Health Care Reform

Overview of Federal Health Insurance Reform Requirements and TDI Implementation Planning

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Mike Geeslin, Commissioner of Insurance
Dianne Longley, Director, Research and Analysis

TDI Overview

- Presentation is limited to provisions related to health insurance
- Focuses on major requirements
- Many specific details to be determined by federal Health and Human Services (HHS) regulations or directives
- Effect of reform will be different across states, depending on existing statutory and regulatory requirements and current market structure

Key Insurance Provisions

- Comprehensive health insurance market reforms
  - Varying requirements for group and individual, and grandfathered plans that exist at time bill is enacted
  - Many provisions also apply to ERISA self-funded plans
- Consumer ombudsman program
- Temporary high risk pool
- Reinsurance program for early retirees
- Creation of Health Insurance Exchange
- Purchase of insurance or penalty payment required
- Subsidies for eligible enrollees

Early Insurance Market Reforms

Required Within 6 Months

- No lifetime benefit limits
- Restrictions on allowable annual benefit limits
  - To be determined by HHS
- Rescissions prohibited (except for fraud or intentional misrepresentation)
- Coverage of unmarried dependents up to age 26
- Pre-existing condition exclusions prohibited for children up to age 19
  - Federal clarification to be issued shortly
- Internal and external appeals processes for enrollees
- May not discriminate against employees based on salary
- Benefits for preventive services required, with no cost-sharing
- Coverage for emergency services at in-network cost-sharing level; no prior authorization requirements

Early Insurance Market Reforms

Required for 2010 Plan Year

Review of Premium Rates

- HHS, in conjunction with States, will develop a process for the annual review of premium rate increases
  - Health plans must file rates with TDI
  - TDI will review rate increases, determine whether they are reasonable
  - States are not required to approve/disapprove rates unless otherwise required by State law
  - Health plans must provide to HHS and TDI a written explanation of unjustified rates and post explanation on health plan's website
  - States must provide reports to HHS
- HHS will distribute $250 million in grants over 5 years to cover state costs; $1-$5 million to each state based on population and number of health plans in state

Early Insurance Market Reforms

Required for 2010 Plan Year

Health Plan Loss Ratio Requirements

- Health plans must report to HHS information on loss ratios
- Report must provide percentage of premium revenue spent for:
  1) Reimbursement of clinical services
  2) Activities that improve health care quality
  3) All other non-claims expenses excluding state and federal taxes, licensing or regulatory fees
- Reporting requirement details to be developed by HHS and National Association of Insurance Commissioners (NAIC)
- Beginning January 2011, rebates must be provided to consumers if health plans do not meet minimum loss ratio of 85% for large group plans, 80% for small group and individual
- Loss ratio expenses based on clinical services and activities that improve health care quality
- TDI's involvement in process undetermined at this time; will depend on HHS regulations

Early Insurance Market Reforms

Required Within Six Months

Health Plan Disclosure and Transparency Requirements

All plans are required to disclose the following information:

- Claims payment policies and practices
- Periodic financial disclosures
- Enrollment and disenrollment data
- Claims denial information
- Data on rating practices
- Information on cost-sharing and payments with respect to out-of-network coverage
- Other information as determined appropriate by HHS

Insurance Market Reforms

Required Within 2 Years

- Health plans must comply with uniform requirements for summary of benefits and explanation of coverage documents. Must include the following information
  - Description of coverage and cost sharing for each category of essential benefits and other benefits
  - Exceptions, reductions and limitations in coverage
  - Renewability and continuation of coverage provisions
  - Coverage facts label that describes common benefit scenarios
  - Statement of whether the plan provides minimum essential benefits
  - Statement that summary is an outline only
  - Phone number for consumers to call for additional information
- Health plans must use standardized definitions for certain policy terms
- HHS will work with NAIC and stakeholders to develop standards. Must be published within 12 months; health plan compliance within 24 months.

