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Use the Affordable Care Act as a Sword at Renewal Time Or… Your Insurance Company Will Use It Against You

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Most recent articles about the Patient Protection and Affordable Care Act concern the postponement of employer mandates and the failures of healthcare.gov. The media hype has led many employers to shift their focus away from health care law issues until 2015. But savvy employers are not ignoring the law. They know that many of the law's provisions already affect their bottom line and, if used correctly, the statute can be helpful.

Roughly speaking, three general groups are subject to Affordable Care Act requirements: employers, individuals and insurance companies. Many provisions applicable to insurance companies have a ripple effect, in that provisions enacted for the purpose of limiting insurance companies' ability to charge excess premiums are being manipulated to *increase* premiums instead.

A common refrain from health insurers at renewal time is that due to the health care law, premiums must go up. What is notable, however, is that health insurance companies have been flourishing since the act was passed. Ten of them, for example, were in the Fortune 500 for 2013, and eight of them improved

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their rankings from 2012. It may be useful to keep this fact in mind when they cry poor at renewal time.

It is increasingly common for insurance companies to use the Affordable Care Act to increase premiums while — ironically — blaming the law for the premium increases. By paying attention to the five tips below the informed employer can avoid falling prey to such tactics.

1. Fun and Games with the Medical Loss Ratio

Most renewals start when brokers provide employers with a worksheet reporting on their claims experience in the current year, and documenting (supposedly) the need for a substantial premium increase.

One of the key numbers on that relatively indecipherable spreadsheet is a percentage called the medical loss ratio. It is supposed to designate the ratio between the premium dollars spent on health care and the premium dollars that go to the insurance company's administrative costs and bottom line. Its intent is policyholder-favorable: to keep premiums in line with costs.

Large plans are required by the Affordable Care Act to have a medical loss ratio of at least 85%. That means at least 85% of premiums must be spent on actual health care costs. If that threshold is not met on the group level (e.g., if only 75% was spent on medical costs), the difference is to be refunded to all policyholders in that group, proportionately.

Many employers do not appreciate that they are entitled to this protection. Thus, in the first few years of the health care law, many received refunds in the mail with no understanding as to why.

Since then, the insurance companies have gotten smarter. At this point, most have avoided further refunds by meeting their medical loss ratios every year — or at least claiming to do so.

Think about it — one easy way for insurance companies to meet their medical loss ratio requirements is simply by increasing their payments of claims. That way, they can keep their premiums the same, or even increase them. For fully insured plans, the ability to increase claim payments, and the maintenance of all records about those payments, lies exclusively within insurance company control. There is no disadvantage for insurance companies in increasing their claim payments; they simply pass through all the increased costs to the employers at renewal time.

Next, think about this — as a legal matter, insurance companies actually benefit from overpaying claims, then recovering the overpayment through a fraud recovery action. The overpayment itself increases the numerator of the claim payments; the fraud recovery later provides a credit to that numerator — after the medical loss ratio has been calculated.

This double benefit stands in stark contrast to an insurance company's fraud prevention activities. When insurance companies utilize their already-existing mechanisms for detecting and avoiding fraudulent claims from the outset, they do not get a credit toward their medical loss ratio for *either* the initial overpayment *or* the secondary recoupment. Although they end up in the same place financially in terms of the claim payment, they have missed the opportunity to inflate the numerator of the medical loss ratio calculation — and thereby to avoid owing policyholders a refund.

Against this backdrop, it should not come as a surprise that there has been an increase recently in insurance company lawsuits seeking reimbursement of their own overpayments to providers.

Or — that some insurance companies have been overt in acknowledging that the medical loss ratio creates an incentive for overpayments and a disincentive for fraud prevention.

Or — that top executives of one health insurance company were convicted in 2013 of recording fraudulent claim payments on their books to satisfy a comparable medical loss ratio imposed by Medicaid.

As we said, think about it.

The practical advice for employers at renewal time is to look carefully, and in an informed way, at the medical loss ratio on their renewal worksheets. If it shows a sharp increase in claim payments that makes no sense, e.g., if enrollment had dropped at the same time, it is time to ask questions. Request an audit. Request documentation. Do as much as possible to investigate this type of issue. In some circumstances, merely questioning the representation in an informed way can thwart a baseless attempt to jack up a premium.

2. The Ever-Rising "Trend"

It's renewal time, and you sit down with your insurance company and your broker. Shaking their heads regretfully, they present you with a "trend" chart, which shows that your employees have had a bad year, health-wise. Making matters worse, they advise, there are many claims in the pipeline and the trend is going up. The result is a substantial, unavoidable premium increase — one even larger than is evident from the raw numbers.

Sound familiar? Unfortunately, probably so.

The good news (if it can be called that) is that such claims as to an ever-rising trend may be as factually bankrupt as the medical loss ratio representation discussed above.

