



Congressional Research Service

Assisting the Congress with its deliberations and legislative decisions

Focus on Reform: Private Health Insurance Provisions of PPACA

Bernadette Fernandez

May 14, 2010

Agenda

Private Health Insurance: Market Reforms and Coverage Programs

Pre-PPACA

- Private health insurance regulation

Near-Term Reforms and Programs

- Grandfathered plans
- New coverage options
- New consumer assistance tools
- Requirements on health insurance issuers

Long-Term Reforms and Programs

- Requirements on individuals and employers
- Requirements on health insurance issuers
- Risk mitigation programs





Pre-PPACA

Private Health Insurance Regulation

- Regulated primarily at the state level
 - Guaranteed issue and renewability
 - Mandated benefits
 - Rating rules
 - Many other requirements
- Federal reforms address pre-existing conditions, nondiscrimination, benefits, etc.





Near-Term Reforms and Programs (Prior to 2014)

Near-Term Reforms and Programs

Prior to 2014

Grandfathered Plans

- Existing plans are exempt from most reforms
- Subject to several insurance reforms
 - Extension of dependent coverage to age 26
 - Coverage for pre-existing conditions for those under 19
 - Prohibition on lifetime benefit limits
 - Restriction on annual benefit limits
 - Prohibition on rescissions (except for fraud)
 - Reporting of medical loss ratio (MLR) and rebates
 - Uniform explanation of coverage
 - Prohibition on excessive waiting periods
- Uncertainty regarding conditions when a grandfathered plan becomes a new plan



Near-Term Reforms and Programs

Prior to 2014

New Coverage Options

- Temporary high risk pools
 - Establish 90 days from enactment; terminates January 1, 2014
 - State based, federal fallback
 - \$5 billion for claims and administrative costs
 - Implementation: Secretary's letter to states; proposed allocation of program funding
- Temporary reinsurance program for early retirees
 - Establish 90 days from enactment; terminates January 1, 2014
 - \$5 billion for claims reimbursement
 - Implementation: interim final rules
- Consumer Operated and Oriented Plan (CO-OP) program
 - Effective on enactment
 - \$6 billion in loans and grants
 - Secretary awards no later than July 1, 2013



Near-Term Reforms and Programs

Prior to 2014

New Consumer Assistance Tools

- Internet portal
 - Establish by July 1, 2010
 - Standardized format within 60 days from enactment
 - Implementation: interim final rules
- Office of Health Insurance Consumer Assistance/Ombudsman
 - Effective on enactment
 - \$30 million (first FY) to establish/support state-based offices
- Annual rate review
 - \$250 million for state grants for 5 years beginning FY2010
 - Implementation: request for comments



Near-Term Reforms and Programs

Prior to 2014

Requirements on Health Insurance Issuers

Effective for plan years beginning 6 months after enactment

- Prohibits pre-existing condition exclusions under age 19
 - Implementation: Secretary letter to health insurers
- Prohibits lifetime limits and restricts annual limits
 - Based on essential health benefits
- Prohibits rescissions (except for fraud)
- Coverage for preventive services with no cost-sharing
- Extends dependent coverage to adult children under age 26
 - Implementation: interim final rules
- Medical loss ratio (MLR) reporting and rebates
 - Minimum MLRs: 85% large group; 80% small group/nongroup
 - Rebates provided no later than January 1, 2011
 - Implementation: Secretary's letter to insurance commissioners; request for comments





Long-Term Reforms and Programs (Beginning 2014)

Long-Term Reforms and Programs

Beginning 2014

Requirements on Individuals and Employers

- Individual mandate (with exceptions)
- Employer requirements (no mandate, possible penalties)

Requirements on Health Insurance Issuers

- New plans
 - May be offered inside and outside of exchange
 - Applicable reforms depend on market segment, funding, in or out of exchange, state, timing



Selected Insurance Reforms Applicable to Grandfathered and New Plans

	Grandfathered Plans	New Plans			
		Nongroup	Small Group	Large Group	Self-Insured (small and large groups)
Dependent Coverage	All Plans	X	X	X	X
Pre-existing Conditions	Group Plans	X	X	X	X
MLR Reporting/Rebates	All Plans	X	X	X	NR
Essential Benefits Pkg	NR	X	X	QHP	NR
Adj Community Rating	NR	X	X	Exchange	NR

Source: CRS analysis of PPACA.

Notes: NR – not required. QHP – qualified health plan.



Long-Term Reforms and Programs

Beginning 2014

Requirements on Health Insurance Issuers (cont.)

- Qualified health plans (QHPs)
 - Primarily plans in exchange; may be offered outside
 - Must comply with all new health insurance reforms
 - Standardized benefit tiers based on actuarial value
 - Platinum (90%)
 - Gold (80%)
 - Silver (70%)
 - Bronze (60%)
 - Certified to meet minimum requirements regarding marketing, provider adequacy, clinical quality, etc.
- Other plans: child-only, catastrophic, multi-state QHPs, dental-only



Long-Term Reforms and Programs

Beginning 2014

Requirements on Health Insurance Issuers (cont.)

- Essential health benefits package
 - Applies to qualified health plans, nongroup, small group
 - Coverage of essential health benefits (e.g., prescription drugs)
 - Secretary defines and revises essential health benefits
 - Certified by CMS Actuary to be equal in scope to typical employer plan
 - Cost-sharing requirements
 - Small group deductible limits: \$2,000 self-only coverage; \$4,000 other coverage
 - No deductible for preventive services
 - Out-of-pocket (OOP) limits
 - Limits equivalent to OOP maximums for qualifying high-deductible health plans paired with health savings accounts (\$5,950 and \$11,900 in 2010)



Long-Term Reforms and Programs

Beginning 2014

Requirements on Health Insurance Issuers (cont.)

- Insurance reforms
 - Continuation of near-term reforms (some changes)
 - Prohibits pre-existing condition coverage exclusions (no age limit)
 - Prohibits annual limits based on essential health benefits
 - Guaranteed issue and renewability of coverage
 - Adjusted community rating
 - Age (3:1)
 - Tobacco use (1.5:1)
 - Rating area
 - Self-only or family coverage
 - Non-discrimination in eligibility
 - Discounts for wellness participation (up to 50% of premium for employee-only coverage)



Long-Term Reforms and Programs

Beginning 2014

Risk Mitigation Programs

- Temporary state reinsurance program
 - States establish by January 1, 2014; terminates in 2016
 - Reinsurance for nongroup issuers
 - Secretary develops standards
- Temporary risk corridor program
 - Secretary establishes for calendar years 2014-2016
 - Program applies to nongroup and small group QHPs
 - Program based on risk corridors under Medicare Part D
- Risk adjustment program
 - States administer risk adjustment to nongroup, small group, and certain large group plans
 - Secretary establishes criteria and methods



A parting thought...