Insurance Market Reforms

Effective January 1, 2014

- Guaranteed issuance of all group and individual plans
  - No medical underwriting, no discrimination based on health status
- Elimination of preexisting condition exclusions
- Elimination of all annual limits on coverage (with some exceptions to be determined by HHS)
- Waiting periods for group plans limited to 90 days
- Limitation on deductibles in small group market ($2,000 individual, $4,000 for family coverage)
- Rating restrictions for group and individual market: may only rate based on age (variations limited to 3 to 1), family composition, geography, and tobacco use (variations limited to 1.5 to 1)
- Minimum benefit standards for group and individual plans
- Small employer redefined from 2-50 to 1-100 employees
- Cannot exclude individuals who participate in clinical trials; must cover routine care that would otherwise be covered
- All plans sold (inside and outside of Exchange) are considered a single individual or small group risk pool for rating purposes

Consumer Ombudsman Program

Effective Immediately

- Creates State offices of health insurance consumer assistance or health ombudsman program
- Serves as an advocate for consumers
- Assists with insurance-related complaints and appeals, educates consumers on their rights and responsibilities
- Assists consumers with enrollment in health plans
- Resolves problems with obtaining subsidies
- Collects, tracks and quantifies consumer problems and insurance inquiries; must submit reports to HHS as required
- $30 million in funds will be distributed to states

Action Needed: determine whether Consumer Ombudsman will be located within TDI, or some other agency

Temporary High Risk Pool

Effective Within 90 Days

- Creates temporary high risk insurance pool for individuals with pre-existing conditions
- Must have been uninsured 6 months or longer
- Secretary may contract with states or non-profit entities (including existing high risk pools) to provide coverage
- Requirements for pool coverage:
  - No preexisting condition exclusions
  - Benefit plan must cover at least 65% of allowed costs
  - Out-of-pocket costs limited to no greater than limits for high-deductible health plans
  - Must use adjusted community rating with maximum rate variation for age limited to 4 to 1
  - Premiums must be set at the average standard rate for standard population

Temporary High Risk Pool
(continued)

- Federal funding of $5 billion allocated to fund eligible enrollees until 2014, when state Exchange health plans will be available
- Current enrollees in Texas Health Insurance Pool (THIP) are not eligible for the new program unless they drop coverage for 6 months
- If THIP is selected, existing state law includes provisions that allow for changes in the structure of benefits to accommodate federal law

Action Needed: If HHS Secretary elects to contract with existing Pools, decision will be necessary to permit THIP to enter into agreement with HHS to serve as the temporary pool for eligible Texans. Uncertain whether decision must be Executive, Legislative, or Regulatory

Temporary Reinsurance Program for Early Retirees

Effective Within 90 Days

- Creates temporary reinsurance program for employers providing insurance to retirees age 55 and older
- Program available to all employers including state government programs like ERS, TRS, university plans
- Program pays 80% of claims costs between $15,000 and $90,000 annually
- Payments under the program must be used to lower costs of the plan
- Employers – including government programs – must submit application to HHS to participate
- Funding of $5 billion; HHS may limit participation based on availability of funds

Electronic Health Care Transactions

- Simplifies health insurance administration by requiring compliance with standard requirements for certain electronic health care transactions
- Enhances existing requirements under HIPAA by imposing new, earlier deadlines for HHS rules and implementation
  - Requires use of a single set of operating rules for eligibility verification and claims status (January 2013)
  - Electronic funds transfers and health care payment and remittance (January 2014)
  - Health claims or equivalent encounter information (January 2016)
  - Enrollment and disenrollment in a health plan (January 2016)
  - Health plan premium payments (January 2016)
  - Referral certification and authorization (January 2016)

Health Insurance Exchange

Must be operational by January 2014

- Directs states to establish American Health Benefit Exchanges and Small Business Health Options Program (SHOP). States can expand coverage to large employers in 2017
- Failure to establish Exchange will result in HHS establishing an Exchange within any non-participating state. State must be able to demonstrate by January 1, 2013 that it will have Exchange operational by January 1, 2014
- Exchange must be operational by January 2014; HHS must work with NAIC, states, stakeholders to develop regulations applicable to Exchange
- Must be administered by governmental agency or non-profit organization

