

NHA's Health Reform Executive Summary

(August 15, 2010)

Coverage Expansion and Health Insurance Market Reforms

On March 23, 2010, the Patient Protection and Affordable Care Act (PPACA) was signed into law. On March 25, 2010, the Health Care and Education Affordability Reconciliation Act (HCEARA) of 2010, which revised certain provision of the PPACA, was passed by Congress and the massive overhaul of our nation's health care system was put in motion. The Acts are intended to expand health insurance coverage to 32 million Americans who are currently uninsured, resulting in total health coverage of 95 percent of all Americans.

Coverage Expansion

The PPACA and HCEARA increase insurance coverage for American citizens by:

- Requiring insurance companies to cover individuals with pre-existing conditions;
- Creating high risk insurance pools;
- Establishing state-based health insurance market places know as "exchanges" where individuals not covered by employer-based or governmental health insurance can buy coverage;
- Offering subsidies to low to moderate income Americans who buy insurance through the newly established exchanges;
- Expanding the Medicaid program;
- Requiring all employers of 50 or more people to provide health insurance coverage to their employees;
- Allowing individuals up to age 26 to be covered under their parents' insurance plans; and
- Requiring all American citizens not covered by an employer-based or governmental plan to purchase health insurance.

Pre-existing medical conditions: As of September 23, 2010, private insurance companies will be prohibited from denying coverage to children under the age of 19 due to pre-existing conditions. This requirement applies to all employer plans and new plans in the individual market and it will apply to all individuals in 2014.

High risk insurance pool: By June 23, 2010, a \$5 billion national high-risk insurance pool will be created to allow individuals with a pre-existing medical condition, who currently are unable to purchase private health insurance, to have access to insurance. This provision ends when the state-based exchanges become operational.

State-based health insurance exchanges: By 2014, each state must establish state-based health insurance exchanges open to the individual and small group market. Small employers, with 50 or fewer employees, will be able to shop for coverage in the Small Business Health Options Program (SHOP) exchange. The exchanges will be overseen by state insurance commissioners; the financial integrity of the exchanges will be overseen by the Secretary of the U.S. Department of Health and Human Services.

- **Plan requirements:** Several levels of standardized, comprehensive benefit packages will be available at different levels of cost sharing.
- **OPM plans:** Each exchange will provide access to multi-state, private plans under the supervision of the federal Office of Personnel Management (OPM), the agency that administers and regulates the Federal Health Employee Benefit Plan.
- **Co-ops:** Federal funding for start-up loans and grants will be provided to qualified organizations to assist in the development of nonprofit, member-run health insurance Consumer Operated and Oriented Plans (Co-ops) that will offer health insurance through the health insurance exchanges.
- **Provider payments:** Providers will negotiate rates with the private plans offered through the exchanges, much the same as is currently done.
- **Insurance market reforms:** All plans operating in the exchanges will be subject to new insurance market reforms.

Subsidies for health insurance: The PPACA establishes four levels of plans that can qualify for offering through an exchange: bronze, silver, gold and platinum. As listed, the plans increase in the coverage value of benefits with the bronze level covering 60% of the actuarial value of total benefits and platinum covering 90%.

Premium assistance in the form of refundable and advanceable tax credits will be provided on a sliding scale to individuals and families with incomes between 100% and 400% of the federal poverty level (FPL). The premium credits will be tied to the second lowest-cost silver plan in the area and will be set on a sliding scale such that the individual's/family's premium contributions are limited to 2% of income for those between 100% and 133% of the FPL up to 9.5% of income for those between 300% and 400% of the FPL. The expected contributions will increase annually based upon premium growth rates. Small employers with no more than 25 employees and average annual wages of less than \$50,000 that purchase health insurance for employees will be provided with a tax credit.

Medicaid expansion: In 2014, Medicaid will be expanded to cover non-elderly individuals, including parents; children; and childless adults, up to 133% of the FPL. For most states, a federal matching rate of 100% will be provided for newly eligible individuals. The matching rate will decrease to 95% in 2017; 94% in 2018; 93% in 2019 and 90% thereafter.

