

A take on Health Care Reform from Careington

Health Care Reform has been signed into law by President Obama and the opinions are varied and wide ranging as to what it means. It is important to note that this is only the first step in a long process to interpret and implement the “Patient Protection and Affordable Care Act” and the goal of this measure was more about access than affordability. While the legislation was about 2400 pages there are still many items that are vague and can only be given substance through the implementation of the law. The act routinely refers to “minimum essential coverage”, but what qualifies as “essential coverage” could expand or retract in the future. The next step is for Congress to produce a “blue book” which will define legislative intent and will be the basis for implementation.

We believe the biggest impact to discount medical plans will be in the area of physician and hospital discounts, but that can only be assessed when there are clearer descriptions to the “essential coverage” and how it is delivered. The ancillary fields such as dentistry, optical, etc. may continue to function as they do currently. Essential Health Benefit Package reads as a health insurance issuer (i.e., an insurance company) that offers health insurance coverage in the individual or small group market (defined as up to 50 employees) must offer coverage that includes the “essential health benefit package.” This package includes broad service categories: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance abuse, prescription drugs, rehabilitative services and devices, laboratory services, preventive and wellness services, and pediatric services, including oral and vision care for covered youths. The Department of Health and Human Services (HHS) is given the authority to further define this list and they will play the key role in overseeing the implementation to this act.

A large question in the future of discount medical plans surrounds mandates. The Individual Mandate requires US citizens and legal residents to obtain “minimum essential coverage” beginning in 2014 or pay a phased-in penalty for failure to obtain coverage that is the greater of a fixed fee or a percent of income. The phase-in schedule is as follows: the greater of \$95 or .5% of income in 2014; the greater of \$495 or 1% of income in 2015; and the greater of \$750 or 2% of income in 2016. After 2016, the penalty will be increased by a cost-of-living adjustment. An exemption will be given from the individual mandate if the lowest cost available plan would exceed 8 percent of an individual’s income or if the individual has income below 100% of the poverty level. Other exemptions would be given for those without coverage for less than 3 months, for religious objections, and for incarcerated individuals. It is unclear how the public will react whether they will happily pay the penalty to avoid premiums that would be significant even if the consumer qualified for subsidies from the government or if all will fall in line and become insured.

The future of Limited Medical Plans also will be determined by the key factors of what is an “essential health benefit packages” and how many Americans choose to not abide by the mandates. The cost of premiums for insurance plans that satisfy “essential health coverage” could continue to rise, forcing some consumers to take their chances with the penalty. This could lead to a market of consumers that need options even when they decide they cannot afford to abide by the mandates. Another potential pool of clients could be those that make too much for substantial subsidies and not enough to be mandated to obtain “essential health coverage”.

A graphic in the April 5, 2010 issue of Time shows an estimated 22 Million uninsured in 2019 after much of this act has been in place for years. Estimates such as this can show there could still be a significant need for help regarding Healthcare costs in the way of Discount medical Plans or Limited Benefit Plans.

States would be required to create health insurance exchanges beginning in 2014 for individuals and small employers (defined as 100 or fewer employees). After 2016, States could allow larger employers to participate. The exchanges would be required to offer plans at four different levels (the levels would be determined by the percent of expenses covered by the plan). The four levels would be classified as: bronze, silver, gold, and platinum. The exchanges would also offer a low cost catastrophic plan, limited to those age 30 or younger. Adding the states to the initial Federal approach will lead to additional changes and modifications that will have to be watched doggedly.

We will monitor closely and keep our partners apprised to the changes and clarifications that we find in the process.

Sincerely,

Careington