Health Reform Implementation: The First 90 Days

A State Advocate's To-Do List

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Congratulations! You have achieved a massive, historic victory for health care consumers in America. Take time to celebrate, and then get ready to roll up your sleeves and start implementing all the new protections and opportunities that health reform will bring to your state.

To help you get the ball rolling, here is a "to-do" list for state advocates to take on in the first 90 days to ensure that health reform is implemented effectively and in the most consumer-friendly way. We also offer a list of resources to help you prepare for implementation (the links to these resources are available in the online version of this document), along with more technical materials that examine the parts of this law that will need to be put into motion over the coming years.

The following are the first reforms that will take effect:

- Temporary coverage for uninsured people with pre-existing conditions
- Grants for consumer assistance offices or health insurance ombudsman programs
- Grants for rate review
- Small business tax credit
- Medicaid and CHIP Maintenance of Effort (MOE) requirements
- Option to expand Medicaid before 2014
- Changes to community benefit requirements for nonprofit hospitals
- Some other reforms that go into effect later this year

To vew this document online, go to Health Reform Central at www.familiesusa.org and click on "Implementing the New Law."

Temporary Coverage for Uninsured People with Pre-Existing Conditions

(Section 1101 of the Patient Protection and Affordable Care Act)

Effective within 90 days of enactment, federal funding is available to cover individuals who have pre-existing conditions and who have been uninsured during the six months before they apply for coverage through this new, temporary program. This new "temporary high-risk pool" will continue until 2014, when health reform will prohibit insurers from denying people coverage or charging them higher rates based on pre-existing conditions. The new program can be directly operated by the Secretary of Health and Human Services (HHS), or the Secretary can contract with states or nonprofits (such as existing high-risk pools) to administer coverage to eligible people. Coverage provided with this funding must be at standard premium rates (the rates charged to healthy people) and must meet certain requirements, outlined in an April 2, 2010 news release from the Department of Health and Human Services (HHS) entitled "Sebelius Continues Work to Implement Health Reform, Announces First Steps to Establish Temporary High Risk Pool Program" and available online at www.hhs.gov. The health reform law allocates $5 billion for this program until 2014.

To do:

- Talk with your insurance regulators and the administrators of any existing plans that your state has to cover people with pre-existing conditions (such as high-risk pools or open enrollment products). Is your state planning to use temporary funding to build on an existing program, start a new program (perhaps through a contract with a HIPAA-carrier), or will your state rely on the federal government to operate the new pool? Which do you think would be most beneficial to consumers?
- If your state plans to operate a temporary high-risk pool, what level of benefits will it offer? The plan must have an actuarial value of at least 65 percent. Can you be on an ongoing advisory committee to make decisions about the application process, outreach, benefits, and other operations?
- How does your state currently serve people with pre-existing conditions who have NOT been uninsured for six months, such as HIPAA-eligibles? Work to lower premiums for that population, and ensure that their coverage is equitable with what the new risk pool provides.
- Whether your state, a nonprofit, or a federal entity operates the temporary coverage available for high-risk individuals in your state, make sure that your insurance department provides accessible resources for consumers to understand the temporary coverage that is available and how they can apply for it.
- Talk to both your congressional representatives and your state legislators about any unmet funding needs for the temporary high-risk pool and for existing mechanisms to serve people with pre-existing conditions who do not qualify for the new program.

Additional Resources:

- Letter to Governors, Insurance Commissioners (Secretary Sebelius, HHS)
- Issues for Structuring Interim High-Risk Pools (Karen Pollitz, Kaiser Family Foundation, January 2010)
- High-Risk Pool Charts (statehealthfacts.org, Kaiser Family Foundation)
- Materials from Health Action 2010 Conference session: Richard Popper, Maryland Health Insurance Plan, State High-Risk Pools - Bridges to Health Reform (Powerpoint)
- High-Risk Health Insurance Pools (Families USA, 2006)

Grants for Consumer Assistance Offices or Health Insurance Ombudsman Programs

(Section 1002 of the Patient Protection and Affordable Care Act; Creates Part C, Section 2793 of the Public Health Services Act)

Grant funding will very soon be available for states to establish or support consumer assistance offices and health insurance ombudsman programs. These offices and programs assist health care consumers with filing complaints and appeals, collect and track consumer problems and inquiries, educate consumers on their rights and responsibilities, assist consumers with enrollment into health coverage, and will eventually resolve problems with premium credits for exchange coverage. The health reform law provides $30 million in funding for these offices and programs this year.

