DEMOCRATIC POLICY COMMITTEE

Fact Sheet

DPC

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Senate Democrats Are On Your Side

Implementing Health Reform That Works for Middle-Class Americans

Earlier this year, Congress passed and the President signed landmark health insurance reform legislation, the *Patient Protection and Affordable Care Act* (**P.L. 111-148**) and the *Health Care and Education Reconciliation Act* (**P.L. 111-152**), and Americans are already experiencing the benefits. These two laws, together referred to as the *Affordable Care Act*, put control over health care decisions in the hands of the American people, not insurance companies. Senate Democrats are committed to implementing health reform that holds insurance companies accountable, brings costs down for everyone, and provides Americans with the insurance security and choices they deserve. This fact sheet provides an overview of recent health reform implementation activity, including:

Previous updates and other information are available from the DPC. [DPC]

Ensuring Value for Premium Payments

The *Affordable Care Act* establishes standards for insurance overhead and requires public disclosure to ensure that consumers receive value for their premium dollars, requiring plans in the individual and small group market to spend 80 percent of premium dollars on clinical services and quality activities, and 85 percent for plans in the large group market. [P.L. 111-148; P.L. 111-152] The insurance industry refers to such thresholds as 'medical loss ratios.' In today's individual insurance market, more than 20 percent of consumers are enrolled in plans that spend more than 30 cents of every premium dollar on administrative costs, and another 25 percent of consumers are in plans that spend 25 to 30 cents of every premium dollar on administration. [Department of Health and Human Services (HHS), 11/22/10] All health insurance plans,

with the exception of self-insured and very small plans, that do not meet these thresholds starting January 1, 2011 will provide rebates to their policyholders in 2012. The medical loss ratio provision of the *Affordable Care Act* will provide greater transparency and accountability, ensuring that Americans receive value for their premium dollars.

On November 22, 2010, the Administration issued an interim final rule to implement this part of the *Affordable Care Act*. [HHS, 11/22/10] The regulation certifies and adopts the recommendations unanimously approved by the National Association of Insurance Commissioners (NAIC), which was required by the *Affordable Care Act* to develop uniform definitions and methodologies for calculating medical loss ratios. [NAIC, 10/27/10] Estimates indicate that as many as 9 million Americans could be eligible for rebates, which will begin in 2012 and may be worth up to $1.4 billion, with average rebates in the individual market worth as much as $164 per person. [HHS, 11/22/10]

The rule requires insurance companies to submit aggregate premium and expenditure data for all plans in each state in which it does business, with the exception of "expatriate" and "mini-med" plans, for which insurers may report data separately. Reports are due June 1 of each year, with the first report due June 1, 2012, and any rebates will be due to consumers by August 1, 2012. Activities that improve health care quality may be counted toward the 80 or 85 percent of premiums that must be spent on medical care, while federal and state taxes that apply to health insurance coverage will be deducted from an insurer's premium revenue for purposes of the calculation. The regulation also ensures a smooth market transition by making accommodations for smaller plans and newer plans, and allowing states to request an adjustment to the medical loss ratio if it is determined that meeting the 80 percent threshold would destabilize the individual insurance market in a state. More information, including the text of the regulation, is available from HHS. [HHS, accessed 11/22/10]

Enhanced, Transparent Pricing Information for Consumers

The *Affordable Care Act* enabled creation of a new web portal to facilitate informed consumer choice of health insurance options. [P.L. 111-148; P.L. 111-152] On July 1, 2010, www.HealthCare.gov launched to help individuals and small businesses identify insurance options in their state. In addition to helping individuals navigate private insurance options in the individual and small group markets, the website assists users in determining if they are eligible for various public programs, including existing high risk pools, the Pre-Existing Condition Insurance Plan created by the *Affordable Care Act*, Medicaid, Medicare, and the Children's Health Insurance Program (CHIP). [HHS, undated]

As of October 1, 2010, the HealthCare.gov Insurance Finder included price estimates for more than 4,000 private health plans offered by more than 200 insurers, in all 50 states and the District of Columbia. [HealthCare.gov, 10/1/10] Recently, HHS announced that the Insurance Finder now includes information on more than 8,500 insurance plans offered by nearly 300 insurance companies. [HealthCare.gov, 11/15/10; 11/15/10] This unprecedented transparency is a result of the *Affordable Care Act's* requirement that consumers have easy access to important insurance pricing information, like premium rates and cost-sharing requirements, to help consumers compare health insurance options.

