# 2010 Insurance Economic Summit: Navigating the Era of Reform

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## 2010 Insurance Economic Summit: Navigating the Era of Reform

# HEALTH CARE REFORM

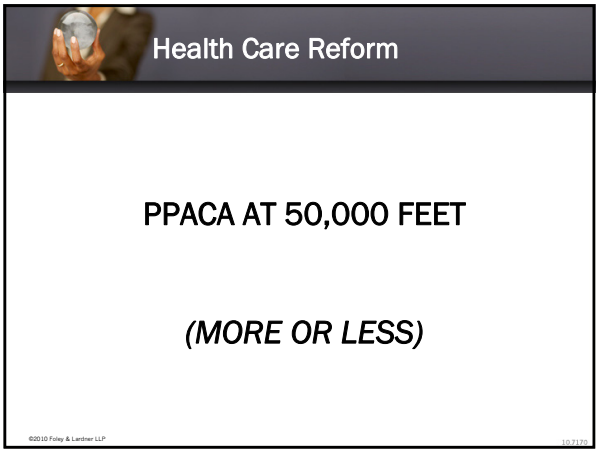
*IMPLICATIONS FOR THE INSURANCE INDUSTRY*

**Panelists:**

**Eileen Mallow**, Assistant Deputy Commissioner, Wisconsin Office of the Commissioner of Insurance
**Michael T. McRaith**, Director, Illinois Department of Insurance
**Randy Wichinski**, Managing Director of Insurance Tax Services, LECG

**Moderator:**
**Thomas R. Hrdlick**, Partner, Foley & Lardner LLP



## Health Care Reform

PPACA AT 50,000 FEET

*(MORE OR LESS)*

## Health Care Reform

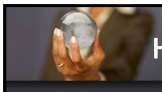
- ***What Didn't Happen***: PPACA is not a "single payor" nationalization of the US health insurance industry, but…
- ***What Did Happen***: PPACA is a huge expansion of the market for, and regulation of, the US health insurance industry through…
  - combination of mandates, penalties and incentives for individuals and/or employers to purchase health insurance and thereby greatly expand the pool of lives, *plus*…
  - broad market reforms that expand the minimum essential benefits provided to every insured while restricting how an insurer underwrites and charges for those risks, *plus*…
  - an expansion of federal programs and financial assistance to those who otherwise cannot afford to purchase health insurance coverage




## Health Care Reform

- *- Expanding The Pool*
  - Imposes federal mandate on ***ALL*** US citizens and legal residents to have qualifying health insurance and imposes penalties for non-compliance (only limited exemptions)
  - Provides premium credits and cost-sharing subsidies to eligible low income individuals and families to facilitate the purchase of qualifying coverage
  - Penalizes employers with 50 or more employees who have at least one FTE receiving premium tax credits for insurance purchased through an Exchange



## Health Care Reform

- *Expanding The Pool (cont'd)*
  - Provides tax credits to lower-wage, "smaller" small employers (25 employees or less) that purchase qualifying coverage for their employees
  - Creates state-based, government-administered insurance exchanges through which citizens and legal immigrants and small businesses may purchase varying levels of qualifying coverage from participating insurers
  - Expands Medicaid to make it available for all individuals under age 65 with incomes up to 133% of the federal poverty level

## Health Care Reform

- *Broad Market Reforms*
  - Creates "essential benefits package" as the minimum "qualifying" coverage that can be offered and purchased to fulfill the individual mandate
  - Prohibits lifetime or annual limits on the package of "essential health benefits"
  - Mandates guaranteed issuance and renewal of coverage
  - Prohibits pre-existing condition exclusions
  - Prohibits rescissions except in cases of fraud or intentional misrepresentation




