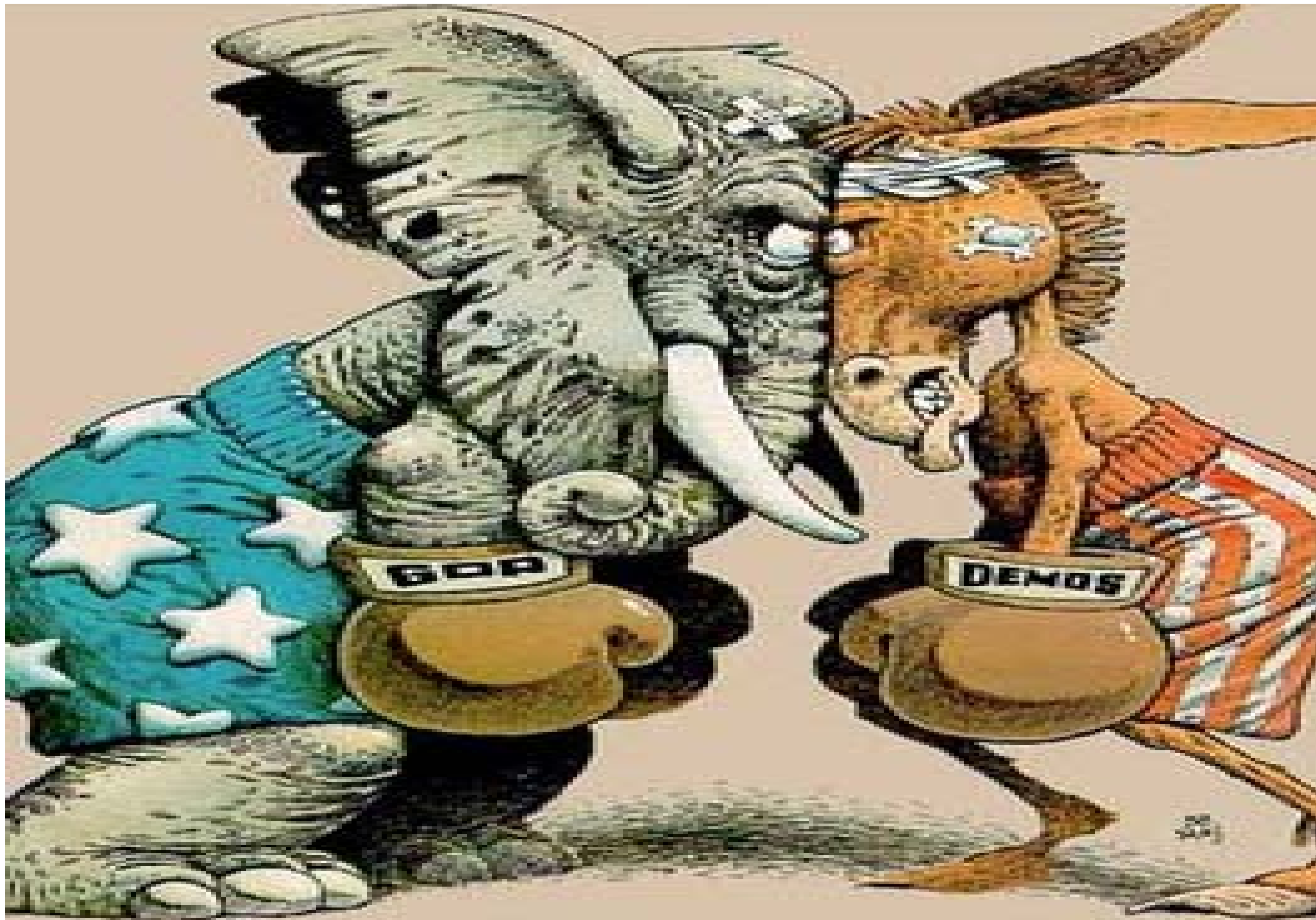
Producers, Politics and PPACA

National Association of Health Underwriters
May 2012

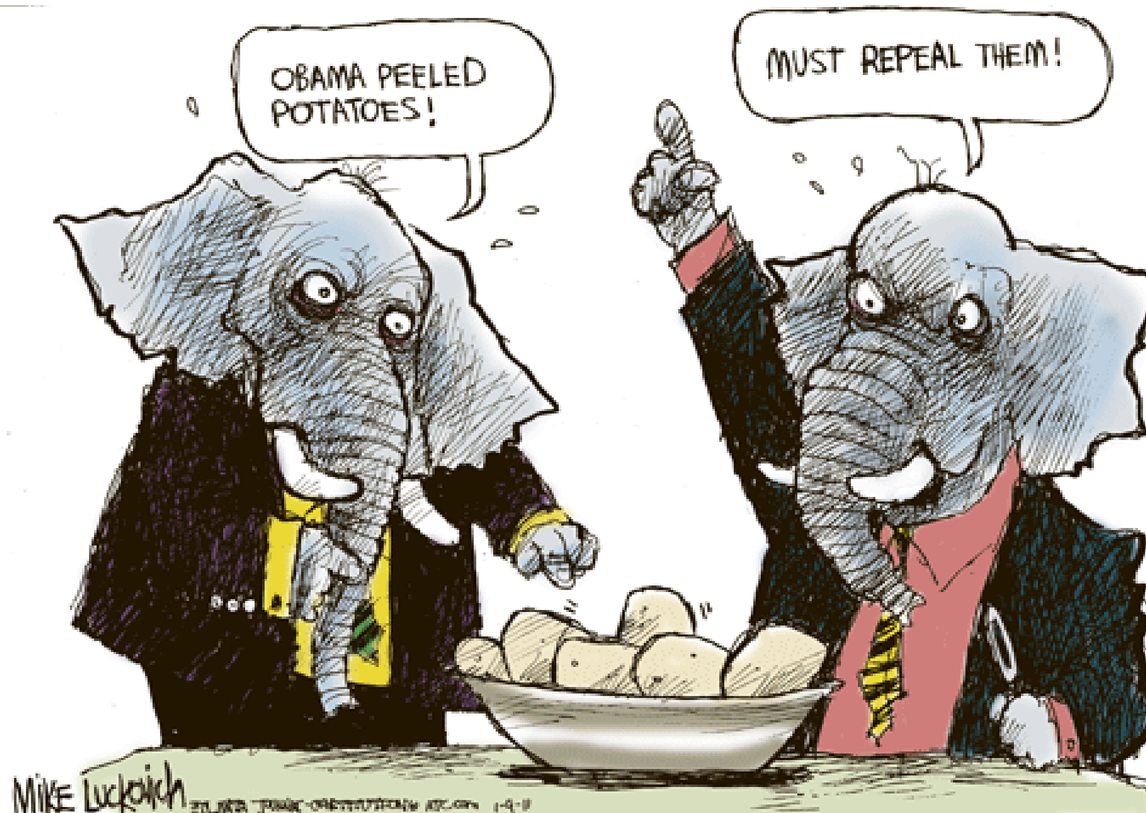
Current Political Dynamic



Political Dynamic

- Washington’s political dynamic is fractured
- Compromise is extraordinarily difficult--moderates are unable to move
- House actions are tempered by conservative pressure and tight Democratic majority in the Senate and President Obama
- Both parties trying to balance delivering on promises now and goals for 2012

Repeal/ Replace vs. Fix It!



