

Division of Insurance



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- The mission of the Division of Insurance is to protect the public and make insurance available and affordable by efficiently providing quality assistance, providing fair regulation for industry, and promoting a healthy, competitive insurance market.

Areas within the Division

- Investigations
- Consumer Complaints
- Rate and Form Filings
- Producer Licensing
- Company Licensing
- Financial
- Legal

Health Care Reform

Patient Protection and Affordable Care Act

March 23, 2010

Immediate Reforms

- Grandfathered vs. Non-grandfathered
- 07/01/2010: Federal High Risk Pool
- 09/23/2010: standards relative to dependents to age 26, preexisting conditions, preventive care, emergency treatment, rescissions, internal and external appeal, and lifetime/annual limits and access to specialists
- 01/01/2011: medical loss ratios

Federal High Risk Pool

➤ Ended February 22, 2013

- If an individual moves here from another state and was part of their high risk pool, they may be eligible.

➤ Information:

- Bureau of Human Resources – 773.3148
- <http://fedhighriskpool.sd.gov/>

2014 Insurance Market Regulations

A Whole New World....



2014

- Guaranteed-Issue/No pre-existing condition exclusions
- Individual Mandate
- Open/Annual Enrollment Periods
- Rating
- Essential Health Benefits
- Actuarial Value
- Exchanges (Marketplace)

Guaranteed-Issue/No Pre-existing Condition Exclusions

Guaranteed Issue

- Health plans must permit you to enroll regardless of health status, age, gender, or other factors that might predict the use of health services

No pre-existing condition exclusions

- Health insurance issuers will be prohibited from denying coverage to any American because of a pre-existing condition, and from charging individuals and small employers higher premiums based on health status or gender

Individual Mandate

- Beginning in 2014, taxpayers (with certain exceptions) will be assessed a “shared responsibility” penalty for any months during which they or their spouse or dependents lack “minimum essential coverage.”

Individual Mandate – What is Minimum Essential Coverage

- The tax penalty is assessed against any “applicable individuals” who, after 2013, do not have “minimum essential coverage.”
- The term “minimum essential coverage” means coverage under any of the following:
 - a government-sponsored program, including coverage under Medicare Part A, Medicaid, the CHIP program, and TRICARE;
 - an “eligible employer-sponsored plan”;
 - a health plan offered in the individual market;
 - a grandfathered health plan; or
 - other health benefits coverage (such as a State health benefits risk pool) as HHS recognizes.

Individual Mandate – Calculating the Penalty

- Those without coverage pay a tax penalty of the greater of \$695 per year up to a maximum of three times that amount (\$2,085) per family or 2.5% of household income.
- The penalty will be phased-in according to the following schedule: \$95 in 2014, \$325 in 2015, and \$695 in 2016 for the flat fee or 1.0% of taxable income in 2014, 2.0% of taxable income in 2015, and 2.5% of taxable income in 2016.

Individual Mandate – Exceptions for Certain Individuals

- Certain individuals (even if they qualify as “applicable individuals”) are exempt from the penalty:
 - individuals who cannot afford coverage—defined as individuals for whom a required contribution for coverage would cost more than 8% of their household income;
 - individuals whose household income does not exceed the threshold for filing a federal income tax return;
 - members of certain Indian tribes;
 - individuals who have a gap in coverage for less than a continuous three-month period. This exemption may only be used for one period without coverage in a year; and
 - individuals who are extended a hardship exemption as determined by HHS.
 - Religious conscience objectors under PPACA § 1311(d)(4)(H);
 - Members of a health care-sharing ministry
 - individuals who are not citizens, nationals, or an alien lawfully present in the United States; and
 - Incarcerated individuals.

Open and Annual Enrollment

Annual Open Enrollment

- Enroll on or before December 15 for coverage to begin on January 1
- Enroll between the 1st and 15th of the month, coverage begins the first day of the following month
- Enroll after the 16th of the month, coverage begins the first day of the second following month

Special Enrollment

- If you enroll between the 1st and 15th of the month, coverage begins the first day of the following month
- If you enroll after the 15th of the month, coverage begins the first day of the second following month
- In the case of birth, adoption or placement for adoption effective on the date of birth, adoption, or placement for adoption

Special Enrollment Triggers

- The death of the covered individual;
- The termination of individual's employer coverage other than by reason of gross misconduct, or reduction of hours of the covered employee's spouse;
- The divorce or legal separation;
- Individual becoming entitled to benefits under XVII of the Social Security Act;
- Dependent child ceasing to be dependent child;
- An individual gains a dependent or becomes a dependent through marriage, birth, adoption, or placement for adoption;
- An individual, who was not previously a citizen, national, or lawfully present individual gains such status; and
- A qualified individual or enrollee gains access to nongrandfathered health plan as a result of a permanent move.