## Health Care Reform

- *Broad Market Reforms (cont'd)*
  - Prohibits cost-sharing obligations for "preventive" services except in the case of "grandfathered" plans
  - Mandates dependent coverage until age 26
  - Imposes adjusted community rating restrictions
    - age (limit of 3:1 ratio), geography, tobacco use (limit of 1.5:1 ratio), and family size are only rating factors for individual and small group plans
  - Requires insurers to refund premiums charged in excess of a minimum 85% loss ratio for large group plans and 80% for small group and individual plans
  - Requires processes for reviewing increases in health plan premiums and requiring plans to justify any such increases or risk exclusion from the state exchanges




## Health Care Reform

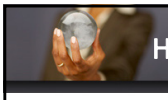
# EXPANDING THE POOL

*Once It's Built, Will They Come?*

## Health Care Reform – The Pool

- *Individual Mandate*: All US citizens/legal residents must have qualifying health coverage or pay a monthly "penalty" that is self-reported on their federal income tax return.
  - By 2016, penalty is *lesser* of (i) average nationwide monthly premium, *or* (ii) greater of flat penalty of $695 per adult ($347.50 per child) capped at $2,085 per family, or 2.5% of household income (annually indexed after 2016).
  - No criminal penalties may be charged for non-compliance, nor may levies or liens be placed on specific property for non-payment.
  - Exemptions for eligible low-income persons, American Indians, financial hardship, religious objections.

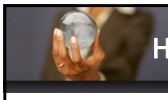


## Health Care Reform – The Pool

- *Employer Penalties*: Employers with 50 or more FTE's are subject to potential penalties if they do not offer affordable minimum essential health benefits.
  - Employer not offering FTE's group health coverage with minimum essential health benefits, with a single FTE that receives premium credits for purchase on an Exchange, must pay penalty up to $2,000/year/per FTE (first 30 FTE's excluded).
  - Employer offering minimum essential health benefits at greater cost than Exchange, such that a single FTE receives premium credits for purchase on an Exchange, must pay penalty up to $3,000/year/per FTE receiving premium credit.



## Health Care Reform – The Pool

QUESTIONS FOR
THE PANEL

## Health Care Reform – The Pool

- *What about those uninsured who already can afford coverage?*
  - Anywhere from 27% to 43% of uninsured can afford health insurance but do not purchase it. If penalty is (i) smaller than the cost of qualifying coverage, (ii) self-reported, and (iii) collected mainly through refund offsets if/when non-compliance is discovered, why will such individuals now purchase coverage?
- *What about higher income families who currently buy health insurance?*
  - Assume family of six making $250K a year; currently self-insured through HSA plan for $12K a year; annual medical spend of $5K - $6K. Or assume same family is fully-insured at cost of $15K - $20K a year. In 2016, family would pay penalty of $6,250. If qualifying coverage costs between $15K - $20K a year, leaves $9K - $14K a year to manage against medical spend. Why not make that play?




## Health Care Reform – The Pool

- *Won't employers just drop their health insurance plans and leave their employees to the Exchanges?*
  - Why would an employer maintain a health insurance plan for its employees at a cost of five-figures per employee when it can drop the plan and pay a penalty of only $2,000 per FTE (excluding the first 30 FTE's)?
  - Particularly employers with substantial numbers of employees who would be eligible for the fairly generous federal subsidies to purchase insurance through an Exchange?
- *Alternatively, will there be a significant increase in employers switching from fully-insured to self-insured plans?*
  - Particularly if, as many expect, the cost of coverage continues to rise?




## Health Care Reform

### STATE EXCHANGES

*How Will They Look And Work?*

## Health Care Reform - Exchanges

- State-based portals administered by a gov't agency or non-profit organization through which individuals and small businesses (up to 100 employees) can purchase qualifying coverage (states can expand to include large employers in 2017).
- Only US citizens and legal immigrants can participate in Exchanges.
- Exchanges will provide 4 benefit tiers of coverage for essential health benefits (Bronze – 60%, Silver – 70%, Gold – 80%, Platinum – 90%). HSA caps on out-of-pocket payments. Plus a Catastrophic plan for 30-and-under's or those exempt from individual mandate. Participating plans must offer at least one Silver and one Gold plan.
- Cost-sharing subsidies will effectively reduce the out-of-pocket limits for those with incomes up to 400% of FPL.
- NAIC Exchanges (B) Subgroup exposed draft model regulation for state exchanges on 9/27/10 – comment period expired 10/6/10.