Health Insurance Exchange Program Features

- Provides one-stop insurance shopping for individuals and small businesses
  - Offers enrollees a selection of "Exchange qualified" plan that meet minimum standards
  - Creates administrative mechanism for enrollment
  - Standardizes presentation of insurance options for plan comparability; provides a "rating" system for plans and significant transparency provisions
  - Redefines small businesses as 1-100 employees; states may limit to 50 until 2016
- Must contract with "navigators" to assist consumers; includes
- All plans sold in the Exchange must be certified by TDI as meeting minimum federal benefit standards
  - Four levels of plans: bronze, silver, gold, platinum
  - Catastrophic plans available to individuals under age 30 or exempt from insurance reqt.
  - Insurers must offer children-only plans
- Exchange must provide a seamless application and enrollment process for individuals who qualify for subsidies, requiring coordination with HHSC
- Federal funding: HHS will distribute grants to states within one year after date of enactment.

Action Needed: Determine which agency will be responsible for implementing and operating the Exchange

Transitional Reinsurance for Small Group, Individual Markets

Effective 2014

- States must establish a nonprofit reinsurance entity by 2014
- HHS and NAIC will establish provisions for program
- Purpose is to stabilize premiums during first 3 years of Exchange when risk of adverse selection is greatest
- Reinsurer collects payments from group insurers (including TPAs) and makes reinsurance payments to individual insurers that cover high-risk individuals (2014-2016)

Other Provisions

- Consumer Operated and Oriented Plan (CO-OP) program to foster creation of non-profit member-run health insurance companies to offer qualified health plans within Exchange. Funds of $6 billion allocated to finance grants and loans to entities to establish CO-OPs by July 1, 2013
- Allows states to merge individual and small group markets (January 2014)
- Permits employers to offer rewards of up to 30% of the cost of premiums for participating in wellness programs that meet certain standards; provisions included for non-discrimination. Creates a 10-state pilot program to allow similar programs in individual health plans
- Permits states to form health care choice compacts that would allow multi-state insurance sales in participating states with joint agreement. Consumer protection provisions prevail in state where enrollee resides. If state wants to participate, must enact law (January 2016)
- Health insurers can apply with HHS to offer nationwide plans; certain conditions apply

Individual Requirement to Purchase Insurance

Effective January 2014

- Individuals (US citizens and legal residents) required to obtain qualifying coverage that meets federal standards
- Can be an individual or group health plan
- Exemptions for individuals below tax filing threshold (currently $12,050 for individual and $18,700 for couple)
- Subsidies for families/individuals up to 400% of federal poverty level (approx $43,000 individual, $88,000 family of 4) to apply towards premium costs

Individual Requirement to Purchase Insurance
(continued)

- Penalties for non-compliance
  - $95 per person in 2014
  - $326 per person in 2015
  - $695 per person in 2016
  - Alternative: 2.5 percent of income above tax filing threshold
- Enforcement: individuals required to file with IRS must include IRS form to verify they have qualifying coverage. Individuals exempt from filing taxes also exempt from insurance requirement.
- Individuals who do not submit form will receive notice from IRS in June of each year, notifying them that they need to file the required information or request exemption

Employer Requirements to Purchase Insurance

Effective January 2014

- Small employers with 50 or fewer employees exempt from requirement
  - Small Employers, with less than 25 employees and avg. wages of less than $50,000, that do offer coverage receive tax credit of up to 35% of their premium payments on behalf of employees
  - AHRQ (Agency for Healthcare Research and Quality) estimates 222,525 small businesses in Texas could qualify for credits
- Employers with more than 50 employees must offer insurance meeting certain cost requirements or pay penalties:
  - Large employers who do not offer insurance and whose employees receive public subsidies pay $2,000 per FTE receiving subsidy.
  - Large employers who offer insurance but have employees who receive premium assistance because they cannot afford the insurance (affordability is 9.5% of income) pay the lesser of 1) $3,000 per FTE receiving subsidy, or 2) $750 per full-time employee with a waiver for first 30 FTEs.

