



Health care reform

The Tennessee Department of Commerce and Insurance has been fielding numerous inquiries related to the Patient Protection and Affordable Care Act (PPACA) that President Barack Obama signed into law March 23, 2010. Health care reform promises to affect a wide swath of our society in different ways, from consumers to employers to seniors and others.

Commerce and Insurance, along with other Tennessee state agencies, is analyzing the components of the PPACA and the respective timelines for those components. Many details are not yet available, so as the state learns more, this website section will be updated with information for Tennesseans to use in making their health insurance decisions.

Please stop in regularly to see how the law will affect you and your loved ones. If you have insurance questions – especially related to policies you have or are considering – please contact Consumer Insurance Services at 615-741-2218 or 1-800-342-4029 (inside Tennessee), or e-mail the Insurance Division at insurance.info@tn.gov.

News

[Beware of health care reform insurance scams](#)

Implementation timeframe

Health care reform comprises various programs and requirements to be implemented over the next several years. What follows is a timeline for these pieces of reform. Click on a year to see when specific reforms will be implemented.

2010

Annual and lifetime limits

Plans may not establish lifetime limits on the dollar value of essential benefits. Plans may only establish restricted limits prior to Jan. 1, 2014, on essential benefits.¹

Preexisting-conditions exclusions

A plan may not impose any preexisting-conditions exclusions – effective six months after enactment – for consumers under age 19.¹

Rescissions

Insurers cannot rescind coverage after a sickness. Coverage may be rescinded only for fraud or intentional misrepresentation of material fact.¹

Small business tax credit

Available to small businesses offering coverage to employees

\$250 Medicare Part D rebate

A \$250 rebate will be available to seniors reaching the Medicare Part D “donut hole.”¹

Coverage of preventative health services

Plans must provide coverage without cost-sharing for:

- Services recommended by the U.S. Preventive Services Task Force
- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention
- Preventive care and screenings for infants, children and adolescents supported by the U.S. Health Resources and Services Administration
- Preventive care and screenings for women supported by the U.S. Health Resources and Services Administration

Current recommendations from the US Preventive Services Task force for breast cancer screenings will not be considered.¹

Extension of adult dependent coverage

Plans that provide dependent coverage must extend coverage to unmarried adult children up to age 26.¹

Provision of additional information

All plans must submit to the U.S. Secretary of Health and Human Services (HHS) and Commissioner of Commerce and Insurance and make available to the public the following information in plain language:

- Claims-payment policies and practices
- Periodic financial disclosures
- Data on enrollment
- Data on disenrollment
- Data on the number of claims that are denied
- Data on rating practices
- Information on cost-sharing and payments related to out-of-network coverage¹

Prohibition on discrimination based on salary

Extends current law provisions prohibiting discrimination in favor of highly compensated employees in self-insured group plans to fully-insured group plans¹

Appeals process

Internal claims appeal process:

- Group plans must incorporate the U.S. Department of Labor's claims and appeals procedures and update them to reflect standards established by the Secretary of Labor.
- Individual plans must incorporate applicable law requirements and update them to reflect standards established by the Secretary of HHS.

External review:

- All plans must comply with applicable Tennessee external review processes that, at a minimum, include consumer protections in the NAIC Uniform External Review Model Act (Model 76) with minimum standards established by the Secretary of HHS that is similar to the NAIC model.¹

Patient protections

A plan that provides for designation of a primary care provider must allow the choice of any participating primary care provider who is available to accept them, including pediatricians.

If a plan provides coverage for emergency services, the plan must do so without prior authorization, regardless of whether the provider is a participating provider.

A plan may not require authorization or referral for a female patient to receive obstetric or gynecological care from a participating provider.¹

Health insurance consumer assistance offices and ombudsmen

Under PPACA, states may choose 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 may be required to collect and report data of all the types of problems and inquiries encountered by consumers.¹

Ensuring that consumers get value for their dollars

States shall develop a process for the annual review of unreasonable premium increases for health insurance coverage. The process shall require insurers to submit to the state and the Secretary of HHS a justification for an unreasonable premium increase and post it online.¹

Temporary high-risk pool program

The Secretary of Health and Human Services (HHS) is required to establish a temporary high-risk health insurance pool program to provide coverage to individuals with preexisting conditions who have been without coverage for at least six months.

Pools must:

- Have no preexisting-condition exclusions
- Cover at least 65 percent of total allowed costs
- Have an out-of-pocket limit no greater than the limit for high-deductible health plans (\$5,950 for individuals and \$11,900 for families)
- Utilize adjusted community rating with maximum variation for age of 4:1
- Have premiums established at a standard rate for a standard population

In Tennessee, CoverTN's AccessTN program

(http://www.covertn.gov/web/access_tn.html) will administer the high-risk pool program.