South Dakota Enrollment Outside Annual Open Enrollment

➤ South Dakota Rules

- A health insurance issuer may issue a health plan to any individual applying for coverage outside of an insurance Exchange (Marketplace) and outside of an open enrollment period, pursuant to South Dakota Rule 20:06:39:63
 - Up to 90 day waiting period
 - No movement between metal levels for those with insurance
 - Uninsured only bronze
 - Uninsured not lapsed within past 12 months

Rating

- Rating variations restricted
 - No health status rating
 - Rate variations limited to:
 - Individual or family;
 - Rating areas
 - Age, except that such rate shall not vary by more than 3 to 1 for adults
 - Tobacco use, except that such rate shall not vary by more than 1.5 to 1
- Single Risk Pool
 - Distinct between individual and small group market

Rating Areas

- Harding, Butte, Perkins, Corson, Dewey, Ziebach, Haakon, Jackson, Bennett, Shannon, Fall River, Custer, Pennington, Lawrence, Meade, Stanley, Jones, Lyman, Mellette, Todd, Tripp, and Gregory;
- Lake, Moody, McCook, Minnehaha, Turner, Lincoln, Clay, and Union;
- Campbell, Walworth, Potter, McPherson, Edmunds, Faulk, Brown, Spink, Marshall, Roberts, Day, Grant, Codington, Clark, Hamlin, Deuel, Brookings, Kingsbury, and Beadle; and
- Sully, Hughes, Hyde, Hand, Buffalo, Jerauld, Sanborn, Miner, Brule, Aurora, Davison, Hanson, Douglas, Charles Mix, Hutchinson, Bon Homme, and Yankton

Essential Health Benefits (EHB)

- The law requires that health plans offered in the individual and small group markets, both inside and outside the Exchange (Marketplace), offer a core package of items and services, known as “Essential Health Benefits.” Under the statute, EHB must include items and services within at least the following 10 categories

Essential Health Benefit Requirements

- 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

Choice of Essential Benefit Benchmark Plan

HHS issued guidance giving States an option to choose one of following benchmarks for their State:

1. Any of three largest small group insurance products;
2. Any of the largest three State employee health plans;
3. Any of the largest three national FEHBP plan options
4. Largest Health Maintenance Organization (HMO).

South Dakota's Choice of Benchmark

- Wellmark Blue Select
 - Does not include pediatric dental and vision
- FEDVIP (Federal Employees Dental and Vision Insurance Program) selected to supplement Blue Select for pediatric dental and vision
- Plans can substitute substantially equal benefits

Cost-Sharing on EHB's

- There is also an annual limitation on cost-sharing.
- All QHPs must comply with these limits, as must insurers offering non-grandfathered coverage.
- HHS regulations provide standards for the cost-sharing features (such as deductibles, co-payments, and co-insurance) of the essential health benefits package along with rules to determine the actuarial value of the plan, which is expressed as a “metal value” (e.g., bronze, silver, gold, and platinum).

Actuarial Value

Beginning in 2014, non-grandfathered health plans in the individual and small group markets must meet certain Actuarial Values

Actuarial Benefit Categories (Metal Levels)

Categories designed to provide benefits that are actuarially equivalent to xx percent of the full actuarial value of the benefits provided under the plan

- Bronze 60%
- Silver 70%
- Gold 80%
- Platinum 90%

***plan can meet a particular metal level if its AV is within +/- 2 percentage points of the standard



Individual Insurers May Offer Catastrophic Plan Option

- Another plan option available to individual insurers in 2014 is a catastrophic plan.
- A catastrophic plan is one that provides coverage for essential health benefits and provides no benefit for any plan year until the individual has incurred cost-sharing expenses equal to the overall cost-sharing limit (described above) for the plan year.
- The deductible cannot apply to at least three primary care visits.
- A catastrophic plan is permitted only in the individual market and only for:
 - young adults who are under age 30 before the plan year begins (a group sometimes referred to as the “young invincibles” because they are more likely than older populations to forego insurance), and
 - those persons exempt from the individual mandate because affordable coverage is not available or they have a hardship exemption.

