The Affordable Care Act

&

Summaries of Coverage and Benefits

Martin Mitchell
America's Health Insurance Plans

Today's Discussion

- **Introduction / General Overview**
- Immediate / Near-Term Reforms (2010 / 2011)
- Long-Term Reforms (2014)
- §2715 Summaries and Definitions
- Question / Answer Session

Affordable Care Act (ACA)

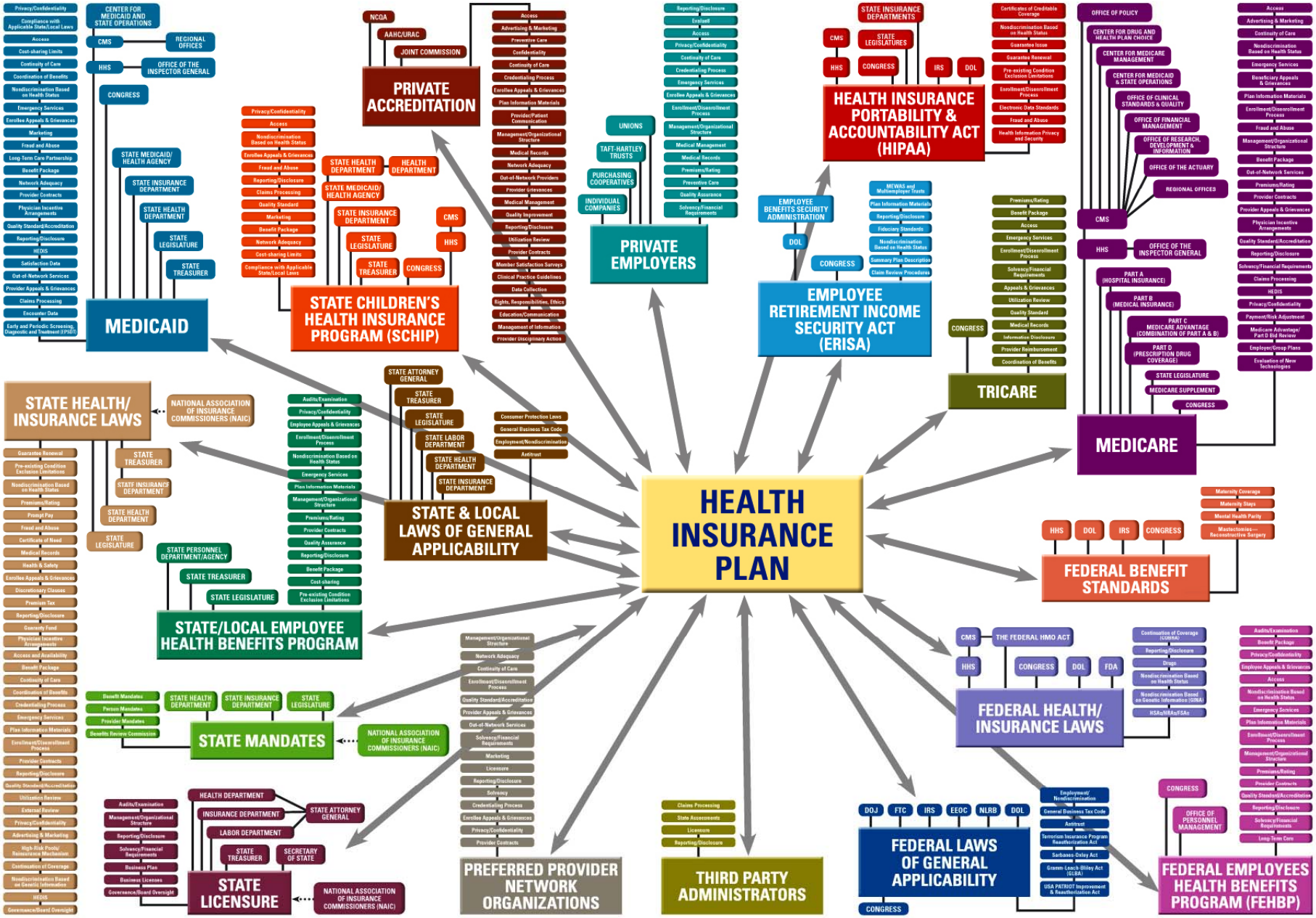
Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010

- Passed by the Senate on December 24, 2009 / March 25, 2010
- Passed by the House on March 22, 2010 / March 25, 2010
- Signed by the President on March 23, 2010 / March 30, 2010

