



# Health Care Reform

## Overview of Federal Health Insurance Reform Requirements and TDI Implementation Planning

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Federal Legislation  
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# TDI Overview

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- Presentation is limited to major provisions related to health insurance
- 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
- Caution when reading reform summary documents or news stories; many interpretations and inaccuracies



# Key Insurance Provisions

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- 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

Effective Within 6 Months (September 23, 2010)

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- 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 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

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## Review of Premium Rates

- Federal HHS, in consultation 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 reasonableness
  - 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
- Federal 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 2010/2011 Plan Year

## Health Plan Loss Ratio Requirements

- Health plans must report to federal HHS (and maybe state insurance departments) 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
- Calculations and reporting requirements to be developed by federal HHS in consultation with 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. Secretary may adjust percentage if 80% minimum may destabilize individual market.
- Loss ratio expenses based on clinical services and activities that improve health care quality

# Early Insurance Market Reforms

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## Federal Request for Comments Regarding Health Plan Loss Ratio Requirements and Rate Review

- Federal HHS, Department of Labor and Department of Treasury published two separate Requests for Comments on April 14
- Loss Ratio: Areas of Interest include:
  - Definition of activities that improve health care quality
  - Standardized methodologies for calculating loss ratios (by line, product type, plan size, geographic considerations)
  - Variability and special considerations for smaller plans, types of plans, newer plans
- Rate Review: Areas of Interest include
  - Existing state rate review requirements
  - Considerations and variations for types of plans
  - Methodologies for evaluating rate reasonableness and justification
  - Public disclosure practices and suggestions
- TDI drafting responses to federal HHS; process will include stakeholder input
- TDI also participating in NAIC working groups
- TDI's regulatory responsibilities, fiscal impact unclear at this time; will depend on federal regulations



# Early Insurance Market Reforms

Required Within Six Months

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## 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 federal HHS



# Insurance Market Reforms

**Required Within 2 Years**

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- 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
  - Federal HHS will work with NAIC and stakeholders to develop standards. Must be published within 12 months; health plan compliance within 24 months.
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# 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 federal 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**

- **Provides grants to states to create health insurance consumer assistance or health ombudsman program**
  - “To be eligible to receive a grant, a State shall designate an independent office of health insurance consumer assistance, or an ombudsman, that directly or in coordination with State health insurance regulators and consumer assistance organizations, receives and responds to inquiries and complaints concerning health insurance coverage with respect to Federal health insurance requirements and under State law.”
- **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 beginning in 2014**
- **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**
- **Federal HHS will provide instructions, qualifications for funds**

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

# Temporary High Risk Pool

**Effective Within 90 Days**

- **Creates temporary high risk insurance pool for individuals with pre-existing conditions**
  - No preexisting condition exclusions
  - 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
- **Must be uninsured for 6 months or longer**
- **Secretary may contract with states or non-profit entities (including existing high risk pools) to provide coverage**
- **Texas Health Insurance Pool has been designated as primary contact for risk pool issues and is working with federal HHS and other states**



# Temporary High Risk Pool

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- Federal funding of \$5 billion allocated to fund eligible enrollees until 2014, when state Exchange health plans will be available
- Federal HHS working with states to develop program participation guidelines, allocation of funds
- Current enrollees in Texas Health Insurance Pool (THIP) are not eligible for the new program as currently defined (must be uninsured for six months or longer)
- Existing state law includes provisions that would allow THIP to implement necessary changes to accommodate federal law pending until legislation can be enacted



# Temporary Reinsurance Program for Early Retirees

**Effective Within 90 Days**

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- 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

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- 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 federal 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**

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- 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 federal 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; federal 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
- 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 those exempt from insurance requirement
  - 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 implementation grants to states within one year after date of enactment of legislation

**Action Needed:** Determine what agency or entity will be responsible for implementing and operating the Exchange



# Transitional Reinsurance for Small Group, Individual Markets

**Effective 2014**

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- 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 Third Party Administrators) and provides reinsurance payments to individual insurers that cover high-risk individuals (2014-2016)



# Other Provisions

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- 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 federal HHS to offer nationwide plans; certain conditions apply



# Individual Requirement to Purchase Insurance

**Effective January 2014**

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- 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), people with religious objections, members of Indian tribes, people not covered for less than three months
- 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

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- Penalties for non-compliance
  - \$95 per person in 2014
  - \$325 per person in 2015
  - \$695 per person in 2016
  - Alternative: 2.5 percent of income above tax filing threshold (whichever is greater)
- 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

# Small Employer Requirements and Tax Credits

Effective January 2014

- **Small employers with 50 or fewer FTE employees not required to offer insurance and not subject to penalties**
- **Part - time workers (work less than 30 hours per week) are counted for purposes of determining number of FTEs**
  - Add total number of hours worked by part-time employees and divide by 120 to determine number of FTEs
  - Example: 10 part-time employees working total of 600 hours per month;  $600 \div 120 = 5$  additional FTEs
- **Not required to offer coverage to or pay penalties on part-time workers**
- **Tax Credits available for some small employers who do offer insurance**
  - Small Employers, with less than 25 employees and average annual 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; credit increases to 50% in 2014
  - Credits phase out gradually for firms with average wages between \$25,000-\$50,000 and for firms with 10-25 FTE workers

# Large Employer Requirements to Purchase Insurance

Effective January 2014

- **Employers with more than 50 full-time 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 1/12 of \$2,000 per FTE per month, with a waiver for first 30 FTEs
  - 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) 1/12 of \$3,000 per FTE receiving subsidy per month, or 2) 1/12 of \$2000 per month for the total number of full-time employees with a waiver for first 30 FTEs
  - Penalties calculated monthly based on number of applicable employees
- **Employers with 200 or more workers who offer coverage must automatically enroll new employees and continue enrollment of current employees; employees may choose to opt-out**



# Impact on Market and Consumers

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- Consumers may begin to see premium changes within the next six months; some will see increases, others will see decreases
- Some premium cost increases may be mitigated by minimum loss ratio requirements, but too early to predict market impact
- 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

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- 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 March 23<sup>rd</sup> must comply with new benefit provisions on their effective date
- 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 Healthy Texas Program

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- Healthy Texas provides a critical insurance opportunity for small employers for at least the next three years
  - Many of major reforms not effective until 2014
  - Small employers need assistance now
- Health Plan Request for Proposal has been published and TDI is committed to working with health plans to ensure effective implementation of Healthy Texas
- Many small businesses who participate in Healthy Texas will also qualify for federal tax credits, which will further reduce employers' costs, creating an even greater demand for coverage
- TDI will work with Legislature and Health Plans during the next three years to identify how Healthy Texas may be adapted to serve small businesses and their workers



# Impact on TDI

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- Aggressive timeline for initial market reforms required by September 23, 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
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# Impact on TDI (continued)

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- 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
- Maintain 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

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- 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 federal HHS requirements

# Fiscal Impact on TDI

## (continued)

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### 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 federal HHS regulations**

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# TDI Implementation Planning

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- TDI developing detailed implementation plans to address immediate needs and long-term needs
- Public Stakeholder meetings will begin in May 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 has been established and will continually monitor and direct insurance 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

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- 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 federal HHS regulations are issued periodically during next 4 years



# Contact Information

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