Most employers purchase health insurance in order to gain access to a medical provider network and claims processing services. The network is supposed to assure that physicians, hospitals and others who render health services charge reduced rates. The health insurer or claims administrator is supposed to assure that the paid claims are only for proper medical charges and covered medical treatment. The dual roles could be described as serving a "gatekeeper" role.

But when the most efficient way to increase premiums is to increase medical payments, as discussed above, the insurance companies have no reason to be effective in their role. Not only do the increased costs help the medical loss ratio, they also produce a rising claim trend that the insurance companies then use to justify further increases.

Every employer should come to the renewal table equipped to ask pointed questions about its insurance company's processing and payment patterns. Demand an audit of those payments, scrubbed of any identifying characteristics as to the claimants themselves. It is an employer's right, as well as its obligation, to inquire into whether claims are being paid properly in its company plan.

3. Unidentified Percentage Premium Increases

The medical loss ratio is not the only example of how insurance companies misuse percentages to the policyholder's disadvantage. Another renewal number is the percentage increase in premiums. Some human resource professionals and risk managers describe a premium increase as a percentage, because insurance companies and brokers often present price quotes as percentages.

At renewal time, many a diligent employer has asked percentage of what, and received the wholly unsatisfactory answer: I'm just not sure. Even when employers and their representatives come prepared for the negotiation, with full knowledge of the actual dollar figures (e.g., the actual per employee, per month expenses), it is far too easy for insurance companies to confuse the conversation by tossing around a series of vaguely defined percentages.

All too often, the backup for a premium quotation is a complicated chart that has some numbers and some percentages, with no relationship between the two. It can require significant work to unpack such charts, but the work is essential.

First, if an employer does not understand the information on which a proposed premium increase is based, the employer will necessarily be hampered in forming an intelligent counteroffer.

Second, employers who undertake to question and unpack the backup data often are astounded at the number of mistakes that they unearth. Understanding this information becomes more important when considering competing offers.

4. Is Your Broker Really Championing Your Cause?

No matter what the field, relationships with brokers usually are complicated. Health insurance renewals are no exception. It is typical for brokers to have divided loyalties between their employer-clients and their insurance company "friends."

The conflict goes straight to the bottom line. The more an employer pays in premium, the more the broker recovers in fees. No employer sitting at the renewal table can afford to forget that fact.

Due to the complexity of health insurance renewals and the other issues competing for an employer's time, most employers are forced to rely heavily on their brokers to analyze renewal offers and ask the hard questions. But as a practical matter, an employer should be clear about where the broker sits — sometimes literally. If "your" broker arrives and leaves the renewal meetings with the insurance company representatives and, during the negotiation, sits on the opposite side from you, take note.

Further, with health care in flux because of the Affordable Care Act, even brokers willing to help may be ill-equipped to do so. This is a time when brokers have no choice but to be educating themselves fully about the ongoing changes in law and regulation. If your broker is the type to sit on the sidelines, approaching the post–Affordable Care Act world just as he or she did before, it may be time to get a new one.

Ask your broker questions before your renewal meeting — questions about how your medical loss ratio was calculated, whether the numbers match the records as to the claim and enrollment history, how to unpack a quote, the facial legitimacy of any alleged trends, and so on. If you are dissatisfied with the answers, consider other options, like retaining an insurance consultant or attorney to assist you.

5. You're Not Alone, But That is No Reason to Wait

Many, if not most, corporations purchasing health insurance have not traditionally followed the approach that is proposed here. The level of complexity involved in these issues is beyond dispute. The best evidence is that the government regulators, who are the reigning experts, keep pushing back implementation of the enforcement components.

But we are living in a new world of health insurance — and there always is time before your next renewal. If you re-set your focus on these issues, accept that the Affordable Care Act is here to stay and start learning about the various ways that the statute can be of help, you should maximize, or at least improve, your company's position at the renewal table.

About Anderson Kill

Anderson Kill practices law in the areas of Insurance Recovery, Commercial Litigation, Environmental Law, Estate, Trusts and Tax Services, Corporate and Securities, Antitrust, Bankruptcy, Real Estate and Construction, Public Law, Government Affairs, Anti-Counterfeiting, Employment and Labor Law, Captives, Intellectual Property, Corporate Tax and Health Reform. Recognized nationwide by Chambers USA for Client Service and Commercial Awareness, and best-known for its work in insurance recovery, the firm represents policyholders only in insurance coverage disputes — with no ties to insurance companies and has no conflicts of interest. Clients include Fortune 1000 companies, small- and medium-sized businesses, governmental entities, and nonprofits as well as personal estates. Based in New York City, the firm also has offices in Ventura, CA, Dallas, TX, Stamford, CT, Washington, DC, Newark, NJ, and Philadelphia, PA.