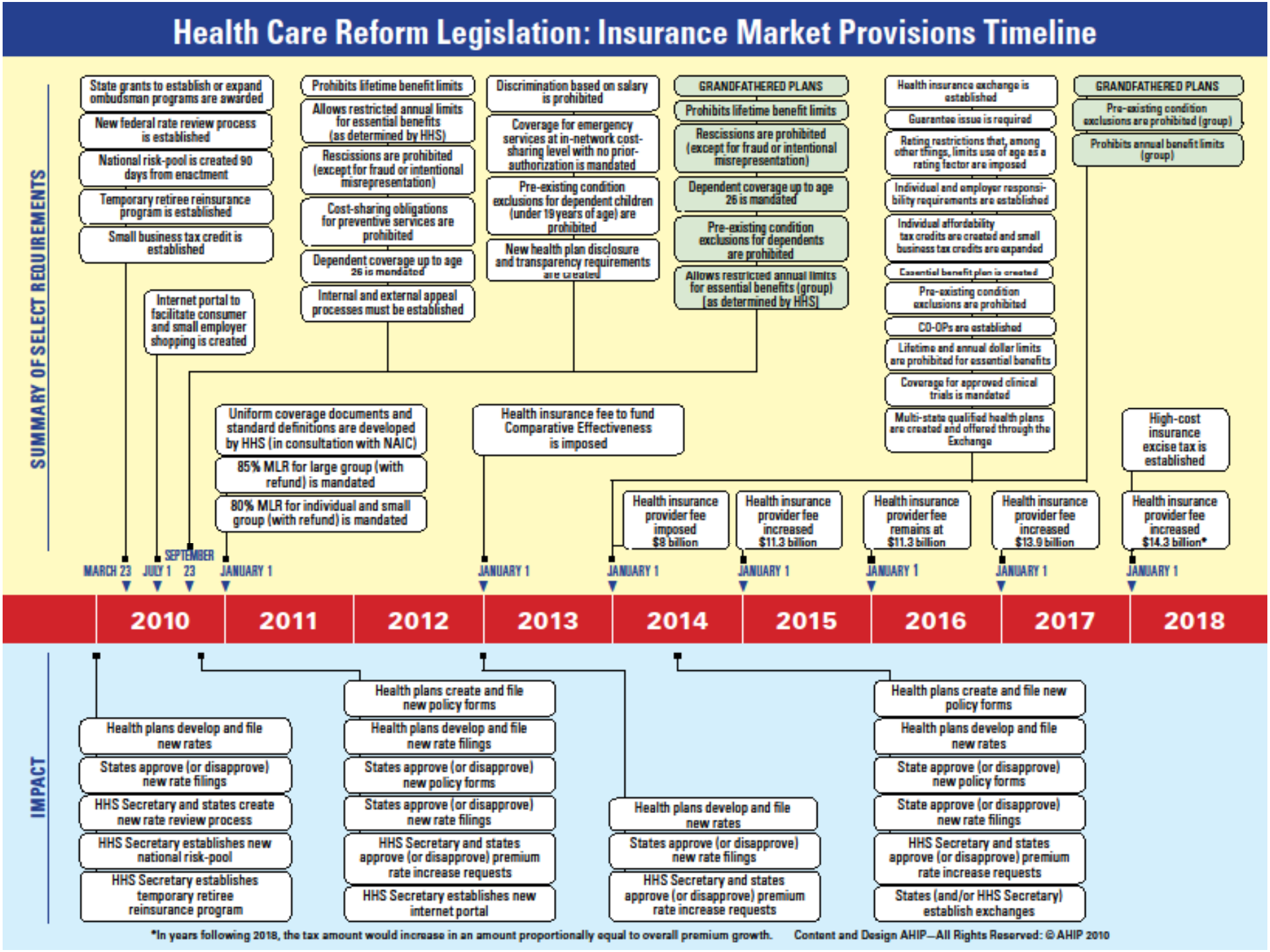
Affordable Care Act (ACA)

- Builds on state proposals and programs to expand access to coverage
- Builds on the existing federal regulatory structure in the Health Insurance Portability and Accountability Act (HIPAA)
  - Amends the Public Health Service Act (PHSA), the Employee Retirement Income Security Act (ERISA), and the Internal Revenue Code (IRC)

SUMMARY OF HEALTH INSURANCE PLAN REGULATION



Health Care Reform Legislation: Insurance Market Provisions Timeline



*In years following 2018, the tax amount would increase in an amount proportionally equal to overall premium growth.

New Concepts / Terminology

- PCIP
- Grandfather Health Plans
- Web Portal / Plan Finder
- Essential Benefit Package
- Exchanges
- OCIIO / CCIIO

