HEALTH REFORM BRIEF

The Impact of Health Reform on Health Insurance Coverage in Kansas

KANSAS HEALTH INSTITUTE

January 2011
KHI/11-HR1

INTRODUCTION

The Affordable Care Act (ACA), the name of the new federal health reform law, stands to produce big changes in the health insurance industry and in the way that consumers obtain coverage. Provisions ranging from coverage requirements for individuals and businesses to new regulations aimed at protecting consumers and expanding their choices — while still controversial — are designed to make health insurance accessible to more Americans and Kansans. Under the new law, nearly two-thirds of all Kansans could meet income eligibility guidelines to qualify for either Medicaid or for federal subsidies to be used to purchase private health insurance coverage in newly created health insurance exchanges. Of the almost 350,000 Kansans who are currently uninsured, nearly 90 percent could meet income guidelines to qualify for subsidies or Medicaid. Not all of the anticipated changes brought about by the ACA are expected to be positive, however. Many industry experts have concerns about the legislation's burden on insurers and about its potential to raise overall medical spending. This brief explores how the ACA may affect the accessibility and affordability of health insurance coverage in Kansas.

WHAT IS IN THE LEGISLATION?

The ACA uses a multipronged approach that will require individuals, employers, private insurers and states to participate in restructuring the health insurance system. The key access and affordability pieces are:

- New insurance regulations such as the guaranteed coverage of pre-existing conditions;
- The creation of health insurance exchanges;
- Individual insurance mandate and employer coverage requirements; and
- Expansion of Medicaid.

Kansas policymakers will play an important role in the design and implementation of these provisions.

KANSAS IMPACT

The ACA dictates new rules for insurers. Some have already taken effect. Others will begin in 2014, the year when many of the most important reforms are scheduled to be implemented.

The changes that took effect this fall require insurance companies to:

- Allow young adults to remain on their parents' policies until they're 26 — three years later than the previous dependent coverage limit of most insurance companies. Around 72,000 Kansans between ages 19 and 25 don't have health insurance coverage for a variety of reasons, including because they choose not to purchase it. This provision for extended dependent coverage may help to insure a significant number of these young adults.

More information

This is the first in a series of briefs about the impact of health reform in Kansas. Contributors to this publication include Suzanne Cleveland, J.D., Jim McLean, Anne Berry, Sharon Barfield, M.S.W., LSCSW, and Cathy McNorton.

Online readers can select the words underlined in blue to be taken to a document with definitions and more in-depth information. This document and the other briefs in the series are available online at www.khi.org.

Funding for this project was provided by the United Methodist Health Ministry Fund, a philanthropy based in Hutchinson, and the Kansas Health Foundation in Wichita, a philanthropic organization whose mission is to improve the health of all Kansans.

- Cover all children regardless of whether they have a pre-existing medical condition. Many insurance companies — including the state's two largest insurers, Blue Cross Blue Shield of Kansas and Coventry Health Care of Kansas — stopped issuing "child only" policies rather than comply with the new rule. This same rule will apply to coverage for adults with pre-existing medical conditions in 2014.
- Stop cancelling policies when people make mistakes on their applications. The practice, known as rescission, received a lot of attention during the congressional debate on reform, though it was not widely used by Kansas companies. The new rules say that companies can only rescind policies if policyholders intentionally misrepresented important facts on their health insurance applications.

Other ACA changes that have already occurred include the creation of a federal high-risk pool that provides insurance coverage to Kansans with pre-existing medical conditions who have been without insurance for more than six months. The federal high-risk pool limits the annual out-of-pocket cost-sharing a consumer could potentially incur. These limits are set at $5,950 for individuals and $11,900 for families, though the federal pool in Kansas offers only individual plans. A state high-risk pool has existed in Kansas since 1992 and continues to operate, now side-by-side, with the new federal pool. The state pool does not impose the same out-of-pocket cost-sharing limits. Initial uptake of the federal high-risk pool has been very low nationwide as well as in Kansas; as of early December, only 121 Kansans were enrolled in the federal pool. Less than 2,000 beneficiaries are currently enrolled in the state high-risk pool. The Department of Health and Human Services (HHS) is exploring ways to encourage greater utilization of these plans, such as by lowering premiums.

Future health insurance changes

In Kansas, many consumer protections already exist for consumers with small- and large-group insurance policies. However, consumers who purchase coverage directly from an insurer — including 137,000 Kansans between ages 19 and 64 — will likely benefit from two important rules set to take effect in 2014. One — known as guaranteed issue — will require insurance companies to offer coverage to anyone who applies regardless of health status or other factors that may predict usage of health services. Another rule will limit the rating factors that can be used when pricing policies to include only age, place of residence, family composition and tobacco use.

Insurers and employers who offer health benefits are concerned about the potential consequences of removing gatekeeping tools like rating factors and pre-existing condition exclusions. Not allowing insurers to deny or limit coverage to people with existing and potentially expensive health needs could threaten the financial viability of insurance companies if people wait until they become ill to purchase coverage. As more sick people enter the insurance pool, costs could go up, causing relatively healthy people to exit the market — which would cause costs to those remaining in the pool to go up even more. This phenomenon, known as adverse selection, is the reason that the ACA also calls for the implementation of an individual mandate to purchase coverage, which is discussed on page 3.

