South Carolina
Department of Insurance

# 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