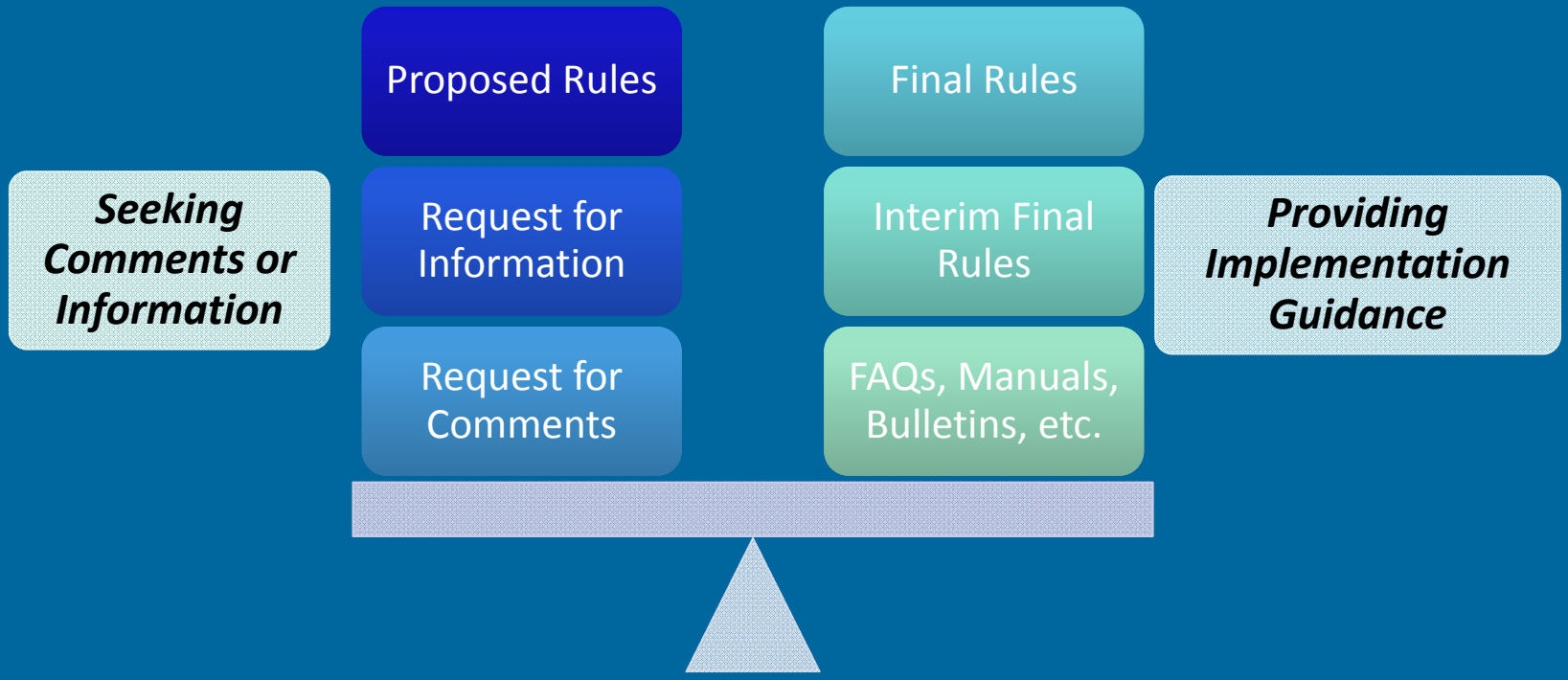
OCIIO / CCIIO

- (Office) Center for Consumer Information and Insurance Oversight
- Relocated within HHS as part of CMS in January 2011
- Involved in ACA Implementation – e.g., Exchanges, PCIP, Internet Portal / Plan Finder
- http://www.hhs.gov/cciio/index.html