2012 Elections Impact

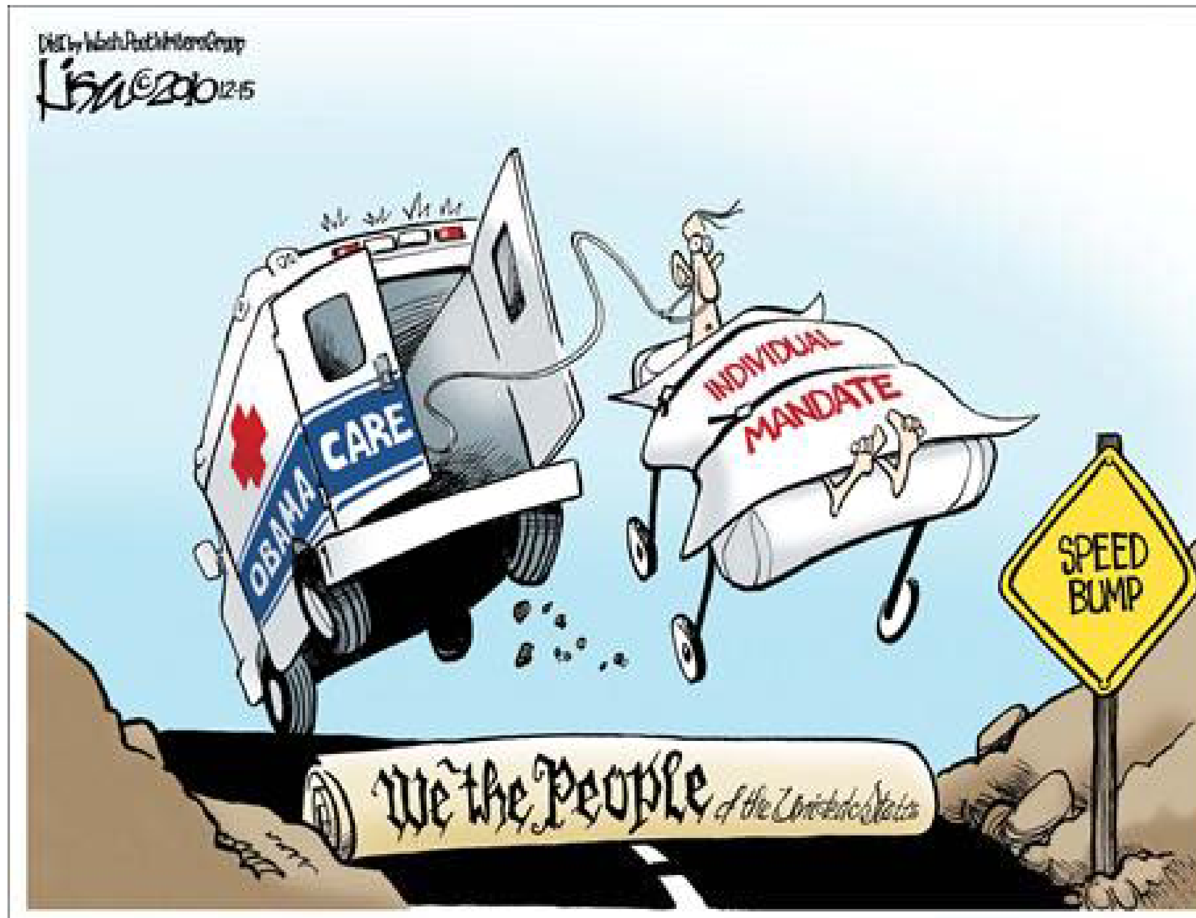
- Things may stay as is, as implementation of health reform moves forward as is
- If President Obama is reelected, implementation moves forward because of veto power
- If a Republican is elected but Senate remains as is, there could be delays but most change measures could be blocked
- If Republicans win in every area, Senate parliamentary procedure could still prevent repeal, but major changes would be likely

What Could Change with GOP Win?

