Overview of the Patient Protection and Affordable Care Act (PPACA)

House Select Committee on PPACA
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Overview and Timeline

- PPACA became law on March 23, 2010.
- PPACA creates:
  - Substantial changes to private health insurance, Medicaid, and Medicare
  - New federal programs and offices
  - New taxes, fees, and credits
  - Grants, incentives, and demonstration projects
- Provisions are phased in between 2010 and 2020.
  - Most of the provisions that directly affect the State of Florida are effective in 2014.
  - Major decisions must be made by Florida before 2014.

Scope of this Overview

- Individual Mandate
- Employer Obligations
- Insurance Regulation and Benefits
- Health Insurance Exchanges
- Medicaid

The State of Florida is affected:

- As an insurance market regulator and administrator
- As an employer and purchaser of state employee health insurance
- As a purchaser of health care services for the poor and disabled in the Medicaid program

Major Decision Points

- Health insurance regulation
- State employee group insurance plan
- Health insurance exchange
- Medicaid expansion

Individual Mandate

- January 1, 2014, all U.S. residents will be required to maintain "minimum essential coverage"; with these exceptions:
  - individuals with a religious conscience exemption
  - incarcerated individuals
  - undocumented aliens
  - individuals who cannot afford coverage (required contribution exceeds 8% of income)
  - individuals with a coverage gap of less than 3 months
  - individuals in a hardship situation (as defined by the U.S. HHS Secretary)
  - individuals with income below the tax filing threshold
  - members of Indian tribes

Individual Mandate (cont'd)

- "Minimum essential coverage" includes:
  - Government-sponsored programs like Medicare and Medicaid
  - Employer-sponsored plans, including governmental plans, grandfathered plans and other plans offered in the small or large group markets
  - Individual market plans, including grandfathered plans

Individual Mandate - Penalty

- The annual penalty for not having minimum essential coverage will be the *greater* of:
  - a flat dollar amount per individual; or
  - a percent of the individual's taxable income.

- The penalty grows over time: $95 or 1% in 2014; $325 or 2% in 2015 and $695 or 2.5% in 2016.

- After 2016, the penalty growth is indexed to inflation.

- The penalty for a child is one half of the adult penalty.

Individual Mandate - Enforcement

- The penalty will be paid as a federal tax liability on income tax returns and will be enforced by the IRS.
  - Only individuals who are required to file income tax returns are subject to the penalty.

Individual Mandate - Subsidies

- Low-income individuals and families may receive tax credits and other subsidies to pay for health insurance purchased through an exchange.
- Subsidies are available for people with household incomes between 100% and 400% of the federal poverty level.
  - Individuals: Incomes between $11,170 and $44,680.
  - Families of four: Incomes between $23,050 and $92,200.
- Subsidies vary by income and family size.

Individual Mandate – U.S. Supreme Court

- The mandate is unconstitutional under the Commerce Clause, because Congress cannot regulate a lack of economic activity, i.e., the failure to buy something.
- The mandate is not authorized under the Necessary and Proper Clause, because that clause applies to the *means* of accomplishing something that is already authorized by the Constitution. Congress cannot use necessary and proper means to do something that it does not have Constitutional authority to do.
- **However**, the mandate was upheld because it is constitutional under another provision:
  - **The mandate is a constitutional exercise of Congress' taxing authority under the Tax and Spend Clause. The penalty for failure to buy insurance is a tax**.

Individual Mandate – Decision Points

- No decisions here – just impact:
  - Medicaid enrollment may increase
    - 'Eligible but not enrolled' population
    - No tax/penalty for those who don't have to file a tax return or are Medicaid-eligible
  - State Employee Group Plan enrollment
    - 'Opt-out' population
    - Existence of spousal coverage
    - Other employers' reaction to the employer obligations
- Estimates rely on predicting human behavior

Employer Obligations

- Large employers must offer insurance benefits that meet the minimum benefits and other requirements of PPACA.
  - A "large employer" is one with more than 50 full-time employees.
- Large employers must offer and help pay for health insurance to all full-time employees.
  - "Full time employees" (FTEs) are those working more than 30 hours per week.
- The insurance must be "affordable" and the policy must pay for at least 60% of the cost of the plan.
  - "Affordable" means the cost of coverage does not exceed 9.5% of household income.

