

**FEDERAL HEALTHCARE REFORM:
PATIENT PROTECTION AND AFFORDABLE CARE ACT
SUMMARY OF RATING REFORMS**



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 rating reforms contained in the Act.

Summary: The Act establishes new rate review procedures, rating requirements, pooling requirements, medical loss ratio definitions and reporting, and rebates when medical loss ratio requirements are not met.

Scope: Applicable to health insurance issuers in the individual and group (large and small) markets as further described in this fact sheet.

Definitions: Large employer – when used in connection with a group health plan, means an employer who employed an average of at least 101 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year. (PPACA § 1304(b))

Small employer - when used in connection with a group health plan, means an employer who employed an average of at least 1 but not more than 100 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year. States may choose to define small employers as having at least 1 but not more than 50 employees until January 1, 2016. (PPACA § 1304(b))

**Rate Review and
Transparency of
Rates:**

- Beginning with 2010 rate years, the Dept. of Health & Human Services (HHS) will establish a process (in conjunction with the States) to review “unreasonable increases in premium” in both the individual and group (large and small) markets. “Unreasonable increase” is not defined within PPACA. Health insurers must submit relevant justification (also undefined) prior to the implementation of an increase. In addition, insurers are required to post the justification on their website(s). (PPACA § 1003 adding § 2794 to the Public Health Service Act (PHSA))
- Beginning in 2014, HHS will monitor increases both within and outside of the Exchange. States are required to consider any excess premium increases outside the Exchange when determining whether large groups will be allowed to purchase through the Exchange in 2017. (PPACA § 1003 adding § 2794(b)(2) to the PHSA)
- \$250 million in grant funding is available for States for 2010-2014 fiscal years to implement the rate review process above. In order to receive a grant, OHIC will be required to report trends in rate increases and make recommendations regarding whether a particular carrier should be permitted to participate in an Exchange. The grant is no less than \$1 million and no more than \$5 million per State per year. (PPACA § 1003 adding § 2794(c) to the PHSA)
- In addition, the grant funds will facilitate the establishment of medical reimbursement data centers (“Centers”) at academic or other nonprofit entities to collect reimbursement information from insurers, analyze and organize the information, and make it available to insurers, providers, researchers, policy makers and the general public. Centers may not compel an insurer to provide data. (PPACA § 10101 adding § 2794(c)(1)(C) and (d) to the PHSA)

Rating and Pooling:

Rating variations (Individual and Small Group). For plan years beginning on or after January 1, 2014, an insurer in the individual and small group market may only vary rates based upon:

1. Whether coverage is individual or family;
2. Rating area (as established by the State in conjunction with HHS);
3. Age, but rates may not vary by more than 3 to 1 for adults (HHS, in consultation with NAIC will establish permissible age bands); and
4. Tobacco use, but rates may not vary by more than 1.5 to 1.

For family coverage, the factors for age and tobacco are to be applied based on the portion of the premium attributable to each family member covered.

(PPACA §1201 adding a new §2701 to the PHSA)

Large group. States have the option beginning in 2017, to allow large employers to purchase through the Exchange (See BCBSRI's upcoming *Federal Healthcare Reform: Exchanges* fact sheet for more information). If the State permits a large employer to purchase through the exchange, then the rating rules above apply to all large groups. (PPACA § 1312 (f)(2)(B))

Risk Pools. The Act establishes separate pools for the individual and small group markets. All individuals that purchase coverage from the insurer in the individual market (other than grandfathered plans), whether or not enrolled through the Exchange, are part of a single risk pool for determining individual market rates. Similarly, all enrollees in plans offered by the insurer in the small group market (other than grandfathered plans), whether or not enrolled through the Exchange, are part of a single risk pool for determining small group rates. States have the option to combine the individual and small group markets. The risk pool provisions are effecting for plan years beginning on or after January 1, 2014.(PPACA §1312(c))

Uniformity across carriers. States are required to apply rating reforms uniformly to all insurers within the market to which the reforms apply. (PPACA § 1252)

Medical Loss Ratio Reporting and Rebates:

Medical Loss Ratio Reporting: For plan years beginning on or after September 23, 2010, Health insurance issuers in both the individual and group (large and small) markets must report medical loss ratio data to HHS. Such report shall include the percentage of total premium revenue, after accounting for money received under risk adjustment and risk corridors and payments under reinsurance programs, that was expended for:

1. Reimbursement for clinical services;
2. Activities that improve health care quality; and
3. All other non-claim costs, with an explanation of the nature of such costs, excluding state and federal taxes and licensing fees.

The NAIC is obligated to establish uniform definitions for these terms and standardized methodologies for calculating medical loss ratio by December 31, 2010.

Rebates. Beginning January 1, 2011 insurers are required to provide an annual rebate to each enrollee, on a pro rata basis, if the medical loss ratio is below 85% for large groups or below 80% for individual or small group coverage. The rebate initially is calculated as the difference between the amount the medical loss ratio is below the required medical loss ratio and the total amount of premium revenue. Beginning in 2014, the calculation of the rebate is based on the average over the prior three plan years.

HHS may lower the medical loss ratio for the individual market in a state if the ratio would otherwise destabilize that market (at any time) or to account for volatility in the individual market as the result of Exchanges. States may set higher rates in any of the markets, but must consider insurer participation and competition.

The medical loss ratio reporting and rebate requirements apply to all insured plans, including grandfathered plans.

Guaranteed Availability and Renewability:	<p><u>Availability.</u> For plan years beginning on or after January 1, 2014, insurers offering coverage in the individual and group (large and small) markets must accept every employer and every individual that applies for coverage. An insurer may restrict enrollment to open and/or special enrollment periods. HHS will issue regulations regarding enrollment periods. (PPACA §§ 1201 and 1562(c)(8)(D)-(E) amending § 2702 of the PHSA)</p> <p><u>Renewability.</u> For plan years beginning on or after January 1, 2014, insurers offering coverage in the individual and group (large and small) markets must renew or continue coverage in force at the option of the group or individual. (PPACA § 1201 amending § 2703 of the PHSA) This does not appear to modify existing rules that permit insurers to withdraw products from the market.</p>
Effect on Rhode Island Law:	<p>It appears that provisions of Rhode Island law that are more strict than those in PPACA may continue in effect (except where expressly preempted within the Exchange). The State will need to make a determination of whether to modify the small group market to extend to groups up to 100 before 2016, but must do so at that time.</p> <p>Small group law (RIGL 27-50) will be preempted in some of the rating provisions (e.g. rate compression for age currently at 4:1 will need to be 3:1 beginning in 2014). Other changes may also be necessary to conform with PPACA.</p>
BCBSRI's Implementation Plan:	<p>The Direct Pay market rating will need to be reformed to conform with PPACA requirements by eliminating health status rating (e.g. Pool 2) and to comply with other rating reforms for plan years beginning in 2014. BCBSRI will need to decide whether to grandfather plans and rating that was in effect prior to March 23, 2010. (See BCBSRI's <i>Federal Healthcare Reform: Grandfathering</i> fact sheet for more information).</p>
Effective Date:	<p>The effective dates for the rating reform provisions vary and are identified throughout this document.</p>
References:	<p>PPACA: http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_bills&docid=fh3590enr.txt.pdf Reconciliation: http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_bills&docid=fh4872pcs.txt.pdf</p>

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