  - Agree to offer at least one Silver and one Gold plan.
  - Agree to charge same price in and out of Exchange.

- Other options:
  - CO-OP Plans
  - Multi-State Plans

*States may require additional benefits, but must assume cost.

Levels of Coverage

- Determined by actuarial value of benefits.

- 4 Primary Levels of Coverage for QHPs:
  - Bronze – 60%
  - Silver – 70%
  - Gold – 80%
  - Platinum – 90%

- Catastrophic plans may also be offered, but enrollment is limited to those under 30 and/ or exempt from individual mandate.

Minimum Exchange Functions

Health Plans

- Implement procedures for certification, recertification, and decertification of health plans.
- Assign a rating to each health plan.

Consumer Information

- Operate a toll-free hotline.
- Maintain Internet website with standardized information.
- Utilize standardized format for presenting options.
- Make available a calculator to determine the actual cost of coverage after subsidies.
- Establish a Navigator program.

Minimum Exchange Functions (con't)

Eligibility Determinations

- Inform individuals of eligibility for Medicaid, CHIP, or other applicable state or local public programs.
- Certify exemptions from individual mandate.
- Grant a certification attesting that the individual is not subject to the coverage mandate because:
  - there is no affordable option available; or
  - the individual is exempt from the mandate.
- Transfer to the Treasury information on exempt individuals and employees eligible for tax credit.
- Provide to each employer the names of employees eligible for tax credit.

Certification of QHPs

- Qualified health plans must meet minimum requirements in order to be certified and maintain certification.

- HHS Secretary to issue regulations to establish certification criteria. ACA requires this criteria include requirements relating to:
  - Marketing
  - Network Adequacy
    - Availability of in-network and out-of-network providers
    - Access to essential community providers for low-income/ medically-underserved
  - Clinical Quality Accreditation by HHS-recognized organization
  - Quality Improvement Strategies
  - Uniform Enrollment Form
  - Standardized Format for Presenting Plan Options

Exchange Subsidies

Individual Subsidies

- Two Types
  - Premium Tax Credits
  - Reduced Cost Sharing
- Eligible Individuals
  - Based on Household Income
  - 100% - 400% of Federal Poverty Level (FPL)
- Advanced to Issuer of Individual's Exchange Plan

Small Business Tax Credits

- 2010 - 2013
  - Up to 35% of employer contribution for employees' health insurance
- 2014 and thereafter
  - Up to 50% of employer contribution
  - Must be Exchange plan
  - Limited to 2 years
- Eligible Businesses
  - 25 or fewer employees
  - Average wages of $50,000 or less
  - Employer contributes 50%+ of premium

To Learn More…

DOI Contacts

Kendall Buchanan
Legislative Liaison
(803) 737-6124 or kbuchanan@doi.sc.gov

Cathy Cauthen
Affordable Care Act Coordinator
(803) 737-6188 or ccauthen@doi.sc.gov

Gary Thibault
Project Manager, Exchange Planning Grant
(803) 737-4972 or gthibault@doi.sc.gov

Keith Rodgers
Project Manager, Premium Rate Review Grant
(843) 577-3363 or krodgers@doi.sc.gov

DOI Office of Consumer Services

(803) 737-6180 or 1 (800) 768-3467
consumers@doi.sc.gov

On the Web

SCDOI's Health Care Reform Webpage
http://doi.sc.gov/Pages/healthcarereform.aspx

NAIC's Health Care Reform Webpage
http://naic.org/index_health_reform_section.htm

Federal Government Websites
http://cciio.cms.gov/
www.healthcare.gov