Temporary reinsurance program for early retirees

The Secretary of HHS shall establish a temporary reinsurance program to reimburse employment-based plans for 80 percent of costs incurred by early retirees age 55 and over but not eligible for Medicare between \$15,000 and \$90,000 annually.¹

Web portal to identify affordable coverage options

The Secretary shall establish a mechanism, including a website through which individuals and small businesses may identify affordable health insurance coverage.¹

2011

Bringing down the cost of health care

Carriers must report to the Secretary of HHS the ratio of incurred losses (incurred claims) plus loss adjustment expense (change in contract reserves) to earned premiums. The report must include the percentage of total premium revenue, after accounting for risk adjustment, premium corridors and payments of reinsurance. Insurers must provide a rebate to consumers if the percentage of premiums expended for clinical services and activities that improve health care quality is less than 85 percent in the large group market and 80 percent in the small group and individual markets. All hospitals must establish and make public a list of its standard charges for items and services, including for diagnosis-related groups.¹

Loss ratio

Medical-loss ratios of 80 percent and 85 percent, respectively, are required for individual/small group and large group plans. Loss ratio is the fraction of revenue from a plan's premiums that goes to pay for medical services.²

Long-term care

A voluntary long-term care program will begin, financed through payroll deductions. (See consumer FAQs for more information)²

2012

Ensuring quality of care

Plans must submit annual reports to the Secretary of HHS on whether the benefits under the plan:

- Improve health outcomes through activities such as quality reporting, case management, care coordination, chronic disease management
- Implement activities to prevent hospital readmission
- Implement activities to improve patient safety and reduce medical errors
- Implement wellness and health promotion activities¹

2013

Administrative simplification requirements

The Secretary of HHS will develop operating rules for the electronic exchange of health information, transaction standards for electronic funds transfers and requirements for financial and administrative transactions.¹

2014

Health benefit exchange

State exchanges must be operational by Jan. 1, 2014. Additionally, the Secretary of HHS must determine by Jan. 1, 2013 whether states intend to operate qualified exchanges. If a state does not create a qualified exchange, the Secretary must create one. There must be two exchanges: a non-group market exchange and an exchange for small businesses. States may choose to operate only one exchange serving both groups.

Some functions to be performed by an exchange include:

- Certify qualified plans to be sold in the exchange
- Maintain a website
- Provide for initial, annual and special open enrollment periods
- Maintain a toll-free number
- Create a rating system for plans and perform satisfaction survey
- Provide a calculator to determine enrollee premiums and subsidies
- Identify those individuals exempt from the individual mandate and notify treasury
- Require participating plans to provide justification for rate increases¹

Preexisting-conditions exclusions

Starting Jan. 1, 2014, a plan may not impose any preexisting condition exclusions on anyone.¹

Requirement to maintain minimum essential coverage

U.S. citizens and legal residents are required to have qualifying health coverage. 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 percent 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 percent of taxable income in 2014, 2.0 percent of taxable income in 2015, and 2.5 percent of taxable income in 2016.

After 2016, the penalty will be increased annually by the cost-of-living adjustment. Exemptions will be granted for financial hardship, religious objections, Native Americans, those without coverage for less than three months, undocumented immigrants, incarcerated individuals, those for whom the lowest cost plan option exceeds 8 percent of an individual's income, and those with incomes below the tax-filing threshold (in 2009 the threshold for taxpayers under age 65 was \$9,350 for singles and \$18,700 for couples).³

State flexibility to establish basic health programs for low-income individuals not eligible for Medicaid

The Secretary of HHS shall establish a basic health program under which a state may contract with standard health plans providing at least essential benefits to individuals between 133 percent and 200 percent FPL and legal immigrants above 133 percent FPL who are not eligible for Medicaid. The federal government will provide states creating basic health programs the subsidy funds that eligible individuals would have otherwise received.

Individuals eligible to participate in these plans would not be eligible to purchase coverage through the exchange, and premiums may not exceed what the individual would have paid in the exchange. Cost-sharing may not exceed that of a platinum plan in the exchange for individuals below 150 percent FPL or that of a gold plan for all others. Plans must have an MLR of at least 85 percent.

States may enter into compacts to allow residents of all compacting states to enroll in all standard plans.¹

Guaranteed issue and renewability in all markets

The law requires guaranteed issue and renewability and allows rating variation based only on age (limited to 3-to-1 ratio), premium rating area, family composition and tobacco use (limited to 1.5-to-1 ratio) in the individual and the small group market and the exchanges.³

Employers must offer coverage

Imposes a mandate on employers with 50+ workers: offer coverage of by 2014 pay \$2,000/full time worker (excluding the first 30); if offer unaffordable coverage, pay \$3,000/employee receiving taxpayer assistance to buy it or a total of \$2,000/employee, whichever is more. Employers of 50 or fewer workers are exempt.²

2018

Tax on "Cadillac" plans

Imposes new taxes on so-called "Cadillac" health insurance policies²

Sources:

1 [National Association of Insurance Commissioners](#) (NAIC)

2 National Conference of Insurance Legislators
(<http://www.ncoil.org/news/archives.html>) (NCIL)

3 [Kaiser Health News](#)

For more information, visit

(http://www.naic.org/index_health_reform_section.htm#consumers)

Links to other state government agencies:

TennCare (www.tn.gov/tenncare/)

CoverTN (www.covertn.gov/)

Accesstn (http://www.covertn.gov/web/access_tn.html/)

TN Dept. of Health (www.tn.gov/health/)

The Department of Commerce and Insurance works to protect consumers while ensuring fair competition for industries and professionals who do business in Tennessee.
www.tn.gov/commerce/

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