



A RADICAL RESTRUCTURING OF HEALTH INSURANCE

Millions to lose the health coverage they have now

By Grace-Marie Turner • December 2011

One of the most fervent promises President Obama made to the American people before passage of the health overhaul law was “If you like your health care plan, you will be able to keep your health care plan. Period. No one will take it away. No matter what.”¹

But, even before the law fully takes effect, millions of people are losing “the coverage they have now,” and tens of millions more surely will follow.

A major survey of employer plans provides evidence. McKinsey & Company surveyed 1,300 employers across industries, geographies, and employer sizes, and concluded that the Patient Protection and Affordable Care Act (PPACA) will lead to a “radical restructuring” of job-based health coverage.² McKinsey found that 45 to 50 percent of employers say they will definitely or probably pursue alternatives to employer-sponsored health insurance in the years after it takes effect in 2014. One-third of employers say they “will definitely or probably drop coverage after 2014.” Among employers who knew most about the new health law, half said they were likely to drop coverage.

Since an estimated 156 million non-elderly Americans get health insurance at work, according to the Employee Benefit Research Institute,³ that means as many as 78 million people could be forced to find other sources of coverage.

So clearly President Obama’s key promise will be broken after the law fully takes effect. But the deterioration in coverage already has begun as many people already are losing the coverage they

have now as health insurers are dropping out of markets in many states. Some of the carriers are exiting because of onerous state regulations, others are victims of a faltering economy, but the cascade has been accelerated by the rules that already have taken effect and the many more that are to come as a result of PPACA.

In this paper, we provide:

- an overview of carriers leaving the private health insurance market
- the impact of Obama administration rules on the child-only health insurance market
- the disruptions caused by rules governing health premium payouts and “grandfathering,” and
- the threats to the Medicare Advantage market.

Some health plans are already leaving markets

The American Enterprise Group announced in October 2011 that it would stop offering non-group health insurance in more than 20 states.⁴ As a result, 35,000 people will lose the health coverage they have now. The company cited regulatory burdens, including the “medical loss ratio” (MLR) requirements (see page 4 for more), in explaining its decision to leave the markets. This means there will be less competition in these 20 states, resulting in higher prices for consumers in many cases.

In New York, Empire BlueCross BlueShield said it will drop in the spring of 2012 health

insurance plans covering about 20,000 businesses in the state. Mark Wagar, president and CEO of Empire, said that the company will eliminate seven of the 13 group plans it currently offers to businesses which have two to 50 employees. The move is expected to have a great and potentially “catastrophic” impact on small businesses in New York, according to James L. Newhouse, president of Newhouse Financial and Insurance Brokers in Rye Brook, NY.⁵ This loss of competition inevitably will lead to higher prices and fewer choices for businesses and their employees.

In Colorado, World Insurance Company/American Republic Insurance Company announced in October 2011 that it is leaving the individual market, citing the company’s inability to comply with insurance regulations.⁶

In Indiana, nearly 10 percent of the state’s health insurance carriers have withdrawn from the market because they are unable to comply with the federal medical loss ratio requirement. Indiana was hoping to bring the companies back by asking the Department of Health and Human Services (HHS) for a waiver from the rule, but Washington refused in late November 2011 to grant the waiver.

“Once again, the Obama administration took a position in favor of higher health care costs and against personal freedom,” said Indiana Governor Mitch Daniels after receiving the letter notifying him of Washington’s decision. “Today’s letter is further proof that the PPACA is a catastrophe for America and must be repealed.”⁷ The MLR rules are particularly difficult to meet for plans such as Health Savings Accounts which offer high-deductible coverage, and Indiana has a particularly high concentration of the popular cost-saving plans. Indiana had proposed an alternative approach to phase in the MLR triggers, but it was denied by HHS.

These are the latest in a series of announcements that health insurers are leaving the market as a result of ObamaCare’s edicts. But there are many more.

The exodus continues

Citizens in states around the country have learned that carriers are leaving markets, largely as a consequence of the combined effect of the health law and state regulations that make it particularly difficult to offer coverage in the small group market.