Keeping the Health Plan You Like

The *Affordable Care Act* greatly enhances health insurance consumer protections and benefits while ensuring that if you like your current plan, you can keep it. The *Affordable Care Act*

protects the ability of individuals and businesses to keep their current plan, provides important consumer protections to put Americans, not insurance companies, in control of their health care, and provides stability and flexibility to insurers and businesses that offer insurance coverage during the transition to a more competitive insurance marketplace in 2014.

Earlier this year, the Administration issued a new regulation for "grandfathered" health plans, which are plans in place when health reform was signed into law on March 23, 2010. [Federal Register, 6/17/10] The rule requires all health plans to provide certain, important consumer benefits and protections and allows plans in existence on March 23, 2010, to make routine changes without losing their grandfather status. [HHS, accessed 6/17/10] Plans that make changes to significantly decrease consumer protections – such as by cutting or reducing benefits, raising co-insurance requirements, significantly raising co-payments or deductibles, significantly reducing employer contributions, or adding or tightening an annual limit – will lose their grandfather status, and individuals in those plans will gain consumer protections in a new plan. The rule strikes a balance between protecting consumers and allowing plans and employers the flexibility they need to innovate and contain costs.

Under the regulation as originally proposed, one of the ways an employer-sponsored plan could lose its grandfather status was if it switched to a different insurance company. While the original regulation allowed self-funded plans to change third-party administrators without losing their grandfather status, the same flexibility was not available to fully-insured plans. In response to comments, the Administration recently issued an amendment to the regulation, clarifying that all group health plans may switch insurance companies to shop for the same coverage at a lower cost without losing their grandfather status. [Federal Register, 11/17/10; HHS, accessed 11/18/10]

Improving Access to Care

The *Affordable Care Act* creates an expanded and sustained national investment in community health centers by providing $11 billion over five years to these critical health care providers. [P.L. 111-148; P.L. 111-152] Last year, health centers provided quality health care to nearly 19 million Americans, nearly 40 percent of them uninsured. [Health Resources and Services Administration, accessed 11/22/10] The *Affordable Care Act's* investment in community health centers will allow them to nearly double the number of patients they serve. By providing primary care and focusing on preventive services, health centers estimate they save our health care system $9.9 billion to $17.6 billion each year. [National Association of Community Health Centers, accessed 8/23/10]

Recently, HHS announced the awarding of nearly $8 million to existing Community Health Center Cooperative Agreements, which support the development and operation of health centers. [HHS, 11/19/10] Cooperative Agreement organizations provide training and technical assistance funds to support health centers' core functions, such as community development, expansion planning, patient-centered medical home development, meaningful use health information technology adoption, and workforce development.

Supporting Health Care Providers in Underserved Areas

The *Affordable Care Act* makes improvements to and investments in the National Health Service Corps, which provides scholarships and loan repayment to health care providers in exchange for a commitment to serve in a Health Professional Shortage Areas. [P.L. 111-148; P.L. 111-152; HHS accessed 11/22/10] By extending and increasing authorization of appropriations, providing enhanced funding, increasing the loan repayment amount, and increasing participation through

greater flexibility such as allowing for half-time service and for teaching time to satisfy a portion of the Corps service commitment, the *Affordable Care Act* improves the NHSC program and helps to ensure that Americans living in medically underserved areas have better access to the quality health care they deserve.

Recently, HHS announced a new application cycle of the NHSC Loan Repayment Program, which includes a $290 million investment from the *Affordable Care Act*. [HHS, 11/22/10] Primary care medical, dental, and mental health clinicians may apply for $60,000 in student loan repayment in exchange for two years of service in a medically underserved area. Application information is available from HHS. [HHS, accessed 11/22/10] The NHSC Loan Repayment Program addresses the challenges of a primary care workforce shortage, reduced access to care in underserved areas, and the increasing debt burden on new health care providers.