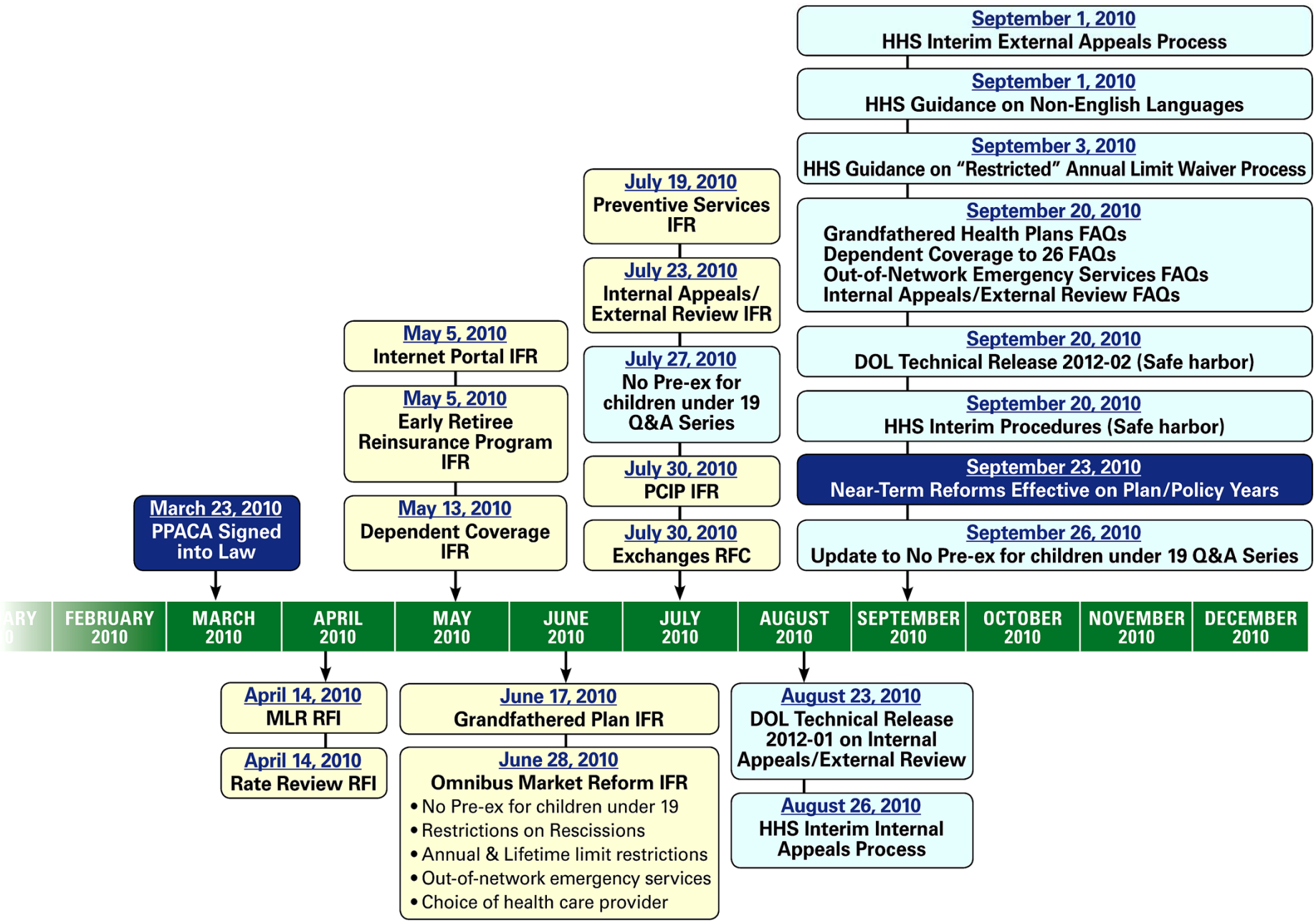
Regulatory / Implementation Guidance

- Rules and FAQs issued by HHS, DOL, and / or IRS
  - http://www.hhs.gov/cciio/regulations/index.html
- Rules and FAQs issued by state regulators
- Model Laws and Rules developed by the NAIC
  - http://www.naic.org/index_health_reform_section.htm

Forms of Regulatory Guidance



PPACA FEDERAL REGULATORY AND SUB-REGULATORY GUIDANCE



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IMMEDIATE TERM INSURANCE MARKET REFORMS

2010 > 2011 > 2012 > 2013 > 2014 > 2015 > 2016 > 2017 > 2018 > 2019

Within 60-90 Days of Enactment:

- National High Risk Pool Established
- Internet Portal Created

For Plan Years That Begin on or After 180 Days of Enactment

- Prohibition on Lifetime Limits for Essential Benefits
- No Pre-Existing Condition Exclusions for Children Under 19
- Restricted Annual Limits for Essential Benefits
- Internal/External Appeals Process
- Rescission Restrictions
- Dependent Coverage Extended up to Age 26

By January 1, 2011:

- Mandatory Minimum Loss Ratio Requirement

Immediate / Near-Term Reforms (2010 / 2011)

- PCIP
- Internet Portal / Plan Finder
- Restrictions on Rescissions
- Review of “Unreasonable” Rate Increases
- Minimum Loss Ratios (MLRs)

Immediate / Near-Term Reforms (2010 /2011)

Preexisting Condition Insurance Plan (PCIP)