- Individual Mandate
- Employer Mandates
- Level of subsidies
- Medicaid Expansion
- Medical Loss Ratio
- Class Act
- Health Insurance Taxes
- IPAB
- Grandfathering rules

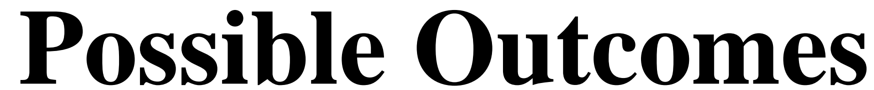
- Cost related to budget deficit
- Areas of implementation already underway:
  - Early Retiree Reinsurance Program
  - Grants to states
  - Part D rebates
  - Coverage to age 26 coverage expansions
  - Lifetime and annual limits beneficiaries
  - Pre-existing conditions exclusions beneficiaries

Individual Mandate



PPACA Constitutionality Challenge

- Four key issues:
  - Is it constitutional for the FEDERAL government to require a person to purchase anything to protect themselves
  - If it is not, is the rest of the bill inseparably tied to the individual mandate
  - Is the Medicaid mandate in the bill an undue infringement on states
  - Can this even be looked at now by the court given that no one has actually been penalized for non-compliance



Possible Outcomes

- Supreme Court could throw out individual mandate only
  - Action needed to mitigate impact of market reforms
- Supreme Court could throw out Medicaid expansion only
  - Potential cost increases relative to premium tax credits
- Supreme Court could defer action at this time
  - Means all cost of compliance and other actions continue
- Supreme Court could void entire bill
- Supreme Court could throw out individual mandate and some other provisions

Other Hot Inside-The-Beltway Issues

- Agency Actions
  - Interim Final Rule (IFR), vs.
  - Notice of Proposed Rule (NPRM), vs.
  - Guidance or Bulletin
- Essential Benefits Bulletin
  - Benchmarks
    - State Mandates
    - Impact on Multi-state plans
    - Cost-sharing/Actuarial value
    - Minimum Value for larger plans

Medical Loss Ratios - 2011

- Minimum loss ratio requirements are in effect in most fully insured markets
- The MLR is 85% for large group plans and 80% for individual and small group plans (100 and below)
- Carriers will have to issue a premium rebate to individuals when MLR is too low (beginning 2012)
  - December interim final and final rules clarified action on:
    - ICD-10 coding will be partially allowed in quality
    - Rebates to employer sponsored plans will allow employers to use funds for good of employees rather than chase down former employees
    - How the MLR applies to ex-patriot employees
    - Did not address agents and brokers

The Latest Activity on MLR

- HR 1206 now has 207 cosponsors
- NAIC passed resolution
- House Activity
  - Janet Trautwein testimony at Energy and Commerce Committee on MLR in September
  - Small Business Committee hearing featured NAHU member from Colorado and Maryland small business owner
- Senate legislation S 2288 has been introduced sponsored by Sen. Mary Landrieu (D-LA), Johnny Isakson (R-GA), Ben Nelson (D-NE), and Lisa Murkowski (R-AK), and now has 9 co-sponsors.
- HHS Waivers- Maine, New Hampshire and Nevada, Kentucky, Iowa approved. Georgia was given a modified approval. Applications pending for North Carolina, Texas
- Denied: Guam, Delaware, North Dakota, Florida, Louisiana, Michigan, Oklahoma, Kansas, Indiana

PPACA Exchanges

- State-based health insurance exchanges not optional, if a state doesn’t create one, federal government will
  - Law requires the creation of and American Health Benefit Exchange (AHBE) (for individuals) and Small Business Health Options Program (SHOP) Exchange for small employers up to 100 lives
  - States can combine their individual and small employer exchanges
  - Regional sub-exchanges optional
  - States can choose to expand their exchanges to serve employer groups of 100+ in 2017
- Transparent and more standardized benefit packages and will feature more choice in plans, carriers, networks (comparison shopping)
- Premium tax credits only available for individuals purchasing through an exchange, not those in an employer group
- People with adequate and affordable group coverage cannot leave group plan for the individual exchange