Principal Financial Group, based in Iowa, announced in 2010 that it would stop selling health insurance, impacting 840,000 people who receive their insurance through employers served by the company. The company assessed its ability to compete in the new environment created by PPACA and concluded its best course was to stop selling health insurance policies.⁸

Another 42,000 employees of small and midsize employers learned in January 2011 they were losing their health coverage with **Guardian Life Insurance Co.** of America. The company announced it was leaving the group medical insurance market (it had reached an agreement with UnitedHealthcare to renew coverage for Guardian clients).⁹ Guardian began withdrawing from the medical insurance market in specific states more than a decade ago, and says it would be leaving the market with or without PPACA.

Cigna announced that it is no longer offering health insurance coverage to small businesses in 16 states and the District of Columbia: California, Connecticut, Florida, Georgia, Hawaii, Illinois, Kansas, Missouri, New Hampshire, New York, North Carolina, Ohio, Pennsylvania, South Carolina, Texas, Virginia, and Washington, D.C.¹⁰

In Colorado, **Aetna** will stop selling new health insurance to small groups in the state and is moving existing clients off its plans this year, affecting 1,200 companies and 5,200 employees and their dependents.¹¹ Aetna also has pulled out of Colorado's individual market because of concerns about its ability to compete there, dropping 22,000 members.¹² Aetna also has dropped out of the small-group market in Michigan and several other states.

Since June of 2010, 13 plans have left the health insurance market in **Iowa**, citing regulatory concerns.¹³

In New Mexico, four insurers — **National Health Insurance, Aetna, John Alden, and Principle** — are no longer offering insurance to individuals or to small businesses — drying up the market and driving out competition.¹⁴

In Utah, **Humana** is ending its participation in the Utah Health Exchange, leaving only three carriers participating in the exchange.¹⁵

In Virginia, **UniCare** has eliminated its individual market coverage for about 3,000 policyholders.¹⁶ And shortly after the health law was enacted in 2010, a new Virginia-based company, **nHealth**, announced it was closing its doors, saying that the regulatory burdens posed by the health law made it impossible to gain investor support to continue operating.¹⁷

These announcements that carriers are exiting markets accelerates a trend that the American Medical Association says leaves four out of five metropolitan areas in the United States without a competitive health insurance market.¹⁸ The report found that in about half of the metropolitan markets, at least one health insurer had a commercial market share of 50 percent or more. In 24 states, the two largest health

insurers had a combined commercial market share of 70 percent or more.

This is a negative and destructive trend, leaving fewer carriers to serve these markets and giving small businesses and the insurance agents who serve them less leverage to negotiate better benefits and lower rates among competing companies.

Children-only policies

One of the provisions of the health law that the Obama administration touts most enthusiastically is the requirement that employers who offer dependent coverage allow employees to add their 26 year old “children” to their policies. It is highly ironic, then, that another provision is causing huge losses of coverage among children whose parents or guardians were buying health insurance policies for them on their own.

One of the earliest indications of lost coverage came in June 2010 when Health and Human Services Secretary Kathleen Sebelius told health insurers that they must write policies for children under 19, including those with pre-existing conditions, no matter when their parents and guardians apply. This creates an incentive for parents to wait to buy the coverage until the children have a significant medical condition. This in turn creates a substantial risk of “adverse selection,” which makes it financially unsustainable for health plans to continue to offer these policies. Rather than wait for this to happen, many carriers have decided to leave this market altogether.

Sen. Michael Enzi, ranking Republican on the Health, Education, Labor, and Pensions Committee, asked his staff to survey the states to find out how many were offering child-only policies.¹⁹ Of the 50 states that responded to the HELP Committee survey, 17 states said there are

no carriers currently selling these plans to new enrollees. One of the largest insurance markets in the country, Texas, has seen all of its carriers drop child-only health insurance. Other states that no longer have carriers selling child-only plans include Alaska, Arizona, Connecticut, Delaware, Florida, Georgia, Idaho, Minnesota, Nebraska, Nevada, North Dakota, Oklahoma, South Carolina, Tennessee, West Virginia, and Wyoming. The HELP Committee updated its survey of the child-only market and released a paper in August 2011 with a detailed summary of the states impacted.²⁰

Grandfathering rules

Other factors are contributing to disruptions of coverage, including regulations to implement PPACA. The Obama administration's own estimates show that seven out of 10 Americans with employer-based coverage could lose the health plans they have now as a result of the law and will not be able to keep the promised "grandfathered" status. This was the commitment to employers that if they offered coverage now, it would be "grandfathered in" and they could avoid most of the new coverage rules in the health overhaul law.