Employer Obligations – No Coverage Penalty

- "Play or Pay" - If a large employer fails to offer insurance, the employer must pay $2000 for each FTE (excluding the first 30.)
  - The penalty is $2,000 for every employee – not just the employees for whom the employer fails to provide coverage.
  - The first 30 employees are excluded from the penalty calculation.

Employer Obligations – Unaffordable Coverage Penalty

- "Free Rider"- If a large employer fails to provide insurance that is "affordable" and covers at least 60% of the cost of the plan, the employer must pay a penalty.
  - If at least one FTE enrolls in the exchange, the penalty is the lesser of:
    - $3,000 per employee who enrolls in the exchange
    - $2,000 for every FTE, minus the first 30.

Employer Obligations – State Group Insurance Program

- Florida is a large employer under PPACA.
- OPS employees currently cannot participate in the State Group Plan.
  - Florida will be subject to “Pay or Play” penalties if coverage is not extended to full-time OPS employees.
- Employees who currently choose not to participate in the State Group Plan may do so to comply with the individual mandate.
- Insurance regulatory changes (discussed later) will apply to the State Group Plan.

Employer Obligations – Decision Points

- Extend coverage to OPS employees or pay penalties?
- Amend the plan to match the PPACA benefit and regulatory requirements?

Insurance Regulation

- PPACA establishes many federal insurance regulations on matters previously governed by state law.
  - Effective in the 2011 plan year:
    - No lifetime limits on amount paid out by the plan
    - No copayments or deductibles for certain preventive services
    - No cancellation of the policy except for fraud
    - Coverage for children up to 26 years of age
    - No denial of coverage due to a pre-existing condition for children

Insurance Regulation (cont’d)

- Effective in the 2014 plan year:
  - No denial of coverage to anyone with a pre-existing condition
  - No annual limits on amount paid out by the plan
  - All individual and small group plans must cover federally defined “Essential Benefits”
  - Plan rating factors are set by federal law (limits the degree of pricing differential among differently situated people)

Insurance Regulation (cont'd)

- Insurance companies must modify their offerings to meet the new plan requirements.
- Insurers have new reporting requirements and must adopt specified standards for documents.
- Plans must justify premium increases or be excluded from participation in the Health Insurance Exchanges.

Insurance Regulation - Medical Loss Ratio

- In 2011, plans are required to meet the following medical loss ratios:
  - Large Group – 85%
  - Small Group – 80%
  - Individual – 80%
- Plans who fail to meet these ratios must pay rebates to their customers.

Insurance Regulation - Essential Benefits

- PPACA creates a list of mandatory services that must be included in all individual and small group plans offered in Florida:
  - Ambulatory patient services
  - Emergency services
  - Hospitalization
  - Maternity and newborn care
  - Mental health and substance use disorder services, including behavioral health treatment
  - Prescription drugs
  - Rehabilitative and habilitative services and devices
  - Laboratory services
  - Preventive and wellness services and chronic disease management
  - Pediatric services, including oral and vision care

Insurance Regulation - Essential Benefits

- To measure compliance with the Essential Benefits requirements, each state will designate a "benchmark plan" for comparison.
- For the 2014 and 2015 plan years, states were to choose a benchmark plan from among several types of plans available in the states, by September 30, 2012.
- If a state does not select a plan, the default benchmark plan is the largest small group plan, by enrollment.
- Benchmark plans without all the essential health benefits will be supplemented.

Insurance Regulation - Florida Law

- Florida's insurance code has provisions that conflict with PPACA's requirements.
  - Plans cannot comply with both; state law is preempted.
- Florida's insurance code has provisions that are different from but not in conflict with PPACA
  - Plans can comply with both, but in practice the stricter regulation would dominate.
- The Office of Insurance Regulation does not have statutory authority to enforce PPACA's requirements.

