

Overview of federal health insurance reform and state implementation

Kentucky Department of Insurance

State Implementation

- Implementation coordinated through the Governor's Office
- DOI Internal Senior PPACA Implementation Team
 - High Risk Pool
 - Insurer Oversight
 - Grants
 - Public Relations and Consumer Assistance
 - Administrative Support
 - Exchanges
 - Legislation and Regulations

High Risk Pool

High Risk Pool - Decision Timeline

- April 2, 2010 – HHS asks states to make decision regarding operation of temporary high risk pool by April 30
- April 9 – 23, 2010, DOI provided the following information to the Governor:
 - A white paper outlining the pros and cons of each option outlined in the request letter;
 - A comparison of the requirements for Kentucky Access, Kentucky's current high risk pool, and the requirements for the temporary high risk pool;
 - Information on the maintenance of effort requirement for a state existing high risk pool;
 - Any legislative or administrative actions needed for the state to establish and operate the temporary high risk pool; and
 - Information regarding the exchanges that will become operational in 2014, and the impact of the decision to operate the temporary high risk pool on the ability of a state to operate an exchange.

High Risk Pool - Decision Timeline

- April 29, 2010 – Kentucky expressed its interest to HHS in operating a high risk pool, but identified the following areas needing additional information/assurances:
 - A guarantee that there is no transfer of risk to Kentucky and no financial liability to the Commonwealth.
 - Flexibility to control or impose restrictions on various aspects of the program including enrollment, residency requirements, waiting periods or capping of premiums.
 - Ability to negotiate for services under terms agreeable to both state and federal governments and any sub-contractors.
 - Additional information or clarification on the Maintenance of Effort requirements for the states.

High Risk Pool - Decision Timeline

- May 10, 2010 – Kentucky received the solicitation for state operation of the risk pool and continued to have the following concerns:
 - The adequacy of the \$63M in funding allocated to the operation of Kentucky's temporary high risk pool;
 - The requirement that states would be expected to mitigate costs to ensure they did not exceed allocated funding, when, through experience with Kentucky Access, the Department knows that claims may not be submitted for payment until several months after treatment has occurred;
 - The lack of provisions allowing the Commonwealth to terminate the contract;
 - The lack of clear guidance regarding flexibility in various eligibility and operational requirements that would serve to control the cost of the program.

High Risk Pool - Decision Timeline

- May 17, 2010 – DOI recommended to Governor Beshear that Kentucky opt for the operation of the temporary high risk pool by the federal government.
 - Allows Kentuckians ability for coverage in this temporary program
 - Protects the state from unknown liabilities

Temporary High Risk Pool

“Pre-Existing Condition Insurance Plan”

- The federal government operates the Pre-Existing Condition Insurance Plan (PCIP) in Kentucky
 - Administered by Government Employees Health Association (GEHA)
 - Operational July 1, 2010
 - Members will transition to the exchange in January 2014
- Eligibility
 - Citizen or national of the US or lawfully present in the US
 - Uninsured for at least the last 6 months
 - Had a problem getting insurance due to a pre-existing condition
 - Must provide a copy of a denial letter, dated within the past 6 months, from a private insurer or a evidence of a rider excluding coverage for the pre-existing condition.

Temporary High Risk Pool

“Pre-Existing Condition Insurance Plan”

- Rates
 - Rates must be set at the standard market rate
 - Adjusted community rating with maximum variation for age of 4:1
- Coverage
 - No pre-existing condition exclusions
 - Cover at least 65% of total allowed costs
 - Out-of-pocket limit no greater than the limit for high deductible health plans
- For more information, application, etc. ~ www.pciplan.com or www.healthcare.gov

Insurer Oversight

Grandfathered plans

- “If you like your health plan, you can keep it.”
- Defined as a health plan existing on March 23, 2010
- Changes to grandfathered plan that will result in a loss of grandfathered status
 - Elimination of all or substantially all benefits to diagnose or treat a particular condition
 - Any increase in percentage cost-sharing requirements
 - An increase in fixed-amount cost-sharing other than a copayment of more than medical inflation plus 15% (i.e. deductible)
 - An increase in a copayment of more than medical inflation plus 15% or \$5 increased by medical inflation, whichever is greater
 - A decrease in the proportion of premiums paid by the employer of more than 4%
 - Addition of an annual limit on benefits if the plan had neither an annual or lifetime limit in place on March 23, 2010
 - Addition of an annual limit that is lower than the lifetime limit the plan had in place on March 23, 2010
 - Decrease of an annual limit that was in place on March 23, 2010