Exchanges – Inside and Outside Markets

- Congress specifically provided that individual and group health insurance markets are to exist outside of the exchanges
- The law specifies that "grandfathered" plans will continue to exist outside the exchange
- Other plans are also permitted to exist outside of the exchange, and from experience in Massachusetts and Utah, some individuals and businesses will continue to purchase coverage there
- Subsidies only currently available through the exchanges. Fixing that will require a federal statutory change

Exchange Legislation and States

- HHS awarded almost every state one or more planning grants in 2010
- More than a dozen states have been awarded Level One establishment grants
- About half of the states have either enacted exchange legislation, have pending legislation or have created an administrative path to move forward
- Exchange legislation failed in about 20 states
- Several states have chosen not to move forward/returned funds

State vs. Federally Operated Exchange

- If a state doesn't create an exchange, the federal government has to do it instead, **on behalf of the state**
- The new 3rd option: **Federal Partnership Model**
- Federally operated exchange with a great deal of state interaction
- States can choose their role in the Partnership Exchange from three basic options. These options are:
  - Option 1 – Plan management. States take the lead on working with health plans who want to participate in the exchange to offer coverage.
  - Option 2 – Selected consumer assistance. States will help you understand your options—they will do conduct outreach and education, provide in-person consumer support for Exchanges, and manage the call center and the consumer website where you can get the most up to date information.
  - Option 3 – Both Option 1 and Option 2.
- For the foreseeable future, or simply as a means of phasing in a State-run Exchange.

Agent/Brokers/Navigators

- Exchanges will be a purchasing portal for subsidized and unsubsidized qualified health plans, as well as an enrollment point for Medicaid, CHIP and other state public health assistance programs.

- PPACA **requires every exchange to have a Navigator program** to facilitate health plan enrollment.

- Agents and brokers are specifically listed by the law as one of the groups that may be Navigators, but the law also stipulates a compensation/financing method that conflicts with traditional agent compensation structures.

- PPACA specifically provides for state health insurance exchanges to choose to utilize the services of agents and brokers beyond the navigator program to help exchange customers both with enrollment in qualified plans and also with the premium tax credits.

- Existing laws in every state provide for licensed health insurance producers to sell and service all health plans offered in the state.

Employers and Exchanges

A very important point relative to Exchanges is how to predict employer response.

Because of the many changes to employer plans as a result of PPACA, employers are weighing all options for coverage of their employees in the future….

Timeline for Employers

2010	•Grandfathered Plans Take Effect •Small Business Tax Credits •Federal High Risk Pool •Federal Retirement Reinsurance Program •Retiree Drub Plan FAS Liability •Federal Premium Rate Oversight • Sept. 23rd Reforms for All Plans-- Dependent Coverage to Age 26, No Preexisting Condition Limitations for Children, Rescission Restrictions, Annual and Lifetime Limit Restrictions •Sept. 23rd Reforms for Non-Grandfathered Plans--Preventive Care, 105h Nondiscrimination (enforcement delayed), New coverage appeals process requirements
2011	•FSAs/HRAs/HSAs — OTC drugs not allowed without Rx •HSA distribution tax increases •Simple cafeteria plan rules •Medical Loss Ratio requirements begin •Medicare Park D discounts for drugs in donut hole •Federal Rate Review standards begin •Small business wellness grants should be made available, but have not been yet

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Immediate Benefit Timeline for Employers

2012	•Newly defined preventive care requirements for non-grandfathered plans begin •New longer Summary Plan Description requirements (60 day notice of material change) •New quality reporting requirements (to HHS and beneficiaries) for all employer plans and all individual and group carriers •Delayed W2 Reporting begins (requirement is optional for employers who issue less than 250 W2s until further notice) •Employers whose carrier did not meet MLR standards may receive a rebate. Carriers responsible for ensuring that any rebate is shared with employees based on employer-contribution standards. •New Medicare Taxes on unearned income and higher income employees and self-employed
2013	• New federal premium tax on fully insured and self-insured group health plans to fund comparative effectiveness research program begins. It imposes an annual fee on private insurance plans equal to two dollars for each individual covered. •Exchange notification requirements for employers •FSA contributions limited to $2,500 •Employers no longer able to deduct for expenses related to drug subsidy (retirees)