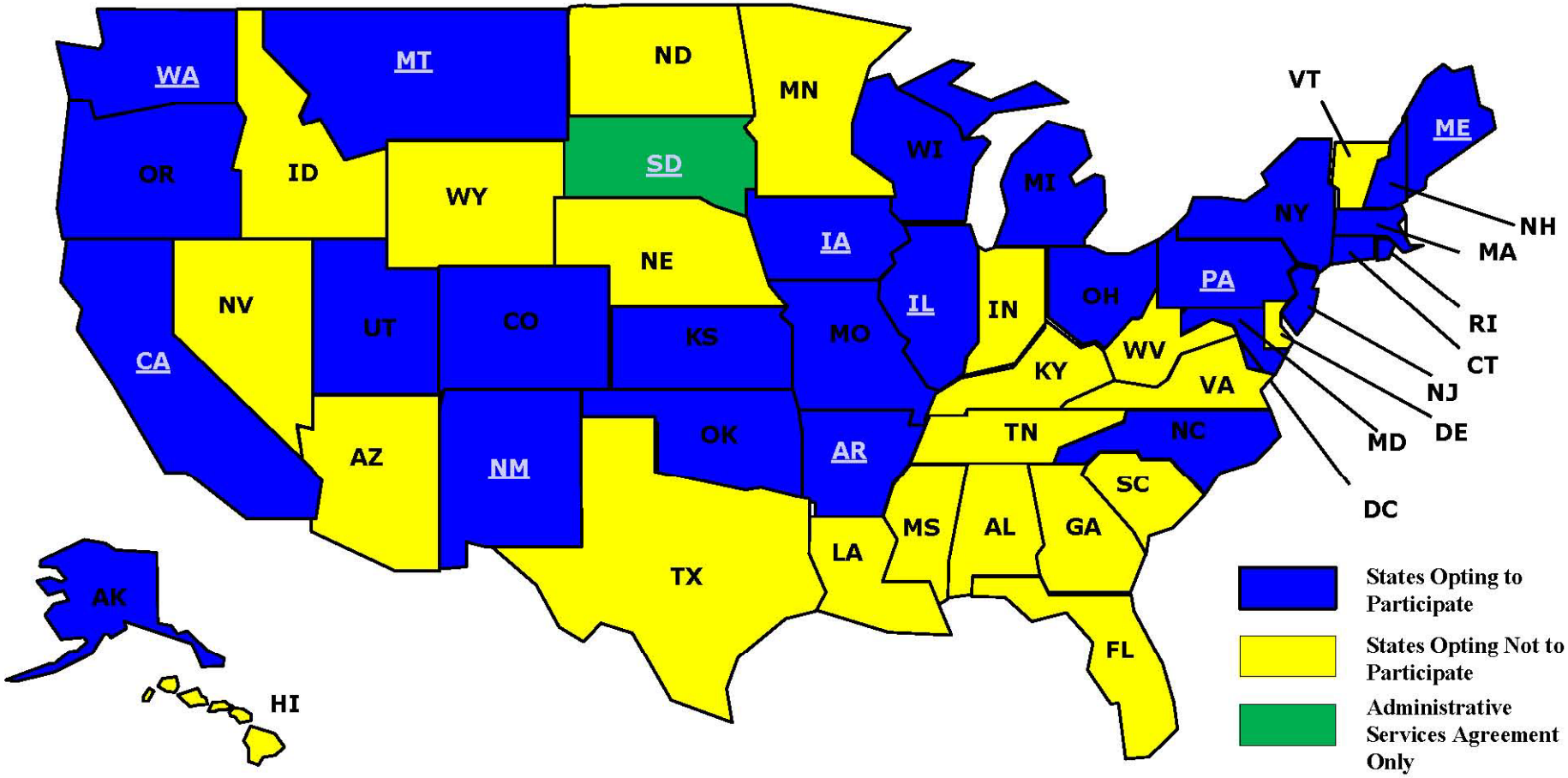
ACA requires the HHS Secretary to create a temporary program (from July 1, 2010 until January 1, 2014) to provide coverage at a "standard" rate to individuals who have been uninsured for at least six months and have a pre-existing condition

- $5 billion in Federal funds is appropriated to run the pool
- http://www.healthcare.gov/law/provisions/preexisting/index.html

America's Health Insurance Plans

State Implementation of Federal High Risk Pool Program

As of August 5, 2010



- Click on each state name to access either the pool administrator's contract with HHS or the state's response to HHS' solicitation for state proposals (depending on availability)
- Click here to access AHIP's summary of state administration and benefit designs for the federal high risk pool program

Immediate / Near-Term Reforms (2010 /2011)

Internet Portal

Requires the Secretary to create an internet portal to facilitate consumer and small employer purchase of coverage

- Must make information available about different coverage options including: public programs, the state high risk pool (if applicable), the federal high risk pool program, and private market coverage
- **www.healthcare.gov**

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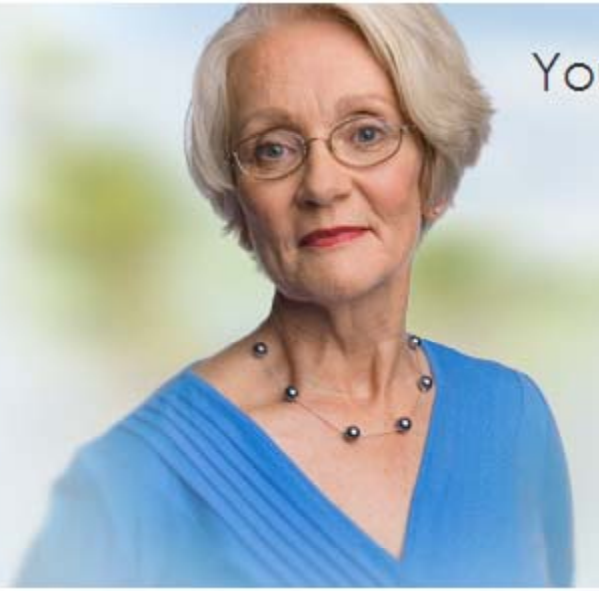
Find Insurance Options | **Learn About Prevention** | **Compare Care Quality** | **Understand the New Law** | **Information for You**

Explore your coverage options

Find out which private insurance plans, public programs and community services are available to you.

