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Health Reform Update: Selected Policy and Legal Implications of the Patient Protection and Affordable Care Act to Date

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Patient Protection and Affordable Care Act Near-Term Implementation Timeline

Near-Term Implementation Timeline

2010
- Temporary federal high risk pool program
- Temporary early retiree reinsurance
- Interim Web Portal
- Annual rate review process established
- **Dependent coverage until age 26[*G]**
- **No pre-ex for kids until age 19[*G]**
- **Rescissions prohibited except for fraud[*G]**
- Lifetime benefit limits prohibited; annual limits restricted[*G]
- Preventive benefits with no cost sharing[*]
- Pediatricians as PCPs, direct access to OB-GYNs[*]
- ER coverage as In-network, no prior auth[*]
- Internal/External review standards[*]
- Limited small business tax credits established
- Part D rebate for beneficiaries in the gap

2011
- MLR: 85% for large group; 80% for small group and individual (non-group)
- HSAs & FSAs can't cover OTC drugs
- Discounts in Part D "Donut Hole"
- Annual fee on pharmaceutical manufacturers begins

2012
- Uniform coverage documents & standard definitions[*G]
- Medicare Advantage phase-in of capped FFS rates begins
- Quality bonus begins to be phased-in for MA plans
- Employers to report value of employer-sponsored health benefits on W2s (Jan.)

2013
- FSA contributions limited to $2,500
- High earner tax begins
- Annual fee on medical device sales begins
- State Medicaid plans required to pay PCPs at Medicare rates
- Deduction for expenses allocable to the Part D subsidy for "qualified prescription drug plans" eliminated

2014
- State-run Exchanges
- Guarantee issue rules
- No annual limits, pre-existing condition exclusions, health status underwriting[*]
- Rating restrictions
- Individual & employer responsibility rules
- Individual tax credits/ subsidies; small employer tax credits (thru Exchange)
- Standardized minimum essential benefits
- Cost sharing/ deductible limits[*]
- 90-day max wait periods
- HIPAA Wellness Reward increase to 30%
- Mandatory coverage for clinical trials[*]
- Risk adjustment/ Reinsurance
- Waiting period limits[*]
- Medicaid expansions (<133% FPL)
- CO-OPs & multi-state plans offered thru Exchange
- Annual insurance industry tax begins
- MLR for MA & coding intensity changes

2015 & Beyond
- States can open Exchange to all employers (2017) and CHIP eligibles (2015)
- High-value plan excise tax begins in 2018
- "Donut hole" closed by 2020

2010/2011 Provisions are the main focus of current implementation efforts

[*] Applies to ASO (self-funded) & Fully Insured
[G] Applies to "Grandfathered Plans"
Blue font = Implemented

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Health Reform Update

- Major Federal Regulations Issued so far:
  - Early Retiree Insurance
  - Dependent Coverage to 26
  - Grandfathered Plans
  - Preventative Care Benefits
  - Pre-existing Conditions / High Risk Pools
  - Internet Portal
  - ACO Rules – “Accountable Care Organizations”
  - MLR (minimum loss ratio or medical loss ratio)
  - Waivers (and their political implications)
  - Exchange Rules
  - Essential Benefit Benchmark Guidance

Accountable Care Organizations

- ACOs – hospitals, provider groups, payors, others
- Agree to coordinate Medicare patient care from pre-intake to discharge and beyond into care management and chronic care
- Will operate under evidence-based best practices
- Global budgeting, bundled payments, grouped episodes, shared savings arrangements
- Pioneer pilots underway
- Interesting potential anti-trust issues

Producers and the Medical Loss Ratio: NAIC

- Representative Mike Rogers (R-Michigan) bill would exclude fees paid to agents and brokers when calculating how much health plans are spending on administrative costs versus medical care. 97 co-sponsors. (Rebates required if > 15 or 20 percent)
- NAIC Task Force voted to ask full NAIC to support Rep. Rogers' bill.
- NAIC full membership voted by a narrow margin to support a resolution to HHS asking that agent/broker commissions be treated either as taxes are treated, or as quality improvement efforts are treated, or suspend implementation for some period of time