Encouraging Innovation to Improve Care, Reduce Costs

The *Affordable Care Act* establishes a Center for Medicare and Medicaid Innovation (Innovation Center) within the Centers for Medicare & Medicaid Services (CMS) to research, develop, test, and expand innovative payment and delivery arrangements to improve the quality and reduce the cost of care provided to patients in each program. [P.L. 111-148; P.L. 111-152] The *Affordable Care Act* provides dedicated funding for the Innovation Center to allow for testing of models that require benefits not currently covered by Medicare, and successful models may be expanded nationally.

On November 16, 2010, CMS formally established the Innovation Center and launched the first three demonstration projects within the Innovation Center to strengthen primary care and better coordinate care through "health homes" and "medical homes." [CMS, 11/16/10] The Innovation Center will drive advancements to improve health care quality and health outcomes while reducing costs by testing new models of care and consulting with stakeholders across health care sectors for input on operations and to build partnerships. The first three demonstrations include expansion of the Multi-Payer Advanced Primary Care Practice Demonstration, a new Federally Qualified Health Center Advanced Primary Care Practice Demonstration, and a new Medicaid Health Home State Plan Option. In addition, a future demonstration project will examine programs that integrate care for individuals who are eligible for both Medicare and Medicaid. A fact sheet on the Innovation Center and the demonstration projects is available from CMS. [CMS, 11/16/10]

Establishing the CLASS Independence Advisory Council

The *Affordable Care Act* establishes the Community Living Assistance Services and Supports (CLASS) program, to provide a lifetime cash benefit that offers people with disabilities some protection against the costs of paying for long term services and supports, and helps them remain in their homes and communities. [P.L. 111-148; P.L. 111-152] CLASS is a voluntary, self-funded, insurance program with enrollment for people who are currently employed. Individuals qualify to receive benefits when they need help with certain activities of daily living, have paid premiums for five years, and have worked at least three of those five years. Beneficiaries receive a lifetime cash benefit based on the degree of impairment, which is expected to average roughly $75 a day or more than $27,000 per year, and may be used to maintain independence at home or in the community, and should be sufficient to cover typical costs of home care services or adult day care. Benefits also can be used to offset the costs of assistive living and nursing home care.

On November 16, 2010, the Department of Health and Human Services announced the establishment of the CLASS Independence Advisory Council (Advisory Council). Provided for under the *Affordable Care Act*, the Advisory Council will consist of not more than 15 members appointed by the President to advise the Secretary of Health and Human Services on general policy matters relating to the CLASS program. Advisory Council members will serve three-year terms and may serve for no more than two consecutive terms. [Federal Register, 11/16/10] Nominations to the Advisory Council may be submitted to HHS by December 1, 2010.

Guidance on Establishing Health Insurance Exchanges

Starting in 2014, the *Affordable Care Act* creates state-based Health Insurance Exchanges where individuals and small businesses can compare and purchase health insurance online at competitive prices and access the same coverage options that Members of Congress will have. [P.L. 111-148; P.L. 111-152] Exchanges will offer consumers a choice of quality, affordable health insurance plans presented in a consumer-friendly format to ensure individuals and families can choose the right plan for their needs. To make coverage even more affordable, premium and cost-sharing tax credits will also be available through the Exchanges to help middle-class families afford coverage.

Recently, HHS issued initial guidance to assist states and Territories with planning to establish an Exchange. [HHS, accessed 11/18/10] In a cover letter accompanying the guidance, Secretary Sebelius wrote that the guidance "provides transparency in our efforts and offers states interested in acting in the coming year input into the structure and function of Exchanges." [HHS, 11/18/10] The department indicates regulations are forthcoming in 2011. The guidance focuses on principles and priorities, statutory requirements, clarifications and policy guidance, and federal support for the establishment of state-based Exchanges.

Additional Information

The Democratic Policy Committee has released 15 previous updates on health reform implementation, available on the DPC website here. In addition, DPC maintains a centralized listing of health reform implementation resources which is frequently updated and is available here.