Insurance Regulation

Impact:

- OIR implementation costs
- Medicaid crowd-out
- State employee group plan premiums

Insurance Regulation – Decision Points

- Repeal provisions in the state insurance code which conflict with PPACA, eliminating federally-trumped language?

- Grant OIR authority to enforce some or all of the provisions of PPACA, and modify the Florida Insurance Code to reflect federal law?

Exchanges

- An exchange is a forum for purchasing health care coverage, particularly for individuals and small groups.
- PPACA requires every state to have an individual exchange and a small group exchange (or a combined exchange) by January 1, 2014.
- Individuals receiving federal subsidies (100%-400% of poverty) must use those dollars in the state exchange.
- Individuals without subsidies can also purchase coverage in the exchange.

Exchanges - Duties

Consumer Assistance	Consumer support assistors; education and outreach; Navigator management; call center operations; website management; and written correspondence with consumers to support eligibility and enrollment.
Plan Management	Plan selection approach (e.g., active purchaser or any willing plan); collection and analysis of plan rate and benefit package information; issuer monitoring and oversight; ongoing issuer account management; issuer outreach and training; and data collection and analysis for quality.
Eligibility	Accept applications; conduct verifications of applicant information; determine eligibility for enrollment in a Qualified Health Plan and for insurance affordability programs; connect Medicaid and CHIP-eligible applicants to Medicaid and CHIP; and conduct redeterminations and appeals.
Enrollment	Enrollment of consumers into qualified health plans; transactions with Qualified Health Plans and transmission of information necessary to initiate advance payments of the premium tax credit and cost-sharing reductions.
Financial Management	User fees; financial integrity; support of risk adjustment, reinsurance, and risk corridor programs.

Exchange Options

- The State can directly manage the exchange, contract with a not-for-profit, partner with the federal government, or allow the federal government to establish the exchange.

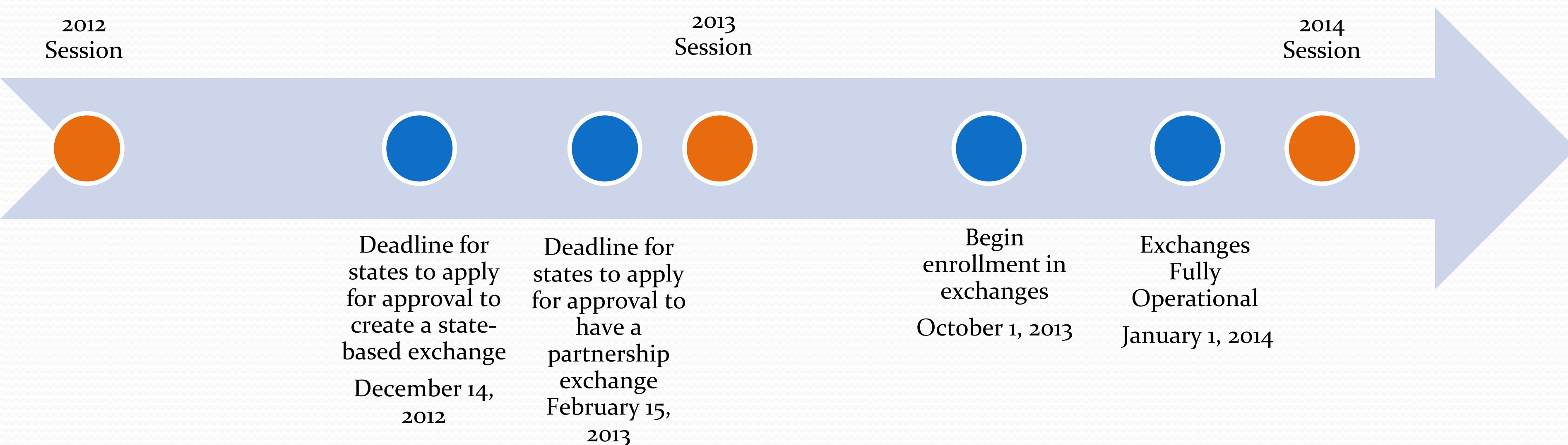
State-based Exchange	State Partnership Exchange	Federally-facilitated Exchange
State operates all Exchange activities; however, State may use Federal government services for the following activities: • Premium tax credit and cost sharing reduction determination • Exemptions • Risk adjustment program • Reinsurance program	State operates activities for: • Plan Management • Consumer Assistance • Both State may elect to perform or can use Federal government services for the following activities: • Reinsurance program • Medicaid and CHIP eligibility: assessment or determination*	HHS operates; however, State may elect to perform or can use Federal government services for the following activities: • Reinsurance program • Medicaid and CHIP eligibility: assessment or determination*

