Healthcare Reform Act

The Healthcare Reform Act voted into law in 2010 has both bright spots and spots of blight. It was a very lengthy negotiation in congress that resulted in a long document with many things related to healthcare insurance and other things that do not. Generally though the idea behind the new law is to reform (and increase) access to healthcare for all legal US citizens and residents, it does not really reform the provision of healthcare so that is important to understand. Thus, it would be more appropriately named health insurance reform.

Many feel that access to healthcare is difficult at best. Of course part of the issue speaks to the core question; is healthcare a right or a privilege? Most would say that the country is still divided on that question. Even within the camp that believes it is a right, there is no complete agreement on how to pay for care and what care should be included. The law was passed on the premises that everyone should be able to access healthcare. Further the law was designed to force everyone to share in the cost of the provision of healthcare to everyone thru mandated purchase requirements and penalties (taxes) for those who choose not to take coverage.

The act is designed to both force the purchase of coverage and provide means for those who can't otherwise afford coverage, to make the purchase. By causing everyone to put money into the "pot" used for claims payment, the theory is the cost of uncompensated care will diminish and help control some of the other costs associated with providing healthcare to everyone. The economic impact of this is argued by various sides as having very different levels of impact.

It is a good theory, but not perfect because people can opt to pay penalties and skip taking coverage. The penalty is far less for most than their premium would be otherwise. When they choose to pay the penalty/tax they not paying into the claims funding pot of those in a single insurance pool, usually defined as an insurance carrier, but instead paying the penalty/tax to the government. These same people can then sign up for coverage only when it is needed for a major medical issue thus adding big expenses to be paid out of the claims pot but paying disproportionally little into the pot. If too many people do this, the government will collect plenty on fines, but the cost of coverage will increase to cover the higher expenses. That is one area not yet addressed in the healthcare reform act.

Overall the act was designed to increase access to care. To that end, guaranteed issue coverage is part of the plan. Pre-existing conditions can no longer be left uncovered by carriers, so if someone signs up and already has a brain tumor, the insurer will cover the associated treatment.

The plan also has provisions to ensure the insurance industry does not receive profit levels beyond a point, set by the new law, with this calculated using medical expense ratios at different levels for different segments of their of business, small group, large group, and individuals. The calculations leave between 15-20% for administrative costs and profit. Of course self insured groups pay an admin fee only to the carrier so the carriers can make money off self insured groups at any level they really want.

In order to make it easier for people to choose between plans standardized summary of benefits are going to be required and there will be a few plan designs that must be followed by all of the carriers. Thus, there should not be a huge discrepancy from one carrier to another in terms of what coverage levels exist. This is a real benefit to everyone as being able to compare offerings from different carriers will be far easier going forward.

Ultimately there will be a few levels of plans mandated by the reform act. These levels will supposedly be called gold, silver, and bronze (wonder where lawmakers came up with those names) which signify the level of coverage provided. Further various mandated coverage items will end up included in all of the plans. The levels of coverage will relate in part to out of pocket cost sharing between insurer and beneficiary.

The reform act was also intended to cut down on the practices that some insurers used that haunted the industry. These included accepting issuing coverage and then waiting for a large claim to hit before digging into the application and looking for a reason to cancel the member. Usually, when this happened minor items were cited as misstatements on the application yielding a plan termination notice. Not all of the carriers did this, it was a few who caused problems for every carrier because of these actions, in fact most do a good job reviewing applications up front first and then issuing the policies. This was one of the areas that needed definite reform and was an area virtually everyone supported being reformed. Of course those who blatantly lie on their application are still able to be terminated off of their policies,and prosecuted for fraud.

The healthcare reform act's various provisions kick in at different times. In 2010 provisions guaranteeing kids health insurance regardless of health status went into effect. In 2011 the medical cost ratio provisions went into effect. Also, in that time frame new laws requiring 90 day notices of rate increase went into effect, essentially pushing out one month (for Texans) ahead of when they came out before renewal offers. Coming up this year and next are the mandated standardized benefit summary plans, as well as a host of other minor changes to health insurance. Preventive health at no out of pocket cost to the insured along with no limit on the amount of preventive care which can be received, started in 2011. There are also no longer lifetime maximums on care.

We still wait until 2014 to get guaranteed issue major medical insurance for adults. At that same time the mandates that everyone must buy coverage begin. Also, not until 2014 do the provision for subsidies by the government going to begin that will assist people buy coverage when they meet specific income and family size guidelines. Generally the limit for a subsidy is 400% of the federal poverty level.

So what does all this mean for those who are consumers, either in the Indivdual insurance world or as members of a group with health insurance? Right now, generally speaking not much has changed. You must still if applying for individual coverage o thru the underwriting process to get the coverage. Groups remain guarantee issue for new group members. Groups as a whole are still subject to various state laws where they generally are guaranteed issue but not always. Children 18 and under are guarantee issue, but carriers no longer sell child only policies so ultimately you must have an adult apply with the child to get the coverage.

Generally speaking we have seen some improvements in how the health coverage works, but there have been trade-offs so we aren't able to clearly state everyone is better off yet. In fact at the present moment those with insurance are better off than they were before and those without coverage are somewhere between no better off and possibly even worse off, as is the case for kids in need of children's only coverage.

Politics will likely further shape the law as it is implemented over the next few years. Many provisions are agreed bilaterally (by both the Democrats and Republicans) to be inappropriate and in need of change. Other aspects of the law will be fought thru until they meet the needs of a greater audience. Although upheld by the United States Supreme Court the fight about this law is far from over.