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PPACA Requirements for Employers (Changes from Statute)

- Enforcement delayed on 105 (h) non-discrimination rules for all fully insured non-grandfathered plans
  - IRS solicited comments in March, 2011
  - No word on when new guidance will be issued/enforcement could begin
- W2 Reporting made optional for 2011
  - New Guidance Issued March 29 for 2012, additional FAQ January 2012.
  - Relief for smaller employers (those filing fewer than 250 W-2 forms) by making this requirement optional for them at least for 2012 and possibly longer (till more guidance is issued)
  - For larger employers includes information on how to report, what coverage to include and how to determine the cost of the coverage
- 1099 Reporting requirements repealed
- Employee Free Choice Voucher Program eliminated
- Funding for Cooperative Plans Reduced

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The Big Year - PPACA in 2014

- Individual Mandate
- Health Insurance Exchanges
- Employer Mandate
- Other significant changes:
  - Modified community rating
  - Individual market guaranteed issue
  - Subsides available for qualified individuals purchasing through the exchanges
  - New premium taxes on fully-insured plans
  - Essential benefit requirements
  - Minimum value standard
  - Deductible Limits for Small Businesses

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Employer Responsibility Requirement

- Effective starting January 1, 2014
- Employer must count all full-time employees and part-time employees – on a full-time equivalent basis – in determining if they have 50 or more employees
  - Certain seasonal workers are not counted in determining if employer has 50 workers
  - Full-time = 30 or more hours per week, determined on a monthly basis
- Penalties assessed for “no coverage” or coverage that is “not affordable”
- Minimum value standard to be developed to determine adequacy of coverage
- Premium used to calculate affordability versus household premium is the single employee rate, regardless of how many dependents employee has covered on the employer plan

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"Affordability" Penalty Calculation

Federal Poverty Limit - FPL	2011 FPL	Hourly Rate	Household %	Premiums per Mo @ 9.5% FPL
	1 Unit			Self ONLY
100%	$10,890	Medicaid		N/A
133%	$14.484	Medicaid		N/A
150%	$16,335	$7.85/hr	9.5%	$130/mo
200%	$21,780	$10.47/hr	9.5%	$172/mo
250%	$27,225	$13.09/hr	9.5%	$216/mo
300%	$32,670	$15.71/hr	9.5%	$259/mo
350%	$38,115	$18.32/hr	9.5%	$302/mo
400%	$43,560	$20.94/hr	9.5%	$345/mo
400% family of 4	*$89,400*		*9.5%*	*$708/mo*

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Will the Employer Pay A Penalty?
beginning in 2014

Are you a large employer?
at least 50 full-time equivalent workers
- including full-time [30+hours per week] and part-time workers [prorated]
- excluding seasonal workers [up to 120 days per year]

yes → **Are any of your full-time employees in an exchange plan and receiving a premium credit ?**
no → **No penalty**

Are any of your full-time employees in an exchange plan and receiving a premium credit ?
yes → **Do you have more than 30 full-time employees?**
no → **No penalty**

Do you have more than 30 full-time employees?
yes → **Do you provide health insurance?**
no → **No penalty**

Do you provide health insurance?

yes → **Pay Monthly Penalty, *lesser of:***
1/12 x $2,000 x (Number of full-time employees - 30)
or
1/12 x $3,000 x (Number of full-time employees who receive credits for exchange coverage)

no → **Pay Monthly Penalty**
1/12 x $2,000 x (Number of full-time employees - 30)

Summary of Potential Employer Penalties under PPACA, Congressional Research Service, May 14, 2010