While most companies initially hoped they would be able to preserve much of their existing group health plans under the new grandfather provisions, a survey by Aon Hewitt Consulting found almost will not.²¹ The rules developed by the Obama administration to define what grandfathered status entails were so onerous that few companies will be able to comply.

The Obama administration expects that by 2013, between one-third and two-thirds of the 133 million people with coverage through large employers will lose their grandfathered status. Up to 80 percent of the 43 million people in small employer plans will lose their

grandfathered protection. Up to 70 percent of those with coverage in the individual market would be forced to comply with expensive new federal rules within a year.²² Few of them are likely to lose coverage in the short term, but most will lose the coverage they have now.

The grandfathering rules back employers into a corner. They cannot make changes, other than minor modifications, to their health plans to keep costs down without being forced to comply with expensive PPACA regulations that increase their health costs.

ObamaCare regulations cause havoc in the insurance market

Another provision in the health overhaul law, the "minimum medical loss ratio" (MLR) requirement, mandates that health insurance carriers spend most of the money they collect from premiums on direct medical care. The MLR is another contributor to lost coverage.

Sec. Sebelius refused to listen to the carriers when they asked her to use her authorized discretion to delay for at least a year the MLR requirement. The MLR rules require insurance companies to spend at least 80 percent of premiums received in the individual and small-group markets and 85 percent in the large-group market on medical claims. These rules are designed to limit supposedly wasteful spending on administration and profits. But insurers are hardly careless with premium dollars. According to *Fortune* magazine, health insurance is among the least profitable industry sector in America. *Kaiser Health News* concludes, "With the nation's health care spending estimated at \$2.5 trillion this year, even the elimination of insurers' profits and executive compensation would lower health care spending by just 0.5 percent."²³

Many states have applied to Washington to give them flexibility because they say it's impossible for some carriers to comply with the MLR rule. Thirteen states that have applied to the federal government for temporary "adjustments" in MLR rules have been granted waivers. But the Obama administration has turned down requests from Indiana, Louisiana, North Dakota, and Delaware that they be granted waivers from the health law's strict directives.

The stakes are high. Beginning this year, insurance plans must provide rebates to plan enrollees if they can't meet the standards. Overall, Aetna warns it may hemorrhage up to \$100 million thanks to MLRs this year.²⁴ Many others face the same predicament.

Companies that sell policies to individuals have higher marketing costs and higher customer service expenses, and it is especially difficult for them to meet the MLR tests because their administrative costs are necessarily higher. In addition, high-deductible policies provide customers protection against large medical expenses, but carriers may not pay out the required percentage of premiums every year in medical claims, making it very difficult for them to meet the MLR test. Many health insurance companies have slashed the number of employees, cut agent commissions, and taken other harsh steps to reduce overhead, but this is also slashing customer services.

Indiana argued that some carriers would be forced to stop selling policies in the state if they were not given relief from the rules. This would lead to less competition and higher prices for consumers. Indiana asked HHS to lower the threshold MLR percentage companies would have to meet, provide a permanent waiver for high-deductible plans, and provide a waiver for new entrants into the individual market until 2014. Louisiana asked HHS to lower the MLR

percentages to 70 percent for 2011 and 75 percent for 2012.

Health and Human Services officials said in letters on November 27, 2011, to the insurance commissioners in Indiana and Louisiana that the government is denying their requests.²⁵

In addition, North Dakota warned that if the government denied its request for a waiver that "consumers would be left without coverage" and many would have trouble finding new coverage, especially if they have a health condition. Washington denied its request as well.

This Washington-knows-best attitude that is guiding the creation of more than 10,000 pages of rules and regulations to implement the health law will continue to cause a cascade of lost coverage because it is ignoring market forces in favor of Washington rule-making.