Pick Your State GO



Your Health Care, Explained

- **Families with Children**
- **Individuals**
- **People with Disabilities**
- **Seniors**
- **Young Adults**
- **Employers**

IT'S A NEW DAY FOR HEALTH CARE CONSUMERS

Several important provisions of the Affordable Care Act are in effect September 23, including strong consumer protections and more choices in health care. Learn

INSURERS CAN'T:

- Deny coverage to kids with pre-existing conditions
- Put lifetime limits on benefits
- Cancel your policy without proving fraud

CONSUMERS CAN:

- Receive cost-free preventive services
- Keep young adults on a parent's plan until age 26
- Choose a primary care doctor, ob/gyn and pediatrician

Immediate / Near-Term Reforms (2010 / 2011)

Minimum Loss Ratio (MLR) Standards / Rebate

- By 2011, health plans must conform to an 80% MLR in the individual and small group markets and 85% MLR in the large group market
  - Plans are required to pay rebates to enrollees if they fail to meet this requirement
  - HHS Secretary is permitted to adjust the individual market MLR in a state if the application of the threshold could destabilize the market
- The NAIC had primary responsibility for developing uniform definitions for and standard methodologies

Immediate / Near-Term Reforms (2010 / 2011)

Review of Rate Increases

Requires the Secretary to establish a process, in conjunction with the states, to review "unreasonable" premium increases

- Proposed rules establish a threshold that triggers additional review:
  - For 2011*, an increase that meets / exceeds the 10% threshold
  - For 2012, an increase that meets /exceeds the state-specific thresholds (as determined by the HHS Secretary) or 10% (if such a threshold is not established)

** Applies to rate increases filed in a state on or after July 1, 2011; or effective on or after July 1, 2011, (for states that do not require filings)*

Immediate / Near-Term Reforms (2010 / 2011)

Reforms Effective for Plan Years on / After Six Months After Enactment

- Prohibition on lifetime dollar limits for essential benefits
- "Restricted" annual dollar limits for essential benefits
- Restrictions on rescissions
- Prohibition on pre-existing condition exclusions for enrollees under age 19
- Establishment of internal appeals and external review
- Dependent coverage extended to age 26

Immediate / Near-Term Reforms (2010 / 2011)

Two recent significant federal Rule Making Notices

- Exchange Functions for the Individual Market on Eligibility Determinations and Exchange Standards for Employers
  - In the individual Exchange market the proposed rule addresses key enrollment and eligibility issues, and requires an appeals process
  - In the small group market the proposed rule outlines requirements, processes and timelines qualified employers must comply with for the duration of their participation in the SHOP
- Summary of Benefits and Coverage and the Uniform Glossary
  - Establishes disclosure provisions to help individuals better understand coverage options so that they may make informed coverage choices

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IMMEDIATE AND LONGER TERM INSURANCE MARKET REFORMS

Upon Enactment: **FEDERAL RATE REVIEW PROCESS ESTABLISHED**

IMMEDIATE REFORMS

Within 60–90-Days of Enactment:

- National High Risk Pool Established
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For Plan Years That Begin on or After 180 Days of Enactment

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By January 1, 2011:

- Mandatory Minimum Loss Ratio Requirement

LONG-TERM REFORMS

Beginning January 1, 2014:

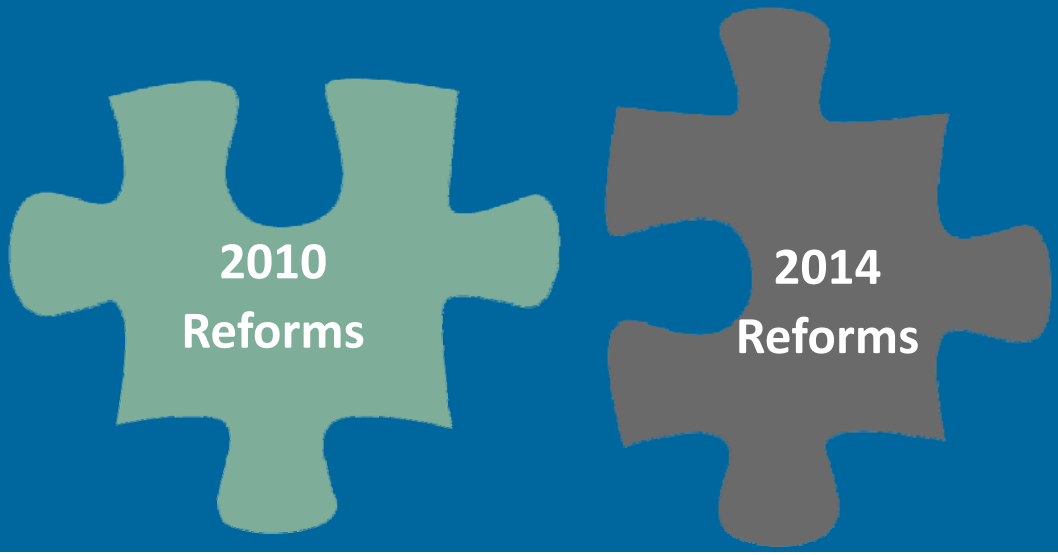
- Co-Ops and Multi-State Qualified Plans Are Created
- Guarantee Issue Required, No Health Status Rating and Limited Age Rating, No Pre-Existing Condition Exclusions, Annual Dollar Limits Prohibited
- Individual and Employer Responsibility Requirements Established
- Individual Affordability Tax Credits Are Created
- Health Insurance Provider Fee Imposed
- Establishment of Exchanges