Federal Exchange Rules

- Number and type of health plan choices
- Standards for health plans
- Stabilizing premiums for health plans
- Enrollment: assisting and educating consumers
- SHOP program
  - Bronze
  - Silver
  - Gold
  - Platinum
  - Catastrophic (age 35 and under)
- Employee size up to 50 until 2016, then up to 100
- Employee size >100 in 2017 (optional)
- Tax credits up to 50% of premiums if 25 or fewer employees in 2014
- For tax credits, average annual wage less than $50,000, offer all full-time employees coverage, and pay at least 50% of premium

Essential Benefits Categories

- Ambulatory Patient Services
- Emergency Services
- Hospitalization
- Maternity and Newborn Care
- Mental Health and Substance Use Disorder Services
- Prescription Drugs
- Rehabilitative/Habilitative Services and Devices
- Laboratory Services
- Preventive and Wellness Services/Chronic Disease Management
- Pediatric Services

IOM Recommendation: "Typical Small Employer Plan"

Essential Benefits “Pre-Rule Bulletin”

- States will be allowed to select an existing health plan as a benchmark for services offered by “typical employer plan”
- Four Choices for states:
  - One of the three largest small group health plans in the state, by enrollment
  - One of the three largest state employee health plans by enrollment
  - One of the three largest federal employee health plans by enrollment
  - The largest HMO plan offered in the state’s commercial market by enrollment

Mandates

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- Individual mandate:
  - Everyone must purchase insurance that includes essential benefits (some exceptions)
  - Penalty for non-compliance: $95 or one percent of gross income
- Employer mandate:
  - Employers with over 50 full time equivalent employees must purchase coverage for their employees or pay penalties ($2-3000 per employee after the first 30 employees depending on coverage)
- Enforced by IRS(?)
  - “Coverage Mandates: existing and new State mandates vs. Federal Essential Benefit Mandates”

UHG Exchange Advocacy Principles

- In the development of the state-based Exchanges established by PPACA, we believe it will be critical for HHS and the states to be guided by the following principles:
  - Develop Fair and Efficient Markets
  - Create a Positive Consumer Experience
  - Advance Consumer Choice and Innovation
  - Promote Responsible Consumer Behavior
  - Balance National Standards and State Flexibility

UHG Exchange Advocacy Principles

- Develop Fair and Efficient Markets
  - Governance of Exchange should be through an independent, transparent and non-politicized entity with a Board consisting of broad constituent representation including consumer representatives, employers, health plans, and other stakeholders
  - Avoid duplication of existing state regulatory functions regarding rate review, licensing, and market conduct
  - Rely, to the extent possible, on standards established by national accreditation agencies (e.g. NCQA) in the health plan certification process
  - Rules need to be applied predictably, fairly, and consistently to all health plans (i.e. level playing field)
  - Risk adjustment and reinsurance processes should be developed with due consideration for recommendations from the American Academy of Actuaries, and finalized well in advance of 1/1/2014 to support pricing accuracy

UHG Exchange Advocacy Principles

- Create a Positive Consumer Experience
  - Aggressive promotion and outreach regarding eligibility for Medicaid and federal subsidies to facilitate broad participation and stable risk pools
  - Streamlined eligibility and enrollment processes with strong coordination with Medicaid and CHIP programs
  - Facilitate informed decision-making through effective plan comparison tools
  - Continuity of coverage rules should be developed to minimize disruption in coverage associated with minor or temporary changes in income or circumstance