Employer mandate: Effective March 1, 2013, employers will be required to provide notice to employees of their health insurance options, including options available via the exchanges. Employers with 200 or more employees will be required to automatically enroll employees in health insurance plans, allowing individuals to opt-out. Employer penalties will apply for failure to provide affordable coverage as follows:

- Employers with 50 or more full-time workers, that do not offer health insurance coverage will pay an assessment of \$2,000 per full-time worker (not including the first 30 workers) if any of their employees receive a tax credit to purchase insurance through the exchange.
- Employers that offer unaffordable health insurance or a plan that does not cover at least 60% of allowable costs will pay \$3,000 for any employee that receives a tax credit in the exchange up to an aggregate cap amount set at \$2,000 multiplied by the number of full-time employees.

Dependent coverage for young adults up to 26 years of age: As of September 23, 2010, any group plan or plan purchased on the individual market that provides dependent coverage for children, must continue to offer such coverage until the child turns 26 even if the child is married; unless the dependent child is eligible for employer-sponsored coverage on his/her own.

Individual mandate: Beginning on 2014, most individuals who are not covered by employer-based or governmental plans will be required to obtain acceptable health insurance coverage. Failure to purchase such coverage will result in a financial penalty equal to: the greater of \$95 or 1% of income in 2014; \$325 or 2% in 2015; \$696 or 2.5% in 2016; and continued indexed amounts after 2016, up to the cap of the national average "bronze" plan premium. Families with children will pay half of the penalty amount for children, up to a cap of \$2,250 for the entire family.

Health Insurance Market Reforms

Before September 23, 2010:

- **No lifetime or annual limits:** Health plans must eliminate lifetime, annual, or unreasonable limits of coverage on the value of essential health care benefits.
- **Prohibition on rescissions:** The ban on the practice where insurers retroactively cancel health coverage will be extended to employer-based group policies, except in the case of fraud.
- **Annual review of premiums:** The Secretary, in cooperation with the states, will establish a process for the annual review of unreasonable increases in premiums. The process will require health plans to submit a justification for an unreasonable premium increase prior to the implementation of the increase. In 2014, the Secretary and the states will begin monitoring premium increases offered through and outside of any exchange. When determining whether to offer a health plan in the large group market through an exchange the state must take into account excess premium growth outside of the exchange compared to the rate of premium growth inside the exchange.
- **Mandated coverage for preventive health services:** A health plan must provide coverage without cost-sharing requirements for certain preventive care services.
- **Extension of non-discrimination rules:** Health plans may not discriminate in favor of highly compensated employees in terms of eligibility to participate and the level of benefits under a plan.

By 2012:

- **Ensuring quality of care:** The Secretary will develop reporting requirements for use by health plans aimed at improving health outcomes. These reporting requirements may affect provider reimbursement. The Secretary will also promulgate regulations that will provide criteria for determining a reimbursement structure aimed at improving health outcomes.
- **Uniform explanation of coverage:** Before March 23, 2012, plans must provide a summary explanation that accurately describes the benefits and coverage to participants prior to enrollment.

Beginning in 2014:

- **Waiting period restrictions:** Health plans may not establish rules for eligibility to enroll based on the individual's health status.

- **Mandated coverage for clinical trials:** Plans cannot deny participation of a qualified individual in a clinical trial, deny coverage of routine costs in connection with the clinical trial or discriminate on the basis of participation in a clinical trial.
- **Fair health insurance premiums:** premium rates may only vary by:
 - Whether the plan covers an individual or family;
 - Rating area which is established by the state;
 - Age – may not vary more than 3:1 for adults; and/or
 - Tobacco use – may not vary more than 15:1.
- **Mandated cost-sharing limits:** Health plans must limit cost-sharing amounts to the limits applicable to high deductible health plans. Group health plans cannot have deductibles that exceed \$2,000 for single coverage or \$4,000 for any other coverage. The amounts are subject to cost-of living adjustments after 2014.