2014 Changes to the Way Employer Plan Premiums Are Calculated

- Changes for all fully insured group plans:
  - All guaranteed-issue with no preexisting condition limitations
  - Annual and lifetime limits will be fully prohibited, including for grandfathered plans
  - Size of a small-employer group will be redefined to one to 100 employees (although states may elect to keep the size of a small groups at 50 employees until 2016)

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2014 Changes to the Way Employer Plan Premiums Are Calculated

- Market reforms for fully insured small groups up to 100 employees (and any larger fully insured groups if a state allows groups of 100+ in their exchange):
  - Strict modified community rating standards with premium variations only allowed for age (3:1), tobacco use (1.5:1), family composition and geographic regions
  - Experience rating would be prohibited
  - Wellness discounts will be allowed for group plans under specific circumstances
  - Could have a SIGNIFICANT price impact

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Other Employer Plan Reforms in 2014

- The essential benefit standards for qualified coverage begin
  - Initial guidance released by HHS – establishes state benchmarks based on a choice of standards modeled on plans offered in small employer market
  - Standard will apply to all fully insured small group (1-100; possible 10-50 until 2016 based on state decision) and individual products to be sold both inside and outside the exchanges
  - If a state allows fully insured large groups in its exchange after 2017, then it will apply to all fully insured large groups too
  - The essential benefit standards include specific mandated benefits, cost-sharing requirements, out-of-pocket limits and a minimum actuarial value of 60%
- Large groups and self-funded plans will be subject to a different, to-be-determined minimum value standard, to be developed by IRS/DOL/HHS for employer mandate compliance purposes

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Other Employer Plan Reforms in 2014

- Employee waiting periods of more than 90 days are prohibited for all plans, including grandfathered plans.
- Employer-sponsored wellness program rules for all employer group plans under HIPAA improve and employers can increase the value of workplace wellness incentives up to 30% of premiums, with HHS discretion to increase the incentives to 50%
- Small businesses prohibited from buying coverage with deductibles in excess of $2000 individual/$4000 family

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Other Employer Responsibilities

- Employers must automatically enroll "new *full-time* employees" in employer-sponsored coverage *delayed*
  - Must provide adequate notice and opportunity to opt out
  - Applies to employers with "more than 200 full-time employees"
- Notice to current employees and new hires about exchange and subsidies
  - Existence of exchange, services and how to obtain assistance
  - Availability of subsidies if employer coverage is unaffordable or below minimum benefit level.

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More Employer Responsibilities

- New rules are out relative to the reporting on W-2s the value of employer provided health insurance
- A new four-page summary of benefits must be provided to employees beginning in 2012 *new flexibility*
- Completion of form 5500 will become more complex
- New requirements on claims and appeals will be in place
- Tracking and notification of number of months employees covered by minimum required coverage.

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Enid was finally ready to admit that compliance was a bit more complicated than she first thought.

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- Cadillac tax goes into effect for all group plans, including self-insured plans. The tax would be paid by the insurer in the case of a fully insured group or the TPA in a self-insured arrangement, but would be passed on directly to the employer.
- 40% excise tax on insurers of employer-sponsored health plans with aggregate values that exceed $10,200 for singles and from $27,500 for families takes effect in 2018
- Arbitrary numbers and lack of adequate indexing may be problematic