*Coordinate with Medicaid and CHIP Services (CMCS) on decisions and protocols

Exchange Options

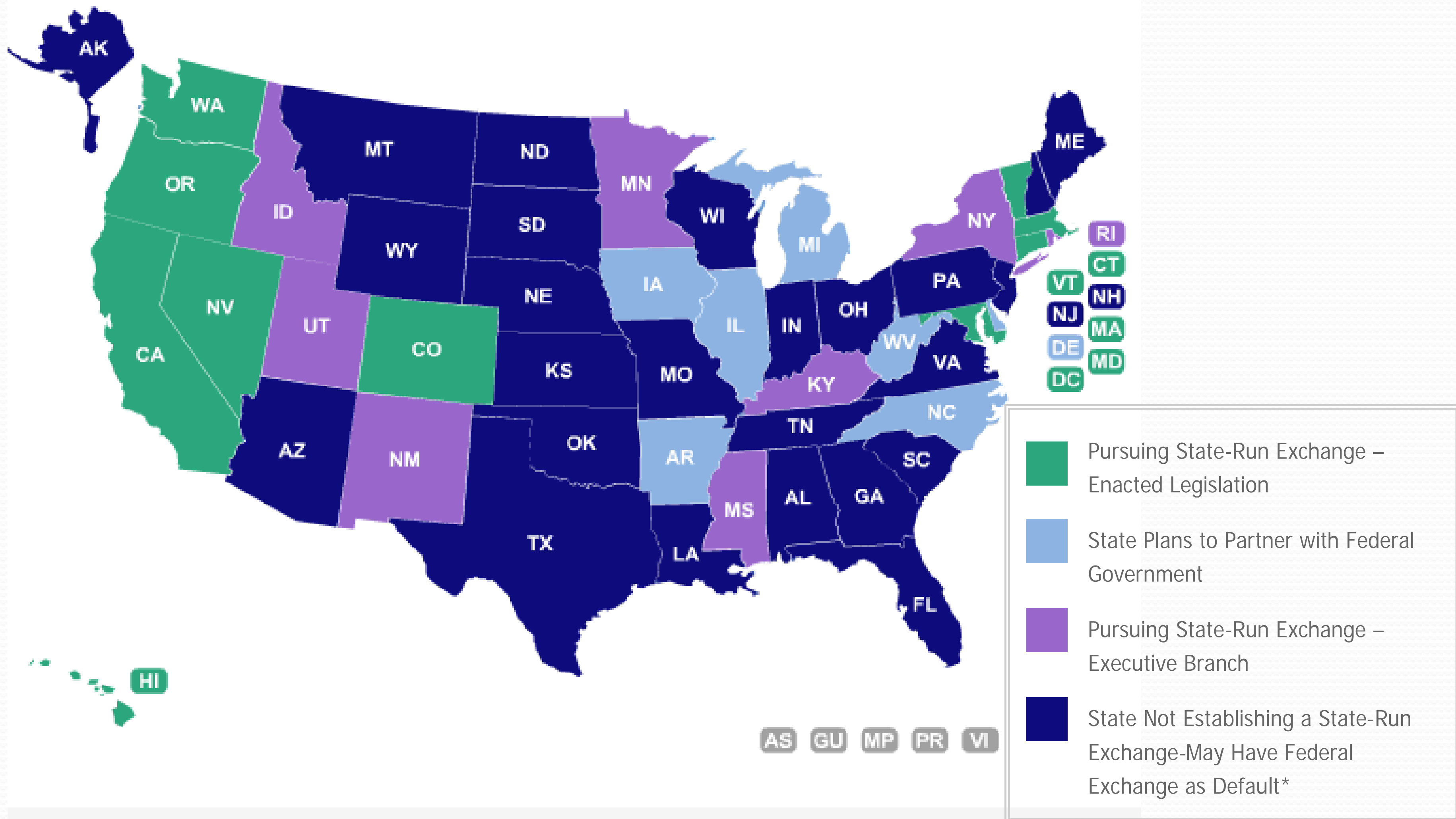
- State-based: A state must have notified HHS by December 14, 2012, and demonstrated that it has taken actions necessary to set up the exchange.
- Partnership: A state must notify HHS by February 15, 2013, and demonstrate that it has taken actions necessary to set up the exchange.
- Federally-facilitated: After 2014, a state may take over operation of the exchange or partner with the federal government.
  - Initial federal guidance is that a state must give the federal government a one year notice of its intent to take over or partner in an exchange.

