

HEALTH REFORM BRIEF

The Impact of Health Reform on Insurance Benefits and Mandates in Kansas



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Helping consumers purchase coverage that meets their health care needs is one objective of health reform. But balancing that objective against the need to control costs will likely prove to be a challenge for policymakers at all levels.

Online readers can select the words underlined in blue to get more in-depth information.

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INTRODUCTION

The [Affordable Care Act \(ACA\)](#) — if fully implemented — will make private health insurance or Medicaid coverage available to tens of thousands of Kansans. All but 10 percent of the approximately 347,000 Kansans who now lack coverage will meet income eligibility criteria for either the expanded Medicaid program or federally subsidized coverage.

The ACA also contains new rules to help ensure that the private insurance that Kansans purchase, either through a state-based health insurance exchange now being planned or in the open market, will be adequate to meet their health care needs.

The rules are intended to prevent people from being [underinsured](#), a growing problem evidenced by the fact that medical debt is largely responsible for approximately 60 percent of personal bankruptcies in the United States.

Adequacy, of course, is in the eye of the beholder. Some will say that the essential health benefits required by the ACA are too generous and potentially too costly. Others will maintain they are not robust enough. Rather than contribute to that debate, this brief seeks to provide a concise overview

of the provisions in the law and to highlight some of the ways they could affect Kansas consumers and insurers.

Many of the ACA reforms intended to ensure adequacy of coverage target practices used by insurance companies to control their risks and costs. The Congressional Budget Office (CBO) — Congress' independent research arm — has estimated that the reforms will likely increase premiums for some consumers but lower them for others.

WHAT IS IN THE LAW

Some of the provisions intended to ensure adequate coverage have already been implemented. Others will take effect between now and 2014. The law's key reforms include:

- A requirement that health insurance policies cover a yet to be finalized set of essential benefits;
- The elimination of lifetime and annual benefit limits;
- A requirement that insurance plans cover the full cost of preventive services such as screenings and vaccinations;
- A requirement that insurers provide coverage to individuals regardless of pre-existing medical conditions and chronic illnesses; and

- New rules requiring that insurance companies spend most of what they collect in premiums on benefits, not to cover administrative costs.

KANSAS IMPACT

The key provisions listed above are intended to protect consumers, encourage Kansans to get preventive care and help ensure that the coverage they purchase is adequate to meet their health care needs. Keeping premium increases to a minimum while achieving that goal will likely prove to be a challenge for Kansas policymakers and their federal counterparts.

Establishing a Benefit Baseline

The ACA will require Kansas insurers starting in 2014 to cover a list of [essential health benefits](#). Exactly what these benefits will be is not yet known because the rules and regulations specifying them are still being written. However, the ACA outlines broad categories of services that insurers will be required to cover, including hospitalization, emergency services and prescription drugs. It is virtually certain that the ACA will require essential health benefits beyond the [42](#) that Kansas now requires.

To help make comprehensive coverage affordable, starting in 2014 the ACA will impose limits on the amount of [cost sharing](#) that insurers can require. As illustrated in Table 1, insurance plans offering essential health benefits will no longer be permitted to require individuals to pay more than \$5,950 in out-of-pocket costs, such as deductibles and co-payments. Cost sharing for families will be limited to \$11,900. Cost-sharing limits will be even lower for Kansans with incomes below 400 percent of the [Federal Poverty Level \(FPL\)](#) — \$89,400 for a family of four.

A recent study by the Commonwealth Fund illustrated why policymakers thought such limits were necessary. It showed that the deductible for the average Kansas family covered by private employer-sponsored insurance grew by 28 percent

between 2003 and 2009. Kansans with individual coverage saw their deductibles go up by 38 percent during the same time period.

Prohibiting Benefit Limits

The ACA prohibits insurance companies from continuing the longtime practice of limiting the amount they pay in benefits either [annually](#) or over a policyholder’s [lifetime](#). The prohibition on lifetime limits took effect in September 2010. Annual caps will no longer be permitted in 2014. Prior to the prohibition on lifetime limits taking effect in 2010, an estimated 55 percent of Americans with employer sponsored insurance were potentially subject to the caps, which typically ranged from \$1 million to \$2 million.

