



Health Reform Effects on Payers

The 2010 Reconciliation Act amends the healthcare reform legislation included in the Patient Protection and Affordable Care Act. Health insurance companies will feel the effects of these two major legislative changes more than any other industry. But they may also benefit by having more insured lives through coverage expansions in the insurance exchanges.

Payers will have to react quickly to ensure they are compliant with the following new regulations that will become effective within the first six months after enactment:

Ban on Benefit Limits: Payers can no longer put a lifetime or annual dollar limit on essential benefits.

Ban on Pre-existing Condition Exclusions: Payers will be prevented from denying coverage based on underlying health status or restrict eligibility if a family member has or had any neither illness, nor will coverage be denied or watered down based on medical history.

Mandatory Coverage of Preventative Services: Payers must pay for immunizations as well as infant, child and adolescent preventative services without any cost-sharing/co-payment required from members. They must cover women's preventative care and screenings and can no longer require prior authorization before emergency services are covered. Payers cannot rescind enrollee coverage because of a member's health status nor bar them from renewing plans.

Rating Restrictions: Payers in the individual and small group markets may only vary premiums based on family structure, geography, tobacco use and the actuarial value of the benefit. They are also limited on differences in premiums based on age.

Limits on Executive Pay: Payer will be subject to limits on executive compensation. They will only be able to deduct \$500,000 of compensation. This applies to companies that derive at least 25% for their gross income from plans that meet the coverage requirements established under the bill.

Medical Loss Ratios (MLRs): In 2011, payers will have to report how they spend the premium dollars they collect from their customers. If they spend too much (MLR of 80% for small insurance companies and 85% for large) on administrative costs and profits, they will have to give some of that money back to their customers.

Extension of Dependent Coverage: Payers must provide dependent coverage for children up to age 26.

Premium Review Process: The Secretary of the U.S. Department of Health and Human Services will institute a premium review process.

Navigation Assistance: Payers are required to develop a standard format to present coverage options to consumers. The government will post a website to help identify coverage options as well as prices.

Temporary High-Risk Pool: The government will establish a high-risk insurance pool for individuals who are uninsured or have pre-existing conditions. This is a stop-gap measure until exchanges open in 2014.

Primary Care/Emergency Services: Coverage of primary care and emergency services will be required.

Insurance Exchanges

By 2014, the Act requires states to establish American Health Benefit Exchanges that assist with the purchase of health plans. The uninsured and self-employed would be able to purchase insurance through state-based exchanges with subsidies available to individuals and families with income between the 133 percent and 400 percent of poverty level. Separate exchanges would be created for small businesses to purchase coverage in 2014. This is expected to increase enrollment by 21 million.

Coverage Mandates

Individual and employer mandates will also introduce new consumers to the insurance market. In 2014, individuals must maintain health insurance for at least 9 months or face a penalty. There are some exceptions for low-income people. Employers with more than 50 full-time employees will face penalties if they do not provide health insurance that covers essential benefits and is affordable to the lowest paid employees.

Industry Fees & Taxes

Payers will face new fees, based on their market share, beginning in 2014. The fees won't apply to companies with net premiums written of \$25 million or less and provides a limited exemption for non-profit health insurance companies with overall MLRs of at least 92%. In 2018, payers will also be assessed a 40% excise tax on high cost self-insured and group market plans. These are defined as plans above the threshold of \$10,200 for individual coverage and \$27,500 for family coverage. The tax would apply to the amount of the premium in excess of the threshold.

Medicare Advantage Cuts

In 2011, payments to Medicare Advantage plans are frozen and cuts begin in 2012. This will be a four year phase-in based on average bids from those plans in each market. Overall, the Act cuts government payments to Medicare Advantage by \$132 billion over 10 years. To offset the cuts, performance bonuses will be created for care coordination, care management and quality ratings.

Administrative Simplification

Between 2013 and 2016 the HHS will adopt uniform standards and operating rules for electronic transactions between providers and payers. These will include adopting a single set of operating rules for claims status and eligibility verification, electronic funds transfer for healthcare payment and remittance, health claims, enrollment, premium payments, referral certification and authorization. Payers that are not able to document compliance with these new standards and rules will face penalties.

Other Provisions

Other provisions of the Act include temporary reinsurance for retirees, tax credits for small employers, filling Medicare Part D "doughnut hole", establishment of a national/voluntary insurance program for purchasing community living assistance services, HHS review for new policies, and the disqualification of over-the-counter drugs as medical expenses.

The number of provisions included in this health reform bill are extensive and complex. Payers will see an increase in covered lives and many of the newly insured will be younger individuals with fewer health issues who may not have previously elected health insurance due to cost. Insurance companies will need to scale their IT capabilities to prepare for a larger volume of members and to maintain trust with their current customers. Progressive payer organizations will leverage these compliance changes to reassess the way they do business, upgrade their IT infrastructure and drive operational changes that create competitive advantage and achieve greater ROIs.