Impact on Market and Consumers

- Consumers may begin to see premium changes within the next six months; some will see increases, others will see decreases
- Uninsured individuals with preexisting conditions will be able to obtain coverage through the temporary insurance risk pool at rates comparable to what is available in the commercial market
- Significant impact on small and individual market due to rating requirements and guarantee issue
- Likely to eliminate need for Texas Health Insurance Risk Pool after 2014

Impact on Market and Consumers

- Grandfather provision for plans in effect on the date of enactment; all plans issued going forward must meet federal requirements but Texans with insurance before passage of the law can continue under their current plan
- Employers with existing group plans can continue to enroll new employees and eligible dependents
- Insurers will continue to market private insurance plans but all plans sold after 6 months must include new benefit provisions
- TDI will continue all regulatory activities, including company and agent licensing, consumer protection, market conduct and financial oversight, enforcement, policy form review and approval

Impact on TDI

- Aggressive timeline for initial market reforms required by October 2010
- Review all policy filings necessary to bring health plans into compliance with new policy provisions beginning in 6 months
- Identify staffing and training needs, both short term and long term (technical, legal, administrative, Information Technology)
- Prepare for new regulatory responsibilities, such as rate review requirements
- Continue oversight and regulation of existing grandfathered plans as well as all new plans issued under reform provisions
- Work with Legislative committees and members to identify required statutory changes; assist in development of legislation
- Identify required rule changes and develop new rules

Impact on TDI
(continued)

- Establish internal processes and procedures to monitor and provide input in development of federal regulations, NAIC standards
- Evaluate internal agency needs to ensure coordination of implementation activities across programs
- Hold public stakeholder meetings to discuss implementation, obtain input on legislative and regulatory changes and new filing requirements
- Develop web page for regular updates on health reform activities, summary documents, Q&As for frequently asked questions
- Participate in creation of Exchange Program as determined by the Legislature, leadership offices

Fiscal Impact on TDI

- Many regulatory provisions will depend on regulations or directives to be issued by Secretary of HHS. Until those details are known, the magnitude of TDI's role in several critical areas of implementation is unknown
- Most immediate regulatory requirements (policy review and approval) can be absorbed using existing staff
- Additional long-term staffing needs under review, but will depend on HHS requirements

Fiscal Impact on TDI
(continued)

Four primary areas of increased costs for TDI in 2010

- Review of health insurance rates beginning in 2010
  - Federal grants will offset some or all costs
  - Number of policies subject to review (which impacts staffing needs) is unknown at this time
- Consumer Ombudsman Activities beginning in 2010
  - If TDI is designated to serve as the Consumer Ombudsman, additional staff will be necessary
  - Federal grants will offset some or all costs
- Legal oversight of rule development, enforcement, implementation
  - Implementation requires extensive rule-making within short period of time
- Information Technology
  - New web-site, reporting and data collection requirements
  - Details unknown – to be determined by HHS

All estimates subject to change pending HHS regulations

TDI Implementation Planning

- TDI developing implementation plans to address immediate needs and long-term needs
- Stakeholder meetings will begin in April to discuss process for initial 6-month reforms
- Some activities/decisions will depend on HHS directives and regulations; timelines may change based on federal decisions
- Internal TDI workgroup will continually monitor and oversee all health reform activities
- Fiscal estimates will be developed and reviewed continually as HHS regulations and directives are released, enabling TDI to develop accurate cost estimate

Implementation Challenges

- Provisions effective within first 6 months will require aggressive implementation effort
- Significant legislation and rules required; availability and timing of federal regulations will impact TDI's implementation planning and execution
- Implementation and long-term management of varying regulatory requirements for grandfathered plans, Exchange plans, non-Exchange plans, multi-state plans; and plans within each market segment (individual, small group and large group)
- Consumer education and assistance
  - Massive public education and information effort, coordinated across state agencies
  - Staffing and training
- Health care provider workforce and network adequacy; impact on existing healthcare infrastructure and ability to manage new insureds
- Long term fiscal planning as new HHS regulations are issued sporadically during next 4 years

Contact Information

Questions regarding federal health reform implementation may be directed to:

Dianne Longley

Dianne.Longley@tdi.state.tx.us

512-305-7298

Katrina Daniel

Katrina.Daniel@tdi.state.tx.us

512-305-7342