UHG Exchange Advocacy Principles

- Advance Consumer Choice & Innovation
  - Exchanges should supplement, but not replace, the existing small group and individual markets to enhance competition, promote ongoing innovation, and increase consumer choice
  - All qualified health plans should be permitted to participate; consumer choice will drive market efficiency
  - Encourage flexibility in the development of plan designs that are consistent with federal requirements regarding specified actuarial values
  - Maintain separate Individual and Small Group markets for ease of administration, accurate risk pooling and to maximize the number of participating health plans
  - Unnecessary and excessive new burdens on health plans inside or outside the Exchange will limit competition, and so should be avoided

UHG Exchange Advocacy Principles

- Promote Responsible Consumer Behavior
  - The affordability and viability of Individual products, inside and outside the Exchanges, will be highly dependent on the development of open enrollment rules that encourage consumers not to delay coverage until the point they incur high health care costs and then cease coverage soon thereafter, but instead to obtain and maintain continuous coverage

UHG Exchange Advocacy Principles

- Balance National Standards with State Flexibility
  - National standards would be preferred for components for which state-by-state variation would add substantial cost and complexity without adding incremental value such as risk adjustment mechanisms, quality standards for common transactions including eligibility and enrollment
  - State flexibility should be rationed for decisions best made locally such as determining the number of Exchanges necessary within a state, whether to participate in regional Exchanges, whether to merge the Individual and Small Group Exchanges and issues relating to provider networks

Issues Related To Eligibility Determinations

- Continuity and stability for consumers is enhanced with coordinated eligibility and enrollment efforts.
- The Exchange will be an entry point and a vehicle to determine both Medicaid eligibility and subsidies for consumers.
- Even with a streamlined definition of eligibility (i.e. Modified Adjusted Gross Income), States will still need to evaluate the extent to which individuals will move between Medicaid, CHIP and the Exchanges, and consider options to promote continuity of coverage such as:
  - Periods of continuous eligibility;
  - Simplified redetermination processes; and
  - Opportunities to collaborate with health insurers and community-based organizations to educate and help consumers navigate the system.
- New Federal dollars can be leveraged to modernize and link State-based eligibility systems to Exchanges and Federal data, streamlining the initial eligibility-determination process.
- Multiple venues for enrollment (online and in-person), pre-populated enrollment forms, and the development of comparative summary tools that consider language, health literacy and reading comprehension will improve consumer navigation and ease administrative burdens.

Enrollment Issues

- Open enrollment period rules must create incentives for consumers to maintain continuous coverage and attract a stable risk pool of members to avoid suffering from severe adverse selection.
- Both initial and ongoing open enrollment periods should be structured to encourage consumers to maintain continuous health care coverage, rather than permitting consumers to wait to purchase coverage until they incur high health care costs and then cease coverage immediately thereafter.
- Specific steps Exchanges should consider to mitigate the possibility of adverse selection include:
  - Limiting the open enrollment to a single 30- to 45-day time frame each year;
  - Prohibiting plan changes between open enrollment periods, and limiting increases in coverage at open enrollment to one step (e.g. bronze to silver) per year;
  - Providing clear rules about the limited exceptions that should be allowed for individuals to enroll outside the open enrollment period; and
  - Establishing staggered open enrollment periods tied to a policyholder’s date of birth to distribute the administrative process evenly throughout the year.
- For programs with income eligibility criteria, the open enrollment periods and eligibility determination process must promote continuity of coverage and reduce shifts between types of coverage and subsidy levels.

Issues Relative to Group Size

- Maintaining separate individual and small group markets would result in ease of administration, more accurate risk pooling and greater likelihood of widespread health plan participation.
- The individual market generally has a higher-risk profile than the small group market, presenting greater potential for adverse risk selection and inherently higher administrative costs for individual coverage.
- Small groups have different eligibility, enrollment and general administrative needs than individuals.
- Combining the two markets would likely result in a rate increase for small groups, which could destabilize the small group market.
- Exchanges would be better served by selecting a maximum of 50 employees as the initial size limit for the small group market, minimizing market disruption and avoiding additional State administrative burdens in operating the small business Exchange. It will also decrease the risk of adverse selection. The 51+ employee group market is very competitive and enjoys significant market leverage.
- Large employers are generally either self-funded or rated based on the experience of the employees within the large group. Allowing employers of this size to be eligible for the Exchanges increases the potential for adverse selection because the highest-cost large employers will likely find the community adjusted rates with the Exchange more attractive than other marketplace options, such as experience-based rates.

