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Independent Insurance Agents of South Florida

New Health Care Law Will Change Our Lives

Immediate Impacts of Health Care Reform Legislation for the Insurance Industry

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On Tuesday, March 30, 2010, President Barack Obama signed the last piece of legislation instituting sweeping changes to the nation's health care system. The reconciliation bill of the Patient Protection and Affordable Care Act (PPACA), which the U.S. House of Representatives passed by a vote of 220 to 207, was slightly changed by the Senate from a version that passed the House late last month, necessitating a second vote by the House.

With PPACA now in place, the insurance industry faces a slew of new regulations, restrictions, and fundamental changes. Although it is too early in the process to know exactly how health care reform will reshape the industry, especially since a majority of the changes will not take place until 2014, it seems clear that the regulatory framework and rules for the insurance industry that will eventually emerge will look significantly different than the one that exists today.

Pre-existing Conditions Coverage

National High-Risk Insurance Pool

PPACA essentially guarantees that those with pre-existing conditions will have the ability to purchase insurance coverage. Within 90 days of enactment, Americans who have pre-existing conditions and have not been covered by insurance for at least six-months may sign up for a new high-risk insurance pool. This high-risk pool will continue until 2014, at which time all insurance carriers will be prohibited from excluding an individual based on a pre-existing condition.

In a recent letter to state governors and insurance commissioners, U.S. Department of Health and Human Services (HHS) Secretary Kathleen Sebelius clarified that coverage offered under the high-risk pool must have an actuarial value of at least 65 percent of total allowed costs, an out-of-pocket limit no greater than $5,950 for an individual and $11,900 for a family, and no pre-existing condition exclusions. Further, premiums under the high-risk pool must not exceed 100 percent of the standard non-group rate and not have an age rating greater than four to one.

Finally, Ms. Sebelius' letter outlined the different ways that states could participate in the high-risk pool. Namely, states can:

– Operate a new high-risk pool alongside a current state high-risk pool

– Establish a new high-risk pool (in a state that does not currently have a high-risk pool)

– Build upon other existing coverage programs designed to cover high-risk individuals

– Contract with a current HIPAA carrier of last resort or other carrier to provide subsidized coverage for the eligible population

– Do nothing, in which case HHS would carry out a coverage program in the state

Of particular concern to the insurance industry are the potential sanctions that can be levied against carriers found to have discouraged individuals from

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remaining enrolled in their health coverage prior to that individual enrolling in the national high-risk pool. Insurers that are found to have "dumped" enrollees will be held responsible for reimbursing the high-risk pool for the medical costs of those individuals. An insurer will be found to have dumped an enrollee if they provide financial incentive to the enrollee to disenroll from the policy, or in certain cases where the enrollee pays premiums higher than the premiums for the national high-risk pool.

In addition to the preceding, there are concerns that the $5 billion dedicated to the high-risk pool by PPACA may not be sufficient to last until 2014. States such as Florida have had to shutdown enrollment in similar high-risk pools due to insufficient funds to pay out claims.

Pre-Existing Condition Coverage for Children

Within six months of enactment, insurers will be prohibited from denying coverage to children under 19 years of age, based on pre-existing conditions. Although there was a minor controversy over whether, under the letter of the law, health insurers could deny new coverage to children based on pre-existing conditions, it now appears that the industry will abide by the intent of the legislation and provide coverage to both enrolled and new children. Regardless, it is likely that HHS will clarify this issue.

Ban on Rescissions, Restrictions on Lifetime and Annual Limits

Within six months of enactment, PPACA will eliminate the ability of insurers to rescind existing policies, except in cases of fraud or intentional misrepresentation of a material fact. Any cancellation also must be with prior written notice. Moreover, insurers will be banned from setting lifetime caps on benefits and restricted in their ability to set annual limits for coverage until 2014, at which point annual limits also will be eliminated.

Until 2014, annual limits may only be imposed on essential benefits, as determined by the U.S. Department of Health and Human Services. Essential benefits are defined in PPACA to include, at a minimum:

– Ambulatory patient services

– Emergency services

– Hospitalization

– Maternity and newborn care

– Mental health and substance-use disorder services, including behavioral health treatment

– Prescription drugs

– Rehabilitative and habilitative services and devices

– Laboratory services

– Preventive and wellness services and chronic disease management

– Pediatric services, including oral and vision care

PPACA allows insurance providers to place annual caps on these benefits until 2014.

Medical Loss Ratio Mandate

Starting no later than January 1, 2011, health insurance issuers in the large group market (more than 100 employees) must have a medical loss ratio of at least 85 percent, while those insurers in the small group (fewer than 100 employees) or individual market must have a ratio of 80 percent. Those insurers that do not meet the required ratio must rebate the "extra" revenue, on a pro rata basis, to their enrollees. Although rebates begin in 2011, the medical loss ratio will be determined based on data collected for the 2010 plan year. Because the ratios will be calculated based on data during the current plan year, health insurance issuers will want to begin carefully monitoring their required medical loss ratios immediately. According to a recent Senate Commerce Committee analysis, the current average for-profit medical loss ratio was 84 percent in policies offered to large employers, 80 percent in policies offered to small businesses, and 74 percent offered to individuals.

Specifically, under PPACA, group and individual insurers must submit a report to the Secretary of Health and Human Services providing information relating to the ratio of the incurred loss or claims and loss adjustment expenses to earned premiums. For purposes of PPACA, the medical loss ratio is calculated as the amount spent on reimbursement for clinical services and "activities that improve health care quality" to the total amount of premium revenue (excluding state and federal taxes, licensing or regulatory fees, and after accounting for payments or receipts related to PPACA's reinsurance and risk adjustment programs). Finally, beginning in 2014, the medical loss ratio for that plan year will be calculated based on the average of the ratio for the previous three years.

We foresee significant debate over whether a particular expense constitutes an "activity that improves health care quality" or is simply an administrative cost. In addition, experts also have voiced concern over a provision in PPACA that would al-

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low each state to set stricter ratios. Currently, no state has indicated that it will mandate higher ratios than those contained in PPACA.

Cumulative Effect of the Changes on the Industry

The changes outlined above, taken together, could significantly increase the level of high-risk patients required to be covered by insurance, while restricting the industry's ability to reduce those risks and to determine how to use the premiums received. This situation will likely continue until at least 2014, at which point the individual mandate goes into effect, which could theoretically result in more healthy individuals in the pool, thereby lowering the risk. The question is whether the industry will be able to collect sufficient premiums in order to operate at a profit until 2014, or if other solutions can be developed and implemented to deal with these expected concerns.

Foley's Continuing Coverage and Analysis of Health Care Reform

In our next alert, we take an in-depth look at the health care exchanges created by PPACA and why the insurance industry needs to start acting now to ensure that they are included in the exchanges when they open in 2014.

The content of this article is intended to provide a general guide to the subject matter. Specialist advice should be sought about your specific circumstances.

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