Historically, insurers used the caps to lessen the risk of providing coverage to people with potentially high-cost health care needs, such as cancer. Many insurers are concerned that removing the limits will require them to raise premiums. Estimates of premium increases due to this and other ACA provisions vary. The CBO estimates the law will have the biggest impact on Kansans who purchase individual policies, raising their premiums between 10 percent and 13 percent. However, [federal subsidies](#) are expected to lessen the impact of these increases for many if they purchase coverage through the exchange. Nearly half of Kansans are expected to be income-eligible for some level of subsidy. Even so, forecasters are estimating that a much smaller percentage will actually apply for and receive the federal assistance. Premiums paid by [small employers](#) could either go up slightly or decrease by a percentage point or two, according to the CBO estimates. Premiums paid by [large employers](#) are expected to either remain flat or decrease slightly.

Incentives for Preventive Care

Virtually everyone agrees that preventive care is a potentially effective way to reduce health care costs and help people to live healthier and more productive lives. But

Table 1. Out-of-Pocket Limits for Coverage Purchased in a Health Insurance Exchange

Poverty Level	Out-of-Pocket Limit
100% up to 200% FPL	\$1,983 per individual and \$3,967 per family
200% up to 300% FPL	\$2,975 per individual and \$5,950 per family
300% up to 400% FPL	\$3,987 per individual and \$7,973 per family
400% FPL and above	\$5,950 per individual and \$11,900 per family

Source: Kaiser Family Foundation, March 2010. For additional information go to <http://www.kff.org/healthreform/8061.cfm>.

research shows that out-of-pocket costs discourage some from seeking preventive care such as physicals, colonoscopies, mammograms and other types of routine screenings. The ACA attempts to address that disincentive by prohibiting insurers from requiring any cost sharing — co-payments, deductibles, etc. — for certain [preventive services](#). That provision has been in effect since September 2010.

While most of the services that Kansas law currently requires insurers to cover are preventive or diagnostic, state law does not require that these services be covered at no cost to the beneficiary.

It is important to note that while insurers and providers will no longer be able to pass along any of the cost of screenings and other specified preventive services, they may still require co-payments for the office visits at which the services are provided.

Prohibiting Coverage Limits

Prior to the ACA, insurers could write health insurance policies that limited coverage and specifically excluded pre-existing medical conditions. For example, applicants with diabetes could purchase policies, but the coverage could specifically exclude services related to their diabetes.

The ACA prohibits this practice starting in 2014. Currently in Kansas, policies sold in the individual market can permanently exclude coverage for pre-existing conditions. However, such exclusions are already prohibited for policies sold in the large- and small-group markets.

The ACA will also prohibit insurers from limiting or dropping the coverage of people participating in clinical trials. Kansas will be among the states most significantly affected by this change because it is not among the 34 that already have laws or rules requiring insurance companies to cover the cost of clinical trials.