ObamaCare spending cuts threaten Medicare Advantage

While seniors are guaranteed coverage in Medicare, early changes impacting Medicare Advantage (MA) plans already are leaving some seniors with few choices of health plans.

For example, about 7,600 seniors in several counties in New Hampshire received notice in November 2011 that their Medicare Advantage coverage is being discontinued. New Hampshire has one of the highest percentages of Medicare Advantage enrollees in New England.

"The private fee-for-service plans are going away and we're left with one HMO in Rockingham, Carroll, and Hillsborough Counties," said Michelle Magarian, Medicare coordinator for Hillsborough County ServiceLink, as quoted in an article in the *Union Leader*.²⁶

A Government Accountability Office (GAO) report found that the number of MA plans offered through April of 2011 had declined from 2,307 to 1,964.²⁷ Most of the drop reflected a decline in private fee-for-service plans.

Nonetheless, the Obama administration touted the report and said that enrollment in the popular Medicare Advantage program had continued to increase, reaching nearly 12 million by April 2011. That means that more than one-fourth of seniors have voluntarily decided to enroll in private health plans through Medicare Advantage.

The administration says that the Government Accountability Office study shows the health law had little or no effect on Medicare Advantage enrollment in the first year after enactment of ObamaCare. But less than one percent of the health law's cuts to MA actually went into effect in 2011, according to the Congressional Budget Office.²⁸

The health law mandates that \$136 billion be taken out of the program over the decade to help pay for new health insurance subsidies. In an effort to delay the loss of Medicare Advantage coverage that will result from PPACA cuts, HHS notified carriers in its annual "call letter" earlier this year of the surprising news that per-capita Medicare Advantage payments will increase by 1.6 percent for 2012. The temporary reprieve from the mandated cuts in Medicare Advantage spending will surely mean much deeper cuts — and coverage dislocations — to come.

The Associated Press previously reported that the MA estimates for 2012 are likely to be skewed due to bonuses paid out from a temporary, multi-billion dollar demonstration/waiver program — one that even Democrats admitted was implemented because Medicare "could not tolerate dislocation, given the political climate."²⁹

The Congressional Budget Office has predicted that the cuts mandated in PPACA would decrease enrollment by about 35 percent through 2019.³⁰ The Office of the Actuary at the Centers for Medicare and Medicaid Services has found that the reduction in MA payments would eventually lead to those plans offering "less generous benefits packages" for seniors and that the coverage will cost them more. They estimate that seniors' costs will go up by as much as \$923 by 2017.³¹ Another report also demonstrated how MA enrollment will decrease.³² The study found that Medicare Advantage enrollment will be cut in half by 2017 as a result of cuts mandated in the health overhaul law, and that the choices of health plans will be reduced by two-thirds, with an average of almost 18 fewer MA plans being offered in each county.

Obama administration actuaries have predicted that the health law will force 7.4 million seniors to lose or be denied access to a Medicare Advantage plan. As described earlier, HHS Secretary Kathleen Sebelius has tried to push off this inevitable loss of coverage with a temporary boost in payments to the plans, but this only means bigger cuts to come in subsequent years.

A new study by the American Action Forum found that PPACA "will dramatically reduce the number and variety of healthcare plan choices available to seniors and reduce benefits and enrollment."³³ The study found that nearly all seniors in Medicare Advantage plans will find that the plan they have chosen is either no longer available or will have reduced benefits, higher out-of-pocket costs, or both within five years. By 2017, nearly 15 million seniors "will either lose their access to MA plans entirely or drop out due to reduced benefits. And, by 2017, the average person who was enrolled prior to PPACA would lose \$3,700 in health care services per year," the authors found. "When the new formula is fully phased in, there will be 66 percent fewer choices

available in each county in the U.S. on average, with at least 152 U.S. counties losing all access to MA plans.”

Conclusion

Long before the law fully takes effect, PPACA is harming workers, employers, and seniors as they face fewer choices for health insurance.

Clearly, millions of people are having their coverage disrupted, violating the promise that President Obama — and virtually all of those in Congress who voted for the law — made to the American people. As the cascade continues, support will grow for an alternative approach to PPACA.

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