Grandfathered plans

- Grandfathered plans can
 - Raise premiums to reasonably keep pace with health care costs
 - Make some changes in the benefits
 - Increase deductibles and other out-of-pocket costs within limits
 - Continue to enroll new employees and new family members
- Insurer (or employer if self-funded) required to provide notice in any plan materials indicating whether the plan is a grandfathered plan
 - Model language is provided in the federal regulation

Grandfathered plans

- Changes to a plan considered in place as of March 23, 2010
 - Changes made prior to March 23 but effective after March 23
 - Changes made after March 23 pursuant to a contract entered into or an insurance department filing prior to March 23
 - Changes effective after March 23 pursuant to written amendments to a plan adopted prior to March 23
- Changes made after March 23 and adopted prior to June 14 (issue date of regulation) will not cause a plan to lose grandfather status if the changes are modified or revoked effective the first day of the plan year beginning 9/23/10

Immediate Market Reforms

Applies to All Plans

- Rate review and medical loss ratios
- Prohibition on lifetime benefit limits; allowance of restricted annual limits for essential benefits
- Prohibition on rescissions
- Extension of dependent coverage until age 26
- Uniform explanation of coverage documents and standardized definitions

Applies to New Plans (Not Grandfathered Plans)

- Coverage of preventive health services without cost-sharing
- Internal and external appeal process
- Coverage for emergency services at in-network cost-sharing levels with no prior authorization
- Selection of primary care provider of choice
- Prohibition on requiring referral for obstetrical or gynecological care
- Health plan disclosure and transparency requirements

Major Issues Pending Guidance From Federal Health and Human Services

Rate Review Process

- Requires HHS, in conjunction with the states, to develop a process for annual review of unreasonable premium increases for health insurance coverage
 - Insurers will be required to submit to states and HHS a justification for an unreasonable premium increase and post it on-line
 - Guidance on “unreasonable” is being developed by HHS

Medical loss ratio

- Insurers must report to HHS ratio of incurred losses plus loss adjustment expense to earned premiums
- Report must include percentage of premium revenue expended on
 - Reimbursement for clinical services
 - Activities that improve health care quality
 - All other non-claims expenses excluded taxes and licensing/regulatory fees
- Insurers must issue a refund to enrollees if the percentage of premium expended for medical claims and health care quality improvement is less than
 - 85% in the large group market
 - 80% in the small group and individual market

Uniform explanation of coverage documents and standardized definitions

- HHS must develop a standard summary of benefits and coverage explanation to be provided to all applicants and enrollees
 - Uniform definitions of insurance and medical terms
 - A 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
 - Illustration of coverage under common benefit scenarios
 - Statement of whether the plan provides minimum essential coverage with an actuarial value of at least 60% (individual mandate requirement)
 - Statement that an outline is a summary and that the actual policy language controls
 - Contact information and a Web address for the location of the policy language
- HHS must consult with the NAIC and a working group of insurers, providers, patient advocates, and representatives of individuals with limited English proficiency

Grants

Premium Review Grant

- Total of \$250 million over 5 years to assist rate review activities
 - Reviewing rates
 - Providing information and recommendations to HHS
 - Establishing medical reimbursement data centers to develop database tools that fairly and accurately reflect market rates for medical services
- First round - \$1 million per state
 - Develop or enhance the state process for health insurance rate review
 - Establish a plan to disclose rates to the public and HHS

Premium Review Grant

- Kentucky was awarded \$1M on August 16. Our acceptance letter is due by September 13.
- Kentucky's proposed the following for use of the grant funds:
 - Increase the categories of data required to be filed by large groups and expand DOI review of large group rate filings to include analysis of rate factors
 - Increase the amount of data to be provided in a rate filing and modify the review process to include consideration of plan years, underwriting issues and policy forms
 - Develop a publication to explain the rate review process, including the information submitted by insurers and reviewed by the DOI, in plain language to give notice of specific rate increases and decreases
 - Conduct surveys and hold open meetings for consumers in order to determine what information would be useful for them to make well-informed health insurance decisions

Consumer Assistance Program

- \$30 million in grants to states to establish and operate offices of health insurance consumer assistance or health insurance ombudsman programs to
 - Assist with the filing of complaints and appeals
 - Collect, track and quantify problems and inquiries
 - Educate consumers on their rights and responsibilities
 - Assist consumers with enrollment in plans
 - Resolve problems with obtaining subsidies
- States will be required to collect and report data on problems and inquiries encountered by consumers
 - Used to identify areas where enforcement action is necessary
 - Shared with state insurance regulators, Secretary of Labor, Secretary of Treasury
- We currently are working on our grant submission. It is due on September 10.