Structured Enrollment Periods

- Reinforce Responsible Consumer and Employer Behavior
  - HHS and States should define a structured open enrollment period promoting market stability. Open enrollment period rules should encourage consumers not to delay coverage until the point they incur high health care costs and then cease coverage soon thereafter, but instead to obtain and maintain continuous coverage. Specific techniques HHS and States can use to mitigate the possibility of adverse selection include:
    - Limiting the open enrollment to a single 30- to 45-day time frame each year;
    - Prohibiting plan changes between open enrollment periods and limiting increases in coverage at open enrollment to one step (e.g. bronze to silver) per year;
    - Providing clear rules about the limited exceptions that should be allowed for individuals to enroll outside the open enrollment period;
    - Establishing staggered open enrollment periods tied to a policyholder's date of birth to distribute the administrative process evenly throughout the year; and
    - For programs with income eligibility criteria, the open enrollment periods and eligibility determination process must promote continuity of coverage and reduce shifts between types of coverage and subsidy levels
  - Generally, we believe that some form of participation requirement makes sense for employer groups within the Exchange to assure a balanced risk pool. Requiring all employees of an employer within the SHOP Exchange to purchase from within one actuarial level also helps to keep costs down by mitigating adverse selection.

Political and Legal Implications

- Political
  - Election November 2nd, 2010 changed political landscape drastically
  - House of Representatives changed from strong D to strong R majority
  - Senate still D majority but by small margin; 2 independents who caucus with Ds
  - Majority of governors are now Republican
  - Republicans picked up over 650 seats in state legislatures
  - Many ran on campaigns of repealing health reform and reducing federal deficit
  - Even though the law is two years old, still controversial and driving much debate in current Republican presidential primary
  - Meantime many states are forging ahead with reform planning and implementation, including Washington

Political and Legal Implications

- Legal
  - 26 States including Washington signed on to an appeal led by Florida
  - Five federal district level judges have weighed in on Constitutionality of the Act (three favoring it, two opposing)
  - Split circuit courts on appeal
  - Supreme Court accepted case and heard six and half hours of argument, March 26-28, 2012
  - Decision expected June/July 2012

Political and Legal Implications

- Major Legal Questions (paraphrased):
  1. Can Congress regulate inactivity vs. activity under the Commerce Clause?
  2. Can Congress require individuals to purchase a private product?
  3. Can Congress monetarily penalize those who refuse and is that penalty a penalty or tax?
  4. Regardless of the answer to #3 above, is this lawsuit ripe for decision since nobody has yet had to pay a penalty/tax?
  5. Can Congress force states to vastly expand their Medicaid programs?
  6. Is the individual mandate severable from the rest of the Act? Are other parts of the Act severable?

Near-Term Policy Implications

- Supreme Court Ruling
- 2012 elections, national and local
- Will employers shift coverage to Exchange?
- Will subsidies continue to be funded?
- Does the Basic Health Plan fit into a reformed system?
- Will Washington State continue state-specific reforms regardless of whether the law is upheld, struck down in part or struck down whole?

Useful Sites

- Federal Department of Health & Human Services
  - http://www.healthcare.gov/
    - Regulations and guidance
    - Fact sheets
    - Grants
    - News
    - Special programs
    - Other
- State: Washington State Health Care Authority
  - http://www.hca.wa.gov/
    - Medicaid
    - Health Benefit Exchange
    - News
    - Other
- State: Washington State Office of Insurance Commissioner
  - http://www.insurance.wa.gov/
  - Consumer information on health insurance reform issues
- National Association of Insurance Commissioners (NAIC)
  - http://www.naic.org/
  - Health reform information for all 50 states

Contact Information

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