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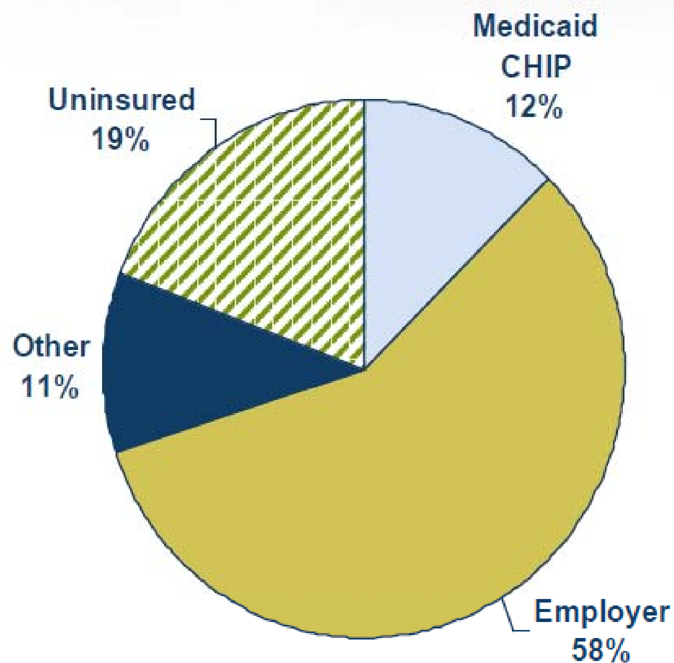
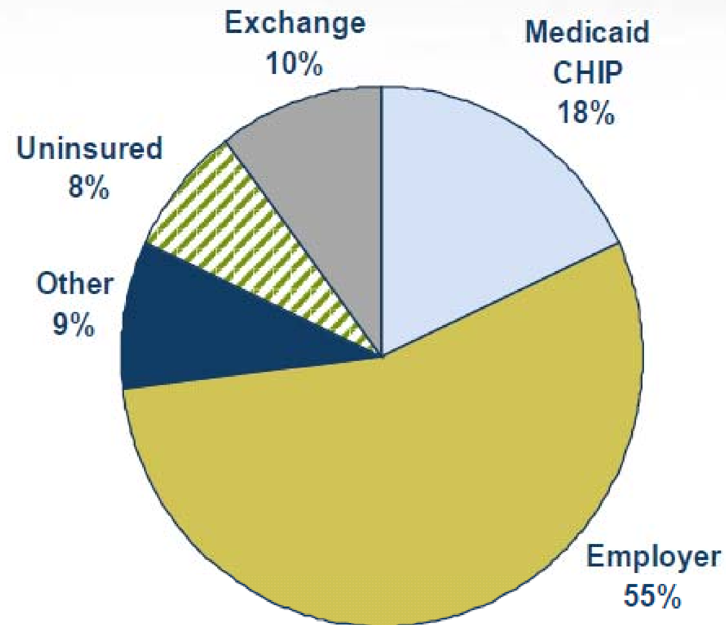
CBO 2019 Estimates of Insurance Coverage





Among noneldery (under age 65). 'Exchanges' include 2% (5M) that CBO counted as 'Employer.' If excluding unauthorized immigrants, CBO's uninsured projection for PPACA would be 6%.

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ISSUES WE ARE WORKING ON

- Cost Containment
- Subsidies Inside/Outside Exchanges
- Employer Mandate
- Definition of a FTE
- Group Size Definitions
- Grandfather Rules
- Rate review
- Child-Only policy access
- Small employer deductible requirement
- Actuarial standards
- PCIP
- Medicare OEP
- Medicare/Medigap/MA Cuts
- Payment reforms
- 105 h Nondiscrimination

ISSUES WE ARE WORKING ON

- HSA/HRA issues
- Medical Liability Reform
- Transparency
- ACOs
- Co-op Plans
- Multi-state Plans
- Value-based purchasing
- New Premium Tax
- Notification requirements on employers
- New Summary Plan Document
- Small business tax credit
- Cadillac Plans
- Preserving employer exclusion

NAHU Moving forward

- MLR, work on Exchanges, and Essential Benefits/Minimum value are our top immediate priorities
- Overriding objective is to ensure continuation of employer sponsored coverage
- Grassroots efforts
- Public Relations initiatives
- Focus on real issues – the cost of health care
- NAHU and broker visibility is high
- We need everyone’s help!

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