To do:

- Encourage your state to apply for grant funding. If your state already has a consumer assistance or ombudsman program, determine whether it would need to take on additional duties or change its structure in order to qualify for grants. Your state may want to talk with HHS about this. If your state does not currently have such a program, work with state agencies and legislators to create one.
- Perhaps a community-based organization in your state already assists consumers in resolving health insurance problems. Could your state contract with that organization for consumer assistance, and apply for federal funding to expand its services? Alert likely consumer assistance organizations to contact your state about potential funding.
- Once grants begin, advocate for continued funding. Let your congressional Representatives know that the consumer assistance or ombudsman program is doing great work and needs continued federal support.

Additional Resources:

- Establishing a Consumer Health Assistance Program in Your Community (Web-based resources from Families USA)

- Examples of state and local laws establishing independent consumer assistance/ ombudsman programs: Connecticut, District of Columbia, Maryland, Nevada, New York City, Vermont
- Materials from Health Action 2010 Conference session
  - Betsy Dooley, Health Assist Tennessee, *Health Assist Tennessee* (Powerpoint)
  - Ellen Kuhn, Maryland Office of the Attorney General, Health Education and Advocacy Unit, *Overview of the Health Education and Advocacy Unit* (Powerpoint)
  - Priya Mendon, New York City Managed Care Consumer Assistance Program, *Consumer Assistance Programs: A Vital Piece of the Health Care Reform Puzzle* (Powerpoint); *Building Consumer Engagement in Health Care* (PDF)
  - Cheryl Fish Parcham, Families USA, *Asking Our Neighbors: Advice from CHAPs on Establishing a Successful Program* (PDF)

Grants for Rate Review

(Section 1003, as amended by section 10101, of the Patient Protection and Affordable Care Act; Creates Section 2794 of the Public Health Services Act)

Under health reform, the Secretary of HHS will work with the states to establish a process for annually reviewing premium increases requested by insurance companies. Insurers will have to justify unreasonable rate increases prior to implementing the increases and post information about rate increases online. Based on this rate review process, states can eventually recommend that any insurers with unreasonable rate hikes be prohibited from selling plans through the exchange. Meanwhile, depending on the laws in your state, your insurance department may be able to deny or reduce a proposed rate increase. To help states implement the rate review process, $250 million in federal grant funding will be available to states over a five-year period, starting in 2010.

To do:

- Encourage your state/ insurance regulators to apply for grants.
- Educate your state legislature and insurance regulators on what legislation your state needs to pass to enhance its rate review process. For example, are rate filings and their justifications public? Is the public notified and invited to comment on proposed rate increases? Would it help to establish a threshold beyond which rate increases should be more carefully scrutinized? Does your state require consideration of the following in setting rates: affordability and likely effects on enrollment, reserves, and surplus; the reasonableness of administrative expenses; the reasonableness of executive compensation; equity of the premium structure, given community needs and the insurer's mission; profitability, surplus,

reserves, and investment savings of the insurer over time; changes in covered benefits and plan design; the insurer's health care cost containment and quality improvement efforts, and their results?

- Respond to the federal government's requests for comments about rate review processes and how they should be improved.

Additional Resources:

- *Rate Review: Holding Health Plans Accountable for Your Premium Dollars* (Families USA, March 2010)
- *Medical Loss Ratios: Making Sure Premium Dollars Go to Health Care* (Families USA, February 2010)
- Requests for public comments, *Federal Register*, April 14, 2010
  - Comments on Rate Review Processes, *Federal Register*, p. 19335-19338.
  - Comments of Medical Loss Ratio Requirements, *Federal Register*, p. 19297-19302

Small Business Tax Credit

(Section 1421, as amended by section 10105, of the Patient Protection and Affordable Care Act; Creates Section 45R(d)(3) of the IRS Code of 1986)

This year, many small businesses will qualify for a new tax credit that helps them afford to cover their workers. Information about the credit is now available online at the IRS Web site, www.irs.gov.

To do:

- Help get out the word to small businesses and encourage them to cover their workers.
- Encourage your state to provide information about the tax credit on relevant Web sites and in state agencies where small businesses apply for licenses, for example.

Medicaid and CHIP Maintenance of Effort (MOE) Requirements

(Section 2001(b) of the Patient Protection and Affordable Care Act; Amends Section 1902 of the Social Security Act)

Effective upon enactment, health reform requires states to maintain eligibility and enrollment policies for Medicaid and CHIP as a condition of receiving federal funding for Medicaid. States cannot reduce income eligibility levels or implement enrollment policies that make it harder to enroll in coverage than it was as of March 23, 2010 (the date health reform was enacted). This includes, but is not limited to, frequency of redeterminations, paperwork and documentation required for application, uninsured waiting periods, and premiums or enrollment fees. This requirement remains in effect for adult Medicaid coverage until state exchanges are fully operational and for children's Medicaid and

CHIP coverage until October 1, 2019. The Secretary of HHS can grant states that experience budget shortfalls during calendar years 2011–2013 an exemption from the MOE for non-pregnant, non-disabled adults with incomes greater than 133 percent of poverty.

