SUBJECT: Qualified health plan designations for health insurance identification cards

COMMITTEE: Insurance — favorable, without amendment

VOTE: 8 ayes — Frullo, Muñoz, G. Bonnen, Guerra, Meyer, Paul, Sheets, Workman

0 nays

1 absent — Vo

WITNESSES: For — Sara Austin, Texas Medical Association; (*Registered, but did not testify*: Tom Banning, Texas Academy of Family Physicians; Joel Ballew, Texas Health Resources; Charles Bailey, Texas Hospital Association; Heather Aguirre, Texas Osteopathic Medical Association; Bonnie Bruce, Texas Society of Anesthesiologists)

Against — Stacey Pogue, Center for Public Policy Priorities; (*Registered, but did not testify*: Laura Guerra-Cardus, Children's Defense Fund - Texas; Tanya Lavelle, Easter Seals Central Texas; John Pitts, Legacy Community Health Services)

On — Doug Danzeiser, Texas Department of Insurance

BACKGROUND: The federal Affordable Care Act (ACA) allows individuals to receive a premium subsidy to apply to the cost of a qualified health plan if their household income is between 100 percent and 400 percent of the federal poverty line for their family size. For 2013, a person would be eligible for a premium subsidy if their household income was between $15,510 and $62,040 for a family of two.

A qualified health plan under the ACA is a health insurance plan that provides federally required essential health benefits, that follows federally established limits on cost-sharing (such as deductibles, copayments, and out-of-pocket maximum amounts), and that was certified by a health insurance marketplace. Qualified health plans are offered in Texas by

many insurance companies, such as Aetna, Blue Cross and Blue Shield, Cigna, Humana, and United.

DIGEST:

HB 1514 would require an identification card or other similar document issued by a qualified health plan to an enrollee to, in addition to any requirement under other law, display:

- the acronym "QHP" on the card or document in a location of the issuer's choice; or
- the acronym "QHP-S" if the enrollee received advance payment of a premium tax credit under the Affordable Care Act (ACA).

The bill would direct the commissioner of the Texas Department of Insurance to monitor federal law governing definitions of terms in HB 1514 related to the ACA and to determine if it was in the best interest of the state to adopt an amended definition of the terms in the bill. The commissioner would adopt by rule changes to these definitions if he or she determined it was in the best interest of the state. The bill would specify how the commissioner would make such a determination.

The bill also would direct the commissioner to prepare a report of a determination made regarding definitions of ACA-related terms in the bill and to file the report with the presiding officer of each house of the Legislature within 30 days of making such a determination. The commissioner could adopt rules as necessary to administer and enforce the provisions of HB 1514.

The bill would take effect September 1, 2015.

SUPPORTERS SAY:

HB 1514 would provide a consistent, easily identifiable way for providers to distinguish which patients were covered by a qualified health plan (QHP) or were receiving a premium subsidy under the Affordable Care Act. While some insurers include this information on a patient's identification card, they are not currently required to do so. Requiring QHPs to be designated on a patient's insurance identification card would streamline the administrative burden for providers, who otherwise would

have to contact an insurance company directly to find out if a patient was enrolled in a QHP and was receiving a subsidy, as opposed to simply looking at the patient's identification card at the time of check-in.

HB 1514 also would allow providers to identify patients enrolled in a QHP who might need more information about the importance of paying premiums on time to ensure that their insurance would pay for a health service. By allowing providers to identify these patients, HB 1514 would address a gap in federal law that could cause providers to be liable for the cost of services provided to a patient who failed to pay their QHP insurance premium during a 90-day grace period. If a patient failed to pay their past-due premiums at the end of the 90-day grace period, the patient's plan could be retroactively canceled, and the provider would have to pay back the insurer for any paid claims. The provider could then pass those costs on to the patient, creating a financial burden for both providers and patients.

HB 1514 would not open the door to discrimination against patients. Insurance cards already include other information about the type of plan held by a patient, such as whether the plan is an HMO or a PPO and the name of the plan or insurance carrier. This type of information is helpful and necessary for a provider to determine the plan's benefits, whether a referral was needed for service, network restrictions, and other information necessary for the patient's visit.

Including the "QHP" or "QHP-S" designations would allow a provider to educate the patient about the importance of paying premiums, especially if the patient was not familiar with using health insurance, but would not lead to providers rejecting patients simply because they had this designation on their card.

The solution proposed in HB 1514 would be more effective than requiring insurance companies to notify providers that a patient enrolled in a QHP had not paid their insurance premiums because it would lower the administrative burden for providers. HB 1514 would allow providers to quickly check a patient's insurance card for QHP information rather than

requiring them to call an insurance carrier to verify the type of plan.

OPPONENTS SAY:

HB 1514 would open the door to discrimination against patients who were insured under a QHP. Requiring health insurance identification cards to show whether a person had received a premium subsidy under the Affordable Care Act would amount to a "scarlet letter" and an invasion of a patient's privacy because a patient can receive a subsidy only if they are low income.

The concern with the premium payment grace period also applies only to a small number of patients who did not pay their premiums. Requiring all patients enrolled in a qualified health plan to have the "QHP" or "QHP-S" designation on their cards would not provide useful information to a health care provider because the grace period issue does not apply to patients who did not receive a subsidy and patients who received a premium subsidy for a certain plan have the exact same private health insurance as patients who did not.

HB 1514 would target only QHPs for liability issues, when these issues can exist with any health insurance plan. Providers risk being held liable for the cost of a provided service whenever a patient provides a new insurance card because providers cannot identify whether a patient's insurance plan is active simply from looking at their card. If a provider had concerns, they could call a QHP patient's insurance carrier to verify coverage as they would with any other health plan to find out if coverage for the patient was active or if the patient was in a payment grace period.

OTHER OPPONENTS SAY:

Providers have a valid concern that they may be held responsible for the cost of providing a service to a patient whose qualified health plan coverage was cancelled after the date of service. However, this issue should be addressed by requiring insurers to inform providers that a patient had not paid their premiums when providers call to verify a patient's coverage.