Exchange Planning

- \$1M in grant funds available to states for planning and activities related to establishment of an Exchange
- DOI and CHFS are working collaboratively on a grant application.
 - County level market research (demographics, income, insured status)
 - Stakeholder input
 - Discussions with other states
 - Assessment of current IT infrastructure
- Due September 1

Public Relations & Consumer Assistance

Web Portal

- www.healthcare.gov
- Web site through which individuals and small businesses may identify affordable health insurance coverage
 - Health insurance coverage
 - Percentage of total premiums spent on nonclinical costs
 - Availability
 - Premium rates
 - Cost sharing
 - Medicaid
 - CHIP
 - Medicare
 - High risk pool
 - Small group coverage, including reinsurance for early retirees, tax credits, etc.

Web Portal

- Phase I – launched July 1
 - Summary level information
 - Coverage options by state and ZIP code
- Phase II – by October 1
 - More detailed pricing and benefit information
 - Plan comparison tool

Administrative Support

Administrative Support

- Eight additional staff needed for implementation efforts, to date
 - Federally funded, time limited positions
 - Filling of positions based upon grant awards

What's Next?

Exchanges

What is an Exchange?

- An exchange is an organized marketplace for the purchase of health insurance
 - Offers a choice of plans
 - Common rules for
 - Eligibility
 - Pricing
 - Outlines of coverage
 - Certification of qualified health plans

Exchanges – General Requirements

- Certify plans offered through the Exchange
- Publish an on-line accounting of administrative costs
- Provide open enrollment periods (initial, annual and special)
- Have a toll-free consumer assistance hotline
- Maintain a website to compare qualified health benefit plans using a standard outline of coverage
- Rate each qualified health benefit plan based on quality and price
- Provide eligibility information and enrollment assistance for public health programs including Medicaid and KCHIP
- Provide information to HHS on individuals covered through the Exchange for enforcement of the individual mandate and employer shared responsibility requirements
- Establish a navigator program to provide public education, facilitate enrollment and provide referrals to ombudsman or consumer assistance programs

Exchange – State Options

- State vs. federal operation
 - HHS will operate a state's Exchange either directly or through agreement with a non-profit entity if, by January 1, 2013, HHS determines that a state:
 - Is not electing to operate an Exchange
 - Will not have an Exchange operational by 1/1/14
 - Has not taken necessary actions to implement the market reforms
- If state operation, governing structure through:
 - Existing state agency
 - New state agency
 - Non-profit entity created by the state
- Goal of the Exchange
 - Informational to health care delivery system
- Number of exchanges
 - One exchange for all market segments vs. separate exchanges
 - Regional exchanges within the state
 - Multi-state exchange

Exchange – State Options

- Size of small group market
 - 1-50 vs. 1 -100
 - Must be 1-100 by 2016
- Funding
 - Exchanges must be self-sustaining by 2015
 - Assessments
 - User fees
 - Other sources

Exchanges – Agent's Role

- HHS is required to establish procedures for agents to enroll individuals and employers in qualified health benefit plans through the Exchange
- Navigator program can include agents
- Kentucky signed the NAIC resolution supporting the role of agents within the exchange

Legislation and Administrative Regulations

2011 Legislation

- The Department of Insurance has compared Kentucky's existing laws and administrative regulations with the consumer protections in the federal health insurance laws.
- The Department will be making recommendations for legislative changes needed to conform Kentucky's specific insurance laws to these federal provisions
 - Limitations on rescissions
 - Restrictions on annual and lifetime limits
 - Coverage of preventive services
 - Extension of adult dependent coverage
 - Prohibition on pre-existing condition exclusions for children under 19
 - Uniform explanation of coverage documents and standardized definitions
 - Annual reports on quality and wellness
 - Requirement to share quality and wellness reports with enrollees
 - Internal and External Appeals
 - Patient protections
 - Emergency services
 - Choice of primary care provider
 - Choice of pediatrician
 - Choice of OB/GYN
 - Rate review