Expanded private insurance options

Beginning in 2014, consumers will have access to an entirely new way to purchase private health insurance. New marketplaces — called health insurance exchanges — will be established by the states to help individuals and businesses with 100 or fewer employees purchase coverage. Until 2016, states may choose to narrow the exchanges to include only businesses employing 50 and fewer employees; Kansas has indicated it will do this. Private insurance plans grouped into four coverage tiers will be sold through the exchanges. All of the exchange plans will be required to cover essential health benefits, to be determined by HHS. The mechanism through which individuals and businesses purchase the coverage will be designed with simplicity and standardization in mind, allowing for comparison shopping between plans. While a few states had implemented some type of health insurance exchange before the adoption of the ACA, this model will be a new method of purchasing insurance in Kansas. The Kansas Insurance Department (KID) is actively engaged in preparing for the exchanges and has applied for, and received, ACA grants related to planning and outreach. Critical decisions have yet to be made about the design of the new exchange model; for instance, whether Kansas will operate one exchange, multiple exchanges or a regional exchange in collaboration with other states.

In order to increase the affordability of the coverage offered through the exchanges, the ACA offsets the cost of premiums and out-of-pocket expenses for some individuals. These premium tax credits and cost-sharing subsidies will be tied to the second tier of coverage in the exchange known as the "Silver" plan, and will be available to consumers with incomes between 100 and 400 percent of Federal Poverty Level (FPL), currently $22,050 to $88,200 for a family of four. Over 50 percent of Kansans are in families with incomes between 100 and 400 percent of FPL. Even if income eligibility guidelines are met, credits and subsidies will only be available to those without access to affordable and adequate employer-sponsored coverage (as defined by the ACA). Participation in the exchanges, however, is open to any U.S. citizen or legal resident.

Medicaid expansion

Starting in 2014, Medicaid eligibility will rise to 133 percent of FPL (Figure 1). This will be a major change in Kansas, where Medicaid eligibility for adults is roughly 30 percent of FPL and is among the lowest in the country. A May 2010 report, prepared for the Kansas Health Policy Authority (KHPA), estimated that more than 87,000 additional Kansas residents may become eligible for Medicaid under the new rules and as many as 33,000 more, who are currently eligible but not enrolled, may choose to enroll in 2014. The federal government will initially pay 100 percent of the cost of covering these additional enrollees. The federal contribution will reduce over time, and in 2020 and beyond will cover 90 percent of the costs for the new enrollees. The states will pay the remaining 10 percent.

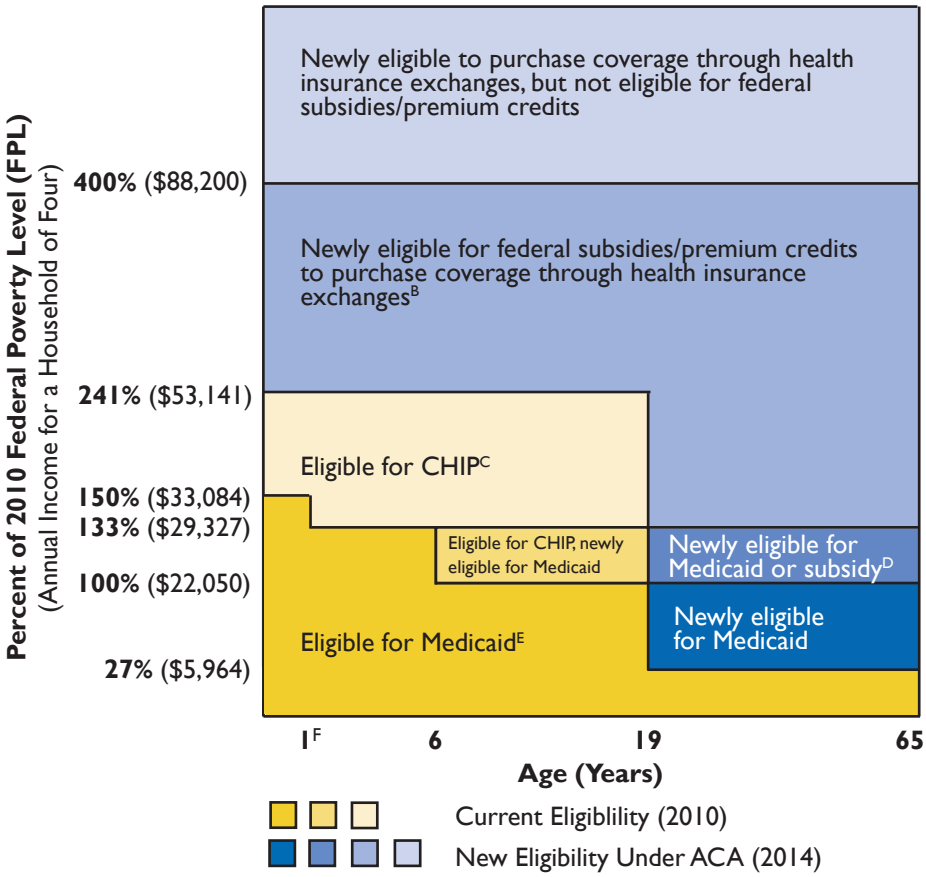
The ACA retains the Children's Health Insurance Program (CHIP), an insurance option for children who are not Medicaid-eligible, but are in families earning less than 241 percent of FPL. The ACA increases the portion of CHIP expenditures that the federal government pays by 23 percentage points. In Kansas, there are 39,000 children currently enrolled in CHIP.