Beginning January 1, 2018:

- High Cost Insurance Excise Tax Imposed

Long-Term Reforms (2014)

Many of the immediate/near-term reforms lay the foundation for the long-term reforms in 2014



National Risk Pool / PCIP	**Guarantee Issue**
Internet Portal	**Exchanges**
"Restricted" Annual Limits	**No Annual Limits**

Long-Term Reforms (2014)

Private Market Reforms

- Guarantee Issue
- Community Rating
- Prohibition on Pre-existing Condition Exclusions
- Essential Health Benefits Package
- Exchanges

Incentives to Purchase Coverage

Long-Term Reforms (2014)

Guarantee Issue

- Requires the acceptance of every individual and small employer* who applies for coverage
- Allows the HHS Secretary to establish open / special enrollment periods to mitigate the potential for adverse selection

Adjusted Community Rating

- Allows for the use of the following factors:

▪ Age (up to 3:1)	▪ Tobacco use (up to 1.5:1)
▪ Family composition	▪ Geography

Prohibition on Preexisting Condition Exclusions

Long-Term Reforms (2014)

Essential Health Benefits Package

Requires the Secretary to define an essential health benefits package (EHBP) that includes coverage for at least the following general categories:

- ambulatory patient services;
- emergency services;
- hospitalization;
- maternity and newborn care;
- mental health/substance use disorder services;
- prescription drugs;
- rehabilitative and habilitative services and devices;
- laboratory services;
- preventative and wellness services and chronic disease management; and
- pediatric services, including oral and vision care.

Long-Term Reforms (2014)

Exchanges

By January 1, 2014, each state must establish an Exchange that:

- Facilitates the purchase of qualified health plans; and
- Provides for the establishment of a small business exchange (SHOP Exchange) that assists qualified employers.

SHOP Exchanges may be separate or merged with Exchange

Coverage must be made available to *qualified individuals* and *qualified employers*

Long-Term Reforms (2014)

Enrollment in Exchanges

- *Qualified Individuals*
  - Limited to lawful residents
- *Qualified Employers*
  - Employers with at least 1 and 100 employees*
- Open and Special Enrollment Periods

** States have flexibility to limit access before 2016 and to expand access in 2017*

Examples of Exchange Functions

- Certification of Plans
- Toll-Free Hotline
- Navigator
- Internet Portal
- Rate Participating Plans
- Connect with Public Programs
- Standard Format for Benefit Options
- Electronic Calculator
- Transfer Data

Incentives to Purchase Coverage

Tax Credits for Premiums

Provides sliding-scale refundable tax credits to individuals with incomes between 133 and 400% federal poverty level (FPL)

Tax Credits for Cost-Sharing Obligations

Increases cost-sharing subsidies on sliding-scale basis for individuals with household incomes below 250% of the FPL

These tax credits are available to individuals for coverage purchased through the Exchange only.

Incentives to Purchase Coverage

Personal Coverage Requirement

Requires U.S. citizens and legal residents, by 2014, to purchase coverage or face a penalty (unless otherwise exempt from the mandate)

Examples of exemptions from penalty include individuals:

- who qualify because of religious conscience reasons,
- below the income tax filing threshold,
- whose period without coverage does not exceed 3 months, and
- whose premium contributions for the calendar year exceed 8% of household income.

Incentives to Purchase Coverage

Personal Coverage Requirement

The penalty charged for failing to maintain coverage is the greater of:

1) a flat fee of $695/year, or
2) 2.5% of income, phased in over time in the following manner:

Year	Penalty Amount
2014	The greater of $95 or 1% of income
2015	The greater of $325 or 2% of income
2016	The greater of $695 of 2.5% of income
2017 and thereafter	The greater of $695 (+COLA) or 2.5 % of income

Incentives to Purchase Coverage

Employer Responsibility Requirement

- Employers with at least 50 employees that do not offer coverage and that have at least one full-time employee (FTE) receiving a tax credit through the Exchange must pay a penalty equal to the number of FTEs (minus 30 FTEs) for that month multiplied by 1/12 of $2,000
- Employers with at least 50 employees that offer coverage and that have at least one FTE receiving a tax credit through the Exchange must pay a penalty equal to the number of FTEs that are receiving the credit for that month multiplied by 1/12 of $3,000

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§2715 Summaries and Definitions

ACA Provision

- § 2715 required not later than 12 months after enactment 3/23/2011 the Secretary develop standards for use by group health plans and carriers, a summary of benefits and coverage (SBC) and a uniform glossary for **applicants**, **enrollees**, and **policy holders or certificate holders**
- NAIC Working Group developed a set of recommendations and sent them to the Secretary at the end of July
- Secretary adopted the recommendations with a few additions and modifications, **BUT WITH SIGNIFICANT RESERVATION**

§2715 Summaries and Definitions

NAIC Working Group

- Health plans and healthcare professional representatives,
- Consumers and patient advocates
- Group met for over a year