## Health Care Reform - Exchanges

- States may create separate Exchanges and separate pools for individual and small group risks, or they may combine these into a single Exchange for administrative purposes and/or for pooling purposes as well.
- States may form Regional Exchanges and/or allow more than one Exchange to operate in a state.
- No public plan option in Exchanges, but federal OPM must contract with insurers to offer at least two multi-state plans in each Exchange, one of which must be offered by a non-profit.
- States can require benefits in addition to essential health benefits, but only if state defrays the additional costs of premium and cost-sharing assistance to enrollees.




## Health Care Reform - Exchanges

- Duties of Exchanges under PPACA and Model Reg –
  - Procedures for certification/decertification of plans
  - Operate customer service hotline
  - Maintain internet portal for plan information
  - Create standardized format for presenting benefit options
  - Redirect/enroll eligible individuals into Medicaid/CHIP
  - Establish on-line calculator enabling customers to determine actual cost of coverage net of credits/subsidies
  - Certify financial hardship or other mandate exemptions
  - Inform HHS of certified mandate exemptions and of enrollees triggering employer penalties
  - Select "Navigators" to educate and assist enrollees in choosing between available options under the Exchanges

## Health Care Reform - Exchanges

QUESTIONS FOR
THE PANEL




## Health Care Reform - Exchanges

- *Director McRaith, can you first describe the current status of the draft Model Reg and what remaining work is ahead for the Exchanges (B) Subgroup?*
- *If an individual state chooses not to create an Exchange, PPACA requires the Feds to step in and create one. What are the implications if that happens?*
- *What implications for the Exchange, for the Industry, and for Consumers are posed by the form of an Exchange (gov't agency vs quasi-gov't vs non-profit)?*
- *Does a state have the ability under PPACA (or otherwise) to limit its health insurance market for individual and small group products to its Exchange?*
- *What are the implications for the Exchange, for the Industry, and for Consumers of creating 1 vs 2 separate exchanges, and/or single vs separate pools, for the individual and small group segments in a given state?*
- *Is it expected that the Exchanges will materially reduce the cost of health care and/or how might they contribute to that objective?*




## Health Care Reform - Exchanges

- *Will plan restrictions be different within the Exchange from those applied outside the Exchange?*
- *What role, if any, will a state-based Exchange have in the selection of multi-state plans available through the Exchange?*
- *What role, if any, is there for the insurance producer/agent in the Exchange mechanism?*
- *We've talked about adverse selection in the market generally, but can we also expect adverse selection against higher benefit plans within the Exchanges, and what risk adjustment mechanisms will exist to address that?*
- *Do you expect your state will expand eligibility to include large employers in 2017 and/or what will factor into that particular decision?*
- *What advice would you give to an insurer today that wants to participate in an Exchange in 2014?*

## Health Care Reform

# MEDICAL LOSS RATIOS

*Where Are We Now?*




## Health Care Reform - MLR

- PPACA requires insurers to refund premiums charged in excess of a minimum 85% loss ratio for large group plans and 80% for small group and individual plans
- Definitions for, and manner of calculating, MLR and corresponding rebates is delegated to NAIC, subject to certification by HHS
- NAIC Blanks form setting forth definitions for MLR data collection purposes adopted in final by NAIC 8/17/10 in Seattle
- NAIC Model Reg setting forth rebate calculation for years 2011-2013 adopted in final by NAIC 10/21/10 in Orlando
- Now before HHS for certification, and Secretary Sebelius stated agency would like to move on it *this month*.