Exchanges - Timeline



State Health Exchange Establishment Actions

As of January 4, 2013. Source: NCSL Research, 2012 and NCSL's Federal Health Reform: 2011 State Legislative Tracking Database, powered by StateNet.



Exchanges - Decision Points

- Enter into a partnership exchange? Take over the federal exchange in the future? Allow the federal government to operate the exchange permanently?

- If Florida has a partnership exchange or takes over the federal exchange, which functions should the federal government perform and which should the state perform?
  - Many detailed policy questions.

Medicaid – Current Status

- The federal government provides matching funds and sets the basic structure.
  - States have some flexibility through optional benefits and coverage groups, but must get federal approval for changes.
  - If a state fails to comply with federal requirements, it could lose the federal funds.
  - In Florida, the federal government pays 57.7% of each dollar spent, and Florida pays 42.3%.
- Currently, federal law requires state Medicaid programs to cover low-income children, pregnant women, elderly and disabled adults.

Medicaid – PPACA Requirements

- PPACA decreases Florida's flexibility in managing our Medicaid programs by requiring us to:
  - Maintain the same eligibility and benefits until 2014.
  - Expand the program to cover everyone (including *non-disabled childless adults*) up to 138% of the federal poverty level ($31,808 for a family of 4).
  - Create a new benefit package for the expansion population that meets the Essential Benefits requirements.
  - Change eligibility from an income- and asset-based standard to one based on Modified Adjusted Gross Income.
  - Pay primary care physicians at the Medicare rate for 2 years.

Medicaid - PPACA Requirements (cont'd)

- States will receive a greater federal match rate for the expansion population (100% the first 3 years, then gradually decreases to 90% by 2020).

- Disproportionate Share Hospital funds are reduced.
  - Reductions over 8 years.
  - Florida's allocation has ranged from $188 to $206 million.
  - DSH accounts for 1.7% of our Medicaid budget (FY '10-'11).

- These new requirements, like all existing requirements, are enforced by the possibility of loss of federal matching funds for the whole program.

Medicaid – U.S. Supreme Court

- The Court decision significantly limited the Medicaid expansion requirement by making it *optional*.
- The Court said it is unconstitutionally coercive for the federal government to eliminate all Medicaid funding for a state that did not comply with the expansion mandate.
- Now, states can choose to expand the program or not, and will not lose federal funding for their existing programs if they choose not to expand.