Small vs. Large Employers

Small Employers

- Under 50 Employees
- Eligible for SHOP Exchange
- No penalties for not providing insurance
- Subject to rating and other market rules
- Minimum participation and contribution allowed

Large Employers

- 50 plus employees, including part time
- Not eligible for SHOP exchange
- May be subject to “shared responsibility” (penalty)
- Minimum essential coverage required

Large Employers

Minimum Essential Coverage

- Must provide no less than a Bronze Level Plan
- The employees share of the premium cannot exceed 9.5% of the lowest paid employees household income

Employer Shared Responsibility Payment

- You may have to make this payment if at least 1 of your employees qualifies to save money on monthly premiums in the Marketplace.

Employer Shared Responsibility Payment

- The amount of the annual Employer Shared Responsibility Payment is based partly on whether you offer insurance
 - If you **don't** offer insurance, the annual payment is \$2000 per full-time employee (excluding the first 30 employees as long as at least 1 employee receives a tax credit)
 - If you **do** offer insurance, but the insurance doesn't meet the minimum requirements, the annual payment is \$3000 per full-time employee who qualifies for and receives premium savings in the Marketplace
- Unlike employer contributions to employee premiums, the Employer Shared Responsibility Payment is **not** tax deductible.

***The Internal Revenue Service has [more information about the Employer Shared Responsibility Payment.](#)

What is an Exchange?

Exchange designed as a one-stop health insurance shopping mall

Feds have branded as marketplace

- Individual health
- Small group health
- Medicaid/CHIP
- Premium subsidies



Exchange Types

➤ Health Insurance Marketplace (Individual Exchange)

➤ Small Business Health Options Program (SHOP)

South Dakota's Participation in the Federally Facilitated Exchange

➤ Federal Responsibility

- Consumer-assistance functions (such as providing consumer assistance in determining individual eligibility for enrollment and insurance affordability programs, including advance payment of the premium tax credit and determination of cost-sharing reductions)

➤ South Dakota Responsibility

- Plan Management Function

Exchange Plan Management Functions

- QHP certification, decertification, recertification
- QHP issuer account management
- QHP oversight and monitoring
- Data collection from issuers
- Verification of accreditation
- Collect and Display Quality Data
- Coordinate with HHS on quality rating and enrollee satisfaction survey

Statutory Requirements for Health Plans

- Only qualified health plans (QHPs) with an Essential Health Benefit package as defined by the Secretary of HHS can be sold in the Exchange (Marketplace).

QHP Certification

- Essential Health Benefits
- Actuarial value standards & Rates
- Licensure and good standing
- Network Adequacy including essential community providers and service area
- Market Oversight
- Accreditation
- Discriminatory Benefit Design
- Meaningful Benefit Difference

Filing Deadlines

Companies

- Filing deadlines for insurance companies looking to offer plans both on and off the Exchange are established annually by the federal government
- The Division establishes a separate filing deadline, usually prior to the federal initial deadline, to allow for the state to complete rate and form filing review

Enrollment Assistance for Federal Exchange (Marketplace)

- A web portal and 1-800 hotline
- Navigator programs to assist individuals in finding the Exchange and purchasing insurance from the Exchange.
- Certified Application Counselors
- Agents/Brokers

Federal Call Center Now Open

www.healthcare.gov

Contact Information: Call the Federal Call Center to get your Exchange (Marketplace) questions answered by a customer service representative

Individual Exchange (Marketplace), available 24/7:

- 1-800-318-2596 or (TTY: 1-855-889-4325)
- Online chat, also available 24/7
- Visit the Help Center to get all of the help resources in one place.

SHOP Exchange (Marketplace) for businesses with 50 or fewer employees, available Monday through Friday, 9 a.m. to 5 p.m. EST.:

- 1-800-706-7893 or (TTY: 1-800-706-7915)

Initial, Annual, and Special Enrollment Periods Required for Exchanges

- Exchanges (Marketplaces) are required by Health Care Reform to have an initial open enrollment period, an annual open enrollment period, and certain special enrollment periods.

Individual Exchange

Annual Open Enrollment:

- Benefit years beginning on or after January 1
- Coverage is effective as of the first day of the following benefit year if enrolled by December 15
- Coverage effective February 1 if enrolled between December 16 and January 15
- Coverage effective March 1 if enrolled between January 16 and January 31

Special Enrollment

➤ Effective Dates

- On the first day of the following month for all qualified health plan selections made by the 15th of the previous month,
- On either the first day of the following month or the first day of the second following month for all qualified health plan selections made between the 16th and last day of a given month, or
- In the case of birth, adoption or placement for adoption effective on the date of birth, adoption, or placement for adoption.

➤ The special enrollment period generally is 60 days from the date of the triggering event.