## Health Care Reform - MLR

- Notable Aspects of NAIC MLR Work Product
  - MLR is aggregated/reported at state level, by reporting entity, by market segment (state can allow individual/small group aggregation).
  - Agent commissions are *included* in the premium denominator.
  - Premium denominator calculated *gross* of reinsurance (except assumption reinsurance and grandfathered 100% indemnity reinsurance).
  - Federal and state income and premium taxes *excluded* from the premium denominator (but taxes on investment income *included*).
  - Quality improvement expenses ("QI") are *included* in the claims numerator but strictly defined (i.e., must be capable of objective measurement and producing verifiable results)
  - Costs for fraud detection, ICD-10 conversion, utilization review, provider contracting, network management, and accreditation fees are not QI and thus are *excluded* from the claims numerator.

## Health Care Reform - MLR

- Notable Aspects of NAIC MLR Proposals (cont'd)
  - Credibility adjustments available from 2011-2013 for "partially-credible" plans; no rebates required for most non-credible plans and no credibility adjustments allowed for fully-credible plans.
  - MLR rules *not* applicable to self-insured plans or medical stop loss
  - MLR rules *not* applicable to "excepted benefits" business (e.g., dental or vision only plans, specific illness coverage, Med-Supp, hospital indemnity or other fixed indemnity, etc.)
  - MLR rules may be applicable to "mini-med" plans (some many mini-med plans received waivers from transitional restrictions on annual benefit caps)
  - 2011 will be first plan year for which rebates are calculated, to be paid in 2012.




## Health Care Reform - MLR

QUESTIONS FOR
THE PANEL




## Health Care Reform - MLR

- *As a practical matter, what will the process be for insurers to claim and support an expense as QI?*
- *Will MLR rules drive structural changes to how agents are used/compensated? What are the potential models?*
- *Will MLR rules shift insurers' spend from fraud detection, utilization review, cost containment, etc., to case management, discharge planning, safety programs, and wellness programs?*
- *Will MLR rules shift risk from insurers to providers through increased use of managed care plans and capitation arrangements?*
- *What will the certification process at HHS entail and is it likely to lead to changes to the MLR rules?*
- *Do you expect the MLR rules will reduce the cost of health care and how will they contribute towards that objective?*

## Health Care Reform

### ROLE OF THE STATES

*Uniformity or Divergence or Both?*




## Health Care Reform – State Role

- PPACA does not preclude the States from imposing additional requirements on health plans
  - *"No Interference With State Regulatory Authority—Nothing in this title shall be construed to preempt any State law that does not prevent the application of the provisions of this title"*
- *E.g.,* states that allow experience rating will have to switch to the adjusted community rating required by PPACA, but states with pure community rating can maintain the same




## Health Care Reform – State Role

### QUESTIONS FOR THE PANEL

## Health Care Reform – State Role

- *Do you anticipate many state requests for waivers from various PPACA requirements? Will the election impact this?*
- *Can individual states diverge from the HHS-certified MLR rules?*
- *What are the most common areas where states will remain or become more restrictive than PPACA?*
- *Will any states roll-back more restrictive components of their legislation to be consistent with PPACA?*
- *Will any states take independent steps vis-à-vis providers, pharmaceuticals, or tort reform to try to reduce the cost of health care?*
- *How uniformly will states determine exemptions from individual mandates and report to HHS those enrollees triggering employer penalties?*
- *Are any states likely to create interstate compacts for sale of insurance across state lines come 2016?*




## Health Care Reform

### THE CRYSTAL BALL

*What Lies Ahead (Maybe)?*




## Health Care Reform – Crystal Ball

- *What is your response to those who say PPACA is a pit stop on the way to single payor?*
- *What will PPACA ultimately mean for the agent force and distribution model in this country?*
- *What will PPACA mean for the relationship between providers and insurers in this country?*
- *In 10 years, the health insurance industry in the US will be _____.”*
- *“In 10 years, health care services in the US will be _____.”*

## Health Care Reform – Questions

QUESTIONS FROM
THE AUDIENCE