Medicaid – Expansion Impact

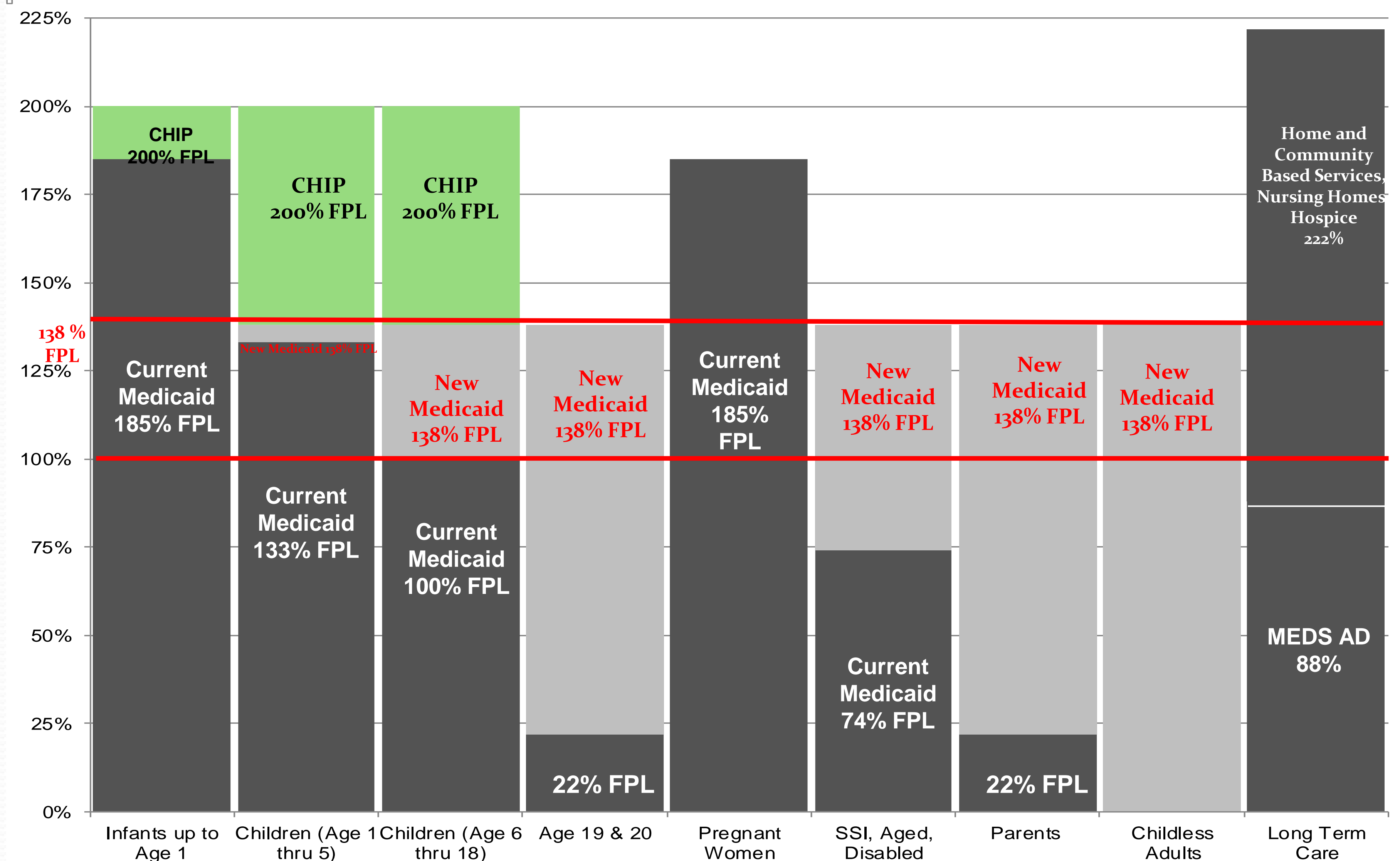
- Enrollment increases:
  - Expansion
  - Crowd-out (shift from private coverage to Medicaid)
  - Individual mandate (currently eligible but not enrolled)

- Cost increases:
  - Expansion population and other new enrollees
  - Plan tax
  - Increased utilization

Medicaid - Exchange Subsidies

- PPACA provides premium assistance subsidies for individuals with household incomes between 100% and 400% of the poverty level.
  - Individuals with income between 100% and 138% of poverty **will** be eligible for premium assistance subsidies.
  - Individuals with household income below 100% of poverty **will not** be eligible for premium assistance subsidies.

Medicaid – Current and PPACA Eligibility



Medicaid - Decision Points

- Expand Medicaid to 138% of poverty?
- No partial expansion at the PPACA increased federal match rate (100% → 90%).

Questions?