Special Enrollment Triggers

- Individual or dependent loses minimum essential coverage
- An individual gains a dependent or becomes a dependent through marriage, birth, adoption or placement for adoption
- Individual lawfully gains Citizenship
- An individual's enrollment or non-enrollment in a qualified health plan is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the Exchange or HHS, or its instrumentalities as evaluated and determined by the director.
- An individual can demonstrate a plan they enrolled substantially violated a material provision of its contract
- An individual is determined newly eligible or newly ineligible for advance payments of the premium tax credit or has a change in eligibility for cost-sharing reductions
- An qualified individual or enrollee gains access to new qualified health plan as a result of a permanent move;
- An Indian, as defined by section 4 of the Indian Health Care Improvement Act, may enroll in a qualified health plan or change from one qualified health plan to another one time per month; or
- Other exceptional circumstances

Eligibility for Premium Tax Credits & Cost-Sharing Reductions

- Determine Eligibility for Premium Tax Credits & Cost-Sharing Reductions
 - The IRS has issued regulations relating to eligibility standards to assist the Exchange to make advance payments of the premium tax credit. And HHS regulations contain standards for eligibility for advance payments of the premium tax credit to determine that—
 - taxpayer is expected to have a household income of at least 100% but not more than 400% of the federal poverty level (FPL) for the benefit year for which coverage is requested, and
 - the applicants for whom the taxpayer expects to claim a personal exemption deduction on his or her tax return for the benefit year meet the standards for eligibility for enrollment in a QHP through the Exchange and are not eligible for minimum essential coverage (with the exception of coverage in the individual market), in accordance with Code §§ 36B(c)(2)(B) and (C).

Credits and Subsidies

- Beginning in 2014, individuals who purchase health insurance coverage through one of the new health insurance exchanges will be eligible for financial assistance if their income is no more than 400% of the federal poverty line.
- Two forms of financial assistance will be provided:
 - A *premium assistance tax credit* will be provided monthly to lower the amount of premium the individual or family must pay for their coverage.
 - *Cost sharing assistance* will limit the plan's maximum out-of-pocket costs, and for some people will also reduce other cost sharing amounts (i.e., deductibles, coinsurance or copayments) that would otherwise be charged to them by their insurance plan.

Credits and Subsidies – Premium Assistance

- The premium assistance tax credit is calculated to limit the amount that an individual or family must pay for health insurance coverage in the Exchange as a percentage of income.
- A sliding scale is used to determine the amount of the tax credit.
- For those at the lowest incomes (less than 133% of the poverty level) the tax credit amount is based on limiting the individual's premium contribution to no more than 2% of income.
- For those between 300% and 400% of the poverty line, the tax credit amount is based on a limiting the contribution amount to 9.5% of income.

Credits and Subsidies – Cost Sharing Assistance

- People who qualify for the premium assistance tax credit will also be eligible for cost sharing assistance if they enroll in a **Silver Plan**.
- This assistance will further reduce the limit on the out of pocket maximum that can apply to their coverage, with the amount of the reduction depending on income.
- For those with incomes between 100% and 200% of poverty, a 2/3 reduction applies.
- For others, the reduction in the limit is either ½ or 1/3, depending on income.

SHOP Exchange

Traditional Employer model

- Employer enrolls and makes choice of plan(s) for employees

Employee Choice (2015)

- Employer chooses benefit level (metals)
- Employee picks which insurer and which plan within metal category
- Defined Contribution only

Small Group Enrollment

- The small group market will have continuous open enrollment.

Small Group Tax Credit

Is available to those employers with:

- Businesses with 25 or fewer employees
- Average wages less than \$50,000.
- Contribution at least 50% of premium
- Phases out as size and wages of business increase

Is worth:

- 2010-2013: Up to 35% of total employer premium contribution
- 2014 and later: Up to 50% of total employer premium contribution

Verification of Employer-Sponsored Coverage

- The Exchange notifies an employer if an employee is determined eligible for advance payment of the premium tax credit, with notice of the employer's right to appeal the determination

Agents selling in the Exchange

- State will continue to license and regulate agents
- State will not dictate commission levels on Exchange business
- Commissions must be the same inside and outside an Exchange
- Agents will sign an agreement with the FFE
- Complete Exchange Training and Registration with FFE

Agent/Broker Training for the FFM is Now Available!

***Information source: <https://www.cms.gov/ccio/programs-and-initiatives/health-insurance-marketplaces/a-b-resources.html>

Federal Health Care Reform Website for South Dakota

www.federalhealthreform.sd.gov

- This site is provided as a convenience by the State of South Dakota.
- Will direct consumers to important information regarding the federal health care reform



Questions?



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