Individual mandate

One of the most debated provisions of the ACA also becomes effective in 2014, the so-called individual mandate. The mandate will require virtually everyone to purchase health insurance or face financial penalties. Exemptions to the mandate can be granted for a handful of reasons, including religious objections and financial

ELIGIBILITY FOR INSURANCE COVERAGE UNDER HEALTH REFORM IN KANSAS

Figure 1. **Current Eligibility (2010) and New Eligibility Under ACA (2014)[A]**



A. This chart represents eligibility guidelines based on income, but does not represent eligibility for individuals that may qualify based on disability or other conditions/criteria.
B. Eligibility for subsidies is tied to the lack of affordable employer-sponsored coverage.
C. A monthly premium between $20 and $75 applies to families with income between 150 percent to 241 percent of FPL.
D. In the legislation, there appears to be overlap between the populations eligible for Medicaid and those eligible for federal subsidies/premium credits between 100 to 133 percent of FPL.
E. Some parents are eligible to receive Medicaid up to about 27 percent of FPL, income guidelines vary slightly by county. Childless adults are not eligible.
F. Pregnant women are also eligible for Medicaid up to 150 percent. of FPL.

hardships. For example, Kansans for whom purchasing the lowest cost plan would expend more than 8 percent of their income would qualify for the financial hardship exemption. In 2014, those Kansans who fail to purchase insurance — and who do not qualify for an exemption — will initially pay the greater of $95 or 1 percent of their annual income, up to a maximum amount set by the law. The fines will increase by 2016 to the greater of $695 or 2.5 percent of annual income — up to a maximum amount set by the law. The penalties then will increase yearly by an amount equal to the annual cost of living adjustment.

Employer responsibilities

Beginning in 2010, small businesses that cover roughly half of the costs of their employees' health insurance coverage are eligible to receive tax credits intended to offset the expense of providing coverage. In Kansas, as many as 50,600 small businesses may be eligible for this credit — and several have already applied for and received this benefit. For purposes of eligibility, a small business is defined as one employing fewer than 25 employees and paying an average annual salary of less than $50,000. The tax credit is initially up to 35 percent of the employer's premium costs (up to 25 percent of the premium costs for nonprofit organizations), and the credit will expand to up to 50 percent of the premium costs in 2014 (up to 35 percent for nonprofit organizations).

Beginning in 2014, larger employers will be required to provide adequate and affordable coverage to their employees or face fines. Businesses employing 50 or more people may face fines if any employees receive federal subsidies or credits to purchase coverage. The amount that the employer will be fined depends on whether or not the employer provides some coverage or no coverage at all. Given the expense of providing health insurance coverage, it is possible that some large employers will opt to pay the fine rather than provide coverage to their employees. It is important to note that almost 75 percent of private Kansas businesses have fewer than 50 employees, so will not be subject to these penalties.

NEXT STEPS FOR KANSAS

Although the ACA provides a national framework for reform, much of the responsibility for translating the legislation into daily operations falls to the states and to the private sector. KID has applied for, and received, federal health reform planning and administration grants, and personnel from both KID and KHPA serve on a national steering committee for the Consortium on Health Care Reform Legislation Implementation, which provides technical assistance to states. With several implementation milestones reached in September 2010, the state is looking ahead to the infrastructure needs underlying the 2014 reform provisions including the creation of the exchanges, enforcement of individual and employer requirements and oversight of private and public insurance changes.

CONCLUSION

Public opinion about the potential success or failure of the ACA varies widely, and there's no doubt that the ACA will be a major topic in the new Congress in 2011. However, even as the legislation continues to be debated, changes that have already occurred in states are having a variable impact. For example, in Kansas, one Kansas City area private insurer has already reported large growth in the sale of small business group insurance policies, attributable to the availability of the ACA's small business tax credits. At the same time, uptake for the new federal high-risk pool has been very low. Further implementation of the ACA over the next several years is likely to yield similarly mixed results. To help Kansans prepare for the changes ahead, it is critical that Kansas policymakers and stakeholders stay informed about the ACA as it continues to be shaped through congressional action, the development of numerous federal regulations, legal rulings and state initiatives.

KANSAS HEALTH INSTITUTE

The Kansas Health Institute is an independent, nonprofit health policy and research organization based in Topeka, Kansas. Established in 1995 with a multiyear grant from the Kansas Health Foundation, the Kansas Health Institute conducts research and policy analysis on issues that affect the health of Kansans.

212 SW Eighth Avenue, Suite 300 ● Topeka, Kansas 66603-3936 ● Telephone (785) 233-5443 ● Fax (785) 233-1168 ● www.khi.org