FEDERAL HEALTHCARE REFORM:
PATIENT PROTECTION AND AFFORDABLE CARE ACT
SUMMARY OF PROVISIONS ON NEW INSURERS

On Tuesday, March 23, President Obama signed into law the "Patient Protection and Affordable Care Act" ("PPACA"). A reconciliation bill making changes to the Act was signed by the President on March 30. The PPACA as amended by the reconciliation bill is collectively referred to as the Act in this summary. This summary provides an overview of the provisions on new insurers via Consumer Operated and Orientated Plans (referred to in the Act and in this summary as a Co-ops), Interstate Compacts, and Multi-state Plans.

Summary:

The Act creates three new classes of entities that might offer health insurance:

- States may establish interstate compacts allowing for the sale of products in the individual market across state borders.
- Co-ops will be created and offer coverage in the individual and small group markets; these non-profit entities can not be existing insurers.
- Multi-state plans, under the oversight of the Office of Personnel Management, will also be available through the Exchange in the individual and small group markets.

Key Dates:

Interstate compacts - By July 1, 2013, the Dept. of Health and Human Services (HHS) in consultation with NAIC is to issue regulations regarding interstate compacts. January 1, 2016 is the earliest date for the interstate sale of insurance. Each state must enact legislation authorizing these compacts.

Co-ops - By July 1, 2013, HHS to begin distributing loans and grants for Co-ops to be established. Co-ops may begin selling in a state only once the state enacts the market reforms required under the Act.

Multi-state plans - The section does not explicitly set dates, but the plans would be offered through the Exchanges, which become operational in 2014.

Interstate Compacts:

HHS, in conjunction with NAIC, will issue regulations by July 1, 2013 allowing states to enter into interstate compacts allowing insurers to sell products in the individual market across state lines. Each state wishing to participate in an interstate compact would need to enact legislation authorizing the compact and the compact is subject to HHS approval. Compacts cannot be in effect before January 1, 2016.

With limited exceptions, the insurance product (the plan) would be subject to the laws and regulations of the state in which the plan was written or issued (although not defined, the section implies that this is the state where the insurer is located). Insurers participating in the compact are required to:

- Offer plans meeting the essential health benefits package and cost sharing protections of the Act;
- Comply with market conduct, unfair trade practices, network adequacy, and consumer protection standards (including rating and addressing disputes) of the state in which the insured resides;
- Be licensed in each state *or* to submit to the jurisdiction of the state with regard to the standards described above; and
- Notify consumers that the policy may not be subject to all the laws and regulations of the state in which the insured resides.

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Co-ops:

By July 1, 2013, HHS will begin distributing $6 billion dollars of financial support to Co-ops through loans for start-up costs and grants to meet state solvency requirements. Co-ops cannot use federal funds for lobbying or marketing. An advisory board will assist HHS in making distribution determinations. Co-ops must repay loans within 5 years and grants within 15 years.

Co-ops will offer qualified health plans for individuals and small groups. A Co-op:

- Be organized as a non-profit corporation under state law;
- Cannot be an organization or a related entity that was a health insurer as of July 16, 2009, nor can it be an organization sponsored by state or local government. In addition, no "representative" of federal, state, or local government, or of a health insurer, may serve on the board of the Co-op or on a purchasing council (see below);
- Must have a strong consumer focus. Any profits must be used to lower premiums, improve benefits, or improve quality;
- Must compete on a level playing field with private insurers in that it must comply with state insurance laws, including licensure, rate and form filing rules and state premium assessments. However, the Co-op is an exempt organization for federal tax purposes under Internal Revenue Code section 501(c) and under the new federal insurer assessment, Co-ops are among those entities assessed at 50% of the rate paid by other insurers (See BCBSRI's *Federal Healthcare Reform: Insurer Tax Provisions* Fact Sheet for more information.); and
- Must offer the essential health benefits package and can sell its plans through the Exchange. (See BCBSRI's *Federal Healthcare Reform: Exchanges* Fact Sheet.)

Co-ops may form "private purchasing councils." These councils are a mechanism by which multiple Co-ops can collectively arrange for administrative services, such as claims administration, technology, and actuarial services. These councils cannot set provider reimbursement rates, each Co-ops will independently negotiate provider contracts. Anti-trust laws apply to the councils and to the Co-ops.

> *Open issue:* the Act does not specifically prohibit the Co-op from contracting with a health insurer for these support functions.

The Act intends for there to be a Co-op in every state, and if one is not initially developed within a state, then HHS will "encourage" a Co-op from another state to expand into the state without a Co-op. More than one Co-op can be established in a state.

Multi-State plans:

The Office of Personnel Management (OPM), which administers the federal employee's health benefit plan (FEHBP), is required to contract with at least two health insurers (at least one of which must be non-profit) to offer insurance in the individual and small group markets in multiple states through the Exchanges. An insurer may include a group of insurers affiliated by the common use of a nationally licensed service mark (such as the Blues).

OPM is not required to award the contracts through competitive bidding. The program will be implemented in a manner similar to the one OPM follows for FEHBP. OPM will negotiate with the insurers on medical loss ratio, profit margin, premiums, and other terms in the interest of enrollees. The contracts will be for a term of at least one year and can be automatically renewed.

State licensure is required**.** The insurers selected must be licensed in each State and are subject to all requirements of state law, except those that would prevent the application of provisions of the Act. OPM may set additional requirements for participating insurers in consultation with HHS.

Open Issue: OPM will need to confirm that this state licensure provision is satisfied under by a group of plans (such as the Blues) which together, but not individually, are licensed in all of the states.

In order to qualify as a multi-state qualified health plan, the insurer must:

- Offer the essential health benefits package (See BCBSRI's *Federal Healthcare Reform: Exchange* Fact Sheet);
- Be uniform in each state – although a state can require that additional benefits be offered to enrollees in that state (in which case the State assumes the financial liability for costs of mandates);
- Meet the qualified health plan requirements including offering the various actuarial levels of coverage (See BCBSRI's *Federal Healthcare Reform: Exchange* Fact Sheet);
- Determine premiums using the rating rules under the Act unless the State has age rating rules less than 3:1 (See BCBSRI's *Federal Healthcare Reform: Rating Reforms* Fact Sheet); and
- Meet FEHBP requirements that do no conflict with the Act.

A multi-state plan is deemed certified for sale in an Exchange. OPM's negotiation of the premium allows the plan to avoid additional review by the state and the Exchange.

An enrollee in a multi-state plan would be eligible for the income-based premium subsidy and cost-sharing subsidy (See BCBSRI's *Federal Healthcare Reform: Individual Mandate & Subsidy* Fact Sheet). However, the subsidies do not to reflect the costs of any state benefit mandate above the essential benefit package; in that case the state must pay the corresponding amount to either the individual or the multi-state plan.

While the multi-state plan provision is intended to create nationwide coverage, the insurers are allowed to phase in the coverage, with coverage in 60% of the states in year one, 70% in year two, 85% in year three, and 100% in year four and each subsequent year.

Relevant PPACA Sections:

- Co-ops: PPACA §§1322 creating the Co-op, 1301 defining it as a qualified health plan, and §10104(l) regarding repayment of federal funds.
- Interstate compacts: PPACA §1333(a).
- Multi-state plans: PPACA §10104(p) striking §1333(b) and §10104(q) creating §1334.
- Level Playing Field: PPACA §§1324 and 10104(m) exempt private insurers from certain state and federal laws if Co-ops & Multi-state plans do not follow such laws.

References:

PPACA: http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_bills&docid=f:h3590enr.txt.pdf

Reconciliation: http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_bills&docid=f:h4872pcs.txt.pdf

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