To do:

- Ensure that your state legislature is not considering cuts that would violate the MOE.
- Push for extended fiscal relief for Medicaid (Congress is considering a six month extension of the FMAP increase that is currently set to expire at the end of this calendar year).

Additional Resources:

- *Maintenance of Effort Requirements under Health Reform* (Families USA, March 2010)

Option to Expand Medicaid Before 2014

(Section 2001(a)(4), as amended by Section 10201(b), of the Patient Protection and Affordable Care Act; Amends Section 1902 of the Social Security Act)

All states are required to expand Medicaid eligibility to 133 percent of poverty beginning in 2014, and will receive full federal financing for all newly eligible individuals in 2014-2016. However, starting April 1, 2010, states can expand Medicaid to adults with incomes up to 133 percent of poverty through a state plan amendment (a waiver is not necessary) and receive their normal federal matching rate for this coverage. The state will still receive the increased federal support for these populations beginning in 2014. Since most states are already facing severe budget crises and cannot afford to expand Medicaid now, this option will be most attractive to the states that already offer state-funded coverage to adults with incomes below 133 percent of poverty. These states can save money by taking up the new option and drawing down federal dollars for coverage they are already providing. They can use the money saved to improve or expand coverage and to ensure the program's survival.

To do:

- If your state offers state-funded coverage to any adults with incomes below 133 percent of poverty, explore what it would take to bring that coverage to Medicaid standards.
- Talk to your state Medicaid agency and any likely supporters in your state legislature to determine whether this idea holds promise in your state.

Changes to Community Benefit Requirements for Nonprofit Hospitals

(Section 9007, as amended by Section 10903 of the Patient Protection and Affordable Care Act; Amends Section 501(r)(5) of the Internal Revenue Code of 1986)

Nonprofit hospitals must conduct a community health needs assessment to determine their charity care policies. They must have written guidelines describing their financial assistance policies that explain how to apply and who is eligible. When a person who is eligible for financial assistance receives emergency or medically necessary services, the hospital must limit charges for that care to the lowest amount charged to an insured person.

To do:

- Find out how your local hospitals are conducting needs assessments and provide input.
- Collect and publicize hospitals' financial assistance policies.

Some other reforms to watch that go into effect later this year:

- **Rescissions** (Section 1001 of the Patient Protection and Affordable Care Act, Section 2301 of the Health Care and Education Reconciliation Act of 2010; Creates Section 2712 of the Public Health Services Act): The federal health reform law protects against unfair rescissions of health plans, which typically occur only after an enrollee submits expensive claims for care. The law states that rescissions may only occur in cases of fraud or intentional misrepresentation and that insurers must provide advance notice to policyholders if they intend to rescind their plans. Your state can enact a clear appeals process for consumers to use if they get such a notice and disagree with the rescission.
- **Internal and External Appeal Rights** (Section 1001, as amended by section 10101, of the Patient Protection and Affordable Care Act; Creates Section 2719 of the Public Health Services Act): Under health reform, health plan enrollees have a right to both internal and external appeals of claim and coverage denials. At a minimum, the external appeals process must comply with the standards in the National Association of Insurance Commissioners's (NAIC) model law for external appeals. It also must provide culturally and linguistically appropriate notice of appeals, and must provide enrollees making appeals with the opportunity to present testimony and evidence to support their case. If your state does not currently have an external appeals process that meets these standards, you can work to improve it.
- **Web Portal for Identifying Coverage Options** (Section 1103, as amended by section 10102, of the Patient Protection and Affordable Care Act): Starting in July 2010, consumers in all states will be able to identify their options for insurance coverage on a new Web site developed by HHS. The Web site will showcase options including private insurance, Medicaid, CHIP, and high-risk pools. In addition, it will provide information on the small business tax credits and reinsurance for retiree health coverage. Watch for opportunities to provide input to HHS on the new Web portal so that it will best serve consumers in your state.

The Department of Health and Human Services, together with other federal agencies, will be promulgating regulations and guidance on a number of reforms this year. Watch for opportunities to comment on the rules for:

- Allowing young adults to stay on their parents' insurance plans until age 26;
- Restrictions on annual limits on benefits;
- Prohibition of pre-existing condition exclusions for children;
- Protections against higher cost-sharing for out-of-network emergency care;
- Access to pediatricians and women's health providers;
- Minimum loss ratio requirements;
- Transparency in health insurance data;
- Closing the Medicare Part D doughnut hole; and
- Changes to Medicare Part D rules designed to reduce the number of low-income beneficiaries that are forced to change plans each year.

This publication is available online at
www.familiesusa.org/health-reform-central/implementing-the-new-law/.

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