Addressed only issues related to the SBC and Glossary

- Did not address operational issues – those "left" for the NPRM
- Written recommendations sent to HHS in December and July
- NPRM issues in August

§2715 Summaries and Definitions

Proposed Rule Coupled with "Solicitation for Comments"

- NPRM contains standards for the creation and delivery of the SBCs and the Glossary
- HHS, Treasury and Labor issued additional "Solicitation of Comments" which contains template for SBC, uniform glossary, sample language and a guide for coverage examples (CEs) calculations; comments are request on these materials

§2715 Summaries and Definitions

Rule Creates Two New Standard Documents

1. Summary of Benefits and Coverage **(SBC)**
2. Uniform Glossary of health coverage and medical terms **(Glossary)**

All documents follow standard templates, 12 point font, text and length

- SBC, including CEs) may be up to 4 double sided pages
- Documents must be presented in a culturally and linguistically appropriate manner (follows the ACA appeals rule)
- NPRM sets forth who is to receive each document and when and by what means (mail, fax, e-mail, Internet, hand delivery)

§2715 Summaries and Definitions

Summary of Benefits and Coverage from the NPRM

- NAIC proposed three doubled sided pages; HHS indicates it may be up to four double sides, twice that indicated in the PPACA
- Need not be printed in color; must be in 12 pt font
- Adopts the CEs and "Why this Matters" section
- Identifies covered and excluded benefits
- Includes disclaimers that an SBC is not actual policy language
- SBCs must follow NAIC template exactly – **BUT, it will change**
- SBCs are to be a stand-alone document

§2715 Summaries and Definitions

Summary of Benefits and Coverage (Con't)

- Contains 9 standardized elements such as cost sharing, deductibles, including possible cost/premium information
- 4 new requirements in the NPRM for which the NPRM solicits additional public comments:
  - Internet address for network providers listings
  - Internet address for more information on prescription f coverage
  - Internet address to obtain "Glossary"
  - Premiums or costs of coverage for self-insured groups

§2715 Summaries and Definitions

Coverage Facts Labels (now called Coverage Examples, CEs)

- HHS to identify and phase-in up to 6 examples for inclusion in SBCs
- Initially 3 scenarios: pregnancy, breast cancer & diabetes management
- HHS will update examples and plans have 90 days to update materials
- CEs are only hypothetical situations – only illustrations
- The CEs will be constructed from averaging national cost data, utilizing HHS approved medical performance standards

§2715 Summaries and Definitions

Uniform Glossary

- 22 terms as identified for defining by PPACA
- Comment process may add terms (NPRM suggests claims, maternity care, internal review, pre-ex and specialty drugs)
- Glossary must be provided within 7 days of a request, but access to an internet address will satisfy requirement
- Glossary can be located on carrier website or DOL or HHS website
- Hard copy version must be provided when specifically requested
- This is a standardized document for use with SBCs - **NO** changes can be made when terms differ from definitions in contracts

§2715 Summaries and Definitions

Individual Market requirements

- New to PPACA, SBCs must be provided to "Shoppers"
- SBC must be provided at time of application or upon request
- If the terms of an SBC changes before enrollment or policy delivery, a new SBC must be no later than the offer or effective date
- If SBC requested at any other time, it must be sent no later than 7 days of receipt of request – this is a new requirement - not in PPACA
- Renewals - must be sent no later than 30 days before the start of a new policy year
- **If beneficiaries reside at a different address, SBCs must be mailed to each such beneficiary at the last known address**

§2715 Summaries and Definitions

Individual Market

- If SBC sent electronically, individual must acknowledge receipt
- Plan must provide interpreter services and written translations in certain non-English languages
- Must disclose availability of language services
- Plan must also provide translated SBC using the 10% language rule by county – same as Internal Claims and Appeals and External Review requirements

§2715 Summaries and Definitions

Individual Market Requirements

- NPRM proposes to have SBCs posted on the HHS web portal at www.healthcare.gov
- **Note: obtaining Web Portal SBCs would satisfy requirements for individuals requesting information about coverage prior to submission of an application – "Deemer"**

§2715 Summaries and Definitions

Additional Group Market Requirements

- SBC are to be provided prior to enrollment for all benefit plans ,
- 60 day notices for material modifications **not** applicable to renewals
- SBCs to be included within written renewal materials, or if renewal is automatic, SBCs to be provided 30 days prior effective date
- SBC must be provided to special enrollees within seven days of a request for enrollment pursuant to an open enrollment period
- Any other request document must still be provided no later than seven days from receipt of request
- If family members have different addresses, SBCs must be mailed to address of record; but only one SBC required per address

§2715 Summaries and Definitions

Enforcement

- States have primary enforcement but Secretary will step act where states have failed to enforce rule against carriers
- If the Secretary enforces, $100 per day for each affected individual
- No more than a $1000 fine for each incident for **willfully failing to provide an SBC**
- DOL & Treasury will issue separate regulations for assessment of the civil fine for those plans under their jurisdiction

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