Premiums for Benefits

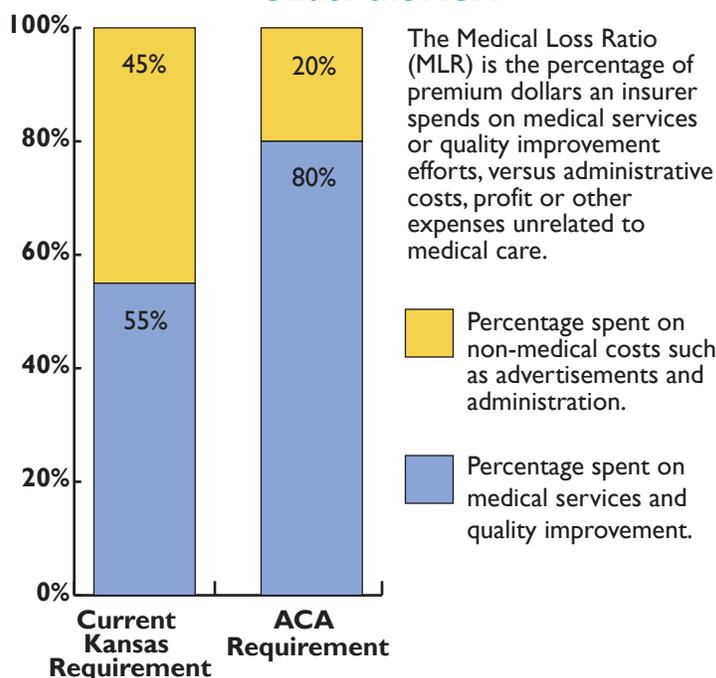
Insurers use the money they collect in premiums to cover all of their operational costs. The proportion of premiums spent on clinical services and quality improvement efforts versus the proportion retained as profits or used to cover administrative costs is known as the medical loss ratio, or MLR.

Effective this year, Kansas insurers in the large-group market must spend at least 85 percent of the premiums they collect on clinical services and other things that directly benefit the people they cover. Only 15 percent of premium dollars can be spent on administration or retained as profits. The ratio is slightly lower — 80/20 — for insurers in the small-group and the individual markets (Figure 1). Kansas Insurance Commissioner Sandy Praeger has asked federal officials to delay imposition of the MLR rules in Kansas to give insurance companies doing business in the state more time to comply with them.

Whenever they take effect, the new MLR rules are most likely to be an issue for insurers in the small-group and individual markets. In Kansas, two of the five largest companies serving those markets have MLRs below what the law requires. Time Insurance Company, which has a 6.5 percent share of the individual and small-group markets in the state, and Coventry Health and Life, which has a 4.6 percent share, have MLRs of 57/43 and 72/28 respectively.

However, the remaining three companies, including the two largest, all have MLRs well above the required threshold. Blue Cross Blue Shield of Kansas, which serves 48.5 percent of the individual and small-group

Figure 1. Change in Individual Market MLR Under the ACA



Source: Kansas Insurance Department Presentation, December 9, 2010.

Provisions in the health reform law aimed at ensuring that Kansans get coverage that meets their health care needs will increase premiums for some individuals but could lower them for many small and large employers.



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

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markets in the state, has an MLR of 93/7 as does American Medical Security, with a 4.6 percent market share. Meanwhile, Blue Cross Blue Shield of Kansas City — market share 16.1 percent — has an MLR of 91/9.

Insurance companies operating in Kansas spend an average of 81.6 percent of their premium dollars on benefits.

CONCLUSION

The Affordable Care Act has two main insurance coverage objectives:

- To expand access to health insurance, and
- To ensure that the coverage people purchase is adequate to meet their health care needs.

Several provisions in the law are aimed at achieving the second objective. Among the most important of these is the requirement that most health insurance plans cover a standard set of essential health benefits. These threshold benefits — which are yet to be specified in rules and regulations — are likely to increase the number of services that Kansas insurers are required to cover.

Other provisions intended to protect consumers and ensure adequate coverage include:

- Limiting the amount of cost sharing that insurers can require for policyholders in the form of deductibles, co-payments and coinsurance;
- Prohibiting insurers from imposing annual and lifetime caps on benefits;
- Prohibiting insurers from specifically excluding coverage of pre-existing medical conditions; and
- Requiring insurers to spend most of the money they collect in premiums to provide benefits, rather than to cover administrative costs or retain as profits.

The CBO has estimated that these changes and others will likely increase premiums for those Kansans who directly purchase coverage in the individual market but lower them for many small and large employers and the Kansans they cover.

More information

This publication is the second in a series of briefs about the impact of health reform in Kansas. It is based on work done by Suzanne Cleveland, J.D., and Gina Maree, M.S.W., LSCSW. Other contributions were made by Jim McLean, Anne Berry and Cathy McNorton. This document and